Assessing the Potential Impact of Gender Norms and Gender Inequality on a Couples' Home-Based Intervention in Malawi

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Abstract (150 words)

Although couple interventions have been shown to positively influence health outcomes, it is important to consider existing gender relations in ensuring equal benefit and protection to both partners. This formative, qualitative study was designed to inform a subsequent intervention study of couples' home-based family planning counseling and HIV voluntary counseling testing near Blantyre, Malawi. Findings from focus group discussions and in-depth, couple interviews indicate that clearly-defined gender roles influence couple communication, as well as knowledge and uptake of reproductive health services. Although male and female participants indicated that wives are expected to defer to their husbands in all matters, they also discussed the ways in which wives avoid confrontation or potential conflict through covert contraceptive use and non-disclosure of HIV test results. Findings suggest that the proposed intervention appears to provide several benefits to both partners, but needs to be carefully implemented given the differential impacts for women versus men.

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Introduction and Background

Malawi, a landlocked country of 13.1 million people in southeastern Africa, is one of the highest HIV prevalence countries in the world (National Statistical & Macro, 2005; Population Reference Bureau, 2007). Among those tested during the 2004 Malawi DHS survey (MDHS), HIV prevalence was 13% for females and 12% for males (National Statistical & Macro, 2005). The MDHS also showed that prior experience with HIV testing was limited, with 83% of women and men reporting never having been tested nationally. In hopes of slowing the epidemic, Voluntary Counseling and Testing (VCT) services are now offered in 184 centers throughout the country and ART services are provided in all hospitals.

National fertility levels are high in Malawi, with a total fertility rate (TFR) of 6.0 children per reproductive aged woman. One-third of all currently married and 26% of all sexually active unmarried women report using contraception. More than 85% of contraceptive practice by married women is with modern methods. Injectables are the most commonly used method of contraception, accounting for 64% of use while female sterilization accounts for one fifth of use. However, there are an additional 28% of married women who have an unmet need for contraception, 17% for spacing and 10% for limiting reasons. Government health facilities remain the primary supplier of services, with the balance coming from hospitals and clinics of missionary and non-profit organizations.

The two common elements of reproduction and heterosexual HIV transmission are that they occur with the involvement of men and they occur in the context of partnerships. Although partnership attributes are critical to the study of pregnancy and HIV prevention, dyadic relations are quite understudied and context-specific. Mbizvo and Bassett have noted that the sophisticated and dynamic linkages of factors in Africa important for women's reproductive health require complementary linkage to the study and education of men, who are often ignored both by researchers and health providers (Mbizvo & Bassett, 1996). Studies have shown positive effects of including both marital partners in VCT such as increased condom use in Zaire (Kamenga et al., 1991) and Rwanda (Allen et al., 1992) and greater uptake of nevirapine among HIV positive pregnant women in Nairobi (Farquhar et al., 2001). Studies have also indicated that couple-based family planning interventions can be more effective, as compared to interventions with women alone (Becker, 1996).

Although couple-based health interventions have the potential to benefit both members of the couple, it is important to also consider any potential repercussions of the intervention for one partner in particular, given existing gender norms and roles, or ways in which the intervention could exacerbate any existing gender inequalities. In Malawi, as in other settings, the effects of gender on health outcomes need to be considered. A DHS comparative study of the status of women in 25 countries found that Malawi ranked 22nd when assessing the status of women according to a range of

domains (e.g., education and exposure, employment and workload, marriage and childbirth, etc.) (Kishor S, 1996). Statistics from the recent MDHS and the 2007 Malawi HIV/AIDS country report indicate substantial differences in HIV/AIDS knowledge and behavior between women and men. HIV prevalence is higher among young women than young men (i.e., 13.2% vs. 3.9% in ages 20-24), likely due to sexual relationships between older men and younger women; however, women are less likely to have been exposed to HIV/AIDS information as compared to men (80% vs. 66%) (Republic of Malawi Office of the President and Cabinet, 2007). In addition, 26% of men report having more than one partner in the last 12 months, as compared to 8% of women. These differences indicate that the context in which HIV is known and transmitted is likely to differ for men and women in this setting.

This study was designed as a formative, qualitative investigation to inform a subsequent pilot intervention study of couples' home-based family planning counseling and HIV voluntary counseling testing. The overall purpose of this qualitative study was to explore the acceptability and feasibility of the proposed intervention. Given the sensitivity and complexity of offering couples' home-based services, particularly in a setting where gender inequalities persist, we were interested in hearing community members' views on the ways in which to best ensure that for both men and women, the benefits of this intervention would outweigh the potential risks of participation.

Methods

Site Characteristics

This formative, qualitative study was conducted in a peri-urban area south of Blantyre, Malawi, where several, large HIV/AIDS clinical trials and behavioral studies have been conducted and are currently ongoing. Four villages within this larger catchment area were purposively sampled based on an effort to minimize research burden (as these areas had less exposure to other research efforts), and due to their similarity to the other villages in this area with respect to social and demographic characteristics.

Study Design and Data Collection

The study team consisted of investigators from the Malawi College of Medicine (COM), the Centre for Reproductive Health (CRH), and the Johns Hopkins Bloomberg School of Public Health (JHBSPH). The study design and study instruments (field guides) were translated in to Chichewa, reviewed and approved by the JHBSPH and COM Institutional Review Boards. Prior to arriving in the field, the field instruments were pretested and further refined. The study interviewers consisted of 3 men and 3 women who were hired and trained in Blantyre

Prior to data collection, research staff from the COM visited the 4 study villages to explain the purpose and scope of the study and to obtain permission from the village chiefs to conduct the study within their villages. The research staff also contacted local

Health Surveillance Assistants (HSAs) to help in the identification and recruitment of study participants.

A total of six focus group discussions (FGDs) (3 male and 3 female) were conducted with community members ages 20-30 years. Each focus group consisted of 8-9 people, was moderated by a same-sex moderator and note-taker, and was conducted in a private location within the community (e.g., church or school building). Focus group participants were recruited from the community, with the help of the HSAs. Each FGD was approximately 1.5 hours long, was conducted in Chichewa, and was digitally recorded after obtaining permission from the participants.

In addition to the FGDs, ten in-depth interviews (IDIs) were conducted with husband-wife couples from each of the communities. For the IDIs, the interview team consisted of one male and one female. The female interviewer conducted 6 of the couple interviews with the male interviewer as note-taker, while the other 4 interviews were conducted by the male interviewer. Both members of the couple were asked to spontaneously respond to the interviewer's questions; however, if only one partner responded, the interviewer probed the other partner for his/her perspective and additional comments. The interviewers also noted non-verbal cues and interaction of the partners within the couple interview. Each interview lasted approximately one hour and was digitally recorded, after obtaining permission from both partners.

Data Analysis

Digital audio files were uploaded to personal computers, then transcribed and translated into English. The interviewer and note-taker reviewed the interview transcripts together and added notes on non-verbals to the transcripts. The research team (FC, CM, and JG) reviewed the transcripts in the field and provided simultaneous feedback to the interviewers as the data collection progressed. The interviews were read and interpreted by several investigators (JG, CM, AT, MH) to determine consistent themes and findings.

Results

Study Participants

The male and female FGD participants were 20-30 years of age (by design) and were predominantly farmers. Apart from residence and age, the characteristics of the FGD participants varied with respect to marital duration, schooling, and number of children. The characteristics of the couples who participated in the IDIs are listed in Table 1. As noted in the table, individuals ranged from 25-40 years, with an age gap between husband and wife of 1-10 years. Couples varied in their marital duration, schooling, and number and sex of children; however, most couples were currently using injectable contraception.

Table 1: Characteristics of Couple IDI Participants

Couple	Age	# years married	# years schooling	# of children (#Boys/#Girls)	Current contraception
Couple 1		14		4 (4B)	Injectable
Male	37		4		
Female	35		7		
Couple 2		20		9 (4B/5G)	Injectable
Male	38		3		
Female	34		0		
Couple 3		4		1 (1B)	Injectable
Male	28		12		
Female	23		5		
Couple 4		10		2 (1B/1G)	Injectable
Male	28		10		
Female	30		4		
Couple 5		11		3 (1B/2G)	Never
Male	32		2		
Female	25		4		
Couple 6		15		2 (2B)	Hysterectomy
Male	38		9		
Female	39		3		
Couple 7		10		3 (2B/1G)	Injectable
Male	33		10		
Female	26		5		
Couple 8		5		2 (2G)	Injectable
Male	33		12		
Female	25		10		
Couple 9		14		4 (unknown)	Injectable
Male	40		0		
Female	30		0		
Couple 10		11			Injectable
Male	30		1	4 (2B/2G)	
Female	28		2		

Gender Roles and Health Behavior

Male and female participants indicated that there are clearly defined gender roles within the household, as well as with respect to health behaviors and care-seeking behaviors. Within both FGDs and IDIs, male and female participants indicated that whereas women are 'used to going to the clinic', men rarely seek health care services. Lack of participation was sometimes attributed to men's inability to miss out on wage-earning opportunities; however, a variety of both social and structural factors seemed to either precipitate or exacerbate men's disassociation from health activities:

- Most family planning methods are female-controlled, especially in this setting where male vasectomy is virtually non-existent and less than 2% of married women current use of the condom (MDHS, 2004). We were also not aware of

any male involvement or couples family planning counseling offered in the local clinic. It is not surprising, then that, according to female FGD participants, men view going to the hospital for family planning as *ndizachizimayi*, or strictly for women.

- Participants indicated that if a man went to the clinic on one of these days for family planning or HIV services, he was likely to be the only man there. Moreover, fellow villagers would see him and assume that he is 'sick' (HIV-positive) and/or engaging in 'kuyenda-yenda' (promiscuity). Men, in particular, said they were uncomfortable with the group family planning counseling that was offered at the health clinic and were shy to ask questions about things they did not understand.
- All women are now routinely offered opt-out HIV testing during antenatal care visits (WHO, Summary Country Profile for HIV/AIDS Treatment Scale-Up, December 2005). According to the MDHS, 92% of women seek ANC from a medical professional (National Statistical & Macro, 2005). Similar opportunities to 'capture' men for family planning and/or HIV VCT in scheduled medical visits do not exist.

Couple Communication

Although several couples talked about the importance of discussion and 'dialog' in a marriage, a consistent theme throughout the FGDs and IDIs was the role of the man as the 'head of the household' and the role of the woman as the 'left-hand' of the man – never equal, but always attached. In one couple interview, the wife told interviewers "and as you can see, my husband is more intelligent than me…". As indicated by a female focus group participant:

"*Women should be weaker. They should bow down to men. The man can choose and decide to use condoms. So in this case, the woman cannot refuse all the same."*

This persistence of gender inequality, in combination with the gendered uptake of health services seemed to contribute to gaps in communication and knowledge between partners with respect to family planning methods and HIV/AIDS VCT.

Whereas awareness and knowledge of contraceptive methods was quite high overall, men were more likely to voice concerns about specific methods and their side effects, whether real or perceived:

"We hear some [contraceptive] methods remove sexual desire. Now some men will think by allowing these methods in their marriage that they are selling away their natural sex creation." - 27 year old male FGD participant

Men openly discussed the reasons for male opposition to family planning (e.g., children as a symbol of wealth; want women to have as many children as possible; may invite

woman's promiscuity or infidelity); however, several also acknowledged the benefits of family planning both at the household level and at the population level.

Both female and male participants indicated that women would access information and services, including contraception, from the local health clinic; however, when they returned home to tell their husbands about what they learned, the husbands would not listen or would not believe the information that the wives relayed:

"…some men are not cooperative with these issues. They never listen to anything we tell them from the clinic. They think and say that they cannot be told anything useful by a wife. So if the counseling was brought to our homes, men would hear it straight from the health workers and maybe do something so that we could space our children and prevent HIV infection." (25 year old woman, married 13 years with 4 children)

"…usually it's only women who receive this family planning counseling when they have gone to the clinic. Now, it's difficult for some women to explain in detail about the family planning counseling to their husbands. But if you offer the counseling to both as a couple, the husband will clearly understand it. Women fail to convince their husbands because in these families some husbands are violent; they take a woman as a useless person. As such, they can't listen to her. But when the counselor has come to the couple, the husbands will be able to understand."

- 24 year old male FGD participant

Defiance of Gender Norms

As mentioned by women in both the FGDs and IDIs, covert use of contraception was a way in which women seemed to avoid their husband's known or suspected disapproval of contraception. Women described elaborate ways in which they could access contraception without their husbands' overt approval or knowledge:

"*In this situation we hide from our husband that we are taking family planning. In this case we tell him on Monday that I am sick. Tuesday, mmm…the headache together with the back is not feeling well. We know that the day we've been told for the next dose is Wednesday. So on Wednesday, we just say I am going for medical treatment, but in truth, we are going for contraceptives. We do this because our husbands are not willing. If he realizes, then we can be in trouble."*

(20 year old woman, married 3 years with 2 children)

Women also found ways to avert direct confrontation and discussion with their husbands regarding HIV. Since the introduction of opt-out testing for women during ANC visits, it is now likely that women receive HIV testing more frequently or recently than their husbands. As one woman indicated, *"We, the women, always go for testing, but the men refuse."* This disparity in the availability and/or the uptake of HIV VCT meant that women were more often put in the position of whether or not to reveal

their test results. Some women indicated that they never revealed their test results to their husbands since he had not been tested, too. Instead, they would wait to see if their husbands tested and revealed their results. Even if both partners tested, however, they would not necessarily disclose their results to one another. As described by this woman about how she would handle receiving VCT on her own:

"There would be lies. We won't tell each other the truth. After testing, I would tell my husband that I'm negative even if it's not true. I would smile when he is around and cry when he is absent. I wouldn't like to disappoint him."

- 28 year old female FGD participant

Interplay of Gender and Home-Based Counseling and Testing

Surprisingly, despite the presence of these strict gender roles in the discussions with our male and female participants, nearly all of our participants indicated that the sex of the FP/HIV counselors did not matter, as long as they were knowledgeable, competent, and respectful and from outside the community.

However, the likelihood of differential consequences for women than for men as a result of this intervention was a consistent theme throughout the FGDs and IDIs as exemplified by this discussion with a couple:

Interviewer: *What if the man wanted to participate, but his partner did not? What do you think would happen?*
Husband*: I would encourage her to go for the test together with me because it will be good for both of us to get tested as a couple and know our HIV status so that we will know how we should lead our lives. If she continues refusing I will force her and if it happens that she still refuses, I will have no option but to divorce her [wife smiles and laughs]. But I will still get tested alone and I will tell her the results.*
Interviewer: *Now madam, let's put the same question to you…Let's say you wanted to get tested for HIV together with your husband but he refuses, what would happen?*
Wife: *Uh, I will go for the test alone so that I know my HIV status and of course I will tell him the results. [Wife laughs]*
Interviewer: *What will happen thereafter in your life as a husband and wife?*
W: *[Wife laughs and husband smiles] We will negotiate, but I will not necessarily divorce him.* (Couple #1)

As evidenced in the quote above, the risks to women seemed to outweigh the risks to men, particularly on the issue of participation in the study and HIV disclosure. Throughout the FGDs and IDIs, men indicated that if they were willing to participate in either the family planning counseling and/or the VCT, a wife's unwillingness would be a defiance of his wishes and would automatically indicate that she is either promiscuous or unfaithful:

"The man should just know that his wife has bad behavior (promiscuity). That is the reason why she is refusing to have an HIV test.

"If the wife is not willing, the man should just go for the test alone and if the testing results are negative, this should be the end of the marriage. Otherwise the woman should go for the test together with her husband."

Male FGD participants

Consistently, through both the FGDs and IDIs, both men and women indicated that if the wife were HIV-positive, this was automatic grounds for divorce. However, if the husband tested HIV-positive, it was likely that the woman would stay with him:

"It may happen that the wife has the HIV virus while the husband is HIV negative. As a result, there will be a break of marriage. But if the husband is HIV positive while his wife is HIV negative you may find that the marriage is still existing according to the way she loves her husband. The only disadvantage is that most men cannot stay with their wives if they know that their wives are positive while the men are not HIV positive."

- Male FGD participant

"If a woman tests positive and the man is negative, she can be divorced. Such a man will go and find a negative woman like him."

-Female FGD participant

When asked about the potential implications of couple family planning counseling, men and women expressed mixed feelings. Some men felt that positively about preventing covert contraceptive use by women:

> *"Now with home-based family planning, it means it's impossible for the woman to go behind the back of the man and take contraception. So this will block the woman."*
>
> - 24 year old male FGD participant

Men and women both indicated that by having the husband and wife involved, husbands would become more knowledgeable and possibly more accepting of family planning. In addition, presenting the opportunity to discuss family planning as a couple would allow husbands and wives to agree on a suitable method and to help each other in remembering to use it consistently. However, a woman's ability to decide autonomously about if/what method to use may be affected by the counseling:

"If men are involved, there would potentially be more discussion and negotiation about if/what method to use. The problem will be in blending the two views into one."

Male FGD participant

Although it was only raised by one of our participants, one male FGD participant indicated that women may prefer to be the ones using contraception since husband's use of contraception may allow them to engage in extramarital affairs. ((P8, M_2)

Discussion/Conclusion

We will work to further revise our findings and talk about how our findings mesh with the existing literature on this topic. A few key points:

- Persistent gender inequality, in combination with the gendered uptake of health services, seemed to contribute to gaps in communication and knowledge between partners with respect to family planning methods and HIV/AIDS VCT.
- Unless widespread opportunities become available for men for FP and HIV testing and counseling, FP and VCT will continue to be a 'gendered' process, with more women being aware of FP and availing FP/HIV services. Similar to the concerns with female-based family planning services, there are considerable drawbacks to providing opt-out, universal services for women, such as those offered through ANC visits, without similar intervention and outreach efforts for men beyond clinic-based VCT. Voluntary workplace testing and community-based VCT can help to address the gender-imbalances in access to HIV VCT. Although any couple-based intervention needs to be cautiously planned and implemented, there are considerable social and household benefits to couples being tested simultaneously, and in the presence of a trained counselor to help mitigate risks.
- Couple IDIs seemed to 'work' in this setting. Both husbands and wives participated in the discussions and seemed to talk frankly about gender norms and how they play out in their own relationships. However, we do not know how the interviews with the couple together would have been different from conducting separate interviews with each spouse. We also must take in to consideration that this was a convenience sample of couples who may have been different, with respect to couple communication and openness in talking with outsiders, as compared to other couples from the broader community.
- Findings from this qualitative component indicate that the proposed intervention can have several beneficial aspects, but need to be carefully and considered given the context and specific findings regarding differential impacts for women versus men.

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