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‘It means there is doubt in the house’: perceptions and experiences of HIV testing in rural Malawi

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Abstract

Research on HIV testing decision-making overlooks a complex array of interpersonal factors that go beyond HIV risk and extend into the realms of intimacy, love and marriage. The current study draws upon two sets of qualitative data, semi-structured interviews and focus-group discussions, to investigate how romantic relationships shape HIV testing perceptions and experiences in rural Malawi. It invokes the classical works of symbolic interactionism to frame how people create meaning around the act of HIV testing that fits with their everyday lives. Pre-marital HIV testing was considered an acceptable method to confirm a partner’s trustworthiness and commitment to the relationship. However, during marriage, a spontaneous discussion of HIV testing signified a breach of fidelity or that a partner could not be trusted. This belief was transposed such that an HIV test could also be used to confirm a person’s moral character in the face of infidelity accusations and gossip. Thus, HIV testing during marriage was labelled as an unusual event, one reserved for special or problematic circumstances, rather than for regular screening of disease. A discussion of how these findings can inform HIV testing programmes and policy in sub-Saharan Africa is provided.

Keywords

HIV testing; infidelity; marriage; couples; Malawi

Introduction

HIV testing and counselling (HTC) provides an important opportunity to reduce HIV transmission through education and behaviour change and timely access to care and treatment (VCT Efficacy Group 2000). Despite efforts to normalise HTC in sub-Saharan Africa, the act of testing is not a straightforward process. HIV and its interventions carry symbolic meanings that are embedded within the social and cultural milieu and strongly shape people’s decisions to test (Lupton, McCarthy, and Chapman 1995; Rhine 2009). The successful expansion of HIV interventions requires that policies and programmes more readily acknowledge and incorporate people’s larger life aspirations (or ‘life projects’), which extend into the realms of intimacy, love, marriage and childbearing (Smith and Mbakwem 2007).

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To date, much research on HIV testing utilisation has focused on individual-level concerns (Obermeyer and Osborn 2007), thereby giving less attention to how decisions to test are formulated within the couple context. In this study, two complementary sets of qualitative data were used to understand how romantic relationships shape perceptions and experiences of HIV testing programmes in rural Malawi – a high HIV prevalence setting undergoing rapid expansion in HTC. This research focuses specifically on young people, who are approaching peak ages of HIV infection as they undergo a series of transitions from adolescence, to marriage and then parenthood.

Symbolic interactionism and responses to HIV testing

The classical works of symbolic interactionism provide the overarching framework for this study. Through social interactions, people learn the meanings and symbols that ultimately shape their thoughts, actions and interactions with others (Ritzer and Goodman 2004). According to Blumer's (1969) perspective: (1) people act on the basis of meanings that things have for them, (2) these meanings derive from social interaction and (3) these meanings are modified by their interpretations in practice. In order to understand human interactions and how they shape behaviours, one needs to study people's experiences as they perceive them (Jeon 2004). A symbolic interactionist perspective gives agency to rural Malawians living within the context of an HIV epidemic, rather than assuming they are passive subjects to be fashioned by western HIV policy. Indeed, research on HIV-related interventions designed in the West, but implemented in Malawi, shows that local interpretations and responses differ substantially from how these programmes are intended to function from a public health perspective (Angotti, Dionne, and Gaydosh 2010; Conroy, Yeatman, and Dovel 2013; Kaler and Watkins 2010; Tavory and Swidler 2009). For example, Kaler and Watkins (2010) find that the reluctance to test is connected to the perception that testing inevitably leads to a positive diagnosis and subsequent death, and many would prefer not to live with this uncertainty.

Other scholars have used a symbolic interactionist approach to examine HIV testing within relationships. Rhine (2009) observed that an HIV test is not only a tool designed to illuminate immunological malfunction, but also social facts. She says, 'The virtues and fears embedded in testing are related to larger questions of how families and relationships might change in light of a positive result' (2). HIV test results have meanings that are tied to relationships, faithfulness and trust (Lupton, McCarthy, and Chapman 1995). For women, bringing up testing with a partner could be interpreted as a sign of infidelity or as an accusation of a partner's infidelity – both of which could result in physical violence (Kim and Motsei 2002; van der Straten et al. 1995). Individuals also take HIV tests when they are ending a relationship or starting a new one and, thus, testing serves to mark these important life transitions. In Tanzania, couples used testing to reaffirm their commitment to the relationship (Maman, Hogan, and Kilonza 2001). Similarly, in South Africa, motivations for testing were related to the desire to 'take the relationship to the next level', to get married and have children and to establish trust (Darbes, Dladla, and Mogale 2006). Thus, for some people, testing may be more of a symbolic act than an attempt to confirm perceptions of HIV risk.

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The meaning of HIV testing is formulated not only between sexual partners, but also at the community level as people interact with each other. In the absence of testing, people learned to collectively diagnose AIDS on the basis of social autopsies that combined knowledge of a person's symptomology with his or her sexual history (Watkins 2004). As more people are tested, social diagnoses will evolve to include hearsay accounts of neighbours and acquaintances seen at testing centres – often conspicuously located in community settings. Thus, the act of HIV testing becomes a form of public knowledge that symbolises one's HIV status, moral character and sexual history. In rural Malawi, marital infidelity is a major source of gossip (Swidler and Watkins 2007). White (2000) discusses how rumours and gossip arise in ambiguous situations that prompt people to debate and reconfigure knowledge. Even though there is well-documented social, economic and cultural significance in having extramarital partners (Hunter 2010; Swidler and Watkins 2007), these adaptive strategies conflict with religious teachings that tend to emphasise the moral content of AIDS (Trinitapoli and Weinreb 2012). When people console with traditional healers for problems in their love life, such as a partner's mobility, they may become the subject of gossip and rumour in their villages (Wilson 2012). An HIV test not only contributes to the community perception of a person's moral character, but also of the couple's marital stability – information that many people would prefer to keep private.

The Malawi context

Malawi is a small, resource-poor country located in southeastern Africa, with a population of 13.1 million (National Statistical Office and ICF Macro 2011). The country is divided into three geographic regions: North, Central and South. This study took place in the Balaka district of southern Malawi. The southern region has the highest rates of HIV infection, where an estimated 15% of adults are infected (National Statistical Office and ICF Macro 2011). As opposed to the patrilineal/local north, the south generally follows a matrilineal/local orientation where men physically move in with their wives' families after marriage (Chimbiri 2007; Peters 1997). Rates of divorce are also higher in this region, which may be partially attributed to this marriage system (Reniers 2003). Regardless, most of the major external influences on the region have come from patrilineal and patriarchal groups (Peters 1997). Today, most households are headed by men and the upper ranks of village chiefs are primarily male.

Pre-marital courting practices in Malawi are complex and centre on ritualistic exchanges of gifts, money and sex that are just as much about love and commitment as meeting the financial and sexual needs of young people (Poulin 2007). Before marriage, women have tremendous decision-making control over the process of relationship formation and dissolution, and they use it to avoid HIV infection (Poulin 2007). Marriage itself is nearly universal and occurs at relatively young ages, with the onset of childbearing occurring soon after (National Statistical Office and ICF Macro 2011). Because of poverty, migration and AIDS, many marriages in the region are celebrated in communities, but never officially recognised by government or religious institutions (Mkandawire-Valhmu et al. 2013).

In Malawi, women's level of power is tied to cultural norms that dictate the division of labour – men dominate the domains of sex and finances, while women are in charge of

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decision-making in the domestic sphere (Mbweza, Norr, and McElmurry 2008). Still, women lament that they have little control over their relationships, such as the ability to choose their husbands, to bear children and to have sex or not (Lindgren, Rankin, and Rankin 2005). In Malawi, intimate partner violence is common within marriage (Mkandawire-Valhmu et al. 2013; National Statistical Office and ICF Macro 2011). However, this is not to say that women are completely vulnerable to HIV. Wives also have extramarital partners (Tawfik and Watkins 2007), but they may be less likely to report it as compared to men (Schatz 2005). Other research suggests that women are not helpless in their marriages. For example, wives invoke their social resources to protect themselves from HIV including bringing in marriage mediators, confronting male partners' mistresses directly and leaving a risky partner (Schatz 2005; Watkins 2004). Nonetheless, women's agency is still constrained during marriage, which has significant implications for how women protect themselves and others from HIV (Mkandawire-Valhmu et al. 2013).

There is some evidence to suggest that husbands play a limiting role in their wives' decisions to test for HIV (Kranzer et al. 2009; Mkandawire-Valhmu et al. 2013), yet, recent population-based data show that most women know their HIV status, more so than men. Approximately 73% of women and 53% of men had ever been tested for HIV as of 2010 (National Statistical Office and ICF Macro 2011). HIV testing and counselling is currently offered through integrated heath services, including antenatal care, and at standalone testing centres, clients' homes and workplaces.

Methodology

In this study, two sets of qualitative data, semi-structured interviews and focus-group discussions (FGDs), were analysed to understand the meaning of HIV testing within a romantic relationship. Semi-structured interviews were selected in order to gain deeper insight into specific experiences of individuals, as compared to group interviews, which generally elicit normative behaviour. Conversely, the FGDs helped to extract information on general perceptions, beliefs and norms around HIV testing that would be difficult to capture individually.

Couple interviews

In 2009, interviews with romantic couples were conducted alongside a longitudinal study on AIDS and reproduction called *Tsogolo La Thanzi* (TLT – 'Healthy Futures' in Chichewa). For the couple interviews, purposive sampling was used to select three distinct geographical areas in order to obtain a diverse set of experiences: (1) Balaka town, (2) a trading centre village and (3) an isolated rural village. It was anticipated that perceptions and experiences of HIV testing would vary based on the level of exposure to health services in these areas. After selecting six villages as the final catchment area, a random sample of dating and married women (n = 90) aged 18 to 24 was selected from a household listing collected as part of TLT. Women were approached at their homes and asked to participate in the study. If the women agreed, their primary male partner[1] (husband or *chibwenzi*[2]) was also recruited

[1]See Angotti (2010) for more details on World Health Organisation policy changes that led to the use of the acronym HTC.

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and asked to participate. When respondents could not be located or did not have a partner, the research staff attempted to locate the next person on the list. Using audio recordings, research assistants immediately translated and transcribed their interviews word-for-word from Chichewa to English before moving onto the next interview. This process allowed the study investigator to review the transcripts for emerging themes as the data were collected. The couple interviews continued until saturation points were reached and no new themes emerged (Strauss and Corbin 1998).

In order to minimise social desirability bias and help respondents feel comfortable, two research assistants were matched by gender and age with the respondents. Given that decision-making and communication often falls within the husband's domain, it was expected that female respondents would be less likely share their true opinions with a male interviewer. Research assistants followed a guide but were trained how to probe respondents and conduct unobtrusive interviews so that fuller responses and new themes could emerge spontaneously. Partners were interviewed simultaneously, but separately, in private locations in order to prevent them from communicating between interviews and potentially biasing the findings. Respondents were asked questions such as: have you and your partner discussed getting tested for AIDS? If so, tell me what you talked about. Why did you decide to test? How did you feel about getting tested? Has anything changed in your relationship after testing? Interviews were conducted with 17 women and their male partners (34 individuals) and lasted from 45 to 80 minutes. All respondents' names were anonymised.

Focus-group discussions

In 2011, FGD respondents were recruited from the same three geographical areas as the interview respondents. FGD respondents had to be between 16 and 24 years old, but married if under the age of 18. Respondents were grouped into separate FGDs by gender and marital status to help them feel comfortable. Two English-speaking research assistants, who were matched by gender and age to the respondents, facilitated the FGDs in Chichewa. Three different sites were selected to conduct the FGDs, each with varying degrees of formality: (1) a teacher development centre in Balaka town, (2) an immunisation clinic in a trading centre village and (3) under a shady tree in a rural farming village. During the FGDs, respondents were asked to share their perceptions and attitudes, rather than their own personal experiences.

Following a similar approach used by Angotti and colleagues (2010), respondents were presented with a series of vignettes on HIV testing involving a hypothetical couple named 'Lucy' and 'Promise' who faced difficulties negotiating testing. The group was then asked for their recommendations on what the couple should do and why. For example, Lucy thinks her husband Promise has another sexual partner and she is worried about HIV. A chain of questions followed such as: should she go for testing on her own? Does she need her husband's permission to test? What if the couple was not married but dating, is she still obligated to tell her partner of her plans?

[2]Chibwenzi is the Chichewa word (gender neutral) for a sexual partner outside of marriage, usually the equivalent to a boyfriend or girlfriend.

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Eight FGDs were conducted with 7–8 participants each, for a total of 62 respondents. The FGDs lasted between 75 and 120 minutes and were audio-recorded. Each facilitator translated and transcribed their FGDs from Chichewa into English word-for-word. During transcription, respondents were assigned a number based on the first time they spoke in the interview. Respondents who could not be identified by the transcriptionist were labeled with a question mark (i.e., 'Man?' instead of 'Man #2').

Data analysis

The data were coded in *Atlas.ti* (interviews) and *Microsoft Word* (FGDs) using the inductive approach outlined Strauss and Corbin (1998). Coding began as an open coding process, in which *a priori* codes were assigned to text in a systematic manner by examining the transcripts line-by-line. As the coding continued, existing codes were modified or deleted and new codes were continuously added until all transcripts were coded. After open coding, axial coding was used to specify the relationship between codes and to group codes into categories. The final coding step was selective coding, or the process of integrating and refining categories. In this stage, the codes were organised around a central, unifying core category that reflected the main actions and events described in the FGDs. After coding the FGDs, the semi-structured interviews were examined to substantiate whether the perceptions, beliefs and norms around HIV testing found in the FGDs were reflected by people's lived experiences. In what follows, three themes that centre around the idea of 'trust' are presented. Other scholarly work from Malawi was incorporated into the analysis in order to provide context and depth to the findings.

Findings

Sample characteristics

For the semi-structured interviews (n = 34), 6 couples were dating and 12 couples were married. The average age of men and women was 23 and 21 years, respectively. Of the 17 couples, 8 resided in Balaka town villages, 5 resided in a rural village and 4 resided in a trading centre village. For the FGDs (n = 62), half of the sample was married. The average age of men and women wasere 21 and 20 years, respectively. The sample was split almost evenly between having primary school and secondary school education. Approximately half of the respondents resided in Balaka town, 26% resided in the trading centre village and 24% resided in the rural villages.

The relationship ideal of 'testing before marriage'

Finding an HIV-negative partner is of critical importance to young people contemplating marriage (Clark, Poulin, and Kohler 2009). In today's era of HIV testing, young people are likely to take advantage of more accurate ways to assess a partner's HIV status. Almost immediately after being asked to describe a perfect relationship, respondents from six of the eight FGDs mentioned the importance of going for voluntary HIV counselling and testing (VCT) together while dating. Respondents in FGDs provided a variety of different reasons for why couples do and should get tested during courtship, such as to determine if a *chibwenzi* is marriage material or when a couple begins to fall in love and have sex.

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There was evidence among the interview respondents that these ideals were sometimes carried out in everyday life. Beyond fears of AIDS, important ‘life projects’, such as marriage and desires for intimacy, trust and closeness with a premarital *chibwenzi*, were deeply embedded in testing decision-making. For example, pre-marital testing was believed to be an important and symbolic step towards advancing a relationship. Several single men informed us that they got tested during courtship as a way to demonstrate their trustworthiness and dedication and, sometimes, to convince a partner to have sex. One young dating man, named Dalitso, shared a conversation he had with his girlfriend about getting tested for HIV before they had sex for the first time.

Interviewer:	Who started this issue of VCT?
Dalitsto:	The girl told me and we agreed not to have sex until we get tested. I asked her to sleep with me. She said first we were to get tested then continue with using *chishango* (a popular brand of condoms in Malawi).
Interviewer:	What was she afraid of?
Dalitso:	I can say two things. She was afraid of these venereal diseases, STIs and pregnancy. This time she was just a girl, still in school. Remembering the bad times we are in [referring to HIV/AIDS], I knew she was saying the truth and I agreed to go with her for VCT. (semi-structured interview, male #3, age 25)

It is notable that his initial reason for testing was to sleep with his girlfriend and to build intimacy, not to prevent HIV. For other people, future aspirations around marriage and childbearing weighed heavily into their decision-making. In the following passage, a married woman named Grace recalled about how she pressured her partner to go for testing before she would officially commit to marrying him:

Grace:	Before we got married, we went for HIV testing. After we went for testing, we got engaged.
Interviewer:	What made you go for testing?
Grace:	We wanted to know my and his status on HIV. I told him that if you want to marry, go for HIV testing first.
Interviewer:	What did he say?
Grace:	He agreed and he said that he will go. So he went and before that time we didn’t do anything.
Interviewer:	What are you trying to say when you say you didn’t do anything?
Grace:	Um, before we started having sex. Yes. So we went for testing first so that we could know how our bodies are. (semi-structured interview, female #4, age 19)

These accounts are consistent with courting practices among young people in Malawi, in which women demonstrate considerable control over the relationship terms (Poulin 2007).

In the current study, respondents also believed pre-marital testing helped couples plan out their families – as suggested by a woman named Edith in the next passage:

Interviewer:	May you explain to me the conversation you had about it [HIV testing]?

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Edith:	We said that our wedding day is near, and before it is reached, I would love if we could go for testing so that we can know how our blood is so that we can have a happy [healthy] family. Then we agreed to go.
Interviewer:	Who was saying that?
Edith:	It was him but still we both had the same thoughts [idea to test] because these days you can't just get married before going for blood testing. (semi-structured interview, female #16, age 21)

At first, Edith talked about how her husband insisted on testing so they could have healthy children, but as she continued, her reason for testing refocused on the marriage itself. One is left to wonder if Edith and her partner are really testing so that they can safely continue with their marriage plans. By using concerns about the children as a way to justify testing, the couple could effectively circumvent the negative association between trust and testing and avoid falsely accusing each other of sexual promiscuity.

But to the contrary, FGD respondents pointed out that not everyone gets tested during courtship and this is how a person can become entangled in a complicated web of love, sex and HIV. Other research from rural Malawi shows that ideal relationship sequences, for example getting tested for HIV then having sex, do not always translate into real-life events (Frye, Trinitapoli, and Namadingo 2011) While some couples may avoid having awkward conversations, other couples may simply get caught in the moment and end up having sex before they intended, as suggested by the man below:

Man #3:	A good relationship is the one that when you have proposed each other and you go for testing. If you are really in love, you can have sex when you get married but also after you go for testing. That's a good courtship.
Man #5:	My idea is the same that in a relationship you should start sleeping with each other after you have gone for testing. But if you find that you are okay [without the virus], you should still use condoms. It can help.
Man #3:	But perhaps we want to have sex with the woman before we know our status.
Man #8:	Maybe the woman had sex with someone that is HIV-positive and she did not go for testing. But maybe you went for testing and you are okay [HIV-negative]. So you get caught in the cobweb and you are found in the group of people being infected. (FGD #8, single men, age 18–24)

In the above passage, the first man took on a relationship-centred as opposed to a risk-centred narrative when discussing the benefits of early testing – evidenced by his references to 'love' and 'a good courtship'. While the other men appeared to be more focused on HIV risk, they still conceptualised risk as embedded in the relationship context – it was perceived to be too dangerous to rely solely on one's own HIV status.

The incompatibility of HIV testing with marriage

While HIV testing was portrayed as a necessary precaution for dating couples, HIV testing during marriage was considered problematic. This suggests that HIV testing may be incompatible with marriage because it goes against ideals of trust, love and intimacy that couples strive for in their relationships. In general, respondents believed that married couples who love each other and have no reason to suspect cheating would have little reason

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to test. In the following passage, a single man summarised the general belief that testing during marriage raises questions of faithfulness:

> Testing has to start while in a relationship [dating]. You have to tell each other to go for testing while in a relationship not just when you are married because if you do [wait until marriage to test], you might start having doubts about the partner, for example, asking why all of a sudden she wants to go for testing? Has she been sleeping around with men? (FGD #3, single men, age 19–22)

When asked about why married people typically go for HIV testing, a female FGD respondent answered, ‘Mostly, it is because of the lack of trust in the relationship and in doing so, they are able to know the truth so that they live happily after knowing their status’ (FGD #1, married women, age 16–24). Simply bringing up conversations around HIV testing with a spouse symbolised mistrust and deception and could lead to major disagreements. In the first HIV testing vignette, ‘Lucy’ ponders whether she should tell her husband about her desire to get tested. A married man shared his thoughts on bringing up testing unexpectedly with a spouse:

> Because by just saying that we should go for testing, it means there is doubt in the house. You can go for testing, but it doesn’t just come up like ‘let’s go for testing’, no. But when there is doubt [mistrust] in the house, like how is my partner moving [behaving sexually]? If I think he is cheating, that’s when you go for testing. But if you are not doubting [trusting] each other, you’ll see that even if people say that others are getting tested over there [referring to a testing facility], you don’t consider it. (FGD #6, married men, age 23–24)

As the young man in the passage above insinuated, HIV testing during marriage was labeled as an unusual event, one reserved for special or problematic circumstances, rather than for regular screening of disease.

The interviews illustrated how negative perceptions of HIV testing during marriage corresponded with people’s lived experiences. In the following account, a married woman named Ruth lamented how her husband thought HIV testing was for people who suspected they were HIV-positive and therefore he refused to go. As a consequence of his response, she started to question his faithfulness as well as his HIV status:

Interviewer:	So when you went for testing did you tell your husband or you just went?
Ruth:	I told him that there was no reason to be afraid of knowing how your blood is but he denied [refused to go], so I went by myself. So he was saying I was doubting myself.
Interviewer:	Alright, so did you encourage him to go one day or did you just give up?
Ruth:	No, I didn’t give up, I always tell him. The first time I went I told him that you should also go so that we can have proof that we are alright, but if you don’t then I will be having doubts that maybe my husband is positive or negative. I will not be sure. The second time I went I told him the same thing, but to no avail.
Interviewer:	So what does he really say, I’ll go later or I can’t go?
Ruth:	He says that he can’t go, that those who go for testing are doubting themselves [think they could be HIV-positive because of past sexual behaviour]. They

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	don't trust themselves.
Interviewer:	How do you feel when he answers you that way?
Ruth:	It pains me. I see that he is not helping me and the children. (semi-structured interview, female #10, age 23)

In another interview, when a married man named Francis was prompted about whether he tested a second time, he replied, 'As of now, we don't think of getting tested again. My friend, what encourages you to have that feeling is a lack of trust in your partner. You cannot go to VCT, you can only damage the love now' (semi-structured interview, male #4, age 21). Testing for HIV was considered more acceptable during the early stage of a relationship, but inappropriate for those who were already in a relationship defined around unquestioning trust and love.

HIV testing for fidelity confirmation

In general, respondents talked about HIV status as if it was an absolute indicator of marital fidelity. Smith and Watkins (2005) found that Malawians vastly overestimated their chances of infection through a single sexual encounter with an infected person – men worried about their extramarital partners as a source of infection while women worried about their husbands' affairs. In another study from Malawi, marital infidelity was found to be the strongest correlate of overestimating one's own and a spouse's risk for HIV (Anglewicz et al. 2008). According to this logic, married people who were cheating and later found to be HIV-positive would presumably have become infected through these extramarital affairs. In the current study, the narratives suggest that an HIV test could also be used to prove one's faithfulness. For example, in a conversation about jealousy, single women shared their beliefs about how rural villagers could destroy a healthy marriage by spreading rumours about a couple's HIV status and sexual history. One woman pointed out that HIV testing was one way to prove to your spouse (and your accusers) that you weren't cheating – and, by extension, that you did not have HIV:

Interviewer:	So people can go and say your woman has done this and that [referring to cheating]?
Woman #1:	They can lie that the women has diseases when she doesn't have diseases.
Woman #3:	But, if you love each other you can go for testing. They can spread lies, but you can say [to your husband] that if you love me, let's go for testing so that you believe that I don't have [HIV]. (FGD #2, single women, age 18–24)

In Malawi, men are cognisant of the dominant HIV-prevention discourse that blames unfaithful married men for transmitting HIV to their wives. While this belief may deter some men from testing, it may motivate others who wish to exonerate themselves of any infidelity charges. In the following interview excerpt, a married man named George described how he used HIV testing as a way to prove his faithfulness to his wife:

Interviewer:	Who started talking about this issue [testing]?

George:	I am the one.
Interviewer:	What made you to do this?
George:	We wanted to promote trusting each other. We wanted to remove [stop] doubting each other. Just because many times the blame goes to the men, with women saying 'you are the one who brought the virus to me'. Then I decided that we should just go and be tested.
Interviewer:	What was her reaction to this issue?
George:	She was happy and agreed. She said she will follow what I was saying because I am the head of the family. (semi-structured interview, male #9, age

In these scenarios, it is conceivable that HIV testing may provide a ritual for dealing with relationship issues such as infidelity. Long before HIV spread to the region, Malawians consulted with traditional healers for problems with family members (Wilson 2012). In the case of witchcraft, victims were usually intimately involved with the perpetrators as their lovers, relatives or workmates, who then acted out of jealousy to cause harm (Ashforth 2002). Those who turn to diviners or other spiritual experts for remedies must first attribute their illness to a relationship gone wrong. In the context of the HIV/AIDS epidemic, Malawians may blend these health beliefs with Western diagnostic techniques and conceptualise HIV testing more as a way to diagnose or clear up a relationship issue with a spouse or neighbour than to diagnose HIV infection.

Sometimes, however, HIV testing prompted more questions than answers. Several FGD respondents pointed out that just because a person tests positive, it does not mean they necessarily cheated – a spouse could have been positive before marriage and contracted HIV through non-sexual routes, such as during birth. One strategy to retrospectively assess *when* a spouse became infected with HIV was by going for testing during courtship. In the following group of married men, they discussed how failing to go for testing at the start can lead to false accusations of infidelity during marriage:

Man #2:	The problem is when you are proposing a girl, she does not tell you that she has the virus.
Man ?:	But together, you can make the decision of going for testing at that particular time.
Man #4:	It just goes wrong in the beginning because you did not take each other for testing.
Man #7:	Because we can think of the woman as being a bitch [cheater] when she is not. The problem is really based in the beginning when you did not go for HIV testing. (FGD #4, married men, age 20–24)

As the above passage suggests, pre-marital testing provides a baseline measurement to use in future judgment around cheating. If a man or woman tested negative before marriage, but positive afterwards, his or her faithfulness could be questioned and a divorce may be justified. But without this additional piece of knowledge, it becomes difficult for partners to assess faithfulness using current serostatus alone. They come to rely strongly on subjective assessments of a partner's infidelity, which are often less reliable. Indeed, in rural Malawi, Anglewicz and colleagues (2008) found that couples' perceptions of a partner's risk and their actual risk are often mismatched, possibly leading to premature divorce or breakup.

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Discussion

Bringing up testing, refusing to test and testing together are a few examples of the discursive acts used to create meaning around the act of HIV testing. Through these social interactions, rural Malawians utilised the local symbols and signs associated with the act of HIV testing as tools to simultaneously navigate the AIDS epidemic and their relationships. Within pre-marital partnerships, it was considered advantageous for young couples to test together in order to advance a relationship or dissolve a problematic one that could later result in HIV infection. However, during marriage, these same interactions signified an unstable relationship and could result in tension or conflict that could have been avoided earlier. These findings are, however, based on the perceptions and experiences of young people, who may differ dramatically from older generations of married couples with more established relationship patterns. Regardless, this conundrum around HIV testing is likely to be a universal problem, not just in Malawi. Other research from the West, for example, suggests that HIV testing is generally perceived as something done at the start of a relationship and right after a breakup, rather than routinely throughout (e.g., Lupton, McCarthy, and Chapman 1995).

In rural Malawi, and probably throughout the region, HIV risk is at constant odds with other ‘life projects’, such as marriage and childbearing. Scholars have noted that marriage remains one of the most important aspirations an individual can achieve (Smith and Mbakwem 2007). For young couples in the prime of their reproductive lives, an HIV test was more than a marker of HIV serostatus – it also symbolised their relationship status. As others have noted, relationship risk management during the HIV epidemic will require synchronised efforts to protect relationships as intimate, loving and secure, while preventing HIV infection at the same time (Cusick and Rhodes 2000).

This study adds to a growing body of literature that highlights a disconnect between how international HIV policies are intended to function and how they are interpreted at the local level through the process of symbolic interactionism. The findings from this study highlight three examples. First, rural Malawians acknowledge that risky sexual behaviour warrants an HIV test. However, the process of HIV testing requires that people first identify as at-risk for HIV infection (Lupton, McCarthy, and Chapman 1995). Thus, testing publicises to others that one has engaged in so-called ‘risky’ sexual behaviour. Early on in the AIDS epidemic, when testing programmes were rolled out, prevention messages and mass-media campaigns may have inadvertently undermined their own initiatives by emphasising testing for high-risk individuals, such as sex workers. These efforts created long-lasting attachments to the belief that HIV testing was reserved for those who exhibit such behaviours, not faithful married couples.

Parallels can also be drawn from what others have observed regarding the use of condoms during marriage (Chimbiri 2007; Tavory and Swidler 2009). Given their association with high-risk sex, condom use within committed partnerships symbolises a relationship characterised by mistrust, instability and immorality (Smith 2009). Similarly, HIV testing may violate core ideals around love and trust that spouses strive for in their relationships. From a public health perspective, these conflicts between marriage and HIV testing cannot

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be ignored. In sub-Saharan Africa, serious partnerships such as marriage are the place where most new HIV infections occur (Dunkle et al. 2008), making routine marital testing an important point of intervention.

Second, HIV testing programmes often appeal to the human right – a characteristic of individuals, rather than couples – to know one's HIV status (Temmerman et al. 1995). However, in Malawi, it was difficult for some respondents to disentangle the individual from the relationship itself. Thus, there is a strong need to incorporate the couple context into efforts to target individuals and their personal liberties and freedoms. Rights-oriented screening programmes for HIV may also conflict with local values and priorities in Malawi. In settings with good access to health services, people are more likely to see the value in prevention and early detection of disease. In Malawi, however, people required strong reasons to initiate HIV testing when there was no perceived need. Furthermore, it has been argued that AIDS-related concerns simply may not make the list of top priorities in everyday life (Dionne, Gerland, and Watkins 2013).

Finally, international policy emphasises confidentiality as a key component of HIV testing (WHO 2012). However, these top-down approaches do not always translate into resource-poor settings (Angotti 2010, 2012). In rural Malawi, for example, waiting in long lines at overcrowded HIV testing centres that are specifically designated for people who desire to learn their HIV status, threatens people's privacy and personal character. Mburu (1977) writes that southern Malawians are, 'very reluctant to admit to an illness because this would imply … they have committed a moral transgression'(167). Indeed, when rural Malawians were offered door-to-door rapid HIV testing in the privacy of their homes, they were highly receptive to testing (Angotti et al. 2009).

In conclusion, the success of HIV testing programs and policies in sub-Saharan Africa hinges upon our understanding of the local perceptions and experiences with these services. Recently, there have been calls for the urgent scale up of HIV testing with an emphasis on couples and a goal of universal coverage (Bunnell and Cherutich, 2008). In theory, provider-initiated testing may circumvent an exceptionally complex negotiation process for couples who desire to know their status by shifting the burden to the healthcare system. Advances towards universal testing are currently underway in Malawi. However, there are warning signs that these programmes may not align with women's and their partner's desires to test (Angotti, Dionne, and Gaydosh 2010). If universal testing is to be effective and ethical, programmes need to consider both partners and strive to achieve balance between the right to know and not to know one's HIV status.

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