TOGETHER IN REPRODUCTIVE HEALTH RIGHTS: A POLICY AND STRATEGIES ANALYSIS ON MEN`S INVOLVEMENT IN PROMOTING WOMEN`S SEXUAL AND REPRODUCTIVE HEALTH RIGHTS IN MALAWI

Abstract

The writer of this dissertation asserts that concerted national campaigns to improve the reproductive and sexual health of Malawi's women have failed to achieve their goal. This is because, in breach of binding regional and international HR instruments, these campaigns have excluded the participation of husbands who have a duty to share the protection and realization of this right with their wives. This duty is all the more pronounced in Malawi's heavily patriarchal society in which men exert a significant influence over both the public and private lives of their wives, regardless of whether their marriages are matri- or patrilineal. The writer, therefore, reviews Malawi's health system with a view to identifying the areas in which men's involvement in the exercise and protection of their wives' human right may be accommodated and/or improved. His review, which is presented through the eyes of both marriage partners taken from a sample population in the Nsanje and Thyolo districts of Malawi, is based on primary (i.e., human) and secondary (i.e., documentary) evidence which is gathered (using a variety of methods) and analysed utilizing several inter-related gender-sensitive methodologies, in particular, the Grounded, Women's Law and Human Rights based Approaches. Finally, based on the research's conclusions, extensive information/ education campaigns are included among the recommendations put forward to assist Malawi's men in adapting to their new role.

BY

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DEDICATION

To my mother and father Noria and Francisco Malunga. Mom I wish you were near and around. *Baba Na Mama*. You are my heroes!

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All mistakes, whatsoever in this report are the author's liability.

LIST OF ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome.
ANC	Antenatal care
ART	Antiretroviral Therapy
BEmOC	Basic Emergency Obstetric Care
CFR	Case Fatality Rate
CHAM	Christian Health Association of Malawi
COM	College of Medicine
COMREC	College of Medicine Research and Ethics Committee.
CPR	Contraceptive Prevalence Rate
DFID	Department for International Development.
DHO	District Health Officer
EHP	Essential Health Package
FGD	Focus Group Discussion
FP	Family Planning
HIV	Human Immunodeficiency Virus
HSA	Health Surveillance Assistant
IEC	Information Education and Communication
ICPD	International Conference on Population and Development
MDG	Millennium Development Goal
MMR	Maternal Mortality Rate
MMR	Maternal Mortality Ratio
MNH	Maternal and Neonatal Health
MoH	Ministry of Health
MSWL	Masters in Women's Law
NGO	Non Governmental Organization.
NHA	National Health Act
NHP	National Health Policy
NMR	Neonatal Mortality Rate
NRHS	National Reproductive Health Strategy
PMTCT	Prevention of Mother to Child Transmission
POA	Programme of Action
POW	Programme of Work
PSI	Population Services International
RHU	Reproductive Health Unit
SWAp	Sector Wide Approach
TA	Traditional Authority
TBA	Traditional Birth Attendant.
UN	United Nations
UNFPA	United Nations Population Fund
UNIMA	University of Malawi
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
UZ	University of Zimbabwe
VCT	Voluntary Counseling and Testing
VHC	Village Health Committee
WHO	World Health Organization

LIST OF STATUTES

The Malawi Constitution of 2004

Malawi National Health Act 2008

LIST OF INTERNATIONAL INSTRUMENTS

The Convention on the Elimination of all forms of Discrimination Against Women (CEDAW) 1979

The Protocol to the African Charter on Human and People's Rights on the Rights of Women 2003

International Conference on Population and Development ICPD 1994

The Beijing Platform for Action 1995

The Universal Declaration on Human Rights UDHR 1948

The United Nations International Covenant on Civil and Political Rights ICCPR 1966

UN Convention on Economic, Social and Cultural Rights ICESCR 1966

Proclamation of Teheran, Final Act of the International Conference on Human Rights, Teheran, 22 April to 13 May 1968 UNDOC.A/CONF.32/41 at 3 (1968)

DECLARATION

I declare that: ***Together in Reproductive Health Rights:***
A Policy and Strategies Analysis on Men's Involvement in Promoting Women's Sexual and Reproductive Health Rights in Malawi; Is my own work and it has not been submitted at the UZ or any other institution for the award of certificate.

Signed:……..
Anthony Malunga Jeckson .....Date: 26-03-2010

Supervisor: ……...
Ms R. Katsande (PhD Scholar) ……Date:26-03-2010

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CHAPTER ONE

INTRODUCTION AND STUDY BACKGROUND

1.1 Introduction

The empowerment of women which entails the transformation of unequal power relations to allow women to gain equality with men has been recognized through many international, regional and national conferences as a basic human right. Sexual and reproductive health rights (SRHR), male participation and acceptance of changed roles are essential for women's empowerment[1]. In this paper, focus is on how we can best promote women's RHR specifically family planning, maternal and neonatal (FPMN) health rights at policy and intervention level through male involvement in Malawi. The focus on FPMN SRHR was because Malawi by 2006 was still registering higher maternal and neonatal (MN) death rates. Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system (International Conference on Population and Development ICPD, 1994). The study focuses on married women and men in two districts, namely, Nsanje, a patrilineal, and Thyolo, a matrilineal, district in southern part of Malawi.

It should be borne in mind at the outset that the study is based on one key assumption: That married women in Malawian are unable to enjoy their FPMN SRH rights partly because the Ministry of Health (MoH) has no effective policy or strategies on male involvement in their wives/women's SRH rights. The basis of the assumption is that in marriages equality and shared responsibility are among the core principles promoted in law and human rights standards for the couple. I decided to research this topic as a result of studying the human rights course and my experiential data. Having roots in a patrilineal society, I recall having a conversation with a village man in 2008 who had fathered nine (non-spaced) children and asking him whether he had ever considered family planning (FP). The man said *it's a 'taboo' and 'source of misery and sickness'* to the woman if all the children in her

[1] http://web.unfpa.org/intercenter/cycle/introducton.htm#The Rights Agenda –accessed on 23-02-2010

womb were not born. I was shocked and said to myself I would research this issue as and when the opportunity arose.

1.2 Scope of Sexual and Reproductive Health Rights

International understanding about SRHR has broadened considerably in recent years. The ICPD Programme of Action (POA) 1 and the Beijing Platform for Action 2 recognize sexual and reproductive rights (SRR) as inalienable, integral and indivisible parts of universal human rights. The most important SRHR according to ICPD and Beijing Platform include: (i) SRH as a component of overall health throughout the life cycle, for both men and women; (ii) Reproductive decision-making, including voluntary choice in marriage, family formation and determination of the number, timing and spacing of one's children; and the right to have access to the information and means needed to exercise voluntary choice; (iii) Equality and equity for men and women, to enable individuals to make free and informed choices in all spheres of life, free from discrimination based on gender; and (iv) SRH security, including freedom from sexual violence and coercion and the right to privacy. For the purpose of this study SRHR should be understood from the second and third definitions. Those definitions are important as they have implications for a couple's FP choice and its impact on maternal and neonatal health (MNH).

1.3 Reproductive Health and Male Involvement

Since the ICPD, there has been a paradigm shift away from programs focusing solely on women's health and family planning towards SRH more generally. While men have specific and often neglected needs, their roles and responsibilities also impact on the health and well-being of women and children (Power, 2005). Thus, in those cultures like Malawi where men are the main decision makers in the family and community, if men are supportive of the goals of reproductive health programs then it might reasonably be expected that the programs are more likely to achieve success. It is a widely held belief that African men, especially in the rural areas, are opposed to FP. And at the surface of it, it appears that they are. However, FP services in Africa are built around maternal and child health programs, which means they cater almost exclusively for women (Haile *etal* 2000). FP information and services are

designed and implemented with women in mind. Yet men are also affected by the health of their spouses and children. They would like to get information and services in a culturally appropriate environment for them to understand and support FP activities. ICPD was one of the first international conferences to recognize the male role in reproductive health. Its Programme of Action (POA) stated that:

> Innovative programmes must be developed to make information, counseling and services for reproductive health accessible to adolescent and adult men. Such programmes must both educate and enable men to share more equally in family planning and in domestic and child rearing responsibilities and to accept the major responsibility for prevention of sexually transmitted diseases…

As the POA noted, given that men play a significant role in women's SRH outcomes, it 'adds value' to women's health to engage men as partners in programs. The same message was reinforced at the Beijing (1995) Conference,

> Shared responsibility between men and women in matters related to reproductive and sexual behavior is essential to improving women's health.

However, internationally and locally, the role of men in sexual and reproductive health, despite being part of the reproduction function, has been overlooked to a large extent. Alternatively, men's role in promoting women's MNH has been relegated to the role of special groups, gate keepers or disguised as community participation (Wegner, *etal* 1998, Malawi MoH, NRHS 2006-2010, WHO 2004). This is the case in Malawi to the extent that the national policy and its guide lines on FPMN health recognize the lack of male involvement is a threat to women's enjoyment of their SRH rights.

1.4 Problem statement

Sub-Saharan Africa continues to register high MN mortality rates. Malawi is in sub-Saharan Africa, and by 2006 its maternal mortality ratio was 807 per 100,000 and its neonatal mortality ratio was 33 per 1000 (Multiple MICS 2006 in Road Map 2007). With such figures Malawi may not attain the millennium development goals, specifically MDG 4, which calls for reduction in child mortality and MDG 5 which calls for reduction of maternal deaths. However, a lot of effort has been put into reducing MN mortality rates like predicting and preventing obstetric complications, antenatal care; training traditional birth attendants; and community mobilization. In

Malawi and elsewhere studies have shown that some men do not allow their wives to go for family planning for cultural, religious and other reasons (UNHCR and UNFPA 2003, USAID 2005). This has contributed to high MNMR as women are subjected to too many and too frequent pregnancies which pose risks to them and their newborn babies. However, the problem is that the role of men in their wive's FPMN health has not been explored to any great extent; instead it has been overlooked and relegated to the role of special groups in Malawi. This has had a negative impact on women's exercise of their SRH rights. The study intends to explore this role of men in their wives SRH in Malawi.

1.5 Study Objectives

Main objective

To explore the impact of promoting togetherness/male involvement at policy and strategies level on women's exercise of sexual and reproductive health rights in Malawi.

Specific objectives

1. To find out how 'women centered' SRH policy and strategies conflict with the standards as regards to marriage and its shared responsibility.

2. To appreciate the perception that men may not be easy to convince in matters of SRH and hence their exclusion from it; and to determine its negative impact on women given the influential male position in Malawi.

3. To find out whether the perception that 'it is men who decides on SRH roles' is in fact prevalent among women and men in Malawi.

4. To assess whether male's involvement in the 'perceived' women's sexual and reproductive function as shared responsibility in the families would impact positively on women's exercise of their SRH rights.

5. To find out if men are willing and ready to be involved in their (wive's) women's SRH once policy and strategies on this recognizes the joint role of parties to the marriage on reproductive rights.

1.6 Study Assumptions

1. That 'women centered' SRH policy and strategies are against the standards as regards to marriage and its shared responsibility.

2. The perception that men may not be easy to convince in matters of SRH hence their exclusion raises problem given the influential male position in Malawi.

3. The perception that 'it is men' who decides on SRH roles is prevalent among women and men in Malawi.

4. That men's involvement in perceived women's sexual and reproductive function as shared responsibility in the family would impact positively on women's exercise of their SRH rights.

5. That men are willing and ready to change and be involved in their (wive's) women's SRH once policy and strategies on this recognizes the joint role of parties in the family on reproductive rights.

1.7 Research Questions

1. Are 'women centered' SRH policy and strategies against the standards as regards to marriage and its shared responsibility?

2. a) To what extent is the perception that 'men may not be easy to convince' in matters of SRH leading to their exclusion problematic?

b) What is the negative impact of the above perception on women's exercise of their SRHR given the influential male position in Malawi?

3. How prevalent is the perception 'it is men' who decides on SRH roles among women and men in Malawi?

4. How would male involvement in the 'perceived' women's sexual and reproductive function as shared responsibility in the families impact positively on women's exercise of these rights?

5. a) Are men willing to be involved in their (wives) women's SRH rights promotion?

b) How would policy and strategies on SRHR enhance the male willingness to jointly share role with their wives on reproductive health?

Explanation on research design based assumptions

There were some changes to the assumptions due to what was experienced in the data collection process. Initially during the research design the broad aim of the study was to explore the effects that women centred SRH strategies have on married women given the principles provided for in local, regional and international human rights law and standards as regards to marriage and its shared responsibility in patrilineal and matrilineal societies and how male involvement in these strategies could positively benefit women's exercise of their SRH rights. Based on this broad aim the following assumptions were formulated at research design stage.

1. That women centered SRHR strategies are against the principles as provided in local, regional and international human rights law and standards as regards to marriage and its shared responsibility.

2. The perception that 'it is men' who decides on SRH roles is entrenched by women's socialization in matrilineal and patrilineal communities which can be deconstructed.

3. That men are socialized to uphold cultural norms and beliefs that perpetuate male dominance on women's SRH which can be deconstructed.

4. That men's involvement in perceived women's sexual and reproductive roles as shared responsibility roles in the communities would impact positively on women's exercise of their SRH rights.

5. That men in patrilineal and matrilineal societies hold different views on their involvement in women's SRH rights.
-Patrilineal men believe that they should be the only decision maker on reproductive rights like on the number of children.
-Matrilineal men are more liberal and flexible on the number of children they should have as a family.

6. The perception that men may not be easy to convince in matters of SRH hence their exclusion raises problems given the male position in the two societies in Malawi.
-Men are dominant and mostly decision makers in the two societies.
-Men's influential position in families and community could be an entry point to involve in rather than exclude them from SRH rights.

7. That men are willing to be involved in their (wives) women's SRH roles once interventions and strategies on these issues recognize their joint role in the family on matters of sexual and reproductive rights.

These assumptions as can be seen are slightly different from the ones earlier mentioned in section **1.6.** There was such a change because when the process of data collection started it was noted that assumption **3** and **5** independently were actually being challenged as there was no sufficient data that was being collected, instead what respondents said supported assumption **2.** This meant that I had to reword assumption **2** to be able to take some elements of assumptions **3** and **5**. Hence, the assumptions changed to be what they are in section **1.6**. Thus, this was the essence of a grounded approach as will be explained in the methodology section in which data informs the development of new theory and concepts. Another minor change to the assumptions was their wording and placement, as can be seen in section **1.6;** the assumptions were relocated so as to collect data that was deemed consistent with the development of the topic at hand.

1.8 Why this Study

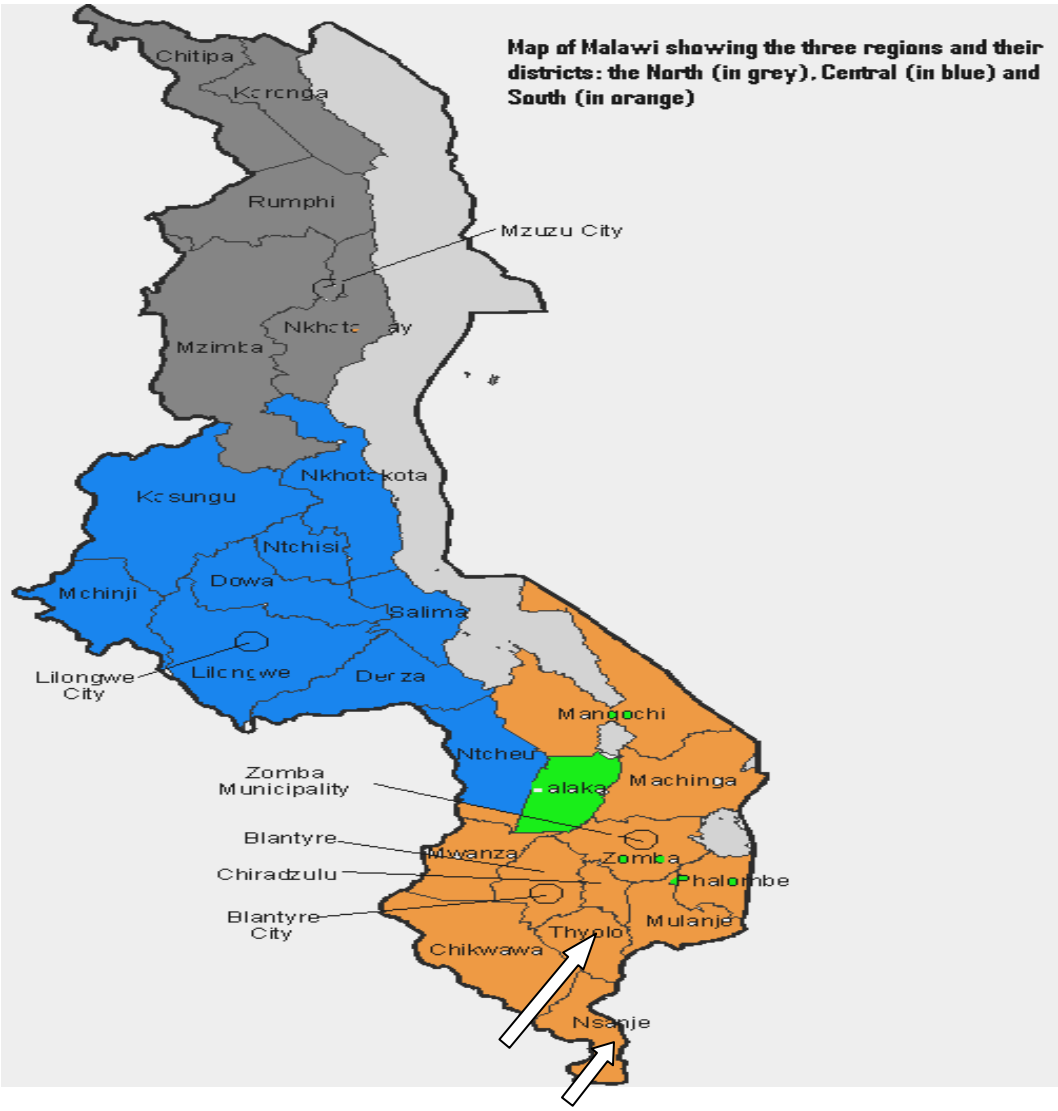
This study was worth pursuing for the following reasons.

- It will contribute to the people's understanding on women's SRH rights from a male involvement viewpoint.
- It will also add to the literature on SRH issues in general.
- Further, it will contribute to the understanding of male and female altitudes on Family Planning, Maternal and Neonatal health and roles.
- It will also help the researcher to be more equipped on issues of women's health rights especially SRH which will enable him to contribute from an informed view point.
- Lastly, it will contribute to the changing of strategies; interventions plus policy direction on how best to ensure married women enjoy their sexual SRH rights in Malawi.

1.9 Delineation of the study

The study was conducted in Thyolo and Nsanje districts as indicated by arrows on the map (See figure.1). Thunga Village, T/A Bvumbwe in Thyolo and Nthukuso Village, T/A Malemia in Nsanje were the main sites for the study. The choice of these two communities was based on their proximity to the District Assembly. Thunga is approximately 20 kilometres either from Blantyre or Thyolo district and only less than 5 kilometres from the main road. Nthukuso is less than 10 kilometres from Nsanje District hospital and the district assembly. It was assumed that the two areas` proximity to the district assembly and main roads meant they are catchment areas of a number of NGOs that are focussing on women's rights and HIV/AIDS. It was also assumed that the two areas` proximity to the main district hospitals and clinics mean that they might be aware of FPMN health issues. For instance Thunga has a clinic within the estate area that provides FP, VCT and antenatal services.

Figure 1: Map of Malawi showing the two study districts (see white arrows)



1.10 Organisation of the work

The research paper starts with the introduction, which includes the objectives of and justification for the study. The second chapter is on conceptual, literature review and best practices analysis. This is followed by the methodology and methods chapter which highlights how the research was done. The fourth chapter brings home the policy, legal and strategies analysis for Malawi as regards to the topic. The fifth chapter is on findings of the study in which discussion takes place in the light of the previous chapters. The last chapter contains the conclusion and recommendations arsing from the study.

CHAPTER TWO

THEORETICAL, LITERATURE AND BEST PRACTICES REVIEW

This chapter looks at the health related theories and reviews literature citing examples of best practices on the issues of male involvement in women's SRH rights.

2.1 Health theories relevant to this study

Theory gives planners tools for moving beyond intuition to design and evaluate health behavior and health promotion interventions based on understanding of why people do or do not engage in certain health behaviors. There are basically two major sets of health theories namely Explanatory and Change Theory[2]. Explanatory theory describes the reasons why a problem exists. Change theory guides the development of health interventions. Health Belief Model (HBM) is one of the explanatory theories used within the ecological perspective in this study.

2.1.1 An Ecological Perspective

It emphasizes the interaction between, and interdependence of factors within and across all levels of a health problem. One concept of the ecological perspective is the multiple levels of influence. McLeroy *etal* (1988) identified five levels of influence for health-related behaviors namely: (1) *intrapersonal factors* (altitudes, knowledge and beliefs); (2) *interpersonal factors* (family, friends and peers support); (3) *institutional factors* (rules and regulations which affect behaviors); (4) *community factors* (social norms among individuals); and (5) *public policy factors* (local or state laws/policies that regulate health practices). All these levels of influence were relevant in some way in this study as will be seen in the findings and discussion chapter. The relevance of HBM is based on intrapersonal factors.

[2] Glanz, K etal (2005)

2.1.2 Health Belief Model[3]

It was one of the first theories of health behavior, and remains one of the most widely recognized in the field.

Recently researchers have expanded upon this theory and it has six arguments. It posits that individuals are ready to act if they:

1. Believe they are susceptible to the condition (*perceived susceptibility*)
2. Believe the condition has serious consequences (*perceived severity*)
3. Believe taking action would reduce their susceptibility to the condition or its severity (*perceived benefits*)
4. Believe costs of taking action (*perceived barriers*) are outweighed by the benefits.
5. Are exposed to factors that prompt action (e.g. Radio/TV advocacy or individual or community involvement (*cue to action*)
6. Are confident in their ability to successfully perform an action *(self-efficacy)*

The above six steps are crucial if one has to appreciate the findings of this study in chapter five and the voices of the respondents involved.

2.2 Literature and Best Practices Analysis

One-fifth of all illness experienced by women of child-bearing age is associated with poor sexual and reproductive health. Each year worldwide, more than half a million women die unnecessarily as a result of complications of pregnancy and childbirth, half of the deaths occurring in developing countries. A woman in sub-Saharan Africa has a lifetime risk of dying during pregnancy or childbirth of 1 in 16, compared with 1 in 3,800 for women in the UK (DFID, 2004). Research has shown that behind these deaths is a failure to assure women's rights, women's low status and lack of power, poor access to information and care, restricted mobility, early age of marriage, and the low political priority and resources given to their health (Malawi Law Commission, 2003; Grant, 2005 and UN, 2008)

The introduction of FP services in sub-Saharan Africa has come late starting in urban centers and expanded slowly to the rural areas. Despite the fact that traditional Africa utilized different mechanisms to space child births, modern FP was not readily

[3] Glanz, K etal (2005)

accepted. Haile *etal* (2000) records that in the late 1970s and early 1980s, the virtues of population programs started to become better understood for reasons including the realization that FP could have a positive impact on the health of mothers and children. Today most African countries including Malawi have embraced FP as an integral part of their reproductive health program. At the ICPD (1994), African countries played an active role in passing the final resolutions which called for the generalization of reproductive health services in member countries. The majority of the African populations like in Malawi [about 85%] live in rural areas while better family planning services are mostly in urban areas, therefore most of the unmet need for FP in Africa is among the rural population (Haile *etal* 2000). Although traditions and cultural beliefs about children, women's position and reproduction are more prevalent in rural areas like in Thunga and Nthukuso in the two study districts. Lack of information and services on FP entails that millions of rural men and women want to regulate their reproductive lives (Haile *etal*, 2000), but this, exacerbated by the lack of male involvement in FP, they are unable to do so.

Haile and others (2000) mentioned a number of suggestions to ensure FP programmes benefit the rural majority. Namely that governments` commitment should go beyond policy declarations and start to play a proactive role to make services available and increase the use of FP by encouraging the private and NGOs sector to get involved in FP services**.** Involving the community in outreach programs like the Kenya, Zimbabwe and Ghana successful Community Based Development (CBD) programs few years ago. For a CBD program to be successful, Haile noted it has to be supported and managed by the community where community leaders [who are often men] play an important role in influencing the attitudes of their subjects. Social Marketing of Contraceptives (SMC) using radio, TV, sports advert among others has also made tremendous progress in Africa in the last few years and this is being championed in Malawi by PSI among others.

Male involvement best practices

Although pilot programs and initiatives for including men in family planning and other reproductive health services have existed for more than 20 years in a number of countries few are well-established, and fewer still have been fully integrated into their country's health care system. Program managers and policymakers in many countries have almost automatically assumed that men are not interested in or supportive of family planning and contraceptive use; even though research shows that many men are (Wegner *etal*, 1998).

2.2.1 Male Involvement in family planning

Men's participation and participatory 'right to heath' based policy and programs are amongst the ways to ensure women enjoy their SRH (Haile *etal* 2000, IPAS, 2009[4]). Despite the belief that African men, especially in the rural areas are opposed to family planning, in few places where men have been involved either in the program design or implementation, they have shown support for the program. Haile asserts that in some places men tend to show stronger support for FP than women. For instance Population Council (1998) reports that in Burkina Faso over 80% of men interviewed were interested in getting information about family planning. In North-West Cameroon, a program that had the support and participation of community leaders (all of them men) was able to increase the use of contraceptives in the community. In a survey conducted in four countries (Burundi, Ghana, Kenya and Mali), more than three quarter of the men approved of family planning except in Mali where the level of support was lower (Population council, 1998).

Haile *et al.* reports of a study in Addis Ababa, Ethiopia by Family Health International which suggested that involving husbands in family planning education significantly influences a couple's decision on whether to begin using contraceptives. More than 500 married women who never used contraception before were involved in this study. After one year, contraceptive use was nearly double among couples who received husband-wife counseling. Johns Hopkins CCP (1997) reviewed 20

[4] http://www2.ohrchr.org/english/issues/women/docs/responses/Ipas.pdf accessed on 19-03-2010

men's family planning programs from Africa, Asia and Latin America and found that contrary to what some supposed, many men wanted to be involved in family planning programs and that those programs in which men were viewed as caring partners rather than as irresponsible adversaries were successful in involving men.

2.2.2 Male involvement in women's reproductive health

There are few reports about men's involvement in maintenance of women's reproductive health**.** Dev reported on an Indian program that aimed at involving husbands in antenatal care checkups (Dev, 1998) and Toubia reported on a program in Mali, which aimed to encourage men to accompany their spouses to family planning and gynecological services. During the Indian program, men were given information about antenatal care services, information about diet, nutrition and weight gain during pregnancy, and information about contraception. Such men had a greater knowledge of the importance of antenatal care services, and their partners made more visits to antenatal care clinics.

UNHCR and UNFPA (2003) compiled a study on one town in Afghanistan on maternal mortality. One of the findings was that, 74 percent of the 4486 women stated that the husband and wife made decisions about the number and spacing of children equally. Thus the study identified human rights factors that may contribute to preventable maternal deaths in the region which included access and denial of personal freedoms suggesting the need for male involvement. Wegner *etal*, (1998) cautioned that neglecting to provide information and services for men can detract from women's overall health. For example, men who are educated about reproductive health issues are more likely to support their partners in decisions on contraceptive use and family planning, support that may be essential if women are to practice safe sex or avoid unwanted pregnancy. Further, the role of men is perhaps most obvious in regard to HIV/AIDS and other STDs.

The Fatherhood Project in South Africa (SA) and SA National Dept of Health (2007) reports of successes of engaging men and boys in SRH, HIV/AIDs and other related programs. They reported that men are willing to change their attitudes and practices

and sometimes to take a stand for greater gender equality. SA further reports of Men as Partners (MAP) Network research which found that 71% of the study participants believed that women should have the same rights as men. Furthermore, through 'One Man Can Campaign' responsible fatherhood on children and the wives on SRH is being promoted in SA.

2.3 Feminists view on SRH

Brown (2004) outlines four feminist's views on SRH. Formal equality theorists (FET) posit that society should treat men and women according to their individual characteristics regardless of gender hence they hold that equalization with men best serves women's SRH rights. Liberal feminists focus on promotion of women's individual autonomy on SRH. Relational feminists while admitting the different SRH experiences women go through, they argue against individual rights instead they advocated for creation of a system of interconnected people to develop a sense of mutual responsibility. Lastly, the dominance theorists posit that men and women are different because of the historical societal fact that men are dominant. Dominance theorists like Catherine Mackinnon have successfully persuaded law makers to recognize some male dominance (like sexual harassment) as abuse of power. In my view this dominance could also be where women have to seek permission for them to go for antenatal care services.

Abdullah (2007) reports of a feminist IRRRAG[5] research in Brazil, Egypt, Malaysia, Mexico, Nigeria, Philippines and the U.S. focused on understanding women's reproductive rights and their relations with men. They found that some women did not want men to take more responsibility for using contraception as they did not trust them to use it as effectively as women would. Women justified their autonomy on contraception by explaining that they were the ones to give birth and take care of the children. It is my argument from the feminists' theories above that some supports male involvement in SRH view as they promote equality, mutual responsibility while others are against it.

[5] www.isiswomen.org accessed on 22-03-10

However, Wegner *etal* (1998) asserts that if men are knowledgeable about reproductive health issues and can communicate about them with their partners, they are more likely to be supportive during pregnancy. For example rather than delaying recourse to ANC men can ensure that their partner receives emergency obstetric services when needed. Thus it would seem that programs that educate test and treat only one partner will not be effective in safeguarding the continued health of both as is the case in Malawi.

CHAPTER THREE

HOW THE RESEARCH WAS DONE: METHODOLOGY AND METHODS

3.1 A Grounded Theory

Data for this study was collected mainly in the two sites mentioned earlier. The data collection was characterized by the development of a grounded theory which according to Glaser and Strauss quoted in Tsanga (1997) refers to the discovery of theory from data systematically obtained from social research and the use of comparative analysis as a strategy to develop new theories on specific issues. A number of emerging issues arose from the study for example, some respondents in the patrilineal area felt they needed more children as it was a gamble to have few for one do not know who will be helpful in future, some women suggested that FP methods should be increased (i.e., that men should also be 'injected' as a method) and that medical officers ask for a female guardian when men take the children to hospital for treatment. In as far as these issues came up new theory and concepts were unfolding regarding FPMN health issues, thus a grounded theory was in practice in the process of data collection on male involvement in women's rights.

The fact that people, members of civil society, and hospital officers from the two districts learned from their experiences to respond to the questions on male involvement on women's rights entails they were consciously or unconsciously engaged in the development and utilization of grounded theory. My field visits to the communities and the in-depth interviews I had with the key informants provided valuable insights. For instance, the discovery that men do not trust maternal health messages they receive from their wives but from 'medical officers' even if they are also 'female' made me use the next question technique in asking 'why' they do not trust them, thus a grounded theory development stage was in use in the collection of the data. As the data collection progressed a question emerged: was there a male involvement program anywhere in Malawi. As Bentzon and others (1998) recommend, using a grounded theory requires having an open mind without a pre-conceived theory. As a result, I was able to conduct phone call interviews with the coordinator of male involvement in the Prevention of Mother To Child Transmission (PMTCT) project at Mwanza Hospital in Malawi to answer that question. Thus

conducting research grounded in nature was useful as it allowed me to develop an open but controlled framework in which I was able to theorize the influencing factors and the quest that communities and other actors and structures had on issues of male involvement in women's SRH. In using this theory I adopted a qualitative framework in which field research in the two sites was the main source of the primary data collected and various methods with different actors and structures were used to triangulate the findings. It was to some extent a comparative study. A comparative analysis in generating theory emphasized theory as a process and an ever developing entity as opposed to a perfect product. As Glaser and Strauss (1967) point out:

> 'generating theory from data means that most hypothesis and concepts not only come from the data, but are systematically worked out in relation to the data in the course of the research'.

Thus, the grounded approach helped me to develop concept and theory from the findings. The only disadvantage it had is that it involved a lot of time with the respondents and additional make up visits in cases when they were not available at the scheduled time.

3.2 A Relational Women's Law Approach

The grounded approach was taken together with a relational women's law approach. The women's law as a legal discipline explores the reality of women's lives and it was taken from a relational perspective in this study. It was realized that a broad based construction of the position of women and that of men and the relationship between them would be more useful for this study (Bentzon, 1998). The approach related to the first assumption on 'women centered strategies' and its conflict with shared responsibility between men and women in marriage. To the extent that the respondents in this study were both women and men, as men were subjects to the study on the issue, then a relational women's law approach was useful. Respondents throughout the study emphasized the need for agreement between women and men on FPMN issues. For such findings to be unfolded it needed a relational women's law approach. The findings about men's willingness and women's desire for their husbands to be involved in MNH issues generated new insights into the study which

needed the inclusion of men in promoting women's SRH rights. Thus, according to Bentzon (1998), the inclusion of men as subjects of research is a natural extension of the women's law research which is concerned with gender differences, gender relations and gender transformation.

However, had I used the women centered 'women's law approach' as was in the research design the strength would have been that only a record and analyses of female life situations and values on issues of FPMN reproductive health rights would have been evident. The only draw back would have been that in highlighting the differences in perception between married men and women on FPNM issues, I needed to assume that they are not all victims of the effects, when in reality in this study both men and women were found to be victims of the effects of non male involvement on FPMN health issues. Out of such findings, new concepts and theories emerged which is the hallmark of the grounded approach. Thus, as Bentzon recommends, a researcher who genuinely wants to obtain a holistic picture of a problem needs to conduct a gender sensitive and balanced research.

3.3. A Right Based Approach (RBA)

This approach related mostly to assumptions one, three and five. Assumption three looked at the positive impact on women should male involvement be promoted and five related to men's willingness to be involved in FPMNH issues. At the core of all human rights are the principles of equality and human dignity. Reproductive health is an integral element of the human right to health and is a basic right of all couples. In this regard governments have a duty to respect, protect and fulfill right to health including SRH without discrimination on any grounds including sex (IPAS 2009).

The principles of interdependently and indivisibly of rights apply to SRH rights of parties in marriage. This approach was useful to ascertain how states should ensure that SRH rights for women and men are protected, safeguarded, and promoted and applied equally for all in the family. During the data collection the approach was used to enlist men and women's view on their shared responsibility as parties to a marriage and how they can mutually and equally promotes women's MN health. The

Deputy Director of the Reproductive Health Unit in the MoH mentioned that a right based approach was useful to allow men and women to jointly work together towards ensuring that MN health is promoted. To extent that she admitted that lack of male friendly infrastructure in the health system was discouraging men to participate in MNH despite their willingness to do so suggested the state [MoH] `s failure on the duty to respect and to fulfill SRHR, hence a RBA was in use.

Some NGOs and Mwanza Hospital key informants noted that men do not have enough information on FP. A medical officer also stated that men ask a lot of questions on maternal health and pregnancy management. Thus, a RBA was useful to help me unfold the lack of government compliance to ICPD provision of ensuring that men are equally equipped with information on SRH issues. It also helped me to question the role of government and civil society in addressing the gender stereotypes to equip men with skills to accept their fatherhood role.

3.4. A Gender and Development (GAD) Approach

This is an approach based on the analysis of roles of men and women. Its goal is to achieve equitable and sustainable development, with women and men as decision makers (Bentzon, 1998). This approach was relevant to the study specifically for the fourth and last assumption. The fourth assumption related to the positive impact on women's health if men are involved. The fifth one related to men's willingness to be involved in their wives FPMN health needs. To the extent that it was uncommon for community people and the key respondents to state that men and women must agree and discuss on issues of FP, a GAD approach was in use. This approach was related to the capabilities model in which men's capacity in advancing women's MNH is being overlooked by the current strategies that are women centered. Some respondents queried the historical tendency of formulating FP with only women SRH needs in mind as biased, since this did not ensure sustainable health on women in the families.

Thus, this approach helped me to appreciate men and women voices on what they would consider appropriate interventions which ensures that men and women get the

FPMN health messages equally for their informed decision making. This according to them would ensure regulated child birth which has implications for MNH. In using this approach cognizance was also taken of women's voices that are sometimes suppressed by men in families. To this end, some respondents were supporting the 'women centered' strategies on SRH because they felt reproductive role is largely a woman issue and it acts as a means of empowering women. These respondents position related to GAD`s stand on the need to assess women's traditional reproductive role to see whether men's participation could give women a chance to venture into other productive roles. In a nutshell the GAD approach helped me to assess the equality and equity principles in ensuring that women enjoy their SRH in the families.

3.5 Negofeminism and Semi Autonomous Social Fields (SASFs) Models

Obioma Nnmaemeka`s N*ego feminism* reflects on what she described as a "concept of negotiation or no ego feminism" as a term that names Africa feminism. She talks of shared values, attitudes and institutions that can be used as organizing principles in talking about Africa. This model was relevant to my study as it informed me of the need between men and women in families to agree on shared values of attaining good health for the mother and the children. During the data collection a good number of respondents were of the view that men have the potential to help reduce the MN mortality rates and promote FP. They stressed that men need to be talked to for them to appreciate their role which could enable them to collaborate with their wives in promoting SHRH. From the responses I noted that Negofeminism could help to deconstruct the perception that 'it is men' who decides on SRH like on the number of children. Thus on shared values, altitudes and principles like the child bearing and rearing function, men might be better positioned to negotiate with as subjects in the family than confront them or label them as a problem.

Negofeminism was also combined in my data collection with the search for rule generating practices, norms and customs known as SASFs (Bentzon 1998) that also impinge on women's rights to SRH. The SASFs identified were values, practices, customs and beliefs. For instance, Lobola practices in Nsanje which according to

respondents was the reason for men's undermining of women's voices on the number of children. Discussing about pregnancy and child birth as a 'taboo' in fear of bad omens was another SASF identified. This taboo according to one key respondent has result in delayed reporting to hospital when labor has set in and in the process women have died. The practice of seeking permission or consent before antenatal visits, or caesarean operation and indeed taking family planning method was another SASF. As much as decision on these needed to be taken together if male involvement was in operational in Malawi but where urgency demands these need not be as rules so that we maternal and child health is safeguarded . In appreciating the effect of these SASFs, negofeminism principle was crucial to consider as a way to change such SASFs. In summary, to the extent that the said SASFs were found in this study then the model was of use to understand some of the things that impede on women's exercise of their rights.

3.6 Actors and Structures Model

There were a number of actors and the organizations they operate in that were identified. The actors were, Nurse/Midwife Practitioners, DHO, Ministry of Health Officials, Heath Personnel Training College Lecturers, NGOs Directors/Officer working in FPMN health or HIV/AIDS advocacy and Religious Leaders. The structures were MoH, Hospitals, Religious centers, Training institutions and the Community. In this study, interacting with the actors helped me to make an assessment on how they are involving themselves in the advocacy on FPMN health issues.

It was also relevant to seek their views on the value that male participation can add to the work of advancing FPMN health in Malawi. It was imperative as well to note how the structures are set to advance the issues of FPMN health. For instance, it was clear that almost all the MoH officers and the lecturers who once worked in the MoH bemoaned the fact that male involvement is not being promoted except in few areas on pilot basis where it is successful. However, they also admitted the lack of conducive environment and capacity to ensure the programme is rolled out across the country. This helped me to ascertain how service delivery and compliance to human

rights standards on MN health is a challenge in Malawi. Interacting with the religious leader, community and NGOs officials, issues of lack of adequate information and specific men targeted programmes on FPMN health were uncommon. Thus the actors and structures model helped me to see which players to engage with to realize women's FPMNH rights. It was also vital to assess the compliance actors and structures as regards to what they are doing on the issue of male involvement.

These methodologies discussed above were used to inform the researcher in the data collection process. However the actual data collection process was achieved in a number of ways as outlined in the following section.

3.7 Data Collection Methods

Data collection is a process in a research in which primary data is gathered using research instruments like questionnaires or interview guide. It also involves compilation of secondary data from already written sources (Malunga, 2007). Both primary and secondary data was collected in this study using the following methods, Focus group discussion, Individual interviews, Key informant interviews, Observation, Phone interviews, Internet search, and documents reviews.

3.7.1 Focus group discussion

Is a method which involves interviewing a group of people with specific knowledge or experience about an issue (WLSA 1997). The researcher acted as a facilitator for the discussion. Realizing that this was a grounded research, issues under discussion were put forward and respondents discussed. In this study the groups largely comprised women or men (see pictures below).

Picture 1: Sex specific focus group discussions in the two study areas

Picture 1: ***Researcher, supervisor (in spectacles) and male respondents at Thunga in Thyolo (After a male focus group discussion)***	**Picture 2:** ***Researcher and female respondents with neonates from within Nthukuso community inside maternity ward few hours before they are released at Nsanje hospital in Nsanje. (After a female focus group discussion)***
	

This was relevant because, considering the cultural setting of male chauvinism prevalent in Malawi, women or men only groups provided freedom of the members to speak out as some of the respondents were couples. Where there was digression as a researcher, I was able to guide the members on the core issues under discussion. During the discussion the researcher took note of key issues on the subject and after the discussion had to write the views that were expressed. Thus, focus group interview was good for this study, as it also acted as a means of awareness on the human rights issues on FPMN health since respondents learned from others in the group. This was evidenced by the confession of some male respondents that they had never had a discussion as men on issues of FPMN health.

3.7.2 Collective Individual and Individual Interviews

Collective individual interview is a method where the researcher may have planed to have the traditional one to one interview {thus individual interview}but the interview process is spontaneously taken over by the community life in the villages where other members joins the discussion when intentionally the researcher targeted one person (WLSA, 1997). This method together with individual interview was used in

the study especially where it was not very easy to isolate one woman or man respondent as others like neighbors and relatives nearby were curious about what was being enquired. So, rather than seeing the other joining members as intruders to the discussion the researcher accommodated them as they too provided insights into the issues that were discussed (see picture below).

Picture 3: Collective individual interview

The researcher intended to talk to the village headman (in blue T-shirt to the left), then his wife seating next to him joined and then the other three also joined in the process.

It was common to see that for women individual interviews, their personal testimonies were shared testimonies with the other joining respondents. For instance, in Thyolo and in Nsanje communities some women were saying they leave their FP hospital book at the hospital if the husbands are not allowing them to go for FP and this was corroborated by others that joined giving testimony about themselves or someone they know in the village that is doing the same. The only challenge was that it needed more time and effort to capture messages that kept flying back and forth as incoming members joined the group. However, the method was good and relevant for the study as the issues affected both men and women hence the interest to take part made them aware about the diverse perspectives of other community members.

3.7.3 Key Informant Interview

This method involves the collection of data from the perceived 'knowers' or experienced about the issue or some people of influence in the community (WLSA, 1997). This method was useful in this study to arrive at gatekeepers like village headmen and religious leaders. It was important to go to the gatekeepers as it also acted as means of getting acceptance in the community, as in some cases it was difficult to be accepted unless you provide a prefix '*I have been to the village headman or DHO for hospital respondents'*. The key informants involved were the actors mentioned earlier in section 3.6. Since the topic bordered on issues of service delivery and human rights compliance, it was relevant to seek policy position and practice on male involvement from those that are working or affiliated with services in the ministry of health, (see picture below).

Picture 4*. Researcher, with two Nurse/Midwife Practitioners after an in-depth interview inside a ward at Thunga Health Centre in Thyolo*

Additionally, it was important to talk to NGOs officials who have programmes related to FPMN health or HIV/AIDS issues to seek their views on male involvement and how they are implementing government strategies related to this. Further, the village heads and religious leaders were relevant informants as custodians of customs, beliefs and practices, the SASFs in their communities and facilitators of community norms on FPMN health issues. Generally, talking to the key informants

provided insights into the topic at a theoretical and practical level and it acted as a way to corroborate information collected from the communities.

3.7.4 Phone and Internet Interview

This was used in the study to solicit views verbal or via e-mail completed structured questionnaire. It was used for some key informants like the Deputy Director in the MoH, RHU who completed an e-mailed structured questionnaire and Mwanza Hospital PMTCT coordinator. Phone calls were used to talk to officers responsible for male involvement programme at Mwanza hospital. The methods were relevant to the study to ensure I have responses from MoH at policy level and where a pilot male involvement project was done. However, e-mail and phone calls denied the researcher opportunity of face-to face questioning.

3.7.5 Observation

Using this method, I was able to take note of the infrastructure in the hospitals, the patronage in the hospital wards and the advocacy, communication strategies, printed and inscribed messages in the hospitals and surrounding on FPMN health. I also observed in particular at Nsanje hospital the maternity ward and the women guardians who accompanied expectant mothers. Of particular interest was that when one looks at advocacy strategies on male involvement, it is only promoted on issues of HIV/AIDS and not on MN health. These observations enriched this study as the next pictures demonstrate.

Picture 5. *Strategy on male involvement focused on HIV/AIDS*	Picture 6. *Non male friendly maternity ward (there is no privacy in the ward)-picture show male nurse/midwife helping women in the ward)*
	

In picture **5** the local vernacular Chichewa message is as interpreted below;

> Kodi mukudziwa kuti mabanja ambiri omwe amayezetsa amapezeka kuti alibe HIV [Do you know that many families that go for VCT are found without the HIV virus]
> Ndibwino kudziwa ngati muli ndi HIV kapena ayi kuti mukonze tsogololanu [It is important to know your HIV status so that you can plan your future]

3.7.6 Policy and documents review

This method involved the reading of policy documents, legal provisions, best practices, past researches on male involvement, human rights provision and other necessary documents both print and on the internet. The method was useful as it enabled the researcher to do an analysis on policy and strategies that Malawi, MoH have on issues of FPMN health and whether male involvement is a priority. Further, for comparison purpose it was necessary to look at previous literature and best practices on male involvement from regional and international perspective. The review of such documents was useful during the research design and the write up process.

3.8 Sampling Methods

This is the process of arriving at the possible respondents for the study. Basically, for a qualitative study of this nature, I largely used the purposive sampling. This is a non-probability sampling technique where the researcher, arrives at potential

respondents based on his/her judgment on the data she/he thinks shall get from that respondent (Malunga, 2007). In using this method, I had already set out during my research design the respondents I needed to talk to in the field. I based on certain characteristics like that they should be in marriage or once having been in a marriage, have one child or more children, have any factual or unclear idea on SRH issues for community respondents. Possessing knowledge on SRH in general and FPMNH issues in particular was the criteria for key informants. I also used the snowball sampling at a micro level. This involves arriving at a respondent whom you have been referred to by another previous respondent with similar characteristics (Malunga, 2007). This was useful for some respondents like the nurse/midwife practitioners whom I was speaking to as key informants based on the recommendation by their colleagues. The sex of respondents was also considered. A total of 90 respondents participated in the study and there were 49 women (55%) and 41 men (45 %) (See table 1).

Table 1: Number of respondents and their sex

PLACE	KEY INFORMANTS TOTAL NO.	SEX		COMMMUNITY RESPONDENTS. TOTAL NO.	SEX	
		FEM.	MALE		FEM.	MALE
THYOLO	11	7	4	28	14	14
NSANJE	8	3	5	35	22	13
LILONGWE	2	1	1	0		
MWANZA	2	1	1	0		
BLANTYRE	4	3	1	0		
TOTAL	**27**	**15**	**12**	**63**	**26**	**27**

3.8.1 Ethical issues in the data collection

I got an introduction letter from the University of Zimbabwe, UZ before I went into field research. The letter was useful to gain access to offices and other places as a student researcher. I also followed the College of Medicine Research Ethics Committee (COMREC) clearance requirements on health research in Malawi. Though, I got COMREC response late, I was able to forward the proposal and other necessary documents to National Health Science Research Commission (NHSRC) in

Lilongwe for their approval. At community level I made sure that I first visited the village leadership to obtain permission to visit the community people. At an individual level I had an informed consent that I used to seek respondents' participation. (See appendix).

3.9 Data Analysis

The findings of this study were Microsoft word processed and presented in thematic and tabular form. A number of themes, sub themes and categories were formulated from the findings and were presented in verbatim. Some data based on intended purpose was processed using Microsoft excel and charts were formed. Further, voices of some respondents were captured and included in the analysis.

3.10 Limitations of the study

This study was not without its challenges which fortunately I was able to overcome. The first one was on COMREC or NHSRC requirement as stated in section **3.8.1**. I was not able to talk to key informants at Thyolo Hospital because I needed NHSRC clearance letter which did not come by the time my UZ schedule for the write up was due. Alternatively, I collected data from key informants at Thunga Health Centre in Thyolo to make up for the key respondents at Thyolo hospital. When the supervisor came in early December 2009, she recommended the data I had collected as sufficient for the progress of the study.

The second challenge was to talk to officials at MoH. They were too busy to grant me an interview during the scheduled period. However, I got relevant secondary literature for my review from an officer at the Ministry Headquarters. I continued to communicate with the MoH officials via e-mail, until early February 2010 when I got an e-mailed response to the structured questionnaire I had sent. This added to the other information I had already obtained from the Ministry in Malawi.

Other minor challenges were the non-co-operation of some community respondents to take pictures with the researcher for fear of their identity though they had consented to take part, and I respected their wishes. Some respondents failed to come

to agreed appointments. As a result, the researcher had to make new appointments or choose alternative respondents. Another one was on the use of phone calls to collect data from the key respondents in Mwanza. However, the researcher did this due to limited time as he got the information of the male involvement project late and could not make arrangement to visit the area and talk to the officers and local community. Through these efforts the researcher managed to collect data, though to a lesser extent the stated limitations may have a bearing on the study.

This chapter looked at the methodology and methods of the study, the sampling process and ethical considerations, the way findings were analyzed and the pitfalls the researcher faced and how he dealt with them in the field during data collection.

CHAPTER FOUR

HEALTH POLICY/STRATEGIES REVIEW ON FAMILY PLANNING, MATERNAL AND NEONATAL HEALTH IN MALAWI

This chapter outlines the MoH policy and strategies on FPMN health to assess the extent of male non involvement in promoting women's SRH. A brief background of the Malawi's health system is provided.

Nearly all health care services in Malawi are provided by three main agencies. The MoH provides about 60%, Christian Health Association of Malawi (CHAM) and other private-not-for-profit NGOs provide about 36% and the Ministry of Local Government (MoLG) provides 1%. The remaining 3% comprises of the private-for-profit sector (NRHS, 2006-2010). There are three levels in the health system, namely: primary level comprising of health centers, health posts, dispensaries, and rural or community hospitals; secondary level made up of district and CHAM hospitals; and the tertiary level consisting of the central hospitals and one private hospital with specialist services. Only 46% of the population has access to formal health facility within a 5 km radius, and only 20% of the population lives within 25 km of a hospital.

Access to RH services is worse in rural areas of Malawi as it was earlier noted in the literature review. The MoH recently completed and launched a national Programme of Work (PoW) for 2004-2010, tied to the now-established Sector Wide Approach (SWAp) and delivery of the Essential Health Package (EHP). This PoW details the priority health activities that the MoH will undertake. The PoW is based on priorities and key activities identified in the MoH. A number of critical RH issues, like FP, MNH and sexually transmitted infections (STIs), among others are included as part of the delivery of the EHP. Services referred in the EHP should be available to every individual free of charge.

4.1 FPMN Health background in Malawi

USAID (2005) report on family planning initiative gives a candid background for Malawi. It states that FP has been remarkably successful between 1992 and 2000, despite high rates of poverty, low rates of literacy and a predominantly rural population. Despite the banning of FP during one party Malawi [1964–1994], "child spacing" was an integral part of the maternal and child health (MCH) program in the 1980s, recognizing the health problems that women faced when pregnancies were too early, too many, too late, or too frequent. During the Multiparty Malawi [1994 to present] the words "family planning" was used and more intensive policy and programmatic activities have been undertaken. This resulted in increased number of facilities providing family planning and by 2005; FP [was] almost universally available.

USAID observed that Malawi involved many actors and structures to achieve this. In particular, the NGO Banja la Mtsogolo (BLM), [which I will refer to in the next chapter] with its extensive outreach efforts, played a significant role in expanding access to reproductive health services. Supply-side interventions focused on improving the contraceptive logistics and supplies, through the training of providers and development and dissemination of service-delivery policies and guidelines. The 1992 guidelines removed barriers of spousal consent, age, and parity and allowed a wider range of cadres to offer various services. On the demand side, multiple channels of communication in multiple languages were effectively used, including radio jingles, posters, dramas, health talks, and CBD activities [almost the same activities being continued to date], so that Malawi was flooded with information, education, and communication (IEC) messages.

This being a background on SRH effort in Malawi, my expectation was that MN mortality rates would have reduced even more by now. It is worth noting that the 1992 guidelines 'removed barriers of spousal consent' among others. The spouse could be a husband, thus male exclusion by implication in their wives` SRHR started way back in 1992 in Malawi. Hence, MN mortality rates by 2010 are still high according to Malawi's Vice President Joyce Banda signifying that the FP initiatives

have not yet ensured safe motherhood goal. For instance, the VP reported recently that Malawi's MMR is currently at 807 per 100,000 births[6]. Though, this is a progress from the rate in 2000 she reiterated that more need to be done if Malawi have to meet the MDGs targets. The following is a brief statistical background on FPMN health in Malawi.

INDICATORS	**1992**	**2000**	**2004**
Total fertility rate (TFR)	6.7	6.3	6.0
Modern contraceptive prevalence rate (CPR)	7%	26%	28%
Unmet need for family planning	36%	30%	28%
Maternal mortality ratio (MMR)	620/100,000	1120/100,000	984/100,000
Neonatal mortality rate (NMR)	42/1,000	49/1,000	27/1,000
HIV prevalence among the adult population		14.4%	14.0%

Source: NRHS 2006-2010

Grant (2005) reports that the major causes for higher MMR in Malawi are among the following, the impact of HIV/Aids, delay in decision to seek services due to lack of knowledge on complications and limited antenatal care. Delay in accessing health services due to cultural issues like where women have to seek permission and funds from men/husbands. Distance to health services and transport difficulties exacerbate this delay. Delay in receiving services since only limited number of health services can perform surgery. Frequently long queues for admission to labor suite and insufficient staff on duty to offer immediate care. Majority of births are at home using Traditional Birth Attendants (TBAs) who are not well trained. Grant further mentions some cultural beliefs which have serious consequence on MN health, for example a prolonged labor indicate a woman has been unfaithful hence the need for her to confess to speed up labor. Lastly, a general lack of knowledge within the community on danger signs and complications of pregnancy. In my opinion some of these causes of MMR could be avoided if male involvement was promoted. This is so because men are the decision makers on health services, provide transport money and they could arrange timely transport to hospitals; roles that can help promote women's SRH in Malawi.

[6] http://www.nyastimes.com/national [accessed on 9-03-2010]

4.2 Policy and Strategies on Male Involvement in FPMN Health

The Ministry of Health's mission is to stabilize and improve the health status of Malawians by improving access, quantity, cost-effectiveness and quality of the EHP and related services so as to alleviate the suffering caused by illness, and promoting good health, thereby contributing to poverty reduction. The MoH implements its programmes using guidance from National Health Act (NHA), National Health Policy (NHP), National Reproductive Health Strategy NRHS (2006-2010) among others.

4.2.1 The National Health ACT 2008

The aim of the NHA is to ensure co-operative management of health services, in line with decentralization policy to enable district level implementation of health policy and delivery of quality health care services. Further, NHA promotes a health system based on principles of human rights and equity; gender sensitivity; efficiency, accountability, community participation and partnership. It also encourages a spirit of co-operation and shared responsibility among all players in public and private health sectors in the delivery of quality health care services.

It is my argument that given such an Act, the policy and strategies that would arise from the same needed to respect and promote the very letter and spirit of the Act and principles namely human rights and equity, gender sensitivity and community participation among others. This would even translate into implementation strategies at grass roots level. The principles of human rights and gender sensitivity by inference points to the need for male involvement in their wives SRH in Malawi.

4.2.2 The National Health Policy (Draft, 2008)

The NHP is based on Malawi constitution provision which provides for adequate health care that is commensurate with the needs of the Malawi people and international standards. On heath systems the policy emphasizes on decentralized health services delivery aimed at improving efficiency and community participation in decision making and implementation of health programmes. Its mission statement emphasizes the need for strategic leadership for the delivery of efficient health services to all people guided by principles of human rights and equity, gender

sensitivity, and community involvement among others. In line with the principles, one of the health interventions strategy in the policy is to enhance community involvement, strengthen institutional and community capacity in the prevention and control of diseases and ensure safe motherhood and health child development in Malawi.

It is my contention that with such a policy statement the implementation strategies needed to be based on constitutional values that respect human rights and equity, gender sensitivity and community involvement as stipulated in the NHA and NHP for men and women in a marriage. If the health ACT and the NHP has such gender sensitive, participatory, human rights based aims to achieve, why then male involvement in their wives SRH is still being overlooked and relegated as role of 'special groups' in Malawi. This is evidenced in the current strategies (NRHS 2006 – 2010).

4.2.3 MoH, National Reproductive Health Strategy 2006 – 2010

The NRHS outlines key strategies for National RH programme components identified as Family Planning, Maternal and Neonatal Health, STIs/HIV/AIDs, Reproductive Cancers, Infertility, Harmful Practices and Obstetric Fistula. It then proposes Strategies for 'special groups' namely Adolescents/youth in RH and Male involvement in RH. The strategies are meant to achieve the RH goal which is to;

> **'**improved sexual and reproductive health for all men, women and young people in Malawi, especially the vulnerable and underserved'

My analysis [in the next table] of this NRHS 2006-2010 document shows that lack of male involvement is mentioned as a challenge to ensure the implementation of FPMN health in Malawi. This is despite the fact that such implementation guidelines are based on NHA and NHP earlier mentioned which promotes gender sensitivity, human rights and equity principles. The following table demonstrates the extent.

Table 2: An abridged analysis of policy strategies on MNFP SRH issues in Malawi

(Source: Republic of Malawi, MoH, NRHS **2006 - 2010, June 2006,** p.17-22)

FOCUS	**Selected current strategies**	**Selected strengths**	**Selected threats**	**Selected weaknesses**
Maternal/ Neonatal Health	-Improving the availability of, access to, and utilization of quality maternal and neonatal health care. -Strengthening human resources to provide quality skilled care. -Empowering communities to ensure continuum of care between the household and health care facility. -Strengthening the referral system.	-Some successful community based MN health projects have been initiated in Mchinji, Dedza, Nkhatabay and Monkeybay. - PMTCT sites assessed for renovation -Development of Malawi National Road Map for MNH and priority interventions shared with DHMTs	-Limited awareness on danger signs in pregnancy among the community -Delays in accessing care -Inadequate community mobilization Inadequate **male involvement with regard to PMTCT** -Lack of **male involvement** in MNH.	-Lack of community mobilization in MNH -Existing MNH services **not male friendly** - Poor infrastructure to integrate PMTCT services - Neonatal Health Care not perceived as priority.
'Special group' **Male Involvement in SRH**	-Strengthening male involvement in RH issues and services	-Successful 'male championship' project initiated in one district (Mwanza) and rolling out.	- Illiteracy and ignorance - Poverty - Cultural beliefs	-Lack of community involvement and/or mobilization in RH issues -Existing **RH services not male friendly** -**Men not aware** of dangerous signs in pregnancy
Family Planning	-Strengthening the availability, access to, and utilization of FP services at health facility and community level. -Strengthening behavior change interventions - Strengthening the integration of FP services into the other EHP components	-Wide variety of methods available including female condom and emergency contraception - More than 300 health facilities provide FP services - Successful CBD programmes in some districts.	-Resistance among political/community and faith leaders to promote condoms for FP -High unmet need for FP -Lack of **male involvement in FP** -Religious beliefs.	- CBD services not sustainable despite successful pilot programme - Lack of IEC materials for Family Planning - Existing FP services not youth friendly

There is a close relationship of the selected threats, weaknesses and strengths with the need for male involvement in FPMN health issues if high MN deaths have to be reduced in Malawi. However, the existing strategies on FPMN do not mention strengthening male involvement as a strategy despite recognizing it as threat or weakness. Strengthening male involvement which is the only mentioned strategy under the male involvement in SRH section is however also recognized as a weakness noting that the current RH services are generally unfriendly to men. I would argue then that the current higher MNMR are in part contributed due to this lack of male involvement exacerbated by women centered strategies in SRH in Malawi thus making it harder to attain the stated RH goal.

4.2.4 Road Map for accelerating the Reduction of Maternal and Neonatal Mortality and Morbidity in Malawi (2005, 2007).

Global evidence indicates that availability of Emergency Obstetric Care (EmOC) and skilled attendance at birth are key to the reduction of MN mortality rates. Realizing this Malawi undertook a national assessment of availability, quality and utilization of EmOC services in 2005. The results revealed poor access and utilizations of EmOC services and poor quality of health care services. Some of the barriers to the utilization of maternal health care services included social and cultural beliefs. These in my view could be issues related to male dominance in decision making and control of economic resources as earlier mentioned. Malawi developed a country-specific Road Map in 2005 to accelerate attainment of MDGs 4 and 5 related to maternal and neonatal health respectively. This roadmap's vision was that,

> All women in Malawi go through pregnancy, childbirth and the postpartum period safely and their babies are born alive and healthy through the implementation of effective maternal and neonatal health interventions.

One of its objectives is to strengthen the capacity of individuals, families, communities, Organizations and Government to improve MNH. Thus, the Roadmap seemingly recognizes the role of men as it refers to families. Strategy number 7 of the Road Map is to empower communities to ensure continuum of care between the household and health care facility. This was to be implemented using interventions like, involve Health Surveillance Assistance (HSAs) to empower communities on

NMH, establish/strengthen community initiatives for RH, raise awareness of the community on MNH issues including birth preparedness and danger signs and empower communities especially men, to contribute towards timely referrals. It could be concluded that the RoadMap as a key documents in the implementation of health services to improve MNH in Malawi has interventions that recognize the need for male involvement in their wives SRH rights. However, one of the roadmap's implementation guidelines is through health initiatives at community levels. This was developed by MoH in 2007 but its implementation is a far fetched dream as shown below.

4.2.5 MoH Guidelines for Community Initiatives for Reproductive Health

This was formulated to provide a standardized method of implementing community interventions in order to achieve some of the following outcomes; community participation, increase health care services, timely referral to health facility, increase access and utilization of reproductive heath services, increase number of pregnant women delivering at health facility and to reduce MN morbidity and mortality. In summary the guidelines were meant to empower women, their partners, families and the community to make appropriate decisions and take timely actions especially when there are complications in pregnancy and child birth. This in my view could entail empower communities, especially men, to contribute towards timely referral which is also mentioned in the Road Map.

To achieve the intervention budgetary allocation in the MoH programme of work (PoW) was crucial (RoadMap, 2005). Strangely, there was no money allocated on this intervention in the PoW to capacitate its effectiveness (RoadMap 2005, p 25-30). Therefore, despite the initiative on male involvement existing in the RoadMap there was no capacity to implement the initiative at community level due to lack of funding. Implicitly, the lack of funding to capacitate community initiatives in which male involvement would be enhanced is another form of systematic male exclusion in SRH of their wives by the government.

Finally, the MoH seems to realize the need for male involvement in their wives SRH, but there seems to be lack of implementation strategies that are human rights based, gender sensitive and more participatory for men in Malawi. Thus the assumption in chapter one section 1.1 on lack of effective policy on male involvement by the MoH is confirmed. This explains the 'women centered' strategies as will be seen in the next chapter.

CHAPTER FIVE

RESPONDENTS VIEWS ON FPMN ISSUES: FINDINGS AND DISCUSSION

Introduction

In this chapter findings of the study are presented and discussed. The results are presented and discussed per objective. An effort to link the findings and discussion to the rest of the work in the previous chapters was made to achieve consistency.

5.1 Women Centered FPMN Reproductive Health Strategies

The first objective of the study was *to find out how 'women centered' SRH policy and strategies are against the standards as regards to marriage and its shared responsibility.* A number of issues came up for example, whether the strategies are indeed women centered, the conflict of the strategies and marriage shared responsibility, and an assessment of justification for women centered strategies. The following are the results.

A number of literature (Wegner *etal* 1998, Haile, *etal* 2000) as earlier stated indicate that a lot of reproductive health interventions, strategies and campaigns are women centered. According to the respondents indeed FPMN strategies are women centered. A total of 35 individuals and group respondents from the two sites agreed that the messages they get from the media and hospitals are all women focused on MNFP issues. For example, a SRH focused local NGO Banja La Mtsogolo (BLM) state on its website that,

> BLM's ANC services aim at providing medical support to a pregnant woman and her unborn baby from conception to onset of labour by: Providing high quality, evidence based antenatal care and increasing a woman's awareness and her family on birth preparedness and possible complications that could arise.

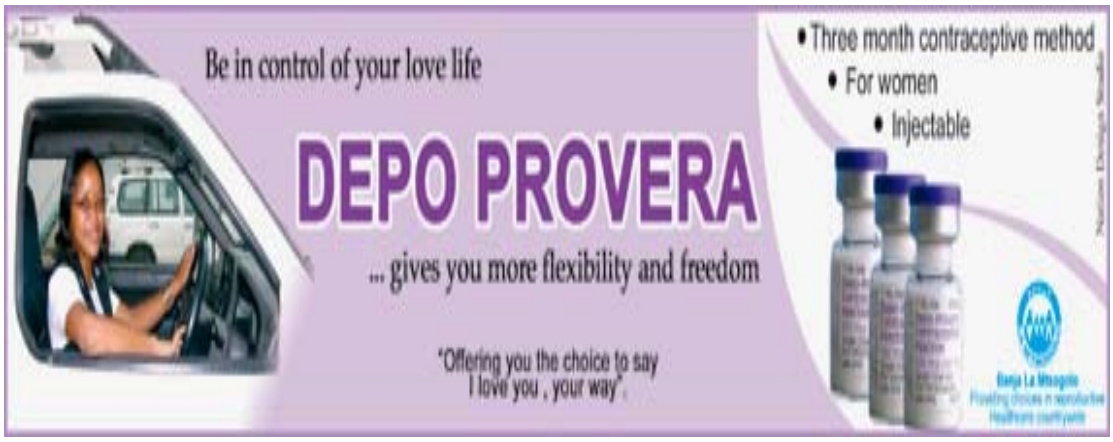
This organization works in partnership with government and other hospitals for referrals. In order to ensure continuity of care, women who attend BLM Antenatal care (ANC) centres are encouraged to return after delivery for a post-natal check-up, immunization of infant and FP as the picture show on the next page.

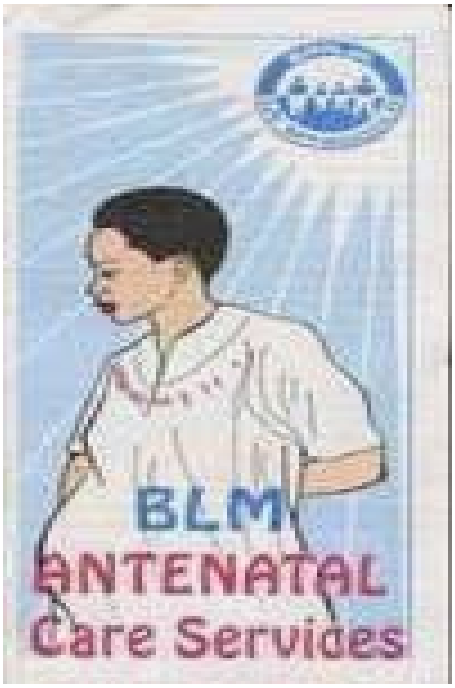
Picture 7: BLM Post Natal Services, source: www.banja.org.mw/profile accessed, 10-03-2010

In the Picture above, there is a nurse offering post natal services to women. She is weighing the children. This is inline with BLM focus as earlier mentioned. BLM`s approach is allowing pregnant women to have at least four (4) goal-oriented ANC visits during pregnancy.

With such type of women focused aims and approach, it might be unlikely in my view that male involvement in FPMN health is considered as one way of promoting women's SRH. Thus indeed as Haile *etal* (2000) observed FP information is built around MNH and caters exclusively for women. From the respondents and my experiential data, in advertising about FPMN health the posters, leaflets, flyers, radio and TV messages are largely women focused in Malawi. This gives an impression that women and children are sole recipients of SRH related messages and services to the exclusion of men in the families. The next pictures underscore the women centered strategies.

Pictures 8: FP methods and Antenal services leaflets. Source BLM website





It is my view that from the leaflets in Pictures **7** and **8** above male exclusion is evident in promoting their wives SRH rights as marriage shared responsibility. This explains the key informants' view that men do not have enough information on FPMN health issues. Women centered strategies contradicts the ICPD recommendation of making available information for couples to exercise their SRH. The result is that they deny their wives chance to visit the hospitals on time or not at all contributing to the one of the three delays that causes maternal deaths in Malawi (Grant, 2005).

Picture 9: Pregnant woman and MN health message. Photo: *taken in the study area*

In picture **9**: There are local language messages produced by Malawi Government to promote MN health. The translations are as follows.

- Mayi Wathanzi [A Healthy Mother]
- Mwana Wathanzi [A Healthy Child]
- Malawi Wathanzi [A Healthy Malawi]
- Uchembere wabwino-Kuchepetsa imfa za Amayi a pakati [Safe motherhood-reduced deaths in pregnant mothers]

An analysis of the picture and message underlines the fact that the messages are indeed women centered. This seemingly contradicts what the Deputy Director in the MoH, Reproductive Health Unit (RHU) said, as follows:

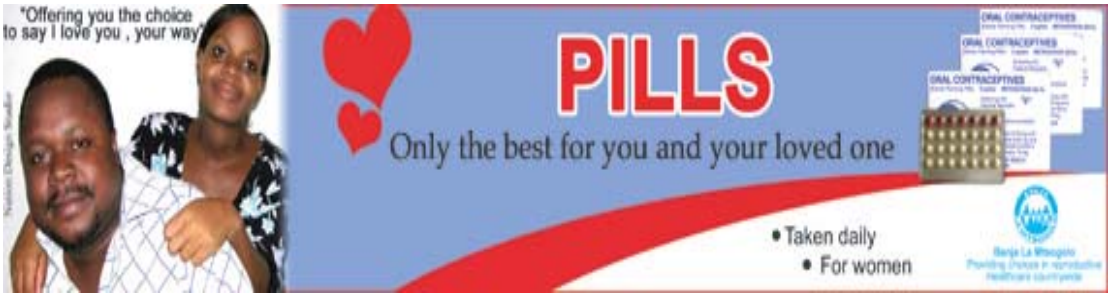
> The focus of SRH rights interventions is centred on improved SRH for men, women and young people of Malawi so as to improve their health status thereby reducing MN morbidity and mortality.

This seems to be just a policy statement, but practically there is not much on male involvement. The result is the higher MNH problems that Malawi is experiencing and according to some respondents' male exclusion leads to violence and divorce when some women go for FP without agreeing with their husbands. The focus on women only which might lead to divorce seems to contradict the state's duty to comply with human rights standards related to the family, as stipulated in UDHR art. 16(3) and ICCPR art. 23(1) where the state is urged to protect the family as a natural unit of society. Furthermore, some respondents bemoaned that modern family

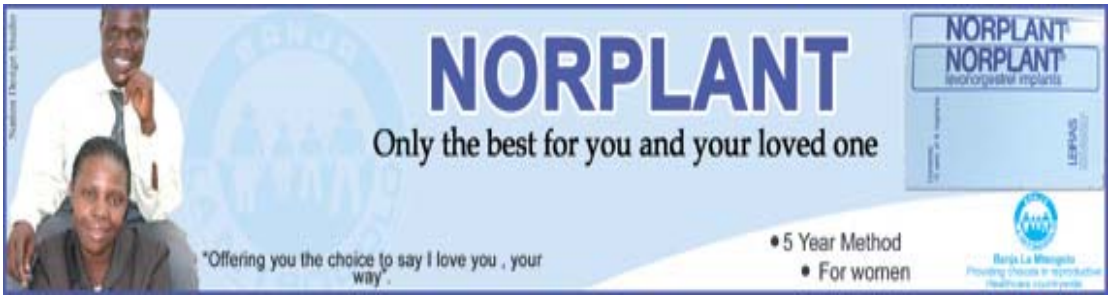
planning strategies are more inclined to women. This might be on the understanding that women should be able to exercise their SRH rights and have autonomy over their body a liberal feminist's view noted in chapter two.

Although the FPMN health services in the pictures and messages above are women focused, men have a role on decision making for their wives to access them hence there was need for gender sensitive messages. It is possible to include men in women focused FP methods even if the message will be addressed to the woman as in the pictures below.

Picture 10A) A gender neutral FP message- source: BLM website



Picture 9B: A FP strategy focused on women. Men are indirectly referred to.



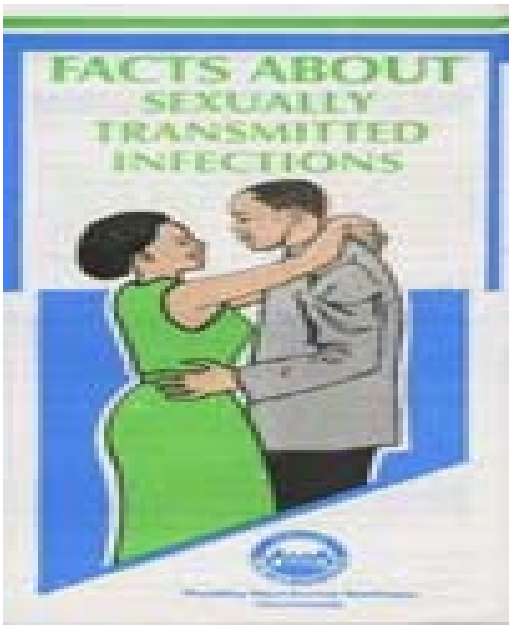
It would seem that pictures **10 A** and **B** above are essentially gender neutral and these are the messages that government and the NGO in SRH need to promote if male involvement on women's SRH is to be successful in Malawi. This relates to relational and formal equality feminists view as seen in chapter two who propagates mutual responsibility and equalization with men which will benefit women's exercise of their rights. It was noted by respondents that men have only two known modern methods thus condoms and vasectomy, as one woman respondent said in frustration:

Amunawa abayembo majakisoni [these men also need to be injected with injection to family plan].

This suggests the need for more FP methods for men as well so that they have a pool to choose from as women have.

7 out of **35** respondents from the two areas mentioned that the messages focus on both men and women. However, they mentioned that this is in case of messages that are meant to instill behavioral change on STIs, HIV/AIDS and PMTCT as earlier mentioned in chapter three. The pictures below emphasize this point.

Pictures 11: On STIs, HIV/AIDS and PMTCT, source: BLM website and study area



Only **4** out of **35** respondents, two being religious leaders in Thyolo mentioned that the messages are focused on men as they are heads of the families, the other two mentioned it out of context as later in the discussion they admitted the strategies being women focused. The notion that 'men are heads' though is mentioned with regard to strategies, it is a prevalent notion among women and men in Malawi in terms of decision making which also affect women's access to health services. That religious leaders can have this understanding is uncommon given the different religious beliefs and teachings on male and female position in the family.

5.1.1 Women Centered Strategies versus marriage's shared responsibilities

A number of human rights standards which Malawi is signatory to and local laws encourage shared responsibility between men and women in marriages on the basis of equality and equity. These provisions touch on reproduction, decision making, entry into marriage, children and child custody, property rights just to mention a few. The basis for this is that human rights are universal, indivisible and are interdependent, and promotes non discrimination in many aspects. As such all human rights need to be respected unless in specific circumstances. Almost all the key informants and the community respondents agreed that indeed the strategies are in conflict with the shared responsibility standard in marriage; however they had some explanations which will be discussed in section **5.1.2** later. Nonetheless, the following human rights standards are particular on the issue of male involvement.

International Conference on Human Rights, Teheran Final Act 1968 Article 16 states:

> The protection of the family and of the child remains the concern of the international community. Parents have a basic human right to determine freely and responsibly the number and the spacing of their children.

CEDAW 1979 Article 16 state that,

> 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:
> (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;

The ICPD 1994 provides that, RH entails that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicitly, the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of FP of their choice which can provide couples with the best chance of having a healthy infant. ICPD promotes shared responsibility for couples on RH issues as it states on Paragraph 7.3;

> …the promotion of the responsible exercise of these [RH] rights for all people should be the fundamental basis for government and community supported policies and programmes in the area of reproductive health, including family planning

However, Article 14 of the Women's Protocol seems to support the women centered strategy that Malawi is using if read alone as it provides that:

> States parties shall ensure that the right to health of women, including sexual and reproductive health is respected and promoted.
> This includes: a) the right to control their 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 contraception;

While I appreciate the Women's Protocol position as it promotes only women's rights, for married women in Malawi, it is worth to consider its implementation in view of Articles 6 (a) and (i) and 7 (c) of the same instrument.

> Art.6 a)…marriage entered with free and full concert of both parties
> Art…6 (i) a woman and a man shall jointly contribute to safeguarding the interests of the family, protecting and educating their children.
> Art.7 c) …women and men shall have reciprocal rights and responsibility towards their children…interest of the child given paramount importance.

There is emphasis on 'men and women, family, couples, 'they' in these human rights provisions and this suggest that married women and men can not each of them independently exercise the reproductive right as reproduction process involves both. Hence strategies that focus on empowering women only with information regarding FPMN health are in contradiction with shared responsibility standard. For the Women's Protocol provision it might be interpreted that, it is the woman alone in a civil or customary marriage in Malawi that has to decide solely whether she need to have children, how many children and the spacing of the children which affects FPMN health rights. The provision as seemingly being implemented by Malawi's women centered strategies is contributing to the failure of women to exercise their FP rights because of their husband's non involvement. In a formal marriage the principle of equality is expected to be respected by all parties to the marriage. For instance CEDAW Article16 (1). Provides that;

> 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: (a) The same right to enter into marriage; (b) The same right freely to choose a spouse and to enter into marriage only with their free and full consent; (c) The same rights and responsibilities during marriage and at its dissolution;

Malawi constitution also provides at;

> Sec. 22 (2) each member of the family shall enjoy full and equal respect and shall be protected by law against all forms of neglect… (3) men and women have the right to marry and found a family (4) No person shall be forced to enter marriage and Sec. 24 guarantees women` s rights and it states at 24 (iii) …to acquire and retain custody, guardianship, and care of children and to have an equal right in the making of decisions that affect their upbringing.

In a nutshell, the provision in CEDAW, ICPD, Women's protocol Article 6 and 7, and Malawi constitution cited above promotes male involvement. Further, the Malawi Heath Act and National Health Policy's human rights based and gender sensitive objectives stated in chapter **4** suggest the need for male involvement if we have to safeguard women's MN rights. Thus in general, marriage is entered on free consent, equal right on mutual benefit are safeguarded for reproduction, child custody and decision making, hence on the decision for child spacing (FP) there must be shared responsibility to promote MNH rights. Any party in the marriage has no exclusive rights on reproduction.

5.1.2 Justification for Women Centered FPMN Strategies

All the 35 respondents and the key informants who mentioned that messages are women centered, also admitted the conflict with the shared responsibility spirit in marriage. However, the justifications for their views are as summarized in the following table.

Table 3: Justification for women centered strategies (Note: M=male, F=female)

Justification	**Respondents** Community = Com. Key Informants = KI
1. Pregnancy and labor/delivery is women's natural activity	Com and KI, M and F
2. Community and hospital campaigns on FPMN issues are patronized by women	Com and KI, M and F
3. Women know to take care of babies and children	Com M and F
4. Women are the victims /they suffer the consequences of labor	Com and KI, M and F
5. Men are not interested in FPMN issues	Com and KI, M and F
6. Men are always busy with business or work	Com and KI, M and F
7. Men do not go for maternity visits at hospital	Com F
8. Men just do sex and go	Com F
9. Women breast feed babies	Com F
10. Women are obedient/they listen to hospital instructions	Com M
11. It's a way of women empowerment/they should know their rights	Com and KI F
12. Its an individual choice or choice for both	Com F
13. Women historically accepted FP methods	KI F
14. Ministry of Health has realized the hospital are not male friendly	KI M
15. Community regard FPMN issues as secret, so men and women don't discuss.	KI F
16. Women can control their sexual emotions than men	Com M

From the table, the majority of the respondents seem to agree that pregnancy is women's natural activity, women are victims of effects of pregnancy and women patronize FPMN health services as key justification. It is my argument that these justifications informs the women centered strategies which unfortunately has not helped much in ensuring women's exercise of their rights. FPMN is a women's issue also confirms some feminists' view who argue for the need to safeguard reproductive function as women's treasurer (Tong, 1989).

It is also apparent that men are busy and men are not interested are also key justification which also confirms what Wegner questioned as in chapter 2 that policy planners have assumed men are not interested in FPMN issues. I would argue that this assumption is incorrect given the fact that the strategies are women centered and that information on FPMN issues is more on women as earlier indicated. The women's rights justification like it is for women's empowerment, its individual choice and that it's their right is known among women only which underscore the women's centered strategies. Article 16 of the Women's Protocol as earlier discussed is thus being challenged in this regard given the negative reaction of men and the

negative effect on women as seen in [section 5.2.2 later]; if women want to exclusively exercise their rights. Though reproduction is largely associated with women, in my view involving men becomes imperative if success on equality and mutual responsibility values in marriage between men and women are to be realized.

Interestingly though, almost 95% of the same respondents expressed their dislike of the strategies being women centered, admitting that it was indeed contradictory with regard to marriage's shared responsibility. Only 5 percent of the respondents felt that strategies are women centered on a temporary basis. Their argument is that when women's rights are fully recognized then there will be a balance of bringing in men into women's RH rights.

Men are actually interested and willing as [in objective 5] and they have been interested before (Wegner, 1998), but the focus has been on women for implied reasons like that maternal issues is women's natural process when in fact it involves men as well. Some key respondents bemoaned the lack of socialization for men from child hood as the major cause for men's lack of interest in FPMN health and their inadequate ability to care and nurture children. It is my view that this could be changed over time if government put up necessary programmes like civic education and school curriculum review to include gender issues in the education system. It is my opinion that socialized gender roles can be unlearned and men can learn new roles that will promote women's rights. In a nutshell, on this objective it is evident that MoH and partner NGO`s strategies on FPMN reproductive rights are women centered, and that these are contradictory to marriage's shared responsibilities.

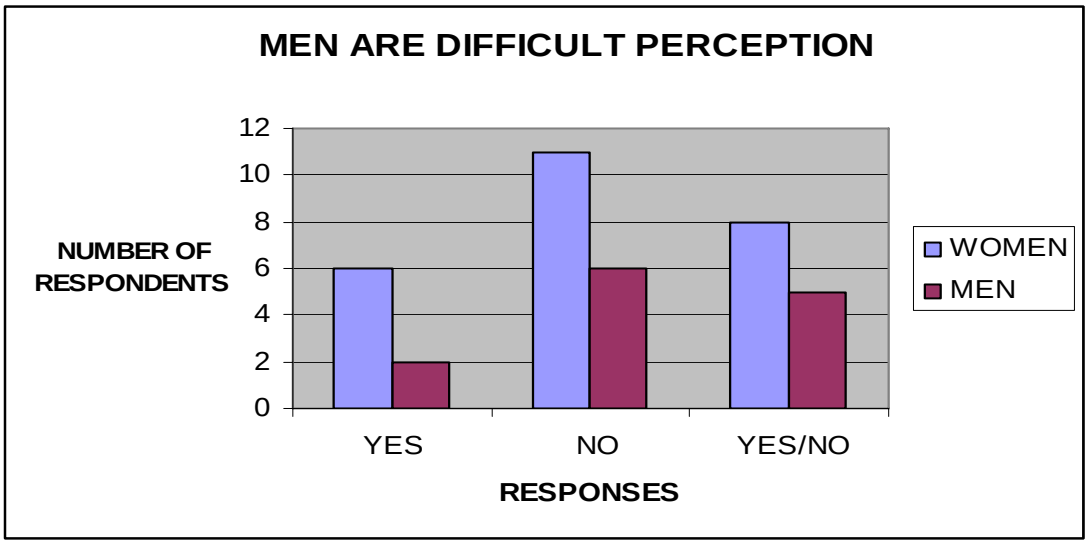
5.2. Men may not be easy to convince on SRH perception

The second objective of this study was *to appreciate the perception that men may not be easy to convince in matters of sexual and reproductive health hence their exclusion and how this raises problems given the influential male position in Malawi.* Based on this objective a number of issues were sought like whether it is true that men are difficult, the negative effects on women if men are excluded and how to exploit men's position to women's advantage.

5.2.1 Men are difficult Perception

A total of 38 individual and group respondents gave their view on this perception. The responses are as shown in the chart below.

Figure 2: Views on the perception that men are difficult to convince on women's SRH



From the results in this table, it shows that both men and women had diverse views on the perception. The fact that there were more women in this study targeted could be the reason for high number of women in each category. However, for the 8 (YES respondents) who said men were difficult they had their reasons. These were, that men do not go to hospital with women because some are not interested in FP, they claim to be busy, they see MN health as women issues and that they succumb to discouragement by peers and community members if they get involved. The following voice shades more light.

> Inde ambavutadi enewa kuti tikwati kulera...denda pyanga kakwata ndekha mwanseri, ambalonga ine mwana ndi mbodzi ndikwatirenji kulera? [Its true they are very difficult on FP, so I went to get FP alone without his knowledge because he argued, with only one child why should I go for family planning][a woman, Nsanje]

The reasons for men being difficult as given by these respondents' are more less related to some justifications given in section **5.1.2** and may not be very convincing in my view as they boarder on lack of socialization, lack of civic education and awareness on men, on their responsibility to their wives` FPMN health. The reasons also suggest that men are not responsible when actually men can exercise their duty

to the community (their wives) when their free and full capacity is possible and exploitable according to UDHR art. 29 (1). It can be argued that should government and civil society sensitize these men they can easily change and take their shared responsibility with their wives.

Those 18 (NO respondents) who said men are not difficult to convince had their own reasons. These were that, the current strategies target women who the majority of them are illiterate, that the strategies have entrusted information on FPMN health to women who men can not listen to, given the male position in the families as the picture below demonstrates.

Picture 12: A woman and a child visit a family planning clinic in Malawi

(The health officer is explaining to her how her husband can use a male condom)

Source:http://www.everyculture.com/Ja-Ma/Malawi.html accessed on 26-02-2010

Furthermore, some said it should be realized that 'behind every successful FPMN health there are men' and that men do not have information as women do. The following voice corroborates the views,

> Its not necessarily that men are difficult but that information has not been given enough to men for them to become receptive, women are different because they feel the pain related to maternal and neonatal health issues...so with sufficient information men would not be difficult… let us bear with men, they are getting the information slowly..[BLM Female Centre Director, Bvumbwe, Thyolo]

> Men may not be easy to convince on matters of MNFP SRHR only if they are not given adequate information but it should be possible to convince men slowly if they are taken as partners in SRHR issues e.g. encouraging males to accompany their wives for antenatal care services or FP allows for couple counselling and shared

> responsibility in decision making. Men would feel part and parcel of the care through that process (Deputy Director, MoH RHU)

My analysis of the reasons that men are not difficult seems to point to the need for human rights based approach, equity and gender sensitive strategies as promoted by the NHP and National Heath Act in Malawi. Further, a negofeminism approach with men given their position in society is also imperative. It should be appreciated that women and men issues need to be solved by involving both as promoted by the relational women's law and GAD models as discussed in the methodology chapter. Therefore, government and civil society as actors and through their structures need to help in reshaping men's perception and girls and boys socialization process on SRH and gender roles.

The last group of 13 (YES/NO respondents) who were divided on the perception that men are difficult had their explanations related to the previous group, but they also observed that the difficult of men is based on conditions. They stated that only men with messages and awareness do respond positively on FPMN issues, if they are in unity they can discuss with their wives, if they are counseled they may not be difficult. Other explanations were that there is need for clarity of information to men on the advantages and disadvantages of their involvement on FPMN issues and lastly they observed that the historical male dominant position makes men to be difficult. The following voices substantiate these findings.

> Inde, koma ambiri masiku ano akumvetsa […yes, but many nowadays are understanding]…mugwirizane nawo, ine ndidakatenga Norplant Injection nditabeleka ana khumi, kenako ndidamuuza mamuna wanga, adamvetsetsa...zitengera m`mene umulankhulire pomuuza za kulera [you need to agree with your husband, I personally went to take Norplant method when I gave birth to ten children and when I told my husband he accepted, it depends on the language you use to tell him] [Female, Moslem Leader, Nsanje]

> Not all men are difficult, it's some, for example I am now personally free because I understood about FP and my wife is at ease [Male respondent, Thyolo]

> Yes, are difficult but if well counseled, talked to and advised they agree on FPMN health issues...kuverana nawo nkhwakufunika [its important to agree with men] [woman respondent, Nsanje]

The explanations above, suggest that 'men are difficult perception' might not be absolute as the majority of the respondents feel men are not difficult. It would seem

from the responses that the difficult seen in men to appreciate FPMN issues has some roots in the socialization, historical male dominance, lack of information, illiteracy, unawareness of FP and lack of gender sensitization. These in my view are things that government and civil society need to address and take men on board to help promote women's SRH right. Hence, state parties are urged to ensure equal rights of men and women to the enjoyment of social and cultural rights according to ICESCR (art.3), like right to information and family's shared decision making. It might no longer be necessary to assume men are not interested as earlier seen men are interested but they are not equipped to fully participate in promoting the FPMN health of their wives and children.

5.2.2 Negative Effect on women due to the exclusion of men on women's SRH rights.

The respondents noted that the perception that men are difficult brings with it a number of challenges more often to women. The broad challenges mentioned were that, men are not available socially and economically for women, secondly is that men fail to understand what needs to be done and their role to care for the family dwindles. Lastly, it was that men become uncooperative, violent and negligent on women and children's health as they think they are not recognized. From these broad challenges women and children's health suffers a lot of negative effects. The following are some of the effects mentioned (see next table).

Table 4: Negative effects on women due to male exclusion in FPMN

Effects	**Respondents** Community = Com, Male = M Key Informant = KI, Female = F
1. Women are not given transport money if they want to go to hospital for ANC 2. Women are denied permission to go for FPMN services 3. Women are delayed to access ANC when pregnant or the child is sick	KI , M and F Com F
4. Unhealthy children and mothers 5. All the work is done by women in the home i.e. productive, reproductive and community roles 6. Poverty in the home as women are overburdened with too often pregnancies 7. Overpopulation at family level which increases burden to mothers 8. Lack of unity in the home as men suspect women using FP as promiscuous	Com, M and F
9. Women's maternal health is threatened leading to abortion, and other delivery problems 10. Deaths of mother and children (neonates) 11. Low life expectancy for women and children 12. Death of child due to home births or TBAs as men deny women to go to hospital	Hospital KI, M and F Com, M and F
13. Women's rights are denied.	KI, M and F
14. Violence that result from women seeking FP alone without their husbands consent 15. Men deserting families and leave the burden of rearing children to woman alone 16. Poor diet leading to malnutrition and deaths of children 17. Mothers have weak bodies and weakened birth canal 18. Women at risk of STIs and Aids as men do not accept condoms	KI, M and F Com, M and F

From the results it is clear that in Malawi the high maternal and neonatal mortality rates are in part contributed by lack of male involvement. Malawi by 2005 had the third highest maternal mortality in the world, only Afghanistan and Sierra Leone had higher figures, reflecting their war torn status (Grant, 2005). Gender relations in Malawi have a great impact on who benefits from health care. Women in Malawi have less access to cash, fewer economic opportunities and limited control over household resources and decision-making (Grant, 2005). Malawi Law Commission (2003) state that the morbidity and mortality rates of children are very high, loading

care givers especially women with huge burdens and sense of loss. This is exactly the effects on women the respondents have stated above. Further, the main causes of child mortality are mostly preventable diseases, malaria, diarrhea and malnutrition related diseases (Malawi Law Commission, 2003). It would then be plausible to assume that if male involvement was promoted as they are decision makers on health and provides the means in terms of economic resources, the health of the mother and the children would be promoted. Thus, if the effects above are any thing to go by, then continued male exclusion due to the perception that they are difficult to convince on matters of SRH is counterproductive and it threatens Malawi's attainment of MGDs 4 and 5 related to neonatal and maternal health respectively.

5.2.3 Exploiting men's influential position in promoting women's SRH rights

Almost all the respondents agreed that there is need to exploit the male influential position in marriages in Malawi to ensure women exercise of their rights. The respondents mentioned a number of areas of exploiting male position. For instance, that if men are taught on SRH they can influence change among fellow men to be positive about their role in FPMN health, men can be encouraged to take their role in SRH as a form of male championship that men already socially enjoy.

Men's position can further be exploited as they can be encouraged to take responsibility on pregnancy and its demands. White *etal* (2005) reported that 64.2% of pregnant women in rural areas had no money for transport to go to hospital. Thus men can take position on pregnancy women's nutritional and health demands in terms of costs and birth plans. They can be encouraged to use their position as chiefs, village's heads and religious leaders to promote safe motherhood among the members in the community and the families. Therefore, according to respondents and literature sources in exploiting men's influential position they can specifically contribute in the following ways to promote women's health. (See table 5)

Table 5. Specific area of male involvement in women's FPMN health rights

SRH aspect	Specific form of male involvement (what men can do)
Family Planning	• Accompany women to seek recommended FP method • Remind the wife to take the contraceptive pills on schedule. • Take alternative FP method like condoms and vasectomy • Ask questions at the FP clinic to ascertain good choice • Discuss with wife on the spacing of their children • Report to hospital if FP method affect the wife • Accept the situation if the FP bring side effect like Deprovera (when wife can not get pregnant on time)
Maternal health	• Accompany wife to ANC visits and attend lessons • To be with their wife during and after delivery • To arrange for blood donation • Plan how to respond to delivery complications • Do exercises with their wives • To arrange for a trained provider at delivery • Arrange for transport /get a ride like bicycle • Accompany wife when transported during delivery • Ask neighbor to look after wife when he is absent • To know danger signs of pregnancy • Go with wife for ANC check up • Arrange for trained provider for post-partum check up • Ensure wife exercise • Ask service provider questions • Go into delivery room for check up • Provide comfort and company during labor and delivery • Being part of PMTCT test and support the wife • Encourage pregnant women to go for VCT • Being part of VCT with wife • Encouraging pregnant wife on ARVs • Encouraging wife on exclusive breast feeding • Influencing wife receiving ART e.g. Nevirapine
Neonatal health	• Some services related to care for mother's pregnancy • Good nutrition to the mother before delivery • Help with baby care and nursing after birth like feeding, bathing • Accompany wife to post natal visits • Ensuring good nutrition for the mother after delivery • Providing sufficient clothing and warm clothes for the neonate • Take the child to hospital • Ensuring neonate is exclusively breast fed • Helping women guardian on the health and care of neonate whose mother may have died • Ensure the newborns of HIV positive mothers receiving ART e.g. Nevirapine

In spite that the mentioned male involvement specific areas presupposes the existence of a stable and trusted health system in place, it will still help to reduce

MN mortality rate. This is so because women will have easier and timely access to medical services, they will have the nutritional and moral support at family level. They will have reduced the chances of becoming pregnant too often and frequent which causes a lot of MN deaths. Thus by exploiting these areas of male involvement, equal relationships between women and men in matters of sexual relations and reproduction, including full respect for the integrity of person, that require mutual respect, consent and shared responsibility for sexual behavior and its consequences according to the Beijing Platform would be realized. Further, male involvement in the areas mentioned could also lead to the reduction of HIV and other STIs infection on women, who are at greater risk because of their disadvantaged and subordinate position in Malawi. (Malawi, National Gender Policy, 2000-2005).

In short in this objective it is evident that men are not necessarily difficult to convince on their wives SRH but they need information to unlock their existing potential to help improve the state of MN health in Malawi.

5.3 The Perception that 'It Is Men' Who Decides on SRH

This was the third objective of the study. Specifically it *was to find out whether 'it is men' who decides on sexual and reproductive roles perception is prevalent among women and men in Malawi.* The findings are presented in combined sections as both matrilineal views and patrilineal views based on common sub themes like men are decision makers, the sources of the perception on male chauvinism and how to deconstruct them.

5.3. 1 Matrilineal and Patrilineal society's views

There were slightly different perceptions on this based on sex and family regimes in the two districts as presented in the next two tables.

Table 6A: Matrilineal perceptions (Thyolo district respondents)

Men are decision makers in families on SRH	**Male Views (voices)**	**Female Views (voices)**
Yes, I agree but…	-We consider our capacity as well -its because women are more vulnerable, economically, socially, and education wise -its because of cultural values in our communities -its because men are breadwinners	-we also get FP advise from friends -I also initiate to talk to him about FP -its because others give births for approval in the family -we always agree on number of children -its because men have upper position in our societies
No, I don't agree because…	-women can exercise their right to FPMN health -we also want to be free from problems associated with frequent pregnancies	-we can agree on the MNFP issues with husband -you should not allow your right to be denied by a man

Table 6B: Patrilineal perceptions (Nsanje district respondents)

Men are decision makers in families on SRH	**Male Views (voices)**	**Female Views (voices)**
Yes, I agree but…	-it's because many children are your team to help you in future. -its because of Lobola culture (women don't have a say here in Nsanje) -its because men are breadwinners -its because men are dominant and have a lot of influence -it's our belief that many children are like your relatives	-its our lobola culture, he think he has bought you - Its due to our culture -its because elders, mother in-laws and father in-laws also influence our husbands -its because men have upper position in our societies -its because they say if you want 'go and exercise your rights at your father's home'
No, I don't agree because…	-its just sometimes when women go for ANC they consult husbands. -about 50% agree with their wives -we should not allow this as it affects women's health	-we can agree on the FPMN issues with husband -because number of children is women's choice -these many children are just born by chance, not choice

These Matrilineal and Patrilineal views suggest that the family regime has an influence on male prejudice and it influences their decision making on FPMN health. Further, as earlier noted in both areas few women mentioned that FPMN health is their own right. This suggests that male involvement in decision making on these

rights is an expected phenomena among many women. Therefore, it emphasizes the fact that in societies like Malawi where male chauvinism is rampant programmes that exclude men might not be very successful given their influential position in families. Consequently, the need to empower women and men to protect and care for themselves particularly in relation to maternal and infant mortality and HIV/AIDS, was a recommended strategy on reproductive health in Malawi (National Gender Policy, 2000-2005).

From the results, it also confirms the assumption that patrilineal men have more control on SRH decision than matrilineal men; this is because of Lobola custom which among others ensures clan lineage through the father's side. This confirms WLSA, (2002) view that Lobola practice affects women's sexual and reproductive rights. For matrilineal societies men's decision making is flexible on the number of children in the family because the family regime allows clan lineage through the mother as one matrilineal male respondent put it;

> ..ee! timakambirana nawo. Chikhalidwe chathu kuno sitikhazikika amunafe, akhoza kukuthamangitsa nthawi iliyonse…ndiye azimayi athuwa aliko ndi ufulu ndithu…[Yes, we discuss with wives because our custom here...we are not really settled we can be chased from the marriage anytime, so women do exercise their rights to some extent]

However, some matrilineal men are very influential on SRH because they claim they came to the marriage to father children as corroborated in this voice;

> ..these men here believe they came to father children in the marriage and they do not listen on issues of FP, they threaten they will leave for another wife... (Female, key informant, Thyolo)

It could be summarized that the basis for male bias on decision making in the families in both areas is largely based on what Mc Leoroy *etal* (1988) identified as ecological factors noted in chapter two. These are intrapersonal (beliefs), interpersonal factors (friends), institutional (family) factors, community factors (social norms) and public policies (rules and regulations on health). These generally require awareness and literacy on both men and women which the government needs to champion than to promote polices that excludes men. It is imperative in such areas that men are empowered with information on women's rights and the need for FP

from a shared responsibility. This could prepare them to be change agents in ensuring women's exercise of their FPMN health rights.

5.3.2 Source of male sexism on SRH decision

The women and men respondents in the two areas mentioned a number of sources of the beliefs as regards to male bigotry in the families on SRH issues. These were, the misconceptions about FP for instance that women who use FP are not 'sexually sweet', that family planning affect men's manhood performance in bed, the view that the bible says lets bear children like 'sand of the sea'. Additionally, the cultural view of male sexual prowess as sex initiators, men are heads and women are tails notion, some women's desire to have more children, the belief that you have to bear many children for fear of your sister to take over your marriage in patrilineal communities.

Furthermore, the socialization of boys as more knowledgeable than girls in the societies, the belief that if women take FP method they will become promiscuous since men can not notice because there will be no pregnancy. The belief of attracting 'bad omens' like witchcraft if you have few children and religious belief that teach against FP. Some of these socialized notions; misconceptions and beliefs are as expressed in these voices.

> ..mmudzi muno azibambo ena amakaniza njira zakulera akuti nkazi womwa mapirisi samakoma...amati imaapha misana [in this community, some men don't allow their wives to use FP methods because they say a woman taking contraceptive pills is not 'sexually sweet'... and they sexually under perform, [A woman, Thyolo]

This notion was corroborated by a man in another focus group discussion.

> "I know these things are not good, I used to do it three times in a night, but when she started taking these tablets, I do not do it as often any more. [A man, Thyolo]
>
> …wa ba imwe akazi anthawi zino nakuleraku ambakachita pyawo uputa na amuna anango, angabwerako unamva wa lero nkhabembo funa ndipume...ba ndinyatwatu!! [Ooh!! my brother.. women nowadays if they are using family planning methods, they go out with other men, when they come home they say excuse me,.. no sex tonight ..It's pathetic my brother! [A man, Nsanje]

My analysis of these socialized norms, beliefs and misconceptions that lead to men thinking they are decision makers on SRH and the women's acceptance of this perception boarders largely on ignorance, lack of gender sensitization and

misinformation to men and women regarding human rights, equality, and respect for each other as parties in the family. This can be addressed by the concerted action by civil society, government and community leaders to challenge and change the misconceptions. This will be in line with CEDAW (art.12) which calls for states to eliminate stereotypes and integrate gender sensitization and human rights at all levels of education and (art.5) calls for the creation of public awareness in all sectors of the society on practices that can be harmful to women. The following table gives a summary of respondents' suggestions on the ways of changing the misconceptions.

Table 7: Ways of changing the misconceptions

Response	**Respondents** Community =Com., Key Informant = KI, Male = M or Female = F
1. Information on FP should come to our villages **2.** There must be behavior change messages on the need to work together on FPMN health **3.** There should be community gathering though village leaders	Com M and F
4. Men should be sensitized on FPMN rights **5.** We need to tell the husbands nicely until they understand the need for FP	Com F
6. Church and mosques should take part on male sensitization	Religious KI, M and F
7. Government hospitals should invite men for FPMN health talks **8**. There should be a man to man approach on FPMN health	Com M
9. There should be civic education on women's rights. **10**. Target the young generations to change their altitudes through the school curriculum **11**. We need to talk to men and never impose on them solutions **12**. We need to check tribes and their beliefs and work together with village leaders to modify these beliefs	NGO KI M and F
13. We need laws in place to check male dominance **14**. International human rights that protect the rights of people should be domesticated and disseminated to local people	NGO KI, M

The suggestions outlined in the table shows that community people, NGOs and other Key Informants together realize the challenge they have and know also what need to be done. This relates to Health Belief Model position in chapter two. The model postulates that people can only change if they believe they are susceptible to a condition which has a serious consequence and which they can address through

action. The stated suggestions show that the respondents are aware of the negative effects of male sexism on SRH. The challenge in my view is on government and civil society to bring home these suggestions so as to change the perceptions of male dominance that undermine women's rights.

In a nutshell, 'it is men' belief that decides on SRH especially on number of children is common in the two areas, but more common in the patrilineal society due to Lobola. However, the respondents have identified the sources of this male chauvinism and they have proposed the ways to change the beliefs to ensure women enjoy their SRH responsibly in the families.

5.4 Male Involvement and its Positive Impact on Women

The fourth objective of the study was *to assess whether male's involvement in the 'perceived' women's sexual and reproductive function as shared responsibility in the families would impact positively on women's exercise of their sexual and reproductive health rights*. The impact of male involvement and the effects of their non involvement on FPMN health issues were tackled in this objective. Male involvement from a shared responsibility need to be understood from the perspective that as much as women carry the pregnancy and a number of care related activities, men too are subjects in reproduction and they have a role to play as noted in objective two. As in objective two (table 4) the specific areas of male involvement should be able to enhance women's exercise of their rights. Almost all the respondents said there would be positive impacts on women's exercise of their rights if men are involved. The following table gives a summary of the views of the respondents.

Table 8. Positive impact on women's exercise of their rights through male involvement

Response	**Respondents** Community =Com., Key Informant = KI, Male = M or Female = F
1. Able to space children and reduce unsafe abortions 2. Good health and happy families 3. Improved care on children as they would be few 4. They would be able to go together with children to hospital 5. Good nutrition of children and mother	Com M and F KI M and F
6.Able to give women freedom to take part in community work, business and studies 7.Women will get proper and sufficient support 8. Good relationship among couples	KI F
9. They will look health and admirable 10. They will look young and healthy 11. Children are likely to be healthier	Com F KI F
12. Reduction of STDs and HIV/AIDS 13. Access to FP services would be easy as they will agree and support each other. 14.Help each other with work like baby cuddling and nursing 15. Some pregnancy complications would be reduced 16.Safe motherhood will be ensured	KI M and F
17. Gender equality would be achieved 18. Men would be more understanding on the health needs of the wife and children and provide the necessary support like transport money to hospital 19. Men would not go out with other women as there will be love and intimacy 20. Reduced early marriages	NGO KI, M Com M

The following voice also sheds light on the issue;

> …indeed male championship would assist women positively, size of the family would be small, maternal complications would be reduced...for sure if pregnancies were to be alternating between men and women, by second child there would be none to take the pregnancy, because then men would have felt it too..so we need men to be involved. [DHO, Nsanje]

These positive impacts above might ensure that women exercise their FPMN health rights. This agrees with Wegner *et al* (1998) as noted in chapter two, that if men are knowledgeable about RH issues they are likely to be supportive during delivery and may make better decisions on health care. These positive impacts will only be realized once interventions and strategies recognize the role that men can play in their wives SRH. They are also of benefit to men, since according to respondents men too are affected by their exclusion in their wives SRH issues. This was also

observed by Kauffmann (2003) who emphasized that participation of men in their wives reproductive health is not only beneficial to women but men as well as the effects from their non-involvement also affect both. Respondents observed the following negative effects on men.

Table 9: Negative effects on men from their non involvement in their wives SRH.

Responses	**Respondents** Community =Com., Key Informant = KI, Male = M or Female = F
1. They run away from home due to being overburdened with the needs of many children	Com F KI F
2. They fail to do their work/business as they take the sick mother or child to hospital. 3. Economically affected as they might spent a lot of resources to support the sickness of the mother and children.	KI M Com M and F
4. Failure to support many children like on school fees and other needs 5. They become orphans with the children upon the death of their wife due to pregnancy complication /they face guardianship challenges	Com M and F KI F
6. They can contract STDs and HIV/AIDs from their casual sex episodes which also affect women and children. 7. They are psychologically affected due to the illness of the mother or children due to poor health. 8. Their chances of having other children are affected if the woman has had a ruptured uterus. 9. Their sexual relationship is affected due to their wife's sicknesses. 10. They risk their lives from thugs and robbers when they accompany their wives to hospital in the nights.	Hospital KI M and F

The following voice emphasizes these findings,

> Yes men are affected but they just don't say, they have family health problems if children are sick, they fail to provide for the home like food and clothing…they are even psychologically affected if a woman is pregnant two months after giving birth…men just put up with it…others run away from marriage to marry another wife. [Key informant, Thyolo]

These negative effects on men also have some direct link to women. For instance when men desert the family, when they contract STDs and HIV/Aids, when they fail

to support and provide for children both parents are affected. This underscores the need for a shared responsibility in decision making on SRH to avoid such effects. This was echoed in the Beijing Platform that,

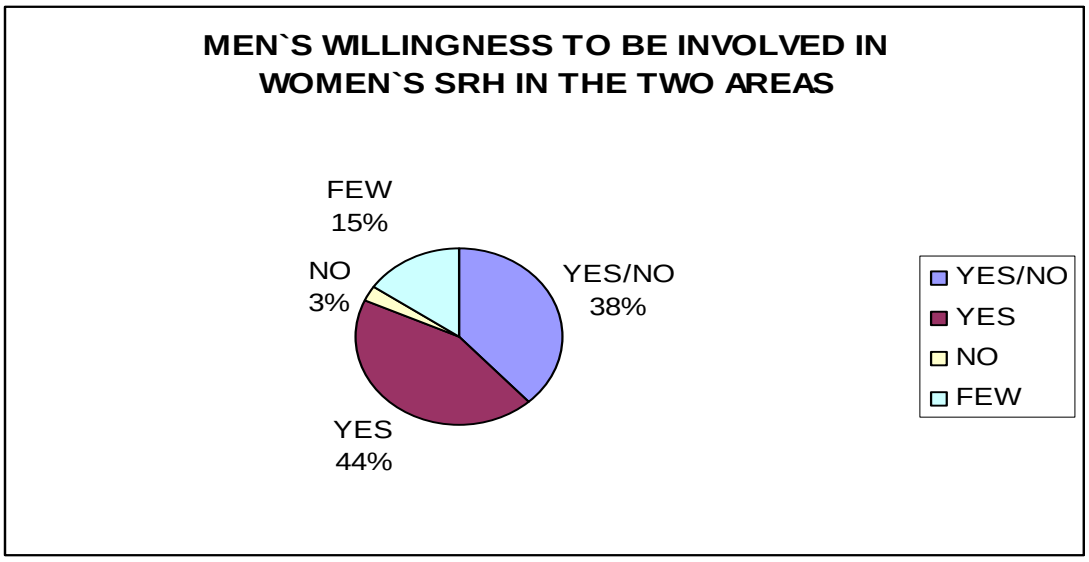
> …The promotion of responsible exercise of these [RH] rights for all people should be the fundamental basis for government and community supported policies and programmes in the area of reproductive health including family planning.

Finally in this objective positive impact on women's exercise of their rights have been noted if male involvement is promoted. Further, it has been found that men are also affected by their non involvement in their wives SRH issues. Therefore, male involvement if promoted has a multiplier effect on women, men and children's health in the two areas in Malawi.

5.5 Men's Willingness to be involved in women's FPMN Health

This was the last objective of the study. It was aimed *at finding out if men are willing and ready to be involved in their (wives) women's SRH once policies and strategies on this recognizes the joint role of parties to the marriage on reproductive rights*. The respondents had different views as summarized in the pie charts below.

Figure: 3 Pie chart on men's willingness to be involved in women's SRH



The respondents` views were fourfold, 3% said men are not willing, 15% said there are few men (less than 50%) that are willing, 38% said (yes and no) suggesting 50% willing men and 50% unwilling, while 44% said men are willing. The views were

that diverse due to the level of literacy among respondents, the sex of the respondents, their personal experiences and their observations as regards to male willingness to be involved in their areas. The following voices underscore the diversity of the views.

> Some are and others are not…my personal experience was that during my previous labor experience, my husband was there in the delivery room and he saw the process, since then he has completely changed his appreciation on FPMN issues in our family [Female Lecturer at Malawi College of Health Science, Blantyre]

> Chidwi chilipo koma sizitheka, chifukwa azibambo sakutenga mbali, amaziona ngati zachibwana akamamva kwa akazi awo za uchembere wabwino ndi kulera [willingness is there but it's not possible because men are not involved, they think it's childish to be told by their wives about FP and safe motherhood] [Male respondent, Thyolo]

> Chidwi ntchakuchepa kuno nthangwi ya chikhalidwe chathu, mafumu anango ambakhondesa kuti si mwambo wawo kuti amuna azichita pepi...pikhulupiriro pyoti mamuna angaona mkazache akubala kuchipatala, banja na mkaziyo yamala. [Willingness is very low, because of our customs on FPMN, some village heads challenge the idea of male involvement, because they say it's not inline with our customs…the belief that if a man observes what happens in labor during delivery he will divorce the woman]. [Male and Female respondents, Nsanje]

The respondents had diverse explanation for their position. It was said that men are not willing because of lack of love to their wives. It was also noted that few were willing because some men disregard SRH message even if they are informed due to some beliefs and ignorance. The ones that were divided (50% Yes and 50% No) had explanations like, most men do not have information on FPMN health as they ask a lot of questions when they go to hospital with their wives, some claim they are busy to be involved in women's issues and for others it was because interventions mostly targets women than men. Those that said men are willing was because they had personal experience of male involvement, they saw men involved in a pilot project, and they believe men can change given enough information on their role and responsibility on FPMN from a shared responsibility view in the family.

Therefore, from the results I infer that men are largely willing to be involved in women's sexual and reproductive health issues. This agrees with most of the studies that men have responded positively to being involved in interventions and that they do in fact care about the welfare of their families (Wegner *etal*, 1998, Kauffmann

2003). Since the respondents were majority women it would seem that most women are in support of their husband's involvement in their SRH. This relates to what Kauffmann also report that women generally express interest in men's participation in SRH. For instance, in a Kenyan study, 90% of women said they desired men's participation in antenatal care, post-partum visits, and FP (Kauffmann, 2003). However, this willingness requires sufficient information and awareness on the part of men.

Even though, some respondents reported unwillingness of some men, it might be because of ignorance and how they could get involved amidst challenges. For instance where there is disregard for their bicycles as the case was reported at Thyolo hospital where watchmen deny men to get into the hospital yard with their bicycles when they accompany their wives. Such challenge might deter men from being involved. However, almost all the respondents stated that men's willingness can be enhanced if a number of measures are taken by the government, civil society, the community and men and women themselves. The following are the measures that were suggested to different actors and structures to enhance men's willingness.

5.5.1 Enhancing men's willingness to be involved in women's FPMN health.

For MoH, respondents bemoaned that it has overlooked men's role in their wives SRHR which has led to the promotion of women centered strategies. Hence, they proposed that there should be regulations and policy to ensure that men are equipped with necessary information on SRH rights so that they can participate. The hospitals should allow men to bring their bicycles in the hospital yard. Men needed to be trained on FPMN issues through gender sensitive messages. Government should redesign labor/delivery wards in hospitals to ensure privacy so that men can be available in the wards.

Respondents urged the civil society to intensify civic education in the communities particularly to men on their role in promoting women's SRH rights. This could be through community mobilization to train men in the communities. These men can then promote FPMN health issues to others. The NGOs were also urged to work with

government to promote participatory FPMN health messages since they are in touch with people at grassroot level.

The communities, men and women were encouraged to regard their local leaders as entry point for community mobilization on FPMN issues. The chiefs, village heads and religious leaders needed to be empowered to appreciate the need for male involvement in FPMN issues if they have to mobilize their subjects. The men in the community particularly asked for a 'man to man initiative' on male involvement in FPMN health at community level. This would see trainers trained to propagate the message about the need for male involvement.

It was also mentioned that the role of satisfied clients or role models on male involvement should be identified at community level who can also talk to others. Satisfied clients could be men and women from such places like Mwanza PMTCT Male Involvement project, Family and Reproductive Health and Rights' project implemented few years ago in Mchinji, Dedza and Nkhatabay districts in which male involvement was successful according to Key informants at Mwanza District and MoH RHU. The following voice exemplifies how male involvement is enhanced in Mwanza,

> The men are coming with their wives for PMTCT testing. They are told about labor, pregnancy management, and preparation for delivery, child health, nutrition, nursing, care and FP, and through the safe motherhood coordinator they conduct community nursing. It was observed that if medical people visit men they respond very well than if message is sent through their wives. Generally, women do have more knowledge on FPMN health than men but through this programme men are becoming knowledgeable and they are forming their own community forums in the villages to talk to each other. (Mwanza PMTCT Male Involvement Project Coordinator)

The above suggestions also relate to some strategies already designed by the MoH on community involvement and partnership with civil society as indicated in chapter four. However, the MoH need to capacitate the process by providing funding and adequate information to men who are often the gate keepers. From the key informants it is evident that male involvement in FPMN health in Malawi is possible. What the government needs to do is to ensure that its policy and strategies are gender sensitive.

To this end, I agree with Kauffmann (2003) that in SRH promotion, the inescapable conclusion is that although perhaps no longer seen just as part of the problem; men have yet to be regarded seriously as part of the solution. Therefore, this study has generally found that men are willing to be involved provided that they are equipped with the skills and knowledge for them to promote their wives SRH rights in the two communities in Malawi.

CHAPTER 6

CONCLUSION AND RECOMMENDATIONS FROM THE STUDY

6.1 CONCLUSION

This study was aimed at assessing the need for togetherness at policy and strategies level on male involvement and how it can promote married women's exercise of their FPMN SRH rights in Malawi. The study was done in Thyolo and Nsanje districts. It was generally found that the existing policy and strategies used by MOH and partner organizations to promote FPMN health are women centered. It was established that women centred strategies are a hindrance for women to exercise their rights as they are against the standards regarding marriage and its shared responsibilities. In both communities respondents expressed the need for male involvement in FPMN issues if married women have to exercise their SRH rights.

It was also realized that as much as women and neonates suffer more negative effect due non male involvement in SRH, men too are affected by their non involvement. The areas where men can be involved in their wives FPMN SRH rights were identified as support, care, direct participation and encouragement to their wives. Men were found to be willing to be involved but their willingness would only be guaranteed if they are equally empowered with information and together with their wives be sensitized on the need for shared responsibility in SRH. This can be done by government, NGOs, community and religious leaders' efforts to bring men on board on issues of FPMN health. Government is also expected to address issues of infrastructure and provide in-service training for some health personnel to be gender sensitive in dealing with men. Thus in a nut shell, male involvement has been suggested by respondents as one of the ways to help reduce the high incidence of MN deaths and ensure that only well planned for children are born in families in the two communities in Malawi.

In view of this conclusion the following recommendation are made.

6.3 RECOMMENDATIONS FROM THE STUDY

Ministry of Health

- That it is not enough to recognize that lack of male involvement is a challenge but there is need for action like having gender sensitive strategies to ensure women's FPMN health rights are realized than continue to propagate strategies that are male unfriendly in the hospitals in Malawi.
- That policy and strategies should practically recognize male involvement in women's FPMN SRH as one way of tackling MN health issues in Malawi.
- That the ministry should start to progressively work towards infrastructure re-design in the maternity wards to allow men accompany their wives.
- That the medical personnel in the ministry are fully sensitized on the need to be gender sensitive in dealing with men who will be responding positively to messages on male involvement when they come to the hospitals.
- That the ministry should ensure the use of Health Surveillance Assistance (HSAs) who often are the most common health personnel at community level. HSAs should be equipped with enough skills on FPMN health so that they can talk to community leaders, men and women in the villages than to expect the donor funded initiatives which are unreliable and insufficient to meet the country's needs.
- That in conjunction with other ministries like Ministry of Education Science and Technology and Ministry of Gender and Child Development, gender stereotypes on SRH rights and women's rights should be challenged in Malawi.
- That the ministry and other partners explore the opportunities of actively promoting other FP methods like the natural FP methods or come up with new methods for men to have a diversity of methods as well.

Civil Society

- They should work together with government in promoting gender sensitive messages through the radios, TV, news papers and in the communities.

- That they help government to mobilize communities and empower them with SRH messages that recognize the shared responsibilities of men and women in the families.
- That they should work together with government in efforts to disseminate women's rights and other human rights instrument that Malawi is party to in all communities in Malawi.
- It should ensure that government is progressively making available services related to SRH as a human right for the people of Malawi.
- That they should champion the implementation of government policy and strategies that encourage male involvement in FPMN health rights given their strategic position at grassroot level.

Community

- That the community leaders should be at the forefront of encouraging men and women to go for ANC together to promote male involvement initiatives.
- That through their religious and community leaders, communities should be mobilized to work towards the promotion of women's SRH rights in a gender sensitive manner.
- That they should work towards modifying some gender stereotypical forms of behaviour such as women seeking their husband's consent if they have to go for ANC or delivery at hospitals.
- That they should be able to organize themselves and have some volunteer community men and women who within the community can sensitize others on FPMN health issues.
- That they provide a conducive environment for government and civil society initiatives to address the MN health challenges. For instance, where taboos related to pregnancies and practices like lobola exists, there is a need to modify or redefine the implications of such beliefs in the community.
- Communities should arrange for the quick transport for cases of emergency pregnancy complications and others.

6.3 Areas for Future Research

A number of areas for future research have been created by this study. They include, for example, the role of community leaders in promoting SRH rights; and whether men`s willingness to be involved in their wife's SRH may become yet another form of male dominance, i.e., whether the increased involvement of men in the pursuit of women's rights and empowerment will prejudice those very rights and empowerment.

BIBLIOGRAPHY

Abdullah R. (2007) *Feminist Project Seeks to Understand Men* [see also] www.isis.women.org/index.php?option=com.content&task=view&id=635&ltcmid=200

Bentzon, A.W.etal, (1998) *Pursuing Grounded Theory in Law; South- North Experiences in Developing Women's law*. Tano.Aschehoug Oslo, Mond Books Harare,

Brown M.L (2004?) *Feminist Theory and the Erosion of Women's Rights:* Washington College of Law: US

Dev, A. (1998) 'Involvement of Husbands in Antenatal Care: Evaluation of Deepak Charitable Trust's Outreach Programme'. In: Population Council, *Men as Supportive Partners in Reproductive and Sexual Health,* Narrating Experiences Workshop, Kathmandu, Nepal, June 23–26. Population Council, New Delhi

DFID (2004) *Talking about health, sex and pregnancy,* DFID, UK [available at] www.dfid.gov.uk accessed on 23-03-2010

Glanz, K *etal* (2005) *Theory at a Glance, A Guide For Health Promotion Practic*e. National Institutes of Health: National Cancer Institute, US

Glaser, B.G and Strauss, A.L (1967), *The Discovery of Gounded Theory: Strategies for Qualitative Research*, Aldine De Gruyter, New York

Grant E. and Logie D (2005) Scottish Executive International Development Report of health sector visit to Malawi 18th- 22nd April 2005 Lothian NHS Board, Edinburgh.

Haile S. *etal* (2000), *Provision of reproductive health services in Sub-Saharan Africa: Lessons, issues, challenges and the overlooked rural majority.* Sustainable Development Dept, FAO

http://www2.ohrchr.org/english/issues/women/docs/responses/Ipas.pdf accessed on 19-03-2010

Johns Hopkins Center for Communication Programs (1997) *Reaching Men Worldwide: Lessons Learned from Family Planning and Communication Projects*, 1986–1987. Johns Hopkins School of Public Health, Centre for Communication Programs, Baltimore

Kaufman. M (2003) *Addressing and Involving Men and Boys to Promote Gender Equality and End Gender Discrimination and Violence* Prepared under a contract with UNICEF [see also www.michaelkaufman.com] accessed on 18-03-2010

Malawi Law Commission. (April, 2003.) *Overview and Issues of Gender based Law Reform in Malawi.* Lilongwe

Malawi, Ministry Of Gender, Child Welfare and Community Services (2000) National Gender Policy, 2000 –2005 Lilongwe

Malawi, Ministry of Health (2006): *National Reproductive Healthy Strategy 2006-2010 Draft 2*, MoH: Lilongwe.

Malawi, Ministry of Health (2007) *Guidelines for Community Initiatives for Reproductive Health.* Reproductive Health Unit: Lilongwe

Malunga A. J (2007) *Dissertation: A Simple Approach, Guidance on how to write a project proposal and paper.* FGI, Blantyre [unpublished]

McLeroy KR, *etal* (1988). 'An ecological perspective on health promotion programs'. In *Health Education Quarterly* 15: 4:**351–37**

Ministry of Health (RHU), *Road Map for Accelerating the Reduction of Maternal and Neonatal Mortality and Morbidity in Malawi,* March 2007

Population Council (1998) *Volunteers Prove Successful at Increasing Men's Knowledge of FP*. Population Council, New York.

Power, J and Kenyon, M (2005). *Working with men to improve reproductive health. An activity manual for the Pacific*. Australian Reproductive Health Alliance. Canberra,

South Africa National Department of Health (2007): *Policy Approaches for Working with Men, to improve men's health and achieve gender equality*, National Consultative Meeting Birchwood Conference Centre, Gauteng, Sept. 17-18, 2007

Tong, R. (1989) *Feminist Thought; A Comprehensive Introduction*. Westview Press, Inc.: Great Britain.

Tsanga, A (1997) *Taking Law to the People. The case of Legal Education in Zimbabwe*, Ph.D Thesis, the Faculty of Law, University of Zimbawe

UNDAF Malawi (2009) Final Draft, *Mid-Term Review of the UN Development Assistance Framework for Malawi (2008-2011).* United Nations, MALAWI

UNITED NATIONS (2008) Claiming the Millennium Development Goals: A human rights approach New York and Geneva

USAID, The AQUIRE Project (2005), *Moving Family Planning Programs Forward*: *Learning from Success in Zambia, Malawi, and Ghana. The Repositioning Family Planning Case Study*. USAID, New York

Wegner, M.N *etal* (1998) Landry, 'Men as Partners in Reproductive Health': From Issues to Action. In *International Family Planning Perspectives*, Volume 24, Number 1, March 1998

White, S. *etal* (2005) *Beyond Inequalities 2005: Women in Malawi*, WLSA Malawi, Limbe and SARDC WIDSAA, Harare

WHO Regional Office for South East Asia (2004) *Improving Maternal and Newborn Health –The Role of Family Planning Report of a Regional Consultation Chiang Mai, Thailand, 19–21 November 2003* WHO Project: ICP MPS 001, New Delhi

WLSA (1997) *Paving a way forward: A Review of WILSA Research Methodologies*: WILSA Research Project: Harare

WLSA (2002) *Lobola: Its implications on women's reproductive rights in Botswana, Lesotho, Malawi, Mozambique, Swaziland, Zambia, and Zimbabwe* Weaver Press: Harare

APPENDIX

1. RESEARCH TOOL USED IN THE STUDY

TOGETHER IN REPRODUCTIVE HEALTH RIGHTS:
A POLICY AND STRATEGIES ANALYSIS ON MEN`S INVOLVEMENT IN PROMOTING WOMEN`S SEXUAL AND REPRODUCTIVE HEALTH RIGHTS IN MALAWI

DATA COLLECTION GUIDE

Objective 1

To find out how 'women centered' SRH policy and strategies are against the standards as regards to marriage and its shared responsibility.

Respondents: MoH, DHO, Training Institutions, Communities men/women, Opinion leaders, NGOs officials, Health officers

Issues

- Sexual and reproductive health rights understanding.
- Focus of interventions and strategies on women's SRH rights
- Policy focus on the exercise and approach on women's SRH rights
- Why are SRH rights women centred
- Conflict between the SRH strategies with marriage shared responsibility

Objective 2

To appreciate the perception that men may not be easy to convince in matters of SRH hence their exclusion and what is its negative impact on women given the influential male position in Malawi.

Respondents: NGOs, Health officers, Community men/women, opinion leaders, Training Institutions.

Issues

- Comment on the view that men may not be easy to convince on matters of SRH rights
- How problematic is the view given their influential position in marriages.
- How can men's influential position be used to promote women's exercise of SRH rights
- Negative effect on women due to not involving men in their wives SRH rights

Objective 3

To find out whether 'it is men' who decides on SRH roles perception is prevalent among women and men in Malawi.

Respondents: community men/women, opinion leaders, church/mosque leaders, health officers.

Issues

- Men and women socialized beliefs on women's SRH in matrilineal and patrilineal society
- Whether men are the main decision maker on SRH rights e.g. number of children

- Do women and men accept that `it is men` who have to decide on SRH issues
- How to change the perception that 'it is men' who have to decide on SRH rights

Objective 4
To assess whether men's involvement in the 'perceived' women's SRH function as shared responsibility in the families would impact positively on women's exercise of their SRH rights.

Respondents: MoH, Health officers, NGOs, Training institutions, Community men/women, opinion leaders
Issues
- Are men/husbands affected by women SRH issues
- Men's involvement in women/their wives SRH as a shared responsibility
- Specific positive impacts on women and children (neonates)

Objective 5
To find out if men are willing and ready to be involved in their (wives) women's SRH once policy and strategies on this recognizes the joint role of parties to the marriage on reproductive rights.

Respondents MoH, DHO, Health officers, NGOs, Training institutions, Community men/women, opinion leaders
Issues
- Men`s willing to be involved in women/your wives` SRH issues
- Comment on men's willingness to be involved in their wives SRH
- Strategies and focus on women and men's willingness
- What need to be done to enhance willingness

THANK YOU!

2. RESEARCH CONSENT FORM

Principal Investigator: Anthony Jeckson Malunga

Sub-investigators: …Ms Rosalie Katsande (supervisor), University of Zimbabwe

Introduction
We invite you to join in this study. The purpose of the study is to find out people's views on women's SRH rights from a male involvement viewpoint in the society. Specifically focusing at Maternal/Neonatal and Family planning (MNFP) aspects of sexual and reproductive health.

Detail
This is an academic research and the information that you are going to provide will solely be used for that purpose. We will ensure your confidentiality and we will abide by your view whether to include your name or picture in the write up of the report. Feel free to withdraw from the interview if you feel uncomfortable or you are busy.

Persons to Contact
If you have any further questions or concerns about this study because you think you have not been treated fairly or think you have been hurt by joining the study, you can call the Principal Investigator, Mr. A.J. Malunga at any time on the following telephone number (+265) 888676958. You can as well write him on this address; Blantyre Secondary School, P/Bag 10, Blantyre Malawi. Or you can contact my supervisor on the address provided on my University of Zimbabwe introduction letter attached.

1. Do you agree to participate in this study?

Yes, I agree….. No, I do not agree…..

_____	_____
Participant Identification Number/Name/Contact	Date
_____	_____
Signature/thumb print of participant or expressed commitment	Date
_____	_____
Signature of person obtaining consent/interviewer	Date

(Abridged version adapted from COMREC, University of Malawi Guideline)

3. INTRODUCTION LETTER

P.11/09/837

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18 September 2009

Re: Student Request to conduct interviews and research

The Southern and Eastern African Regional Centre for Women's Law (SEARCWL), which is a Department within the Faculty of Law at the University of Zimbabwe, runs a regional Masters in Women's Law. This Master's programme brings together students from Kenya, Tanzania, Uganda, Zambia, Malawi, and Zimbabwe. The students, comprising of men and women, include magistrates, prosecutors, legal practitioners, NGO activists and social scientists.

In partial fulfillment of the Master's programme, one of the key requirements is that students must carry out research on a topic of their choice within their own country. This is to enable students to get hands-on experience of the issues affecting women's lives from a research perspective in their own countries. The research period runs from October through to January after which they return to the University of Zimbabwe for data analysis and the final write up of their dissertations.

In carrying out their research, the students need to liaise with different departments and institutions.

This letter serves to confirm that **Anthony Jackson Malunga** is one of our Master's students. His research topic is entitled:

> **Together in Sexual and Reproductive Rights; A Policy and Strategies Analysis of Men's Involvement in Promoting Women's Sexual and Reproductive Rights in Patrilineal and Matrilineal Societies in Malawi**

As one of the institutions that he would like to get data from, we are writing this letter to request that you kindly grant him the necessary permission to carry out interviews and collect the relevant data from your institution. Should you like a copy of the research once the student has completed his programme, we would be happy to avail this as the research exercise is done in the spirit of co-operation in order to bring meaningful change to women's lives.

As I am directly responsible for supervising the student in question, kindly feel free to email me should you require further information. My address is rkatsande@law.uz.ac.zw I thank you for your co-operation.

Yours Sincerely

Katsande R.K (Ms)

Dissertation Supervisor

UNIVERSITY OF MALAWI
COLLEGE OF MEDICINE
OCT 2009
P/BAG BLANTYRE 3