PREGNANCY PREVENTION AND THE RIGHT TO CONTROL FERTILITY BY YOUNG WOMEN AGED 15 TO 24 YEARS: A CASE STUDY OF LILONGWE PERI URBAN AREAS, MALAWI

BY
Elita Thokozani CHAYALA

Supervisor: Professor J. Stewart

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Abstract

This dissertation seeks to explain why, despite the sufficient funding to implement its policies which are inspired by its laudable Human Rights commitments, the Malawi Government persists in its failure to help its young women realise their right to understand and effectively manage their reproductive health. As a result the country continues to suffer the highest percentage of unwanted pregnancies in Sub-Saharan Africa. This occurs mainly within the poor peri-urban areas of Lilongwe, Malawi's capital city, from five of whose schools the writer critically draws most of the female respondents for this study. Intent upon revealing this problem from the point of view or lived reality of these unfortunate women, the writer effectively uses the Women's Law Approach to initiate and direct her research. It allows her to apply several helpful methodologies (including the Human Rights and Sex and Gender approaches) to the evidence of the problem in such a way that they reveal many of its critical gender-related aspects which would remain undetected by more traditional and less gender-sensitive methods of research. Adopting a strictly grounded approach to the work, the writer scientifically collects, analyses and presents her findings based on a wide range of evidence, including relevant literature and law on the subject as well as evidence recorded directly from the respondents, family members, community leaders and relevant key informants within government and non-government bodies. She finds that young women remain ignorant of their reproductive rights and become susceptible to abuse because of, among other things, (1) the social, cultural and religious resistance to providing sex education to unmarried girls/women and (2) the government's failure to subject its impressive reproductive health policies to thorough gender impact assessment tests; if it did so it would discover, among other things, the crucial gender-related reasons why girls and women such as the respondents are unable to access its elaborate inter-Ministerial reproductive health facilities and programmes. The writer finally suggests several helpful recommendations, including: amending the abortion laws; raising the minimum marriageable age to 18 years; sensitising parents, teachers, community, religious leaders and all health workers to the importance of early and well-informed sex education for children.

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Declaration

I Elita Thokozani Chayala certify that this dissertation is my original work; it is an honest and true effort of my personal research. I certify that the work has not been presented anywhere else before any other thesis.

Signed……..

Date……

The dissertation was submitted for examination with approval as the University Supervisor

Signed…….

Date…….

PROF. JULLIE E. STEWART
Director of the Southern and Eastern African Regional Centre for Women's Law

Date……..Signed……

Dedication

This dissertation is dedicated to all young women aged 15 to 24 years

To my late parents,
Charles and Eunice Chayala

My husband,
Lawrence Chifundo Yobe

My Daughter,
Laureen Thokozire Yobe

My Son,
Laurent Thokozani Yobe

My Niece,
Faith Alinafe Makina

For the moral support and encouragement in my academic life.

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Acronyms

AIDS	Acquired Immune Deficiency Syndrome
BPfA	Beijing Declaration Platform for Action
CEDAW	Convention on the Elimination of Violence against Women
CRC	Convention on the Rights of the Child
FGD	Focus Group Discussion
ICESCR	International Convention of Economic, Social and Cultural Rights
ICPD	International Conference on Population and Development
HAS	Health Surveillance Assistants
HIV	Human Immune Deficiency Syndrome
MIE	Malawi Institute of Education
MOE	Ministry of Education
MOH	Ministry of Health
NAC	National AIDS Commission
NGO	Non Governmental Organization
SEARCWL	Southern and Eastern African Regional Centre for Women's Law
SRH	Sexual Reproductive Health
SRHR	Sexual Reproductive Health Right
STI	Sexual Transmitted Infection
YFHS	Youth Friendly Health Services
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund

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Child Care Protection and Justice Act 22 of 2010 of Malawi
Malawi Constitution 1995
Malawi Penal Code 2003
Malawi Abortion Policy
National Sexual Reproductive Health and Rights (SRHR) Policy
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List of International and Regional Human Rights Instruments cited

International Covenant on Civil and Political Rights (ICCPR)
International Covenant on Economic, Social and Cultural Rights (ICESCR)
African Charter on the Rights and welfare of the Child (ACRWC)
Convention on the Rights of the Child (CRC)
Elimination of all forms of Discrimination against Women (CEDAW),
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Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa (Women's Protocol)
Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa (Maputo Protocol)

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International Conference on Population and Development (ICPD)
Beijing Declaration Platform for Action (BPfA)

CHAPTER ONE

1.0 INTRODUCTION TO THE RESEARCH

1.1 Introduction

Young women in Malawi have challenges in preventing unwanted and unplanned pregnancies. The challenges contribute to their failure to enjoy their right to reproductive health because they end up reproducing offspring without planning. In this thesis the phrase '*fertility rate*' is used interchangeably with the word '*prevalence*' of pregnancy. This is the case because relevant statistical documents on the subject refer to the prevalence of pregnancy and/or the fertility rate of all age groups, including adolescents. The Malawi Demographic health surveys and Population and health census use the term 'fertility rate' for all age groups even when they are seem to be referring to the prevalence of pregnancy. '*Fertility*' means fruitfulness or productiveness. In human beings it means the ability of being able to reproduce off-spring. For adolescents (15-19), the research's focus is on pregnancy prevention because the recommended minimum age for the child bearing is 18 years. It is only at this stage that women are biologically mature enough to bear children. For the young women (20-24) the focus is on both pregnancy prevention and fertility control. For the young women aged 20 to 24 years both aspects are considered because some of them are still pursuing their education and others are already married. Therefore, the fulfilment of their reproductive right is their ability to prevent unwanted and unplanned pregnancy.

The choices young women make about their fertility have an impact on their careers and personal development. As people who are still in the traditional learning process, seeking their identity and being sexually active, they need to make informed choices and decisions about their reproductive health, especially fertility.

1.2 Background of the Study

The study was conducted in peri-urban areas. A peri-urban area is a transitional and an interactional zone where urban and rural activities co-exist. I chose Peri-urban areas because it has socioeconomic system which rural and urban administrators neglect. More than 70% of

people living in peri-urban areas are poor and cannot afford their minimum daily nutritional intake of food (Duncan et al, 2006). My interest was to find out how unmarried young women both in school and out of school manage their sexuality and reproductive capacity in peri-urban areas. A major concern is that many forces are at play in the peri-urban situation which creates the undesirable circumstances which give rise to young women having unwanted and unplanned pregnancies. Poverty is one of the major factors that impact on young women. Some end up dropping out of school and going straight into early marriages. In the marriage, most of the young women start childbearing too early which, in turn, leads into premature motherhood.

Motherhood at an early age has a long term adverse impact on the quality of life in terms of educational and employment opportunities (Beijing Platform for Action paragraph 268). It is very detrimental to those who are less educated because they tend to suffer higher school drop-out rates than their better-educated counterparts. The difference is that the more educated woman is more empowered to cope with the additional burden of her gender-imposed chores while simultaneously pursuing her economic interests and social development. However, the less educated woman who may not be able to adjust, may forfeit her future employment opportunities as a result of school dropout caused by unplanned pregnancy.

The aim of the study was not to promote sexual immorality. The purpose was to explore how young women may be assisted in making informed decisions about their reproductive life. Unprotected sex leaves a young woman vulnerable to both unwanted pregnancy and to the contraction of Sexually Transmitted Infections (STIs). For young women, the use of condoms is encouraged because it has the dual function of preventing the contraction of Sexually Transmitted Infections and pregnancy. Contraceptives on the other hand, only help to prevent pregnancy; one may still contract Sexually Transmitted Infections and HIV while using them. In most cases, condoms work for those who are not married because have more freedom to make an independent decision whether or not to use them; married women, on the other hand, should consult their sexual partners.

The motive to conduct this research study is the belief that, with access to accurate and appropriate information on Sexual Reproductive Health and services, young women will

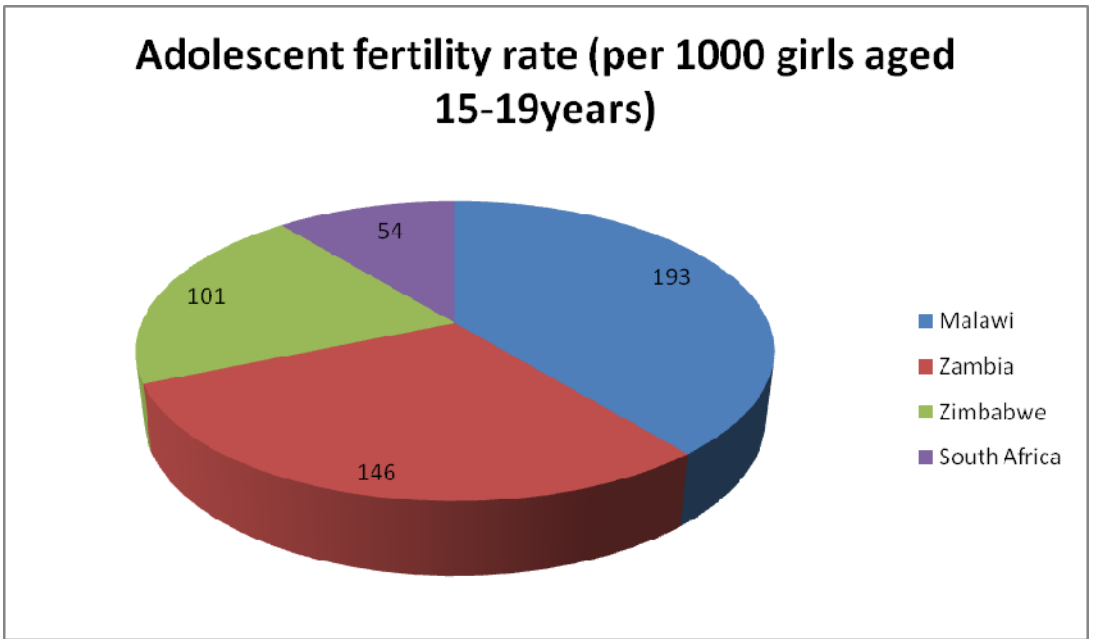
make better choices about their reproductive health. With better choices, young women will be able to protect themselves from catching Sexually Transmitted Infections (STIs) including Human Immune Virus (HIV) and unwanted pregnancies.

1.3 Problem Statement

According to a Malawi Demographic Survey carried out in 2010, 26% of young women aged 15-19 had already begun child bearing: 20% were already mothers and in addition a further 6% were pregnant. The other reason that has contributed to high fertility rates in Malawi is a lack of knowledge about contraceptives. The Demographic Health Survey for 2004 established that 95% of adolescents had no knowledge of contraceptives. An intervention in response was the establishment of Youth Friendly Health Services in 2007 (Malawi Government; 2010). However, the findings of the 2008 Population and Housing Census confirm that the programme is yet to produce tangible results.

The examination of the age pattern of fertility rates during the 2008 Population and Housing Census shows that the peak of child bearing in Malawi occurs during ages 20-24. The same age pattern was observed in 2004 Malawi Demographic Health Survey (Malawi Government, 2010). Some young women aged 15 -24 may have unwanted pregnancies which they either carry to full term or abort. When they carry to full term, they miss out on educational opportunities. This is because they either postpone their education or do not go back to school. When they abort, they put their health at risk or even lose their lives. Figures for the study on strategic assessment of unsafe abortion in Malawi revealed that 20% to 30% of girls left school due to unwanted pregnancies, and that although the education re-entry policy allows them to go back to school, very few did so (Jackson et al, 2011). The high rate of adolescent pregnancy in Malawi is a very serious problem that needs to be addressed. Malawi, as compared to other countries in sub-Saharan Africa, has the highest rate of adolescent pregnancy which is referred to as '*adolescents' fertility rate*' in the 2008 population and housing census, analytical report; volume 8 of Children and Youth (Malawi Government, 2010).

Figure 1: A pie chart showing the adolescent fertility rates (Adolescents' Pregnancy prevalence) of Malawi and three other Sub-Saharan African countries



Both Malawi and South Africa have ratified the International and Regional human rights instruments that address the issue of Sexual and Reproductive Health. One of the main reasons for this is the socio economic situation whereby South Africa is much better off financially and able to implement its policies more effectively than compared with Malawi. South Africa has put population concern in all its development strategies and has worked towards fulfilling that goal by allocating enough resources for it (Malebo: 2002).

In view of the aforegoing, I decided to conduct a study on the right to pregnancy prevention and control of fertility for young women aged 15 to 24. The prevalence of pregnancy and high fertility rate for this age group which is the highest of all the age groups in Malawi, necessitated study age brackets. Instead of having the highest fertility rate, young women at this stage should be preparing for the long life ahead of them. The young women in this age group are either in primary or secondary school or undergoing tertiary education. Some are already married and have children but controlling their fertility can help them concentrate on other things that contribute to their development, rather than putting all their energy into motherhood. It is very necessary that reproductive function of women should not impede their pursuit of their careers or choice of work.

1.4 Point of Departure

As a non-lawyer, I have always looked at this issue from a social perspective. With the knowledge acquired in the women's law course, I decided to go back into the field and approach the issue from a human rights point of view. From the onset of the research, I went through the international and regional Human Rights Instruments that Malawi has ratified in order to understand the obligation Malawi has. I started with checking the human rights instruments Malawi ratified because I found that it was one of the best ways to find out how young women have benefited from policies and strategies on reproductive health. In the Women's Law course, I was informed that, using international standards, exploring different ways of assessing and implementing compliance within the international, regional and local context is an appropriate way to monitor and stimulate development which effectively benefits women (Stewart, 2011:32).

1.5 Objectives of the Study

The objectives of the study were:

1. To unearth challenges young women in Lilongwe Peri-urban areas face in order to prevent pregnancy and control their fertility.

2. To analyze efforts made to assist the young women in Lilongwe Peri-urban areas to access contraceptives.

3. To assess how the law affects young women's right to prevent pregnancy and control fertility.

4. To identify ways of addressing problems the young women in Lilongwe peri-urban areas face in relation to pregnancy prevention and control of fertility.

1.6 Research Assumptions

The following assumptions informed the research:

1. Young women aged 15 to 24 years are having sex before marriage.

2. Young women aged 15-24 years are having unwanted pregnancies.

3. Young women do not have accessible, appropriate and accurate information about sexual and reproductive health.

4. Culturally and religiously, young women aged 15 to 24 years are not expected to have sex before marriage.

5. Cultural beliefs, religious beliefs and the attitude of some health personnel hinder young women from accessing contraceptives.

6. There is a gap between National Sexual and Reproductive Health Right policies and their implementation.

7. There is no suitable strategy or clear information dissemination about contraceptives.

1.7 Research Questions

The following research questions were based on the abovementioned research assumptions.

1. Are young women aged 15-24 years having sex before marriage?

2. Are young women aged 15-24 years having unwanted pregnancies?

3. Do young women have enough, appropriate and accurate information about sexual and reproductive health?

4. Are young women aged 15-24 years expected not to have sex before marriage in keeping with their religious beliefs and their culture?

5. Do cultural beliefs, religious beliefs and attitude of health personnel towards young women prevent them from accessing contraceptives?

6. Is there gap between National Sexual and Reproductive Health Right policies and implementation?

7. Is the information dissemination on contraceptives proper and clear?

CHAPTER TWO

2.0 HUMAN RIGHTS BASED REVIEW

Malawi has signed and ratified most of the international and regional Human Rights instruments with recommendations on Sexual Reproductive Health (SRH). The following are the human rights instruments that Malawi has ratified. The first is the International Covenant on Economic, Social and Cultural Rights which provides for the highest attainable standard of health for everyone.

Article 12 of the International Covenant on Economic, Social and Cultural Rights provides the fundamental formulation of the right to health. It obliges states parties to the present covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. The International Covenant on Economic, Social and Cultural Rights also provides steps to be taken by the states parties to the present covenant to achieve the full realization of the rights. The Malawi Constitution recognizes the right to health as a directive principle of national policy as stated in Section 13:

> *"The state shall actively promote the welfare and development of the people of Malawi by progressively adopting and implementing policies and legislation aimed at achieving the following goals:*
>
> *13 (C) Health*
>
> *To provide adequate health care, commensurate with the health needs of Malawian society and International standards of health care."*

The implication is that an individual cannot claim this right by appealing to a court. However, an individual can claim his or her right to health by appealing to court using the right to development through which the state can take measures to provide opportunity to access to health services as stated is section 30:

> *Right to development, Section 30*
>
> *Section 30 (1)*
> *All persons and peoples have a right to development and therefore to the enjoyment of economic social and cultural and political development and women and children*

and the disabled in particular shall be given special consideration in the application of the right.

Section 30 (2)
The state shall take all necessary measure for the realization of the right to development such measures shall include, amongst other things, equality of opportunity for all in their access to basic resources, education, health services, food, shelter, employment and infrastructure.

The International Covenant on Civil and Political Rights provides Right to life in its article 3 and has been domesticated in Malawi's Constitutional Bill of Rights in article 16. This implies that Malawi as a party to this convention has an obligation to ensure that, right to life of Malawians is protected, promoted and fulfilled. It is very necessary that women's right to life should be protected even in the issues of reproductive health by dealing with avoidable maternal deaths. An example of avoidable maternal death, is the death that is caused by abortion complications. This can be avoided if young women have easy access to contraceptives that can enable them to prevent unwanted pregnancies.

The Convention on the Rights of the Child (CRC) has provisions for young people in terms of access to information and family planning education services. The Convention on the Rights of the Child Articles 24 and 17 state that:

CRC, Article 24

State parties recognize the right of the child to the enjoyment of the highest attainable standards of health and to facilities for the treatment of illness and rehabilitation of health. States parties shall strive to ensure that no child is deprived of his or her right to access to such health care services.

CRC, Article 17

States Parties recognize the important function performed by the mass media and shall ensure that the child has access to information and material from a diversity of national and international sources, especially those aimed at the promotion of his or her social, spiritual and moral well being and physical and mental health.

Malawi as a state party to Convention on the Rights of a Child has an obligation to provide necessary and accurate information to children concerning their health. This should include information to Sexual and Reproductive Health rights. Accurate information about sexual and reproductive health is very vital because it can help them to make informed choices.

The Protocol to the African Charter on Human and People's Rights on Rights of Women in Africa (Women's Protocol) promotes women's rights to reproductive health and in its Article 14 it states:

> *14(1) State parties shall ensure that the right to health of women, including sexual and reproductive health is respected. This includes:*
>
> *(a) the right to control fertility;*
> *(b) the right to decide whether to have children, the number of children and the spacing of children*
> *(c) the right to choose any method of contraceptives;*
> *(g) the right to have family planning education.*

As a state party to the Protocol to the African Charter on Human and People's Rights on Rights of Women in African (Women's Protocol), Malawi should make sure that family planning education is provided. Malawi should also make sure that contraceptives are easily accessible to women. The promotion of family planning education and access to contraceptives will promote women's rights to control their fertility by being able to choose any method of contraceptives they want.

The Protocol to the African Charter on Human and People's Rights on Rights of Women in Africa (Maputo Protocol) calls for the enactment of policies and legal frameworks to reduce incidences of unsafe abortion and provision of broad based legal grounds. To comply with the protocol Malawi should review the abortion law, so that it may broaden the circumstances under which abortion can be permitted.

The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) promotes information dissemination to enable the women and children to exercise their rights. CEDAW 16(e) states that:

> *Article 16*
> *States parties shall take all appropriate measures to eliminate discrimination against women in all matters relating to marriage and family relations and in particular shall ensure, on a basis of equality of men and women:*
>
> *16(e) The same rights to decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights.*

In order to comply with CEDAW, Malawi is supposed to make sure that family planning facilities are accessible to women. The accessibility of family planning facilities will enable women to decide when to have their first pregnancy, how many children they want to have and the timeframe within which to have them.

As a state that has ratified several Human Rights instruments on sexual reproductive health, Malawi is obliged to provide comprehensive Sexual and Reproductive Health Services. In addition to these instruments, Malawi has also made a number of commitments at international level to ensure public availability of information and services on Sexual and Reproductive health. For instance under International Conference on Population and Development (ICPD) held in Cairo in 1994, particularly in paragraphs 5 and 6 which states that:

> *"Governments are required to remove barriers that inhibit family planning services, information and education and help support provision of family planning services as widely as possible and are also called upon to reduce the need for abortion by providing universal access to family planning information and services."*

Malawi, as a state that made commitments to the outcome of the 1994 International Conference on Population and Development held in Cairo and accepted various binding obligations under the international human rights instruments, has not yet made services of family planning universal within its jurisdiction. This is clearly noticed especially by and through young women who still up to now cannot have easy access to family planning methods.

Malawi has also made a commitment to Millennium Development Goals (MDGs). Millennium Development Goals are a set of goals agreed by the United Nations member states at the United Nations Millennium Summit in 2000 to enable the poorest countries improve the quality of life of their citizens (United Nations, 2000). At the Millennium Summit in 2000, states agreed on Millennium Goal number 5 to improve maternal health. According to Millennium Goal number 5, there is a need for member states to put in place policies and programmes to make sure those maternal health facilities are accessible to women. Improvement of maternal health facilities will also improve women's reproductive health. The 2007 revised Millennium Development Goal 5 recognizes the need for a broad

approach to maternal health that encompasses women's access to contraception and safe abortion (Corner, 2008).

Malawi has also signed and ratified the Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa (Maputo Protocol) which calls for the enactment of policies and legal frameworks to reduce the incidence of unsafe abortion and the provision of abortion on broad based legal grounds. However the standards are at odds with Malawi's current abortion law (Jackson et al 2011). The Malawi abortion law is strict and limited to only those women whose lives are in danger. The Section 243 of Malawi Penal Code states that:

> *"A person is not criminally responsible for performing in good faith and with reasonable care and skill a surgical operation upon any person for his benefit, or upon an unborn child for the preservation of the mother's life, if the performance of the operation is reasonable, having regard to the patient's state at the time, and to all the circumstances of the case."*

(See **Appendix 1: Malawi Abortion Policy**)

The Malawi Abortion policy does not fully comply with article 14 (2) (c) of the Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa (Women's Protocol) which states that,

> *"States parties shall take all appropriate measures to protect the reproductive rights of women by authorizing medical abortion in cases of sexual assault, rape, incest and where continued pregnancy endangers the mental and physical health of the mother or the life of the mother and foetus."*

The Malawi abortion policy has partially complied with this article because some aspects which are enshrined in the article are not permissible grounds for abortion in Malawi. The following table shows conditions that are considered in the Malawi abortion policy:

Table A: Grounds on which Abortion is permitted in Malawi

GROUNDS ON WHICH ABORTION IS PERMITTED IN MALAWI:	YES OR NO
To save the life of the woman	Yes
To preserve physical health	No
To preserve mental health	No
Rape or incest	No
Foetal impairment	No
Economic or social reasons	No
Available on request	No

"Additional requirements for abortion to be conducted:
Authorization must be obtained following consultation with a professional. Permission of the spouse is, in theory, required."

The restrictions on inducing abortion are laid down in Chapter XV of Malawi Penal code which covers, "*Offences against Morality*".

> *"Section 149*
> *Any person who, with intent to procure a miscarriage of a woman, whether she is or is not with child, unlawfully administers to her to take any poison or other noxious thing, or uses any force of any kind, or uses any means whatever, shall be guilty of felony and shall be liable to imprisonment for fourteen years.*
>
> *Section 150*

Any woman who, being with a child, with intent to procure her own miscarriage, unlawfully administers to herself any poison or other noxious thing, or uses any other means whatever, or permits any such thing or means to be administered or used to her, shall be guilty of felony, and shall be liable to imprisonment for seven years.

Section 151
Any person who unlawfully supplies to or procures for any person anything whatever, knowing that it is intended to be unlawfully used to procure the miscarriage of a woman, whether she is not or with child, shall be guilty of felony and shall be liable to imprisonment for three years."

The Malawi abortion laws deny many women the right to enjoy their Sexual Reproductive Health (SRH) and safe abortion is supposed to be a Sexual Reproductive Right (SRHR). However, Malawian women are denied this right because of limited access (Malera as cited in Malawi Daily Times, 2011).

The policy on abortion in Malawi has contributed to having unwanted children, because in some cases women may keep children from unwanted pregnancies. As a result women find themselves in a situation where they have too many responsibilities. For women in the peri-urban areas, where most of the women are struggling financially, it is difficult to afford a safe abortion. Women who have money, go for safe abortion but most of the women in my study area are poor and cannot afford to pay. Some young women still try to access the facilities where they pay less for abortion though it is usually unsafe. The backstreet abortion is not safe but some women still use the facility because they are poor (Masina, 2011).

Most of the girls I interviewed indicated that they know the chemicals and herbal medicine that are used to induce abortion. Most of the girls interviewed mentioned herbal medicine like aloe vera, surf washing powder and "*zongendau*". In one of the primary schools where I conducted interviews, the girls indicated that *zongendau* is a chemical that is sold by vendors who sell their items like combs, toys and cosmetics in residential area. Such vendors usually go door by door and one cannot easily notice that they also sell the chemical which is used to induce abortion. There was no proof as to whether the chemicals and herbs really induce abortion since no one gave self testimony. All the interviewees referred to the friends and relatives as people who have used these chemicals and herbs. The girls said they know both aloe vera and zongendao doses but only outlined the aloe vera dose. The following is the aloe vera dose that was outlined:

> "Soak aloe vera plant in 2 litres water for maximum of 10 minutes once it becomes bitter it can be taken. Make sure that enough aloe vera is soaked in order to have a required dose for abortion. Inadequate amount of aloe vera usually cause complication."

In the event where women fail to access contraceptives or sometimes when a family planning method fails to avoid unwanted pregnancies, abortion is their last option. Malawi's rate of unsafe abortion is 36 per 1000 women aged 15 to 49 years. Unsafe abortion is the second leading cause of pregnancy related mortality in Malawi accounting for 18% of all maternal deaths and is leading cause of obstetric complications at 24 to 30% (Jackson et al;2011). The Government of Malawi is very reluctant to change the policy on abortion which is very restrictive. Malawi needs to consider its obligation to fulfil the right to life as a compliance with article 3 of The United Nations International Covenant on Civil and Political Rights (ICCPR) which Malawi signed and ratified by controlling maternal death caused by abortion. Malawi did not only sign and ratify the United Nations International Covenant on Civil and Political Rights (ICCPR), it managed to domesticate article 3 in the ICCPR by including it in the constitution's bill of rights' in article 16 which states that: "Every person has right to life and no person shall arbitrarily be deprived of his or her life."

Therefore, a review of the Malawi Abortion policy is very important since it will enable women to have safe abortions and this will be one way of promoting their right to reproductive health and right to life.

Malawi has also made a commitment to The Beijing Declaration and Platform for Action (BDPFA). Paragraph, 94 of the Beijing Declaration and Platform for Action, defines reproductive health as a state of complete physical, mental and social well being in matters relating to reproductive health. This therefore, implies that people are able to have a satisfying and safe sex life and have the capability of reproducing and the freedom to decide if, when and how often to do so. This implies the right of men and women to have access to safe, effective, affordable and acceptable methods of family planning of their choice. The Beijing Declaration and Platform for Action paragraph 94 is in line with what is stipulated in article 14 of the Protocol to the African Charter on Human and People's Rights of African Women (Women's Protocol) which promotes women's access to family planning of their choice.

According to these articles and paragraphs, Malawi has an obligation to make sure that women have the right to control their fertility. The right is realized through making a choice from contraceptive methods they may want to use and access sexual and reproductive health services in line with National health policies and the recommendations of International Conference for Population Development (Malawi Government, 2009). In 2009 Malawi formulated its Sexual Reproductive Health Right policy in terms of its National Health Policy. Despite this compliance and the adoption of reproductive health policies, numerous challenges still exist. Young people in Malawi are faced with challenges such as early marriages, early and unwanted pregnancies, unsafe abortions, early child bearing, drug and alcohol abuse, a high illiteracy rate, poverty, and the HIV and AIDS pandemic (Malawi Government, 2009).

One of the implementation strategies of Malawi's Sexual Reproductive Health Policy is the establishment of Youth Friendly Services to address Sexual Reproductive Health needs for the youth. In order to reach out to the youth, the Sexual Reproductive Health Policy is linked to Malawi's National Youth Policy. One of the goals of having the Sexual Reproductive Health Policy is to reduce the incidence of HIV/AIDS, Sexually Transmitted Infections, unplanned and unwanted pregnancies. In the Sexual Reproductive Health Policy, the Malawi government acknowledged that;

> *"Many health facilities are not adequately equipped to provide comprehensive Sexual Reproductive Health Rights services and there is uneven distribution. Communication and transport systems remain inadequately developed. Supply of essential drugs and equipment is also a major challenge. Access to Sexual Reproductive Health Rights services is worse in rural areas as there is inequitable deployment of health personnel, which favours urban areas, the secondary and tertiary levels of care. This is aggravated by the critical shortage of health workers across the board, but especially shortage of midwives."*
>
> (Malawi Government, 2009)

The challenge for someone from peri-urban areas begins with the non-availability of health facilities in peri-urban areas because these facilities are located either in urban or rural areas. The next challenge is where the Youth Friendly Health Services are placed. Since, the Youth Friendly Health Services are offered within a health centre, most young women find it challenging to access them because of its forbidding location. During the research, the youths

interviewed mentioned that the environment is too intimidating to ask for contraceptives. Although Youth Friendly Services is a very good programme however there are some factors that need to be considered in order to make the services more accessible to young people. The Ministry of Health has managed to establish the YFHS in some of the health centres, but the challenge is that very few youths are accessing the services. It will be beneficial to so many young women if the Ministry of Health would simultaneously provide community Services on reproductive health as stipulated in the Sexual Reproductive Health policy:

> *3.1.2.5*
> *All public health facilities shall provide supportive supervision to community health workers in their catchment area including Health Surveillance Assistants, and shall function as depots for Community Based Distribution Agents, commodities and supplies.*
>
> *3.1.2.6*
> *Injectable contraceptives shall be available through the community-based delivery system using appropriately trained service providers.*
>
> (Malawi Government, 2009)

Malawi has signed and ratified several International and Regional Human Rights Instruments. In addition it has made commitments to International agreements on Reproductive health. Malawi has only partially complied with the human rights Instruments. The compliance is partial because in some cases there is a selective adoption of articles as shown in the Protocol to the African Charter on Human and People's rights for the African women article 14(2)(c) which has been selectively adopted in Malawi's abortion policy. Malawi has also managed to comply with the human rights instruments by coming up with sexual reproductive rights policies and their implementation strategies. However the compliance is more on paper than in the implementation as far as Sexual and Reproductive Health rights for the youth are concerned. This is very clear with the challenges the youth are still facing which clearly indicates that more needs to be done to address the challenges of the youth.

CHAPTER THREE

3.0 METHODOLOGY AND METHODS

3.1 Methodology

I needed to develop a suitable research framework in order to review young women's capacity to prevent unwanted and unplanned pregnancies. The research framework consists of the following approaches: Women's Law, Grounded Theory, Sex and Gender Analysis, Actors and Structures and Legal Pluralism.

3.1.1 The Women's Law Approach

I decided to use the women's law approach because it takes women as a starting point. My decision of using this methodology was influenced by the knowledge that reproductive health by young women is influenced by various factors which are social, religious and cultural. Within the mentioned context, there are various laws at play that influence a young woman's decision.

The Women's law approach to the lived realities of young women in the decision making of their reproductive lives is very significant. This methodology relies on empirical data collected on the ground focusing on women's lived realities and experience as a starting point for the analysis of the position of women in law and society (Bentzon, et al, 1998). The methodology helped in providing a clear picture of the lived realities of young women that assisted in understanding young women's experiences pertaining to pregnancy prevention and control of fertility. The understanding helped in analysis of women's lived realities and unearthed the reality of legal pluralism in influencing young women's decisions in every aspect of life, including reproductive health life.

3.1.2 Grounded Theory

In this methodology, grounded theory was used because of its interactive nature. Grounded theory is an interactive process of data, theory and lived realities about perceptions and norms constantly engage with each other (Bentzon et al, 1998). The grounded approach helped me to decide data collecting methods to facilitate getting the lived experiences of young women about issues of right to reproductive health that affect them. The methodology also helped in the formulation of questions, phrasing of the questions during the interviews and analyzing of collected data on the daily basis during the field research.

The theory was applied throughout the research. It helped to understand lived realities of young women through their experience in the opportunity to prevent pregnancy and right to control fertility.

During the literature review, the grounded approach helped me to have a better understanding of policies and implementation strategies on reproductive health. The literature review helped me to come up with checklist of the data I needed to collect and also helped me in the interpretation of the data I collected.

The approach helped me to have an open mind to emerging issues. Much as my assumptions were not challenged, the emerging issues helped me to come up with new assumptions that help me to continue engaging the theory, data and lived realities. This process was very relevant to review how Youth Friendly Health Services are progressing since I firstly read what was set out as implementation strategy and managed to visit the Youth Friendly Health Centres and finally got empirical data from young women' themselves on how they are benefiting from Youth Friendly Health Services. The empirical knowledge I obtained about young women's knowledge and perceptions about contraceptives helped me to engage with the law and practices in constant with the available policies and implementation strategies.

In the grounded research process, the researcher collects data, sifts and analyses it, considers the implications of her findings, determines what to collect next to meet her needs, and

continues the collection and analysis cycle. Through this process, new methodologies, perspectives and theories are hatched (Bentzon et al 1998).

Through grounded research process, findings from key Informants interviews informed the interviews for young women and Youth Friendly Heath Centres' Coordinators. Daily update of the field diary informed field work for the following day. Writing of narrative summary and field diary helped the daily analysis of the data collected. Through this process, the emerging issues informed the formulation of new questions for particular groups and individuals in order to get empirical data about issues of pregnancy prevention and right to control fertility.

3.1.3 Legal Pluralism

I also used legal pluralism methodology. Legal pluralism refers to different rules, norms, cultural practices, customs and laws that determine how people react to a particular legal or social problem (Mario 2008). These dual systems of law are sometimes conflicting. The methodology was very relevant because of the existence of legal pluralism that influences young women decision of reproductive life. There is always intersection of various laws that influence young women's decision to prevent unwanted pregnancy. The laws that are intersected are customary, religious and general law. This approach calls for an inspection of all laws, practices, customs, culture and religions (James 1995:2) and get to the bottom why people react in a particular manner to a particular problem. In this study, the approach was used to find out how women react in various ways to legal pluralism.

Using this methodology, I was able to understand women's preferences and capacity in issues of pregnancy prevention and control of fertility. Legal pluralist approach allowed me to unearth the challenges that young women face to make a decision about reproductive health in a situation where so many laws are at play and influence every decision a young woman makes in a society.

3.1.4 Sex and Gender Approach

In this study, the sex and gender approach involved an analysis of how the biological make up of male and female affect their reproductive health life. It also involved how the socially constructed roles of men and women affect their reproductive health life.

Gender refers to the culturally defined aspects of being male or female. They could be relationships, status and privileges assigned to women, men, boys and girls in a given culture or location. Sex refers to biologically determined differences between males and females (Malawi Institute of Education, 2009).

The methodology helped me to analyze how young women aged 15 to 19 years are affected biologically if they get pregnant at such an age when physiologically they are not fit to give birth. The challenge young women face was unearthed and led me conduct young men's focus group discussion to find out the role they can play to help the girls in prevention of pregnancy. Most of the young men stated that it is all up to the young women. If they want to prevent pregnancy, they are ready to help them to do so. However, they stressed that if young women do not care about pregnancy prevention, there is nothing they can do. They indicated that the reason for not being in the forefront to prevent women from getting pregnant is the fact that they are not the ones who become pregnant.

The methodology also helped me to analyze how gender constructed roles like how household chores affect young women's attendance at the activities that take place at Youth Centres during week days. It also helped to review a possibility of making Youth friendly Health services more accessible to the young women living in peri urban areas. I further looked at how Youth Friendly Health Services and Reproductive Health take into account gender analysis during programming.

A sex and gender analysis of programmes helps institutions to come up with effective programmes that respond to the needs of both men and women. The methodology helped to do a critical analysis of the programmes on Reproductive health. The purpose of analysis was

to check if the age and sex differences of the people who access the facilities were considered when programming.

3.1.5 Human Rights Approach

Human Rights Approach was also considered in order to assess Government's obligations to ratified Human Rights Instruments and commitment to outcomes of International Conferences. Human Rights obligation requires states to ensure the fulfilment of human rights by acting in a way that enables rights holders to enjoy the rights to which they are entitled (Goonesekere, 2000).

Therefore, government as a primary duty bearer is supposed to take appropriate legislative, administrative and other measures in order to protect rights of the women in reproductive health. In view of the foregoing, I decided to use human rights approach as a methodology to assess how Malawi has domesticated International and Regional Human Rights Instruments ratified.

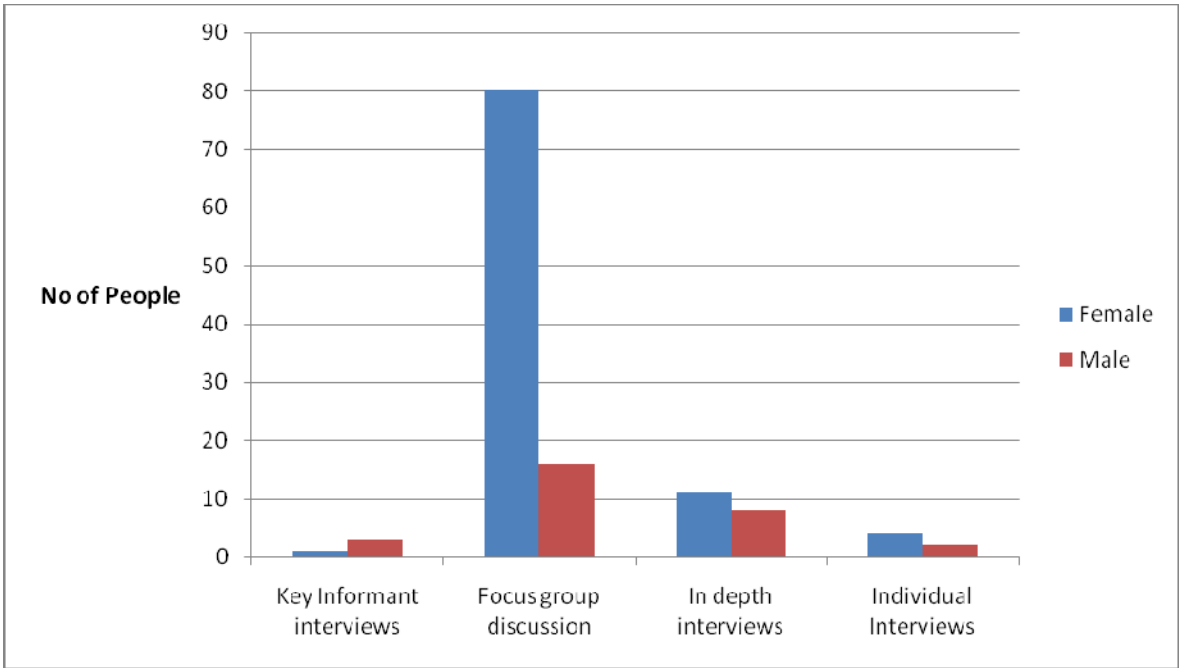
From the beginning of the study, it was important to understand how various structures dealing with youth, sexual and reproductive health work. Therefore, Structures and Actors Approach was used. I tried to map out the structures. The Ministry of Youth, Ministry of Health: Reproductive Unit, Ministry of Education and National youth Council are identified as key structures. Soon after mapping the structures, I realized that the structures cannot work without actors so I had to trace actors within these key structures. These actors were the key informants. They provided information about the programmes on Sexual and Reproductive health. They also provided direction to various stakeholders on sexual and Reproductive health throughout the field research.

3.2 Data collection methods

Various methods were used to collect data, each selected method was chosen according to the needed information and the position of people in the society and institutions. The following methods were used: key Informant Interviews, focus group discussion, group discussion, in-depth interviews, individual interviews, observation and desk research. The following figure

shows the number of people interviewed using the various mentioned methods and sex representation:

Figure 2: Number of Respondents Per Research Method



3.2.1 Key Informant Interviews

These were used in Ministry of Health in the reproductive Unit, the Ministry of Youth Development and Sports and the National Youth council to find out more about the policies on reproductive health rights and the implementation strategies. The following table provides the list of key informants:

Table B: List of Key Informants

Interviewees	Female	Male	Total
Chief Youth officer, Ministry of Youth Development and Sports		1	1
UNFPA Youth Officer	1		1
National Youth Coordinator in reproductive Health, Ministry of Health		1	1
National Youth Coordinator on reproductive Health, National Youth council		1	
TOTAL	1	3	4

3.2.2 Focus Group Discussion

Focus Group Discussions (FGD) was used to have an understanding of the young women's knowledge of contraceptives and how young women and young men work together in sexual reproductive health issues. The FGD for young women helped the young women to be free to discuss the issues. This would not have been possible if I had mixed them with young men. I also had a FGD with young men to understand their knowledge of contraceptives and the relevance of using contraceptives for pregnancy prevention and fertility control. The FGD where young women and young men were mixed, helped me to understand how men and women work together in issues of sexual and reproductive health rights. Therefore, the focus group discussions held, helped me to get various views on issues. It provided room to debate

over issues like misconception about contraceptives and conception based on the knowledge the members of the FGD had. The following table provides the number of the people that participated in the FGD

Table C: The Number of People who participated in the Focus Group Discussions

Interviewees	Female	Male	Total
Young women group1	6	0	6
Young women group2	9	0	9
Young women group3	5	0	5
Young women group4	6	0	6
Young women group5	6	0	6
Young women group6	7	0	7
Young women group7	15	0	15
Young women group8	11	0	11
Young men and young women	9	10	19
Older women	6	0	6
Young men		6	6
TOTAL	80	16	96

3.2.3 Observation

During my visit in different heath centres where youth friendly health services are provided, observation was used to triangulate my data on the environment. This was based on the information that came out during the study that the health centres' environment is not conducive for the provision of youth friendly health services. It also helped to have an idea of the youth who access the Youth centres more between male and female youth.

3.2.4 Desk Research

Desk research has helped me very much to conduct my literature review which informed my research and in the analysis of my findings. During the desk research, I went through the literature on reproductive health from various authors and research reports on reproductive health for research studies conducted in Malawi. It involved review of key policies and strategy documents, statistics on the fertility rate and the use of contraceptives by young women. Specifically, the following documents were reviewed; Reproductive Health Policy, National Youth Policy, Plan of Action (NPA) for Young People in Malawi; National Standards for Youth Friendly Health Services; Population and Housing Census 2008: Fertility and Nuptiality, Population and Housing Census 2008: Children and Youth, 2004 and 2010 Malawi Demographic Health Surveys and other policies, strategies, plans and assessment reports in order to check the progress. I also went through the International and regional human rights instruments that Malawi has ratified in order to find out the extent of Malawi's compliance with them.

3.2.5 In depth Interviews with Key Respondents

The key respondents were selected based on the knowledge of doctrines, policies and implementation strategies of their institutions and their experience in their various posts. I managed to collect the necessary information as the respondents were familiar with the programmes on sexuality education and reproductive health that their institutions have. My focal point was on the right of young women to control their fertility. The following table contains a list of the key respondents during in depth Interviews:

Table D: The List of the Key Respondents who gave in-depth interviews

Interviewees	Female	Male	Total
Coordinators for Youth Friendly Healthy Centers	3	2	4
Teachers	5	2	7
Church leaders	1	3	4
Youth Club Leaders	1	1	2
NGOs	2	1	3
District Youth Officer	1	0	1
Clinical officer	0	1	1
TOTAL	13	10	23

3.2.6 Individual Interviews

Individual interviews were conducted in order to have an idea of the programmes that are in place that target the youth. Officers from Non Governmental Organizations were interviewed and they provided information on goals, objectives and implementation strategy of their programmes. Emphasis was placed on reproductive health programmes that they are implementing and the challenges that they face. Apart from NGOs, individual interviews were also conducted with women from the community in order to hear their views on pregnancy prevention and fertility control by young women. The interviews were relevant because they provided an overview of the programmes that are being implemented and the community perception of prevention of pregnancy by young women. Four officers were

interviewed from NGOs with a representation of 2 women and 2 men. Two women were interviewed at the market.

The individual interviews also helped me to obtain stories of young women who have been pregnant before in order to understand their experiences. This also helped me to understand the impact of lack of knowledge of contraceptives. Three stories were collected from the girls who have ever had unwanted and unplanned pregnancies. The stories provide information concerning the lived realities of young women in terms of enjoying their right to reproductive health.

3.3 The Research Sample

The research was conducted in Lilongwe peri –urban areas, Malawi. Five schools were randomly selected; focus group discussions for girls were conducted in the selected schools. Individual interviews were conducted with some of the teachers who teach subjects that have elements of sexuality and sexual reproductive health in them. Some religious leaders were randomly selected to hear their views of religious laws on sex education. Five communities were randomly selected where individuals were interviewed. The selected communities were Kauma, Mgona, Chinsapo, Senti and Landscape, in the selected areas, group discussions were conducted for youth groups and in depth interviews were conducted with youth leaders and individual interviews were conducted with community members and officers from NGOs. Four health Centres where Youth Friendly Health Services are provided were randomly selected and in-depth interviews on the progress of the Youth Friendly Health Services were conducted with the Youth Friendly Health Services Coordinators.

3.4 Limitations of the Study

The fuel shortage was a hindrance to my study because there were times I had to reschedule my appointments because of lack of fuel. To make a second appointment was very tricky because it was up to the respondent to allocate time to me more than once. Some respondents never gave me a second chance to interview them.

CHAPTER FOUR

4.0 FINDINGS AND ANALYSIS: The Lack of sufficient, appropriate and accurate Information about Sexual Reproductive Health

4.1 Lack of Knowledge about Contraceptives

Some girls have found themselves pregnant because they have never received any information on pregnancy prevention, hence they engage in sex without considering the consequences. One of the contributing factors is culture whereby young women are not expected to have sex before marriage hence parents wait for the girls to be ready for marriage in order to give them information on pregnancy and they do not expect them to use contraceptives. To many people it is a taboo to talk about sex related issues to their children. One of the male respondents gave an example of his own practice whereby he buys sanitary pads for his daughters and people laugh at him. He said:

> "That's a very prohibiting culture, mothers and fathers are not ready to talk to daughters about menstruation and sex and refer their daughters to an Aunt. The Aunt does the counselling and the parents do not have an idea of what transpired in the counselling session. They do not know whether what their daughter learnt was of any value to her life or not. This prohibits girls from getting information at the right time from right people. Some girls have found themselves pregnant because they never had the opportunity to hear about sex."

The only time guardians and parents send their daughters to their aunt's place for counselling on sexual reproductive health is when the girl child reaches puberty which is too late because some girls start intimate relationships at the age of 12, which may be before reaching puberty. The popular counselling in Malawi is when the girls reach puberty; they are advised to refrain from dealing with men. The young women I interviewed said they are advised that:

> "Atsikana asamasewere ndi anyamata and anyamata akhale adani awo."
>
> Translation: *"Girls should not play with boys and boys should become their enemies."*

> "Amuna ndi mikango amaluma, osamasewera nawo kapena amuna ndi moto udzakuotcha, osamasewera ndi moto. Amuna akhale adani anu."
>
> Translation: *"Men are lions, they are very dangerous they can harm you if you play with them; men are fire, fire can burn you, make sure they are your enemies."*

The young women do not understand that why, all of a sudden, boys should be their enemies. The only aspect that the counsellors are free to talk about is how the young women should dress when they are in their menstrual period. The girls are never told the most important thing at this stage, that if they have sex without any protection they have the potential to conceive. As a result the girls get information from friends since they are very eager to know more about the meaning of the metaphors where men are referred to lions and fire. Most of the girls do not get the right information about how to avoid pregnancy because of culture of silence by parents and guardians and one of the Youth Friendly Services Coordinator was quoted:

> "Makolo ambiri samamasukirana ndi ana ndiye ana amakapeza uthenga wabodza, ena amafuna kuyesa pogwiritsa ntchito uthenga wabodzawo."
>
> Translation: *"Parents/ guardians are not free to talk to their children about sexuality, as a result, the girls find the information on their own and sometimes wrong information, some of the girls practice sex based on the wrong information."*

If parents and guardians could hear what young women advise each other on conception, they would be shocked and would make appropriate decisions about the sexual and reproductive health information their daughters need to have as they grow. It would be a matter of assessing which is a lesser evil; i.e. having the information in order to make responsible reproductive choices rather than letting their daughters fall pregnant out of ignorance.

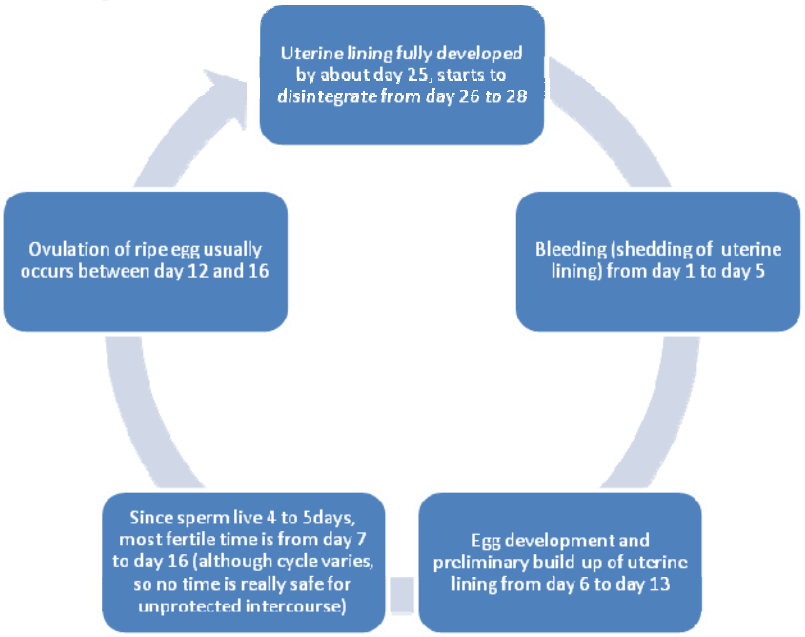
The research revealed that young women have sexual relationships but have limited knowledge about conception. Therefore, they advise each other about conception with limited knowledge.

Some of the young women aged 15 to 19 years I interviewed in schools, indicated that they know natural family planning methods. They also indicated that some girls become pregnant because of wrong calculation of menstrual calendar. The following are some of the quotes of the issues they discuss about conception:

> "Having sex while menstruating can help one prevent pregnancy."
>
> "You can become pregnant when you have sex with a man not a boy."
>
> "You cannot get pregnant during the first sexual intercourse."
>
> "One can conceive only if she has sex frequently not when she has it once in a while."
>
> "If you menstruate for 5 days, you can have sex the next five days without prevention of pregnancy and you cannot become pregnant. Even those who menstruate for 7 days. 7 days after menstrual period they cannot conceive."
>
> "Seven to eight days after menstruation are the safest dates to avoid pregnancy."

In most of the focus group discussions, the girls were inquiring from me to verify if the information they have about natural birth control is true or false. I had to take time to give a brief description of monthly fertile cycle (Phillips: 1971).

Figure 3: Diagram of a Woman's Monthly Fertility Cycle: An average menstrual cycle (28 days) (no pregnancy)



The explanation of the fertility cycle indicates that the young women do not have accurate information about conception. Unfortunately they mislead each other with the wrong information they have. The cycle clearly shows that the fertility cycle varies. Therefore, there is no time which is very safe for unprotected sex. The clear knowledge of menstrual cycle can empower young women to have pregnancy by choice.

A number of groups are researching and testing methods of natural birth control and most of these are Catholics who oppose mechanical or chemical contraception (Phillips, 1971). Using natural birth control method needs women to pay attention to the menstrual cycle and it is better for those whose partners want to work with them in preventing pregnancy. The most difficult part is where it requires woman's recognition of bodily signs which indicate to her whether she is in a fertile or infertile phase of her menstrual cycle (Phillips, 1971).

4.2 Lack of Assertiveness

With the insufficient information young women have about conception, they know that there is a risk of falling pregnant if one has unprotected sex. However, most of the young women have never had an opportunity of being told on how to be assertive in a sexual relationship. Parents and guardians do not tackle that issue with their daughters because it is linked to sexual relationships and they do not expect their daughters to have sexual relationships. The young women age 15 to 24 said sometimes young women fall pregnant because of lack of assertiveness. Young women who are not assertive do not have the ability to tell their intimate friends of the opposite sex about their opinion about sex. They end up submitting to men's sexual desires. Some young women want to impress their opposite sex intimate partner by not using condoms and I quote:

> "Nyamata amaona ngati mtsikana akupepela akayuza condom."
> Translation: *"The boy thinks a girl is silly when she demands condom use."*

Hence, they have unprotected sex in the name of love in order to maintain the relationship. Some have sex for financial gain and others as a result of peer pressure. Sometimes sex is done in exchange for money. This leaves no room for condom negotiation. Some girls do not prefer to use a condom as a matter of fashion and to increase the degree of pleasure. They say:

> "Sweet wampepala sakoma,"
>
> Translation: *"Sweet which is eaten with a wrapper does not taste as nice as the actual sweet."*

Assertiveness is very important because if the girls are not assertive the boys actually discuss among themselves strategies for targeting them. One of the girls I interviewed said:

> "Mtsikana akakhala sali assertive amati, tapitani mukangomufunsira ameneyo sakana."
>
> Translation: *"If a girl is not assertive, the boys actually encourage each other to target her."*

Most of the girls who have been pregnant before are the ones who are more likely to obtain contraceptives more than those who have never been pregnant before, because the latter have never experienced the consequences of being pregnant. Some they start using contraceptives as a way of controlling fertility in order to allow delay of pregnancy and continue with their education. This is even practiced by those who are currently married but want to continue with their education. This came out clearly through the following story narrated by one of the young women I interviewed:

> I am 20 years old. My story on use of birth control started when I moved from Mulanje to Lilongwe for my studies. I came to Lilongwe to do a Secretarial course and was told to collect fees from my father's relative working in Government. Honestly, I do not know my father's relatives since my father and mother divorced when I was 3 years old and had no chance of knowing most of my father's relatives since I grew up with my mother.
>
> In the process of getting school fees, my so called father's relative asked me to have sex with him. I had no choice since he was paying my fees. I started having sex with him and later on it became a habit. While doing my course, I also fell in love with a boy and was having a sexual relationship with him.
>
> After sometime I heard from some of my relatives that the man who pays school fees is not my father's relative but my mother's intimate partner. I felt bad about it and decided to get rid of him without causing problems between him and my mother. I did not want my mother to know about my intimate relationship with him. Before I got to know about my mother's affair with the man, I was using condoms for both men. I decided to have unprotected sex with my younger intimate relation in order to get rid of my mother's intimate partner. Actually I wanted to become pregnant.
>
> As soon as I realized that I became pregnant, I withdrew from the course and went back to Mulanje. I told my mother that I was pregnant and my intimate young man was responsible. I and my mother we agreed to conceal this information from my mother's intimate partners who happened to be my sexual partner as well. My mother felt he would be disappointed since he was paying fees for me. So my mother lied to him that I found a job and am working in Mulanje. My mother emphasized that the man so called my uncle should not see me because will be very disappointed.
>
> After a year, my child's father insisted that I have to come back to Lilongwe and I did, we are now cohabiting. I want to go back to

> school but this man cannot afford the fees. I am currently looking for scholarship; I want to rewrite my form four exams so that I qualify for nursing college because I want to become a nurse. I started secretarial course because my grades are not good enough to qualify for nursing school. I now use a contraceptive called depo-provera to prevent pregnancy.

The issue of lack of assertiveness came out clearly as negative effect of misinformation on sexual reproductive health. It is very important to build the capacity of young women in assertiveness. This is possible by telling young women about their physiological development, the sexual desires and how they can handle it. They also need to know various reasons why men need to have intimate relationships with members of the opposite sex and how they can manage and handle them. Generally, young women need to know about their sexuality. The information can help them to make informed choices.

4.3 Misconception about Contraceptives

Most of the young women had knowledge of the effects of contraceptives and are afraid to use them since they fear they may develop cancer or become infertile. The young women also mentioned that they know the natural planning method which can be used. However, they are not sure whether the information they have about the natural family planning method is true or false. This came out clearly when they asked that they wanted to have accurate information about contraceptives and natural family planning methods. The information was provided to them. (See Figure 4, below).

The young women aged 15 to 19 indicated that they do not know much about contraceptives. They know two types of contraceptives; pills and depo-provera. The young women indicated that they are advised by elders that contraceptives are for the people who have ever given birth and want to delay the next pregnancy. It was emphasized to them that contraceptives are for married people who want to control the space between two children.

Young women who are between the age of 20 to 24 (whether single or married). They reported being told by counsellors, either at home or at church, that there is no need for them

to use contraceptives before having a first child and the disadvantage is they will have difficulties in conceiving and this was quoted:

> "Amafunsidwa kuti; alelelanji alibe mwana?"
>
> Translation: *"They are asked that; why should they do child spacing when they do not have a child?"*

Pictures of various methods of contraceptives without labels were shown during some of the Focus Group Discussions. The purpose was to find out if the young women could easily identify any birth control method they have ever used or seen before in the picture. Young women managed to recognize the pills and male condoms. Later on the picture of birth control methods with labels was provided in order to discuss if they have ever seen or used any of the contraceptives. The labels on the pictures were read out to them and almost all of them mentioned that they knew one or two methods of birth control. Most of them were familiar with condoms, pills and injectables but indicated they had no idea of some of the methods of contraceptives in the picture. Most of them indicated that they had never seen a female condom and the female condom was shown in one of the Focus Group Discussion with young women aged 20 to 24years and one woman volunteered to demonstrate how it is used. The following are the pictures that were used during some of the Focus Group Discussions:

Figure 4: Photographs of various Birth Control Methods

4.4 Legal Pluralism

An analysis of the legal pluralism that influences the young woman's decision to control her fertility was done. The research revealed that it is difficult for young women to make decisions to control the fertility. This is the case because a young woman is under several regulations. These are religious, customary and general law. Most of Malawians are religious. Christians comprise 76% of Malawi's population, Muslims comprise 17% and 7% is comprised of other traditional ethnic religion (OM International, 2011). Each religion has its own teaching about the control of fertility. Customary law has got its own teaching about control of fertility and the general law also has a take on control of fertility. A young woman

is supposed to manage these three types of law before she makes her decision on fertility control. Therefore, the decision a young woman makes to control fertility is influenced by the different types of laws and norms that surround her. Analysis of the intersection of the various laws provided me with an opportunity to explore the feasibility of a young woman to have a right to prevent pregnancy and control her fertility.

During the research, it was discovered that young women are referred to various types of norms that prohibit them from using various methods of fertility control. The most prominent were customary and religious norms. They both prohibit sex out of wedlock and assume that issues of fertility control cannot be discussed with someone who is not married.

4.4.1 Customary Norms and the Use of Contraceptives

Cultural beliefs emphasize that contraceptives cause infertility, which is a myth. Most of the young women end up not having clear and sufficient information because of religious and cultural beliefs. Amongst the women aged 20 to 24 years I interviewed, very few indicated they have ever used contraceptives. The type of method that was mentioned by most of them was depo-provera. They said pills are problematic to take and need a lot of discipline. It was revealed that there is inconsistent use of contraceptives because women still fear taking contraceptives due to the misinformation they have about them. For the young women aged 15 to 19 years, most of them said they have never used any birth control methods but would be comfortable to using condoms since they had heard a lot about side effects of other birth control methods and they did not want to be victims. Members of one of the girls' organizations I interviewed said:

> "Tikanali ang'ono, sitingagwiritse ntchito ma contraceptives ndipo tikudziwa kuti ali ndi ma side effects ambiri monga kusabereka nde timaopa kugwiritsa ntchito. Timalandira makondom kuchokera kwa Youth Coordinator koma timagwiritsa ntchito tikakhala ndi ma outreach activities, ifeyo sitigwiritsa ntchito chifukwa timayenera kupewa kugonana."
>
> Translation: *"We are still young to use contraceptives and we know they have so many side effects like causing infertility. We are afraid to use them. We receive condoms from our youth coordinator but we*

distribute them for outreach activities. We do not use them ourselves because we are supposed to abstain."

African women realize their motherhood rights in an environment that often differs substantially from that pertaining in the global or western human rights arena (Munalula, 2009). In Africa, the concept of a woman is linked to motherhood. Therefore women prove their womanhood through childbearing. Women who bear many children are considered powerful. In Africa women who are unable to bear children are stigmatized. In view of the foregoing, most women deliberately shun contraceptives because they want to increase their chances of conceiving. This issue of motherhood goes along with these misconceptions about contraceptives through which women mislead each other based on the misinformation that contraceptives cause infertility. This indicates that women have little access to information about contraceptives. Enough information about contraceptives will enable women to make informed choices. As for young women, they are afraid of contraceptives because they want to have children when they are older.

Young women who have ever been pregnant out of wedlock are likely to become assertive because of experience. They start using contraceptives after giving birth to avoid going through the same experience again. This is an account of a young woman who has gone through such experience:

"When I reached puberty at the age of 13 I was counselled by women from the church who advised me to avoid intimate relationship with boys. I acted contrary by having intimate relationships due to peer pressure. When my parents realized that I started having intimate relationships they advised me to end the relationship to avoid getting pregnant. I ignored the advice.

In the long run I started having sexual intercourse with my *chibwezi*[1]. The first sex sessions we used condoms but when we got used to each other we were not using condoms until I got pregnant at the age of eighteen. The boy accepted the responsibility but was still in school hence could not support me financially. I was in form four but had to drop out of school due to my condition.

At the age of 20 I asked my parents if I could go back to school, they accepted I started the school and will write Malawi School Certificate

[1] Chibwezi is the intimate lover of the opposite sex.

> of Examinations June 2012. After having a child I was very interested to learn about contraceptives to avoid becoming pregnant again. I have been using depo-provera to prevent pregnancy. I used the contraceptives for 6 months and no longer use it because I have decided to finish my school first before I indulge in sex again."

A woman's ability to plan her reproductive life depends upon her having access to the full range of contraceptive methods, provided in a setting in which she may make informed choices (The Centre for Reproductive Law and Policy,2000). Therefore, poor access to contraceptives leaves a woman with no control of her own fertility. This becomes very tricky for a woman to plan her own reproductive life. There are some women who manage to use natural methods of family planning, and this is possible for those who have access to accurate information on natural method of family planning. Beyond access to this information, they need to have the capacity to use this method and it works better for those who have regular menstrual periods. It is very hard however, for women who do not have regular periods to use this method.

Much as there are misconceptions about contraceptives, the fact is each contraceptive has its advantages and disadvantages. This varies from one individual to another.

> *"Each of the available contraceptive methods has disadvantages as well as advantages. Some methods we find to be a nuisance, others may make us sick. Many may have long-term dangers still unknown. The choice usually involves deciding where we are willing to make a compromise. We weigh up whether effectiveness, safety, or inconvenience matters to us, and most important, what method we feel the most comfortable with which one will use most consistently. We will choose differently according to where we are in our lives-no one method is likely to be satisfactory enough to carry us all the way through our fertile years."*
> (Phillips, 1971)

If misconceptions about contraceptives are cleared up, most of the women will be helped to make the right choice of the method of contraceptives they want to use. Hence helping women use modern contraceptives successfully requires improving the accessibility and quality of contraceptive information and services, (Darroch, 2011). Improved information about and services for contraceptives, could dismiss misconceptions about contraception and change attitudes that discourage the use of contraceptives prior to first pregnancy (Malawi government, 2010).

4.4.2 Christianity and the Use of Contraceptives

Most of the Christian women I interviewed from various churches, indicated that the church is not ready to teach unmarried women about sexuality and reproductive health. This is because they fear that this would expose them to sexual immorality. This was revealed during the interviews where young women from various churches were represented and some of the churches were; Roman Catholic, Seventh Day Adventist, Presbyterian Church of Central Africa, Zambezi Evangelical, Anglican, Assemblies of God and Living Waters. All the interviews indicated that as far as teaching of unmarried young women is concerned, the church only teaches about abstinence. It is only those who are about to get married that are given the information about sexuality and reproductive health. The church is only ready to talk about such issues to the people who are about to get married so they are prepared for sexual life in marriage.

The youth in Theological colleges and Seminaries are taught about contraceptives. The purpose is simply to equip them with such knowledge; they are not expected to use them out of wedlock. One of the catholic priests I interviewed indicated that in Catholic Seminaries students are taught about contraceptives but are not supposed to use them. Some churches do not permit the use of contraceptives even between married couples e.g. Roman Catholic. For such churches the issue of providing information on contraceptives to young women is out of the question. The tragic thing is that some youth centres that are in mission health centres (e.g. catholic mission health centres) promote abstinence and do not stock any type of contraceptives.

In Christianity, sex out of wedlock is considered a sin according to one of God's commandments found in Exodus chapter 20 verses 14: *"Do not commit adultery"* (Good News Bible; 1994:80). This verse, only talks about adultery. Christians however use the same verse to mean "do not commit fornication". Much as this verse is used to refer to both adultery and fornication, the two terms are different. Adultery means sexual intercourse by a married man or woman with someone other than their lawful spouse, while fornication means sexual intercourse by an unmarried person. The argument for Christians is that, fornication is like adultery because it is committed before marriage and hence out of wedlock. During the

study, a certain leader from Catholic Church made an argument, on the use of contraceptives, he said;

> "It is important to note that human sexuality is dictated by love, procreation, sensual pressure. Hence any sex that is not towards life creation is prone to sin."

The leader made a reference to sexual intercourse done by people out of wedlock where contraceptives are used to prevent pregnancy. This is acting against God and reference was made to the following verses:

> *Genesis 1. Creation vs. 26 to 28:*
>
> *"Then God said now we will make human beings; they will be like us and resemble us. They will have power over fish, the bird and all animals, domestic and wild, large and small. So God created human beings, making them to be like him. He created them male and female and blessed them, and said, 'Have many children, so that your descendants will live all over the earth and bring it under their control.'"*

There are some believers who emphasize the point that the use of contraceptives is the same as killing because it is a denial of life and they refuse to use contraceptives because to them, it would be sinful to use them. They equate the use of contraceptives to abortion and then equate abortion to killing. Reference is made to one of the ten commandments of God; *"Do not kill"* (Good News Bible; 1994: 80). This is a very contentious issue in religious circles because it depends on one's understanding and belief of the particular stage on conception and pregnancy. Much as people have different views on the time when life begins, it is very important to make a reference to the medical point of view when they are making arguments. Cook and others provide the explanation of contraception and abortion from a medical point of view where the distinction between contraception and abortion is clear (Cook et al 1993:27):

> *"Pregnancy is only considered established with the completion of implantation of the ovum in the lining of the uterus. A woman with a fertilized ovum floating in her fallopian tube or uterus is not pregnant. A method that acts before complete implantation is a method of contraception. A method that acts after complete implantation is a method of abortion."*

4.4.3 Islamic Law and the Use of Contraceptives

There is no verse in Koran that prohibits use of contraceptives in Islam. Some theologians indicate that non permanent methods of contraceptives are allowed as long as they are safe and acceptable between a wife and a husband. Most of the Muslims discourage the use of permanent sterilization because they do not want people to regret having done so later (Mwenegoha; 2008). Much as the Koran does not prohibit use of contraceptives, some religious leaders within Islam discourage people from using contraceptives. They misinterpret the Koran to defend their point of view. Just as some Christian leaders, so they equate the use of contraceptives to abortion and then equate abortion to killing;

> *Surah Al-isra 17:32*
> *Do not kill any man whom God has forbidden you to kill, except for a just cause.*
>
> *Surah Alnam 6:151*
> *Come, I will tell you what your Lord has made binding on you: that you shall serve no other gods besides Him; that you shall show kindness to your parents; that you shall not kill your children because you cannot support them (We provide for you and for them); that you shall not commit lewd acts, whether openly or in secret; and that you shall not kill-for that is forbidden by God-except for a just cause. Thus He exhorts you that you may grow in wisdom.*
> (The Koran, 1956).

The misinterpretation of the Koran misleads some women into thinking that contraceptives are not allowed in Islam.

In Islam, for young women, the age at which a girl can marry is the age of sexual maturity. As long as a girl has reached puberty and is capable of exercising a sexual liking for another person, she is mature enough to marry. It is assumed that she will also be able to make family decisions (Mwenegoha, 2008). For such girls, the situation become complicated because culturally a woman is expected to conceive once she gets married. Some girls reach puberty as young as 11years and obviously physiologically and biologically are not mature enough to give birth so they run the risk of suffering from vaginal fistula.

One of the sheikhs I interviewed started by stressing that sex out of wedlock is not allowed in Islam and he quoted some verses of the Koran:

> *"Do not commit adultery, for it is lewd and evil."*
> Surah Al-isra 17:32 (The Koran, 1956)

Another verse quoted was:

> *Al-nur 24:2:*
> *The adulterer and adulteress shall each be given a hundred lashes. Let no pity for them because you will disobey God, if you truly believe in God and the last day; and their punishment be witnessed by a number of believers.*
> (The Koran, 1956)

He emphasized that the verses apply to both married and unmarried people. In Islam, just as in Christianity, the sin of adultery is equated to the sin of fornication since both are done out of wedlock. He also indicated that contraceptives are not allowed because God is against that, "Mulungu sangakuyikira linga." (Translation: *"God cannot bless you")*. Even if you use a condom it is still a sin. He mentioned that girls are encouraged to marry at about 17&18 years of age to avoid pregnancy out of wedlock:

> "Ngati mwana wanu atakwana msinkhu okwatiwa musiyeni akwatiwe. Mukapanda kumumasula mpata olawila umapezeka."
>
> Translation: *"If your child has reached the age sexual maturity (puberty) let her get married. If the girl child is not yet free to get married early, there are more chances of her indulging in sex."*

The issue of marrying off girls when they reach puberty is a very serious issue because the girls miss on opportunities to be educated and employed. It becomes very challenging for such young women because the resources are few, so one needs to fit in to survive. If young women are denied the opportunity to pursue their education and become financially independent, some of them will end up suffering in future or will end up in the hands of a powerful few who will exploit them through cheap labour (Tong, 1994).

4.5 Sexuality Education in Schools

The Ministry of Education introduced subjects that tackle issues of sexual education and these are life skills which starts from grade 4 (standard 4) up to grade 12 (form 4), Science and Technology that start from grade 6 (standard 6) up to form 4. Social and Environmental

studies and Reproductive Health Education are provided in Secondary Schools only. In both the Primary and Secondary Schools curricula, there is an emphasis on abstinence and they promote the use of contraceptives for married couples but not for pupils. In both Primary and Secondary schools, the common topics that are tackled are self awareness, self esteem, assertiveness and sexuality. The importance of self awareness means that pupils should have knowledge about themselves and their bodies. This knowledge makes one feel good about oneself (Mlanga et al, 2002). These are useful topics as they help the pupils to grow with confidence. The topic of self esteem helps them to build high self esteem in order to promote assertiveness in themselves (Domasi Institute of Education: 2009). The topic on sexuality helps pupils to understand the physical and psychological changes that they experience as adolescents and how their behaviour is affected by these changes (Domasi Institute of Education: 2009). In Science and Technology, they learn about Reproduction in Human Beings, this includes information on family planning methods both natural and modern. One family planning topic in The Science and Technology Teachers Guide for Standard 8, provides that:

> *"Some people do not want, or cannot afford to have many children. They practise some form of birth control to space out birth and limit the size of the family."*
> (Malawi lnstitute of Education,2009:64)

Such information is meant to apply to those who want to space or limit the number of children they have and not to those who want to delay having children. Although Malawi has straight forward sex-education curricula when it comes to the use of contraceptives, they are only recommended for the married people as a means for controlling fertility. Most of the teachers I interviewed indicated that they do not expect the pupils to indulge in sex. Therefore, the emphasis for pupils is total abstinence.

Some teachers feel there is no need for them to talk about condoms in class, let alone bring them for the pupils to see because they believe that the students are supposed to abstain. Much as they know about availability of Youth Centers in the health facility, they do not want to encourage students to go there because they are afraid that they will learn about condoms. They believe that once the students are introduced to them they will want to experiment with them by having sex. The teachers also avoid giving detailed information about Sexual Reproductive Health to avoid questions and I quoted one of the teachers;

> "Sindingakambe zinthu zimenezi mwachindunji chifukwa ana akayamba kufunsa mafunso zimavuta kufotokoza, tangoganizani mwana wa standard 7 andifunse zokhudzana ndi kubereka, kuti mwana amatuluka bwanji, zinandivuta kuyankha, nanga munthu ungayankhe bwanji? Kufotokoza zimenezo ndikulaula"
>
> Translation: *"There is no way I can teach the subject explicitly because it is difficult to elaborate when pupils ask questions, an example of a standard 7 (grade 7) pupil who asked me about how the baby comes out of the womb. It was difficult for me to respond to that question. How would you respond to such question? It is a taboo to explain that."*

This is a challenge in the delivery of these subjects. It is a challenge because the teachers do not feel free to talk about things explicitly and as a result children do not get all the required information as it is written in the Teacher's Guide. Another challenge is that the subjects that tackle issues of Sexual Reproductive Health are new and most of the teachers themselves never studied them in college. Hence, they struggle with the issue and it all depends on each individual teacher's own commitment to the teaching of the delicate subject. Some parents/guardians confront teachers over the lessons taught. Not all parents accept the fact that their children are learning about human biology in primary School because they are used to the curriculum where human biology was taught only in Secondary School. The confrontation limits the extent to which teachers can reveal explicit information. This seems to indicate that there is a gap across social spectrum in the way sexuality is handled. Schools are condemned both when they address the issue and when they do not address the issue (Stewart et al, 2001).

The delivery of sex education as a subject is very tricky because it depends on how comfortable the teacher is with the subject and also parental views. Where there is effective sex education it is usually the responsibility of individual teachers who understand its importance (Phillips, 1971).

CHAPTER FIVE

5.0 FINDINGS AND ANALYSIS: Access to Sexual Reproductive Health Services

The health facilities have the information and services but there are factors that prevent the youth from accessing these services. These factors include the lack of sex and gender analysis in programming, attitude of the health personnel, location/ distance, the environment at the health facility and monitoring.

5.1 Lack of sex and gender analysis in Programming

A gender analysis of the male and female youth attendance patterns at the Youth friendly Health Services gave me an insight into why more males than females attend to Health Centres. Individual interviews with co-coordinators were conducted to explore further why the meetings are attended more by males than females. Through observations and discussions, I noticed that during week-days the youth centers are mostly attended by young men, not young women. The utilization profile indicates the gaps in gender analysis; in other words, at the planning stage they did not analyze how young males would benefit and how young females would benefit from the programmes. In one of the youth friendly centres, female condoms were lying in the corner of the office. I was interested to find out more about the female condoms especially since only young men were attending the centre. My question was; how many young women access the female condoms?

The response was;

> "Very few women come to collect the condoms. As you can see, we have so many of them and what you are seeing is just part of the stock we have. Only young women who have children are the ones who usually come and collect condoms. It could be because they have experienced the consequences of having children when one is not financially independent. Young women who live far find them hard to access. It is only when we have outreach activities that we assist them, but it's very rare for us to have such activities. We are even worried now that these female condoms will expire."

If the programme designers and implementers can realize how much more efficient a female condom is for young women as compared with a male condom, then they would realize how vital a part gender analysis plays in programming. A Female condom is more efficient for women than a male condom because it empowers a woman to have control over her own sexual health. The following are some of the advantages of using a female condom (Women' Health Line, 2009):

* It is the amongst the few female contraception means that offer a certain degree of protection from Sexually Transmitted Infections;

* Due to its manner of use, a section of the exterior genitals get a kind of covering that makes it more effectual in warding off Sexually Transmitted Infections as compared to the male condoms;

* The female condom could be introduced prior to the act commencing, thus there is no disruption or waiting time for erection to be able to use as in male condoms;

* It has no evident side effects and does not require doctor's consultation, prescription or any fitting required, which is not the case for several other means of female contraception;

* There is no notable lowering of sensation in the use of female condom as compared to the case of male condoms wherein many men report decreased sensation. Hence, it is favourable for both sexes;

* Following the act, immediate withdrawal by the man is not necessary as in the case of male condoms.

Good gender analysis of their sexual reproductive health programmes will help the authorities to come up with better implementation strategies which will increase young women's access to Youth Friendly Health Services. I believe the authorities would through proper gender

analysis framework, come up with better ways of reaching the young women in order to prevent them from suffering from unwanted pregnancies.

There are various frameworks that are used for gender analysis which stakeholders can select from. I suggest a conceptual framework for gender analysis and planning by Caroline Moser which is commonly known as Moser Framework. The framework is based on her concepts of gender roles and gender needs, and policy approaches to gender and development planning. (International Labour Organization, 1998). Moser categorizes the main policy approaches to women and development into five different policy approaches that can be "identified and categorized in terms of the roles of women on which it focuses and the practical and strategic needs it meets." The five policy approaches are Welfare, Equity, Anti-poverty, Efficiency and Empowerment (See Appendix 2 for details). This framework can be used for planning at all levels from policies to projects (International Labour Organizations, 1998).

The strengths of Moser's Framework (International Labour Organizations, 1998) are that it:

* Moves beyond technical elements of planning, recognizing its political elements and assuming conflict of interests in the planning process. Recognizes the transformative potential of gender planning;

* Conceptualizes planning as aiming to challenge unequal gender relations and support women's empowerment;

* Makes all work visible and valuable to planners, through the concept of triple roles;

* Distinguishes between types of gender needs: those that relate to women's daily lives but maintain existing gender relations (practical gender needs), and those potentially transform existing gender subordination (strategic gender needs);

* Categorizes policy approaches.

A sex and gender analysis of the youth programmes is very important because it helps the stakeholders to appreciate the sex differences and the consequences that are there when

young people indulge unprotected sex. This would be a very good way of recognizing the different impact between young men and women after un-protected sex. The fact is that, it is the woman who bears the more serious consequences of unprotected sex because she is affected personally, biologically, professionally, academically and by the mere fact that she will be the one who will carry the unborn baby.

5.2 Environment of Health Facilities

In most of the hospitals and clinics, the family planning unit is combined with Sexually Transmitted Infections (STI) unit, to an extent that the youth are afraid to access the family planning method for fear of being suspected of having a Sexually Transmitted Infection. In some cases, the hospital environment is hostile to the youth especially where the youth have to use the same queue as the adults they know. Some of them may be their relations or family friends. As a result, the youth do not want to meet people they know when they access information on sexual reproductive health, condoms or contraceptives. To improve this situation there is need for a completely separate area for the youth within the hospitals and health centres.

5.3 Attitude of Health Personnel

Some of the health personnel feel that it is not right to give the information about sexual reproductive health to the youth. As a result, they discourage the youth from accessing contraceptives by asking them awkward questions like;

> "Kodi mwayamba kale zogonanana msinkhu umenewu?"
>
> Translation:"*Have you already started indulging in sex at your age?"*

Some of the health personnel have a very negative attitude towards the youth. They even ask the youth;

> "Mwanamwanawe ukufuna kondomu chifukwa chani?"

Translation:*"As young as you are why do you need a condom?"*

This attitude puts off the youth from accessing condoms because they are afraid of so many questions. Some health personnel even insult the youth who visit the centre. They say:

"Eya kukangoyabwa kumusiku mwayamba kaletu."

Translation: *"Yes, the moment your private parts start itching, you start indulging in sex."*

This actually means they are young and can wait for sex. This usually happens because most of the health personnel do not have the capacity to provide youth friendly health services. The Ministry of Health should aim at improving the skills of many health personnel. So that they literally offer the youth "friendly" services in relation to sexual reproductive health. However, this is a long term strategy. As an immediate strategy, the Ministry should introduce sensitization programmes that are clinic based for health personnel on youth friendly services in order to allow more youth to access the services.

5.4 Location/Distance of Health Facilities

Almost all health facilities are located either in urban or rural areas. This leaves a young woman from peri-urban areas with no option but to use public transport to access the health facilities. Most of the youth in Peri-urban areas stay away from Health centres which are mostly located either in urban or rural areas. Therefore, it is difficult for them to access the services. A good example is Kauma area which is a peri-urban area in Lilongwe. The nearest youth friendly corner the youth of Kauma can access is at Area 18 health centre. The health centre is 30km away and one needs K300 (U$1.50) to go to the youth friendly centre. This is very tricky for the youth, because most of them are not employed. In many households girls rather than boys are the ones who are expected to do household chores. For girls to attend to activities that are provided for the youth at the Youth Friendly Service Centre during the week is very tricky. After school, a girl has to take lunch around 2pm, then do household chores and usually finish around 3pm. For her to walk to the youth centre and go back home it could take several hours. In almost all the youth centres, the meetings are held twice a week. One is during the week and the other one is during week-end. The circumstances of

most of young women cannot allow them to attend the activities at the youth centres during the week. Thus, young men are the ones benefiting more from these youth centres than young women.

5.5 Sustainability of Contraceptives in Clinics and Youth Clubs

There is very good plan and implementation strategies for sexual reproductive health services. The only problem is how best the services can be delivered in order to make an effective impact. One of the issues which are not well addressed is the sustainability of contraceptives in health centres which clearly shows the gap between the Sexual Reproductive Health Policy and its implementation. The research findings provide a clear picture of the procurement process of contraceptives, specifically condoms. UNFPA and other donors are involved in buying of condoms. UNFPA, in particular, supply the condoms to the Central Medical Stores. It's up to the District Health Officer to order the condoms or not. The District Health Officers (DHOs) concentrates more on curative medicine than preventive medicine. The District Health Officers pays a minimal fee that contributes to the handling fee of contraceptives and condoms. The District Health Officers interviewed during the Condom Availability Survey indicated that their drug budgets are able to handle 5% handling fees for condom procurement because it's not too high, relatively speaking.

> *"We do not have strong case for alleviation of condom handling fees, although it appears obvious that it would help move condoms more."*
> (Malawi Government, 2011).

It follows that removal of handling fees would improve the availability of condoms. Therefore, the Government should remove the handling fee attached to contraceptives and condoms to ensure sustainability of contraceptives in all health facilities and in youth clubs.

UNFPA and other donors leave the responsibility of monitoring to the responsible Government departments. Ministry of Youth Development and Sports in particular has the responsibility of monitoring whether the youth are accessing condoms or not.

5.6 Monitoring

From the beginning of the study, it was relevant to understand the mandate of key stakeholders of Sexual and Reproductive Health Rights of the Youth. The mapping out of structures was conducted. The Ministry of Youth Development and Sports, Ministry of Health: Reproductive Unit, Ministry of Education and National youth Council were identified as key players. Soon after mapping out the structures, the actors within the structures were traced. It is through an understanding of these structures and actors that their implementation strategy and monitoring of activities became clear.

Ministry of Youth Development and Sports

The Chief Youth Officer in the Ministry of Youth Development and Sports, explained the mandate of the Ministry of Youth Development and Sports is to disseminate information to the youth. The Chief Youth officer is responsible for information dissemination. The information is disseminated through different stakeholders. The district council is expected to disseminate information at district level to all district stakeholders. There is a District network and Network at Traditional Authority (T/A) level that is used for information dissemination. The Ministry of Youth Development and Sports relies a great deal on Youth Clubs which are at the community level, to discuss issues that affect them as youths including sexual and reproductive health. In the clubs, peer education is the main method that is used. This is guided by National Standards for Youth Peer Education. The Ministry of Youth development and Sports defines "peer education" as defined by Save the Children USA in 2000 as;

> *"a process of sharing information, ideas and opinions between or amongst people of the same age group, interest, goals and experiences."*

The definition of "youth peer education" is derived from the definition of peer education. Therefore youth peer education is defined as;

> *"a process in which youth of the same age, similar likings, experiences and characteristics, impact information or knowledge, values, skills and beliefs on particular issues of their interest or welfare."*
> (Malawi Government, 2009:8)

The challenge is that at the Ministry, there is no special budget for health and reproductive issues. As a result, issues of sexual reproductive health are fitted into the youth budget just like any other issue. Representatives at the Ministry realize that teenage pregnancy is still a big issue because, according to 2010 Malawi demographic survey, the teenage prevalence rate has only decreased by 6% which is very unsatisfactory (Malawi Government: 2011). Therefore, the Chief Youth Officer suggested establishing a special separate budget for health in their ministry. He believes that the special budget for health will assist the ministry to run special programmes on sexual reproductive health.

The monitoring of the programme is done by District Youth offices and is limited to the network level (comprised of youth clubs representatives). Youth clubs within a Traditional Authority area form a network. It is not easy to monitor through clubs because there are so many of them. Each district youth office has a Youth Technical Committee that is involved in the monitoring and the committee is comprised of the following: District Health Office Representative, District AIDS coordinator, and District Education Manager's representative and NGO representatives. The monitoring and implementation of all programmes by all stakeholders of Sexual reproductive Health and Youth Rights is done through the National Plan of Action for scaling up Sexual Reproductive Health and HIV intervention for Young People.

Ministry of Health

The Ministry of Health's Reproductive Health Unit is responsible for Sexual Reproductive Health programmes. The national Sexual and Reproductive Health Rights Policy recognises the fact that young people face a lot of challenges in Malawi due to new patterns of sexual behaviour, harmful and cultural practices, premarital sex and lack of access to family planning education and services (Malawi Government; 2009).

The population and housing census 2008 analytical report, Volume 8: Children and Youth indicates that in 2007, the Malawi Government came up with strategies on how to deal with the issues concerning the youth. One of the strategies is the establishment of Youth Friendly Health Services (YFHS) (Malawi Government, 2010). YFHS are funded by Government and donor e.g. United Nations International Children Education Fund (UNICEF), World Health Organization (WHO), National AIDS Commission (NAC) and United Nations Population Fund (UNFPA). The criteria used for selecting staff for youth friendly health services is age, medical background and interest in youth issues.

The Youth Friendly Health Services are provided in some of the Health Centers and in such centres, there are youth Coordinators. There are 44 health facilities in Lilongwe with youth friendly centres and they are all located in rural and urban areas (Kachigamba, 2011).

The thematic areas for Youth Friendly services are as follows:

* Sexual Reproductive Health;
* STI management (Knowledge, symptoms, care and manifestation);
* Condom promotion (Both male and female);
* HIV Testing and Counselling (in schools and youth friendly hospitals);
* Promotion of family planning.

YFHS promotes family planning through health centres and outreach activities. The outreach activities are conducted in market places and schools. Young women, who get married as young as 18 and below, are encouraged to use long term methods of family planning like Nor-plant. This is offered especially to those who want to continue with their education.

In 2010, National Youth Council was mandated to conduct an assessment for Youth Friendly Health Services throughout the country. The assessment report of Youth Friendly Health Services 2010 reveals that one of the activities for Youth Friendly Health Services is to carry out outreach programmes. This initiative target the youth who stay away from the health facilities, but less than 50% of the health facilities have ever done outreach activities (Malawi government, 2010). In the assessment report, the National Youth council (NYC) recommends the use of outreach activities to reach out to more youth with information and community

distribution of contraceptives. The recommendation by the National Youth Council is good. However the establishment of health centres in Peri-urban areas where Youth Friendly Health Services will be provided will be a big step toward empowering young women to make informed choices about their reproductive health.

The findings by National Youth Council should help the Ministry of Health to conduct a review of the functions of its structures in relation to the people who are targeted. It will also assist the Ministry of health to come up with a monitoring framework that will improve the accessibility of Youth Friendly Health services.

Ministry of Education

The Ministry of Health implements some of its activities of Sexual and Reproductive Health through learning institutions which are under the Ministry of Education.

The Ministry of Education introduced subjects that tackle issues of Sexual and Reproductive Health in mid 2000s. Most of the teachers teaching the subjects that deal with Sexual and Reproductive Health did not learn to teach them in teaching college yet they are expected to teach them to the youth. Therefore, they find teaching the subjects a great challenge. From the information I got from School teachers, the Ministry does not train such teachers in these new subjects. In addition, no Ministry of Education officials go to schools to specifically monitor the teaching of Sexual and Reproductive Health. No special attention is given to new subjects. To improve the situation, the ministry should introduce capacity building programme for new subjects to teachers who never learnt them in teaching college.

National Youth Council

The National Youth Council coordinates youth organizations both in rural and urban locations and there is no clear demarcation as to which organizations work in the peri-urban areas. Some of the organizations which work in the peri-urban areas work there as part of urban. It is very relevant for the council to have a clear demarcation between the

organizations in urban and peri-urban areas. The demarcation will help to enhance access of youth programmes by the youth in the peri-urban since they will have facilities within their reach. The National Youth Council network with various stakeholders which implement youth programmes. The major stakeholders that network with National Youth Council are the Ministry of Youth Development and Sports, Ministry of Health, UNFPA and Ministry of Education. The National Youth Council was mandated to conduct an assessment of the Youth Friendly Health Services and some of the findings of the assessment are highlighted in this report. It has so far played a very good role in the monitoring of Youth Friendly Health Services.

Monitoring is supposed to be done by the above mentioned structures and Actors depending on the role they are playing in sexual reproductive health. A robust, efficient and effective monitoring framework which continually monitors programmes will provide immediate feedback on them. Such feedback will provide immediate information for review and proper reviews will enhance the quality of the delivery of subsequent programmes.

CHAPTER SIX

6.0 IMPROVING IMPLEMENTATION AND UTILIZATION

6.1 Conclusion

This research has helped me and others to appreciate the efforts that the Malawi Government has made in order to reach out to young women in issues of sexuality and reproductive health. It has also helped identify gaps that still exist in the planning and implementation strategies of youth and reproductive health programmes. According to the research findings, there is need to apply more effort in ensuring that a young women's right to prevent pregnancy and control fertility is promoted. It is my hope that the research results will enable all stakeholders dealing with young women to come up with better strategies to address issues of young women and their reproductive health.

The Malawi government as a human rights primary duty bearer has done admirable job ratifying all the necessary international and human rights instruments that deal with reproductive health. In addition, through the Ministry of Health, Malawi has managed to comply with the ratified human rights instruments by coming up with a policy on Reproductive Health. In 2007, the Ministry of Health established Youth Friendly Health Services in order to address the youth's health-related issues in a friendly manner. As part of the establishment of Youth Friendly Health Services, the Ministry also developed standards to be used in health centres where Youth Friendly Health Services are provided. However, this research revealed that even though the Youth Friendly Health Services are available in some health centres, very few young women are accessing them. I believe that the Ministry of Health should make use of the findings in this study by improving the Youth Friendly Health Services which are provided by sensitizing the health workers in Youth Friendly Health Services in order to make the services more accessible to the young women. The Ministry of Health should also consider establishing Youth Friendly Health Services satellites in peri-urban areas. The findings will also be useful for considering the removal of handling fees attached to contraceptives, in order to allow District Health Officers to procure enough

contraceptives for their districts. This can help the sustainability of contraceptives at both district and community level.

The Ministry of Education should make use of the findings to monitor the delivery of subjects that contain issues of sexuality and reproductive health. It will be necessary for the Ministry of Education to go beyond this study to find out the exact nature of the challenges teachers face when teaching these subjects. The ministry will be able to come up with better strategies in capacity building of teachers on issues of sexuality and reproductive health. The current policy on contraceptives by the Ministry of Education is that they should only be provided in tertiary institutions. The Ministry of Education should consider a review of this policy so that the condoms can be available in primary and secondary schools to mature (i.e. those who have reached puberty) students. The availability of condoms to mature students is a very good response to the fact that children still drop- out from school due to unwanted pregnancy.

The Ministry of Youth and National Youth Council has a much bigger role to play by virtue of its working in the community. The findings revealed that the issue of the right to control fertility is very contentious, since there is legal pluralism at work that influences young women's decisions in the area of reproductive health. The youth organizations and clubs should consider using a participatory approach in the sensitization of reproductive health matters, by involving the community and religious leaders right from the inception of their programmes. The involvement of leaders will help to enhance programme delivery. This will definitely yield positive results in the promotion of reproductive rights because it will enable young women to make informed decisions.

To make sure that policies, plans and implementation strategies are making a positive impact, all stakeholders should plan for the ongoing monitoring of the programmes that have been put in place. Ongoing monitoring will help in the proper reviewing of projects and facilitate making the adjustments on them. Malawi has a very good Reproductive Health Policy. If it were to be implemented according to the strategies laid down, young women will enjoy their right to prevent pregnancy and control fertility.

6.2 Recommendations

6.2.1 Capacity Building of Teachers

The schools have the potential for imparting knowledge on sexual reproductive health through three subjects namely: Reproductive Health Education, Life skills, Social and Environmental studies and Sciences. The current weakness in the system is that not all the teachers handling the subjects mentioned have the capacity to handle those subjects. There are various reasons for this lack of capacity and the major reason is that these are new subjects and most of the teachers never studied them in college. Therefore, they are simply expected to read the books on the subjects, understand them and then teach the subjects. The other reasons are cultural and social. Culturally, some teachers feel that it is taboo for an elder to talk about issues of sexuality and reproductive health explicitly to young people who are not married. Socially, some parents feel that their children are too young to get Sexual and Reproductive Health information in Primary school. As a result they confront teachers. Therefore, as a response to parents/guardians' wish, some teachers select from syllabus what they think is proper for pupils.

One of the head teachers stated that some teachers are not very explicit in explaining some of the topics to do with sexual and Reproductive Health, and this she described as being unfair to students. She emphasized that it is unfair, because these children are supposed to have accurate information about sexual and reproductive health. It is unfortunate that up till now some teachers think they are hiding information from children but the truth is that the children already know much more than the teachers think. The only thing the children need is accurate and clear information which can be delivered by a responsible elder. The most unfortunate thing is that all the subjects on sexual and reproductive health are examinable. Hence, poor delivery of the subjects impacts negatively on the students' performance. The head teacher stated that the Ministry of Education should consider coming up with an orientation programme for the subjects that are sensitive. The Ministry should also have continuous professional development programmes to enable teachers to acquire in depth knowledge of the new subjects. This is very imperative because it will improve the quality of their teaching.

In one of the schools I visited, the head teacher initiated peer monitoring which is used to improve the quality of teaching. The monitoring is done in such a way that teachers are not allowed to set examinations for the subjects they teach. In this way, teachers are very serious in making sure that everything is explained clearly to the pupils. This is a very good initiative because the skills of teachers' handling of particular subjects are portrayed through class performance. In order to assist the Ministry of Education, it is very important for head teachers to come up with initiatives for capacity building in new subjects like those dealing with Sexual and Reproductive Health. The initiatives can be implemented at school level.

6.2.2 The Removal of Handling Fees for Contraceptives

The Government should remove handling fees in respect of contraceptives. The removal of the handling fee will improve the availability of contraceptives in the hospitals and health centres. The current situation is that there is no sustained supply of contraceptives in the health facilities. However, the contraceptives are always available at Central Medical Stores. The District Health Officers are supposed to pay a minimum handling fee when they obtain medicines. It is up to the District Health Officers to decide the quantity of contraceptives that are ordered. Unfortunately the tendency of most of the District Health Officers is that they prefer curative medicines rather than preventive medicines. As a result do not order enough contraceptives. In order to promote the reproductive health rights of women, the handling fee relating to contraceptives should be waived.

6.2.3 The Establishment of Health Satellites in Peri-Urban Areas

The Youth Friendly Health Services are provided within health Centres or as outreach activities. The study revealed that, the Health Centres are available in urban and rural areas only. Due to the unavailability of health centres in peri-urban areas, the young people in peri-urban areas are only reached through outreach activities. The assessment of Youth Friendly Services indicates that less than 50% of health centres have managed to conduct outreach activities. The assessment of Youth Friendly Health Services and health centres that I visited indicate that it is very challenging to conduct outreach activities with great frequency because

of lack of finance. This challenge impacts negatively on young women because they are forced to travel long distances to access the services. Most of them do not manage this because of lack of transport money and their involvement in household chores which together prevent them from travelling very far from their households especially during the week. In order to improve young women's access to reproductive health services, the Ministry of Health should establish health satellites in peri-urban areas. The provision of Youth Friendly Services to young women within their reach would be a positive step in the promotion of reproductive health, especially the right to prevent pregnancy and control fertility.

6.2.4 Capacity Building of Health workers

The Ministry of Health should build the capacity of Health Surveillance Assistants[2] in Youth Friendly Health Services in order to allow them to provide information and services on sexual reproductive health. This will enhance the availability of reproductive health services in communities where there are no health centres such as in peri-urban areas. The Health Surveillance Assistants are in a very good position to assist young women in issues of reproductive health since they work in the communities and any member of the community is free to ask for any assistance related to health from them. The fact that any member of community can approach the Health Surveillance Assistants makes it easy for the young women to ask for information or services regarding reproductive health, without encountering the elders of the community. The current situation is that the Health Surveillance Assistants only provide the pills and condoms and most of them are not trained to provide inject able contraceptives. The injectable contraceptives are only available in health centres and are easily accessible to those who live near the clinic and to the adults. I believe that if the services were provided at community level that would help most of the young women access contraceptives and make informed choices. This will definitely be an advantage to young women living in peri-urban where there are no health centres. The ministry should also sensitize the health workers in health centres where Youth Friendly Health Services are

[2] Health Surveillance Assistants (HSA) are health personnel employed by MOH and are based in communities. They are employed to assist the communities in health issues.

provided in order to make the services more accessible to most of the youth especially the young women.

6.2.5 Sensitization of parents and religious leaders

The Ministry of Youth Development and Sports through youth clubs, newspapers, television, and outreach activities should sensitize parents and religious leaders on the importance of imparting correct knowledge on reproductive health to the youth. It is unfair to young women that up to now, parents/guardians and religions feel that the right time to tell young women about issues of sexuality and reproductive health is when they are about to get married. Before reaching that stage, young women often have sexual experiences and end up being misinformed by their peers. Some have ended up having unwanted and unplanned pregnancies because they were misinformed by their peers about contraception.

The process should be participatory in order for it to be successful. The religious leaders and community leaders should be involved from the designing to the implementation stage in order to have successful projects. The involvement of the religious and community leaders will help the removal of religious and traditional barriers which prohibits women from accessing contraceptives. The misconception of conception and contraception clearly shows a serious lack of knowledge about reproductive health, more especially, contraception. The provision of accurate and appropriate information on sexual reproductive health will promote young women's rights to prevent pregnancy and control fertility.

6.2.6 Reform of abortion law

There is an increase in the number of un-safe abortions. This is because the law only permits safe abortions for women whose lives are in danger. The law has to be reviewed in order to broaden the conditions under which abortion is permitted.

6.2.7 Utilization of Gender Analysis frameworks

Utilization of Gender Analysis Frameworks is very important in Sexual Reproductive Health Programmes. It helps effective planning and implementation of programme that target both men and women since there is consideration of gender approach to both policies and implementation strategies. The gender analysis will challenge the assumption that young men and young women are affected in the same way by policies and implementation strategies for Sexual Reproductive Health programmes. Therefore, it allows the key stakeholders to make sure that programmes are designed in such a way that both men and women are benefiting.

6.2.8 Constitutional Amendment

The age of marriage should be increased from 16 to 18 years in order to comply with the age at which a child becomes an adult as stipulated in the Convention on the Rights of the Child (CRC) and African Charter on the Rights and Welfare of the child (ACRWC) in article 1 and article 2, respectively. S22 (7) of the Constitution states that, for persons between the age of 15 and 18 years, a marriage shall only be entered into with the consent of their parents or guardians. This section needs to be repealed because the power vested in parents and guardians is abused.

S22 (8) of the Constitution states that, the state shall actually discourage marriage between persons where either of them is under the age of fifteen years. This section should be amended to allow the state to prevent any marriage of children less than 15-18 years instead of simply discouraging them.

In 2010, the legislature agreed on 16 years as the marriage age for customary law marriages but the President never assented to the bill due to the public outcry and it has been sent back to Parliament for further discussion. The proposed amendment to the constitution on marriage mentioned above will assist prevention of early marriage which in turn will prevent early child bearing. If there will be a possibility for young women to prevent early marriage, they will be able to pursue their education to the level they want. Therefore, will have an opportunity to development in the future. Public awareness after the amendment of the

constitution will be very important. This will enable the public to know the new law and change some norms.

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APPENDIX 1: MALAWI ABORTION POLICY

ABORTION POLICY

Grounds on which abortion is permitted:

To save the life of the woman	Yes
To preserve physical health	No
To preserve mental health	No
Rape or incest	No
Foetal impairment	No
Economic or social reasons	No
Available on request	No

Additional requirements:

Authorization must be obtained following consultation with a professional. Permission of the spouse is, in theory, required.

REPRODUCTIVE HEALTH CONTEXT

Government view on fertility level:	Too high
Government intervention concerning fertility level:	To lower
Government policy on contraceptive use:	Direct support provided
Percentage of currently married women using modern contraception (aged 15-49, 1996):	14

Total fertility rate (1995-2000):	6.8
Age-specific fertility rate (per 1,000 women aged 15-19, 1995-2000):	162
Government has expressed particular concern about:	
Morbidity and mortality resulting from induced abortion	Yes
Complications of childbearing and childbirth	Yes
Maternal mortality ratio (per 100,000 live births, 1990):	
National	560
Eastern Africa	1 020
Female life expectancy at birth (1995-2000):	39.6

BACKGROUND

Under the Malawi Penal Code of 1930 (Sections 149-151), the performance of abortions is generally illegal. A person who unlawfully uses any means with intent to procure an abortion is subject to 14 years' imprisonment. A pregnant woman who unlawfully uses any means or permits the use of such means with intent to procure her own abortion is subject to seven years' imprisonment. A person, who unlawfully supplies or procures anything whatever, knowing that it is intended to be unlawfully used to procure an abortion, is subject to three years' imprisonment.

Nonetheless, abortions can be legally performed in Malawi to save the life of the pregnant woman. Section 243 of the Penal Code provides that a person is not criminally responsible for performing in good faith and with reasonable care and skill a surgical operation upon an unborn child for the preservation of the mother's life if the performance of the operation is reasonable.

Malawi does not follow the holding of the 1938 English *Bourne* decision in determining whether an abortion performed for health reasons is lawful. In the *Bourne* decision, a court ruled that the performance of an abortion was lawful because it had been performed to prevent the woman from becoming "a physical and mental wreck", thus setting a precedent for future abortion cases performed on the grounds of preserving the pregnant woman's physical and mental health.

The Government of Malawi considers its rates of population growth and fertility to be unsatisfactory and too high. For many years, however, it refrained from formulating a policy of explicit intervention to modify fertility or population growth. The Government has emphasized birth spacing as a means of improving the health and welfare of its population. Indeed, when the family planning programme was introduced in 1982, its chief objective was to encourage birth spacing. In September 1987, the ruling party adopted a resolution calling for birth spacing as a national policy. However, the Government's position was that the programme should encourage and facilitate families to space children and should not interfere with their right to have the number of children they desire.

Subsequently, the Government decided to address the fertility issue more directly and began formulating a comprehensive population policy with the explicit aim of reducing fertility and population growth. The Government's goals are to strengthen the national child spacing programme; to increase the availability of family planning services; and to increase the contraceptive prevalence rate from 7 per cent in 1992 to 28 per cent in 2002. This would involve increasing the number of users of modern contraception from 68,000 in 1992 to 680,000 in 2002. 1996 figures place the modern contraceptive prevalence rate at 14 per cent and the Government estimated it to be at 20 per cent in 1999. The total fertility rate for the period 1995-2000 is 6.7 children per woman.

The Government has also expressed its concern about the level of induced abortion and adolescent pregnancies and is strengthening its information and educational programmes. In its reply to the *Eighth United Nations Inquiry among Governments on Population and Development,* the Government reported that it had liberalized its contraceptive guidelines for adolescents. After the International Conference on Population and Development, held in Cairo in 1994, Malawi adopted in 1996 family planning policy and contraceptive guidelines

aimed at liberalizing family planning services to accommodate all individuals within the reproductive age groups needing such services. The new contraceptive guidelines removed limitations on use of specific methods on the basis of criteria such as parity and age. The new family planning policy also promoted new approaches for accessing and expanding family planning services such as community based delivery of contraceptives and social marketing. A safe motherhood plan of action was implemented. In addition, following the adoption of the national youth policy in 1996, a youth adolescent programme for reproductive health was put in place. In the period ahead, Malawi intends to place increasing emphasis on adolescent reproductive health and to finalize a national reproductive health policy.

APPENDIX 2: MOSER'S FRAMEWORK POLICY APPROACHES

Moser categorizes the main policy approaches to women and development as follows:

Policy approaches to low-income Third World women have shifted over the past decade, mirroring shifts in macro-economic development policies. Five different policy approaches can be identified, each categorized in terms of the roles of women on which it focuses and the practical and strategic needs it meets.

Welfare: Earliest approach, 1950-70. Its purpose is to bring women into development as better mothers. Women are seen as passive beneficiaries of development. It recognizes the reproductive role of women and seeks to meet PGNs in that role through top-down handouts of food aid, measures against malnutrition and family planning. It is non-challenging and, therefore, still widely popular.

Equity: The original WID approach, used in the 1976-85 UN Women's Decade. Its purpose is to gain equity for women, who are seen as active participants in development. It recognizes the triple role and seeks to meet SGNs through direct state intervention giving political and economic autonomy, and reducing inequality with men. It challenges women's subordinate position. It is criticized as Western feminism, is considered threatening, and is unpopular with governments.

Anti-poverty: The second WID approach, a toned-down version of equity, adopted from the 1970s onwards. Its purpose is to ensure that poor women increase their productivity. Women's poverty is seen as a problem of underdevelopment, not of subordination. It recognizes the productive role of women, and seeks to meet the PGN to earn an income, particularly in small-scale income-generating projects. It is most popular with NGOs.

Efficiency: The third, and now predominant, WID approach, adopted particularly since the 1980s debt crisis. Its purpose is to ensure that development is more efficient and effective through women's economic contribution, with participation often equated with equity. It seeks to meet PGNs while relying on all three roles and an elastic concept of women's time.

Women are seen entirely in terms of their capacity to compensate for declining social services by extending their working day. very popular approach.

Empowerment: The most recent approach, articulated by Third World women. Its purpose is to empower women through greater self-reliance. Women's subordination is experienced not only because of male oppression but also because of colonial and neo-colonial oppression. It recognizes the triple role, and seeks to meet SGNs indirectly through bottom-up mobilization of PGNs. It is potentially challenging, although its avoidance of Western feminism makes it unpopular except with Third World women's NGOs.