



***Opportunities, challenges and
countervailing narratives:
Exploring men's gendered
involvement in contraception and
family planning in Southern Malawi***

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Declaration

I, Tim John Cairns Shand, confirm that the work presented in this thesis is my own. Where information has been derived from other sources, I confirm that this has been indicated in the thesis.

Tim Shand

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Abstract

Malawi faces challenges regarding increasing its contraceptive use and advancing women's empowerment. Male involvement, and use of male methods, remain low in Southern Malawi, and little is known about how men's gendered understandings, attitudes, norms and behaviours influence their approach to contraception and family planning. This study focuses on male involvement to inform a more supportive and equitable environment for the use of contraception.

A mixed methods community-based design was employed in urban Blantyre and rural Chiradzulu, including a household survey with 417 men, in-depth interviews with 40 men, six focus group discussions with men and women, 38 interviews with health providers and key stakeholders, secondary male client data and observational techniques. Bivariate and multivariate analyses were carried out, with thematic analysis of qualitative data, before data integration. Analysis was informed by Raewyn Connell's theory of hegemonic masculinities.

Gender and contraception were conceptualised and operationalised as female-only. Unmarried men reported greater odds of contraceptive use, using male condoms with their partners, while married men relied exclusively on their wives' methods. Men reported overall inconsistent condom use and objections to male and female methods, alongside gendered understandings and misconceptions of family planning and contraception. Men's support for gender equality was associated with increased method use. Men predominately desired to control contraceptive communication flows and decision-making, while women were primarily responsible for preventing pregnancy. Norms of male fertility, breadwinner masculinities, male stoicism, virility, sexual pleasure, multiple sexual partners and ownership of women's sexuality influenced male involvement in complex and countervailing ways. The health system and government had a limited focus on male involvement and reinforced male hegemony.

Programmes and policies require a greater understanding of how the social production of gender and contraception, the enforcement of hegemonic masculinities, and men's performance of gender norms influence male involvement and undermine women's reproductive autonomy.

Impact Statement

Facilitating supportive and equitable male involvement in contraceptive use is a growing international concern. Among practitioners in Malawi, and more broadly, my results can provide guidance on thoughtful and culturally sensitive ways to engage men in supporting their partners' method use and on how to increase uptake of existing male methods. My study reinforces the need for caution in the implementation of male involvement interventions, and for stronger gender power analysis. My results also speak to the need for practitioners to be more mindful of the use of the term 'family planning' when engaging men. My study results have hitherto fed into guidance on male involvement developed by USAID, and I intend to develop a summary of my findings to share widely among interested SRH practitioners with the aim of informing their work.

My study can support a strengthened focus on engaging men as contraceptive users and partners within public policy on SRH in Malawi, and more broadly, and on the need to reposition condoms as beyond solely an HIV prevention technology. During my study I engaged with policy makers and donors in Malawi, and I will undertake further such public engagement and provide a list of policy pointers based on my findings.

My results could support changes to DHS surveys, and I will engage with the DHS Program to share my observations on the limitations of current measures of contraceptive use among male respondents.

My study provides an example of facilitating South-South linkages between academic institutions, and between academia and civil society. I believe these areas are important in the current geopolitics of academic research, and that these South-South and academic-NGO connections could be strengthened through encouraging donors and practitioners to give them greater priority.

My study could support increased awareness among men on supportive male involvement. During my research, and in the public dissemination of my findings, I found men and women in communities had a strong desire to discuss these issues. I will seek to further share my research results, in collaboration with civil society in Malawi, to help address the limited focus on men's gender in the context of contraceptive use.

Inside academia, this study can highlight the benefits of understanding men's own voices on contraception and family planning, and the need for a greater focus on male gender norms and power within contraceptive research. It provides insight on several areas related to male involvement identified as gaps in the literature. My study also reinforces the need for improved quantitative measures for men's contraceptive use and supports calls for better gender norms measures, and cautions assumptions about men's support for gender equality based solely on quantitative research. My study further highlights both the benefits and challenges associated with undertaking mixed methods research. My methodology offers an example of trying more participatory research approaches, and the potential challenges therein, and ways to feedback findings to research communities. These contributions will be shared through presenting my work at conferences, collaborating with academics and submitting papers to scholarly journals.

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List of Abbreviations

AIDS	Acquired Immunodeficiency Syndrome
AOR	Adjusted Odds Ratio
ANC	Antenatal care
BLM	Banja la Mtsogolo
CHAM	Christian Health Association of Malawi
Depo	Depo-Provera Injection
DHS	Demographic and Health Survey
DHO	District Health Office
FGD	Focus group discussion
HSA	Health Surveillance Assistants
FP	Family Planning
GBV	Gender-based violence
HIV	Human immunodeficiency virus
ICPD	International Conference on Population Development
IDI	In-depth interview
IGH	UCL Institute for Global Health
IMAGES	International Men and Gender Equality Survey
IUD	Intrauterine device
MDG	Millennium Development Goal
MLW	Malawi-Liverpool-Wellcome Trust
MoH	Ministry of Health
MSF	Médecins Sans Frontières
NGO	Non-Governmental Organisation
OR	Odds Ratio
PNC	Postnatal care
RAs	Research Assistants
SRH	Sexual and reproductive health
SRHR	Sexual and reproductive health and rights
STI	Sexually transmitted infection
UCL	University College London
UCT	University of Cape Town
UN	United Nations
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
WHO	World Health Organization

Codes used for qualitative data referencing

BAN – Bangwe, Blantyre (urban)

SL – South Lunzu, Blantyre (urban)

NS – Ndirande South, Blantyre (urban)

CHI – Chitera, Chiradzulu (rural)

LIK – Likoswe, Chiradzulu (rural)

FGD – Focus Group Discussion

IDI – In-depth interview

Chldn – children

Nochldn – No children

I – Interviewer

P – Participant

HP – Health Provider

KS – Key stakeholder

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I dedicate this to my children, Thomas and Alexandra. May they grow up in a world of more supportive male involvement and greater gender equality.

Presentations of PhD data at conferences and events

- Medical Research Council Hegemonic Masculinities Workshop, Pretoria, South Africa, October 2014. Men's Sexual Health/HIV Attitudes, Behaviours and Health-seeking in Malawi
- MenEngage Global Symposium, Delhi, India, November 2014. Engaging men in SRHR: shifting the burden from women
- National Option B plus conference, Lilongwe, Malawi, November 2014. Involving men in Malawi: not the panacea but critical to shifting the burden
- International Conference on Masculinities, New York, USA, March 2015. Family planning objections, myths and opportunities: interviews with men and service providers in Malawi
- World Bank, Washington DC, USA, March 2015. Our blind spot? Engaging men in SRH for their own benefit and for others
- USAID seminar, Engaging Men in FP Programs, Washington DC, USA, March 2015. Family planning objections, myths and opportunities: interviews with men and service providers in Malawi
- Association for the Social Sciences and Humanities in HIV (ASSHH) conference, Stellenbosch, South Africa, July 2015. Engaging men within an already stretched health system? What can we learn from men's attitudes, practices and health-seeking in Malawi
- Africa Seminar Series, University of Amsterdam, November 2015, Amsterdam, Netherlands. Blind spot? Heterosexual Men's Sexual Health Attitudes, Behaviours and Health-seeking in Southern Malawi

- K4Health, Interagency Gender Working Group (IGWG) and USAID webinar on Programming along the Life Course: Men and Boys as Family Planning Users, March 2017. Gender Dimensions of programming for men and boys as FP users.
- International Conference on Assessing Health Literacy and Health-Seeking Behaviour in Men: Challenges and Opportunities for Global Health Initiatives Lisbon, Portugal, January 2020. Men's sexual health literacy, care pathways and health system experiences in Southern Malawi

Chapter 1: Introduction, Rationale and Framing of Thesis

“Malawi men asked to take part in Family Planning.”

Headline, Nyasa Times, Malawi, 18 November 2014

In this chapter I outline the aim of my study, introduce the topic of male involvement, and present the rationale for the thesis and my data collection strategy. I then outline the theoretical approach which frames my study. The chapter concludes with an overview of my research questions and the thesis structure.

1.1 Aim of the study

In this thesis I explore how the gendered understandings, attitudes, norms and behaviours of men in Southern Malawi influence their involvement in family planning and contraception. The study situates itself within a broader behavioural, historical and cultural context, while focusing specifically on men’s gendered relationship with matters of contraception. My hypothesis is that greater male involvement is important for advancing gender equality between men and women and creating a more supportive environment for family planning and the use of male and female contraceptive methods.

1.2 Framing the engagement of men in family planning and contraception

In this section I introduce the concept of male involvement and provide a rationale for the thesis, and then outline the evolution of men’s role in contraception. I conclude the section by outlining the specific challenge with respect to Malawi.

1.2.1 Introduction and rationale

Contraceptive use is both a critical public health issue (WHO, 2020) and central to advancing gender equality (UNFPA, 2020). Unmet need for contraception remains highest in low-income countries (PRB, 2019), where an estimated 214 million women of reproductive age who wish to avoid

pregnancy are not using a modern contraceptive method¹ (Guttmacher Institute, 2019). Women's unintended pregnancy leads to thousands of maternal deaths each year (WHO, 2011), which could be significantly reduced by closing the gap in unmet need (Sedgh et al., 2016). Existing inequalities which favour men over women are intimately linked to women's unmet need for contraception in sub-Saharan Africa (Withers et al., 2015a), and to women's broader rights and wellbeing (UNDP, 2013). This is recognised by a dedicated target on expanding universal access to sexual and reproductive health (SRH) within Sustainable Development Goal (SDG) 5 on gender equality (United Nations General Assembly (UNGA), 2015).

It is increasingly acknowledged that a key driver of inequalities between men and women are harmful male gender attitudes and norms, informing inequitable behaviours among men. Harmful male gender norms are recognised to impact on poor SRH outcomes for women (Edström et al., 2015), with unequal power relations between the sexes often allowing men to dominate SRH decision-making, undermine women's rights, and restrict women's health-seeking (Blanc, 2001; WHO, 2007; McCleary-Sills et al., 2012). With respect to contraception, male gender norms can pose obstacles to men's support for contraception, negatively influencing the reproductive health and autonomy of women (Greene et al., 2006) and perpetuating poor female contraceptive outcomes (Hook et al., 2018). Research with women across Southern Africa finds them to specifically report that men's approval and involvement (or lack of) has a direct impact on their contraceptive use, birth spacing and family size (Chikovore et al., 2002; Grabbe et al., 2009; MacPhail et al., 2009; Peer and London, 2013; Mboane and Bhatta, 2015; McGuire et al., 2015; Prata et al., 2017; Chowdhuri et al., 2019). Such norms also negatively impact on men themselves (Edström et al., 2015), and shape men's attitudes and behaviours in ways that have direct implications for their own wellbeing (Verma et al., 2008; Ragonese et al., 2018). Men's disengagement in health-seeking not only impacts men's own health, but

¹ Modern methods include inter alia oral contraceptives, implant, injectable, IUD, condoms and male and female sterilization (Hubacher et al., 2015)

also negatively impacts their involvement in their family's health and wellbeing (Greene et al., 2006).

Research increasingly suggests that men can be involved to improve equality between men and women and increase contraceptive use (Stern et al., 2015). Interventions successfully report the adoption of more equitable attitudes and behaviours among men (Peacock, 2005; Montgomery et al., 2006; Strebel et al., 2006; Odimegwu and Okemgbo, 2008; Esplen et al., 2012; Baker and Shand, 2017). Data from Demographic and Health Surveys (DHS) in 40 countries

find men to be interested in contraception, and desiring to be involved, and that men who showed more equitable attitudes towards family planning (defined as believing it is both the man's and the woman's responsibility, or that men should share decision-making with women) were more likely to report using a contraceptive method, and to support women's use of methods (Edström et al., 2015). A recent review of male involvement interventions in sub-Saharan Africa² mirrored these findings in terms of men's willingness to participate and found that their involvement was associated with increased uptake of contraceptive services (Nkwonta et al., 2019). Men's involvement has been found not only to support uptake, but to facilitate effective method use and continuation (Vouking et al., 2014). Male engagement has also led to benefits beyond method use, including improved spousal communication and more equitable and harmonious relationships (Shattuck et al., 2011; Withers et al., 2015a). A review of behaviour change techniques to increase modern contraceptive use in low- and middle-income countries found that interventions which target women alone are not as effective as those that target couples (Phiri et al., 2015). A 20-country review of family planning programmes that engage men, undertaken by Johns

Family planning

definitions: This thesis defines family planning as 'planning if, when, and how many children one intends to have' and male and female contraception as 'modern methods used to avoid unintended pregnancy'. Note that the global literature often uses 'family planning' to mean 'methods,' which is reflected in some of the references I include.

² Sub-Saharan Africa has been, and continues to be, a geographic focus for contraceptive use research, with findings presented at a regional level despite the significant economic and social variations across these contexts.

Hopkins University, found that those programmes which take a positive approach to male involvement (as opposed to simply seeing men as irresponsible adversaries) enjoyed far greater success (Edström et al., 2015).

Despite the evidence of the influence of male gender norms, and that men can yield control over decision-making, contraceptive programmes have continued to largely only target women (Edström et al., 2015). The recent Lancet Commission on Sexual and Reproductive Health and Rights (SRHR) identified a gap in programming on men as partners (Starrs et al., 2018). Too often, contraceptive programming perceives involving men as a zero-sum game (that a focus on men and contraception reduces the focus on women's needs), which has stalled further progress in policies, programmes and research in this area. There can be reluctance from donors, programme managers, reproductive health advocates and women's rights activists to promote research targeting men (ibid.). Equally, as Bietsch (2015) notes, much of our understanding of men's attitudes towards family planning and contraceptive use continues to rely on women's reports of men's beliefs and actions, rather than on the voices of men themselves.

1.2.2 Evolution of male involvement and men's method use

Questions of male involvement in contraceptive use are not a new phenomenon. Since the 1980s, studies have found men in sub-Saharan Africa to believe women should not use contraceptive methods without their consent (Adamchak, 1987; Khalifa, 1988) and throughout the 1990s scholars advocated for an increased focus on men's participation and role as a partner within family planning programming (Mbizvo et al., 1991; Becker, 1996; Toure, 1996; Drennan, 1998; Wegner et al., 1998). Male involvement was seen then as particularly important for population control reasons, rather than in relation to women's rights. The need for male involvement was put firmly on the global agenda in 1994 by the inter-governmental International Conference on Population and Development (ICPD), which highlighted that men play a key role in bringing about gender equality and improving communication between men and women, and called for special efforts to

emphasize men's shared responsibility and to promote their active involvement in family planning.³

In 2001, the World Health Organization (WHO) held a meeting on 'Programming for male involvement in Reproductive Health' which highlighted as a key lesson learned that "When men are involved, more women adopt and continue family planning methods" (2002: 2) and recommended the need for services to target men as individuals and as partners. That same year, Varga (2001) published a seminal review of SRH research and programmes focused on men

Defining male involvement: Male involvement has been variously defined. This thesis defines supportive male involvement as men both as partners to women's contraceptive use, and as users themselves (Van den Heever et al., 2012). It also positions the involvement of men as key to advancing gender equality, bringing about positive changes to men's gender-related attitudes and behaviours, and improving the health of women and men (WHO, 2010). As such, contraceptive use is not seen here as solely an end in itself, but as part of a process in which gender equalities may contribute to better health, wellbeing and rights.

and boys in sub-Saharan Africa titled '*The forgotten fifty percent*', in which the author illustrates how male sexuality and gender influence reproductive health. Since then, there has been a growth in inter-governmental commitments and programming approaches focused on engaging men to promote more equitable notions of 'manhood' and change men's behaviours around SRH outcomes (WHO, 2007; Colvin and Peacock, 2009; Barker et al., 2010a; Pulerwitz et al., 2010; Dworkin et al., 2012a; Pettifor et al., 2015).

Alongside this growth in focus on male involvement was an understanding of the benefits of gender transformative programming, which seeks to critically reflect on and transform gender roles and promote more equitable relationships between men and women (WHO, 2007). Gender transformative programming goes beyond gender-neutral approaches which do not acknowledge differences between men and women or gender-sensitive approaches which simply acknowledge that men and women have different

³ The International Conference on Population and Development, Program of Action, paragraph 4.27. See <http://www.unfpa.org/icpd> [accessed 24 August 2017]

needs and roles but do seek to question them. A WHO review of 58 interventions engaging men in gender-based inequity in health found that the programmes rated as gender transformative (as opposed to gender-neutral or gender-sensitive) had a higher rate of effectiveness. A subsequent analysis of SRH-specific programmes with men, using this same methodology, also reinforced the greater effectiveness of gender transformative approaches (Howse et al., 2010). Despite this intention for gender transformation, programming with men has been criticised for the extent to which it ultimately challenges men's overall position of power in society and relationships and promotes women's autonomy (Rasmussen, 2008).

Within the broader research on engaging men in SRH, there has been particular focus on sexually transmitted infections (STI) and men's sexual behaviour, especially around HIV, with comparatively fewer rigorously evaluated approaches in the area of male involvement in contraception (Sternberg and Hubley, 2004; Hook et al., 2018). A recent WHO review on interventions using gender transformative approaches to engage men in SRHR highlighted family planning (contraception) as the least well-developed area within existing interventions (Ruane-McAteer et al., 2019). There remains a need therefore to better understand why male participation in contraception is low in various sub-Saharan contexts and to find acceptable ways to encourage male participation (Withers et al., 2015b), in order to design and evaluate effective gender transformative male involvement programmes (Greene and Levack, 2010).

The evolution of male involvement is also largely one of instrumentalism, with efforts to engage with men focused predominantly on how this impacts on women's health and women's uptake of and access to SRH services (Kaufman et al., 2008; Kululanga et al., 2011; Dageid et al., 2012). This orientation often regards men as largely the problem (Greene and Biddlecom, 2000). There has been less focus, particularly in sub-Saharan Africa, on men's own concerns with respect to SRH and its potential connection to wellbeing (Varga, 2001; Hook et al., 2018). Similarly, on

contraception, while men's underrepresentation in 'family planning' research is beginning to change, few studies appear to explore such issues from the perspective of men themselves (Withers et al., 2015a).

As a reflection of this instrumental orientation, the focus around men as contraceptive users themselves remains nascent (Mwaikambo, 2011). In their global review of 47 interventions on

contraception seeking to reach men, Hardee et al. (2017: 1) notes that most programmes operate from the perspective "that women are contraceptive users and that men should support their partners" and highlighted that there has been insufficient attention to reaching men as users in their own right. Men's global use of contraceptives has barely shifted in the last 20 years from a low

Male modern methods:

Male condoms are a thin sheath placed over the erect penis. Vasectomy, a surgical procedure which stops sperm being ejaculated from the penis during sex, has been found to be highly effective (Trussell, 2011), less invasive than female sterilisation and carrying fewer risks (Sonfield, 2015).

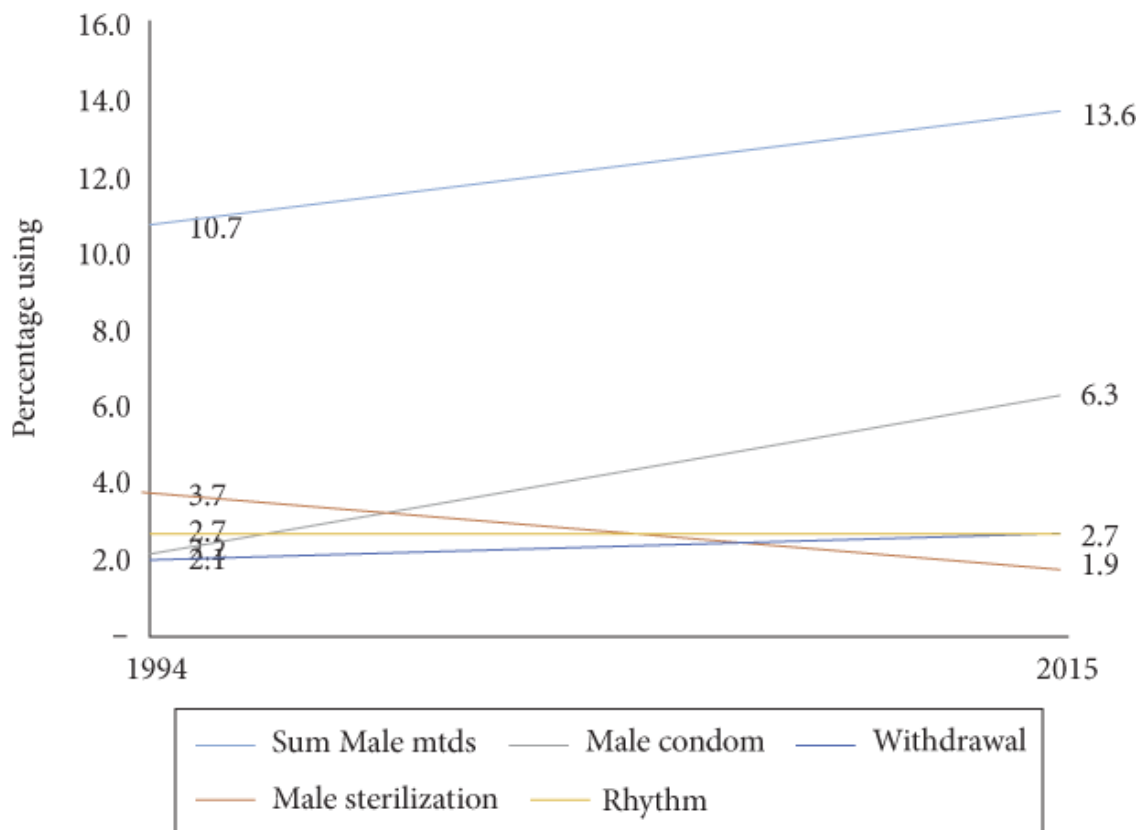
base (Hardee et al., 2016), and it is argued that increasing men's use would additionally increase men's knowledge, reduce gender inequality and improve overall health and wellbeing (Hardee et al., 2017). The most comprehensive data available on contraceptive use among men is based on women's reports of men's behaviour (not men's own reports). A more detailed analysis of men's use is instructive here as part of exploring the evolution of male involvement.

The two current modern methods of male contraception available are condoms and vasectomy or male sterilisation (see box above). Globally, these male methods account for one-quarter of all contraceptive use women report worldwide (Ross and Hardee, 2016). This figure is lower in sub-Saharan Africa, where married women report 10% of contraceptive use is the male condom and less than 1% is the vasectomy (PRB, 2019). In their analysis of time trends in male method use,⁴ Ross and Hardee (2016) found that between 1994 to 2015 women's reports on the prevalence of male methods rose by only 2.8 points (from 10.7% to 13.6%) and as a percentage

⁴ The authors also included withdrawal and rhythm (as methods requiring male co-operation)

of overall method use male methods did not shift: remaining at one-quarter of contraceptive users worldwide throughout the 21-year period. In addition, while male condom use rose substantially during this period, the use of rhythm and withdrawal methods remained steady, and vasectomy fell significantly. See Figure 1 below.

Figure 1: Prevalence of male methods globally, 1994 and 2015



Source: Ross & Hardee (2016: 656). In: Shand & Marcell (2021).
 Reproduced by permission of Oxford University Press

Relying on women’s reports of male contraceptive use is contested as having gaps and potential bias (Ezeh and Mboup, 1997), and in 1998 the DHS began collecting more specific data on men as part of its male questionnaire, in which further questions on contraception were added the following year (DHS changes focus on men, 1999). In the most comprehensive analysis to date of male DHS surveys across 18 countries, MacQuarrie et al. (2015) found significant variation, from 17% to 63%, in men reporting that they or their partner used contraception at last sex. Across the majority of countries, the condom accounted for greater than 50%

of all contraceptive use men reported (*ibid.*), differing from women's data. It has equally been argued that there is a bias in men's own reporting of contraception and men may be reporting use with someone other than their primary partner (Becker, 1999) or may not be aware of what contraceptive method their partner is using, and thus reporting their perception rather than actual use (Tang et al., 2016).

Concurrent with the above, it has been argued that SRH services have continued to focus primarily on women of reproductive age and have failed to respond to men's needs and concerns (Collumbien and Hawkes, 2000). While this has been noted in relation to contraception (Cleland et al., 2011), and is not a new issue (Varga, 2001), there has been a resurgence in the focus on structural challenges for men within SRH health systems largely in the context of HIV (Cornell et al., 2011; MacPherson et al., 2012), with barriers such as privacy, confidentiality and quality of care being raised as reasons for men's reluctance or inability to use services (Ringheim, 2002). On contraceptive services specifically, men are found globally to rarely use such facilities (Hardee et al., 2017).

Overall, despite the increased attention to men and SRH over the last 15 years, there remains a relative absence within SRH programmes and policies on efforts targeting men (compared to women) as well as a limited focus on challenging male gender norms (Edström et al., 2015). The foremost international effort to advance global contraceptive uptake, Family Planning 2020 (FP2020), focuses specifically on increasing women's contraceptive use, with limited recognition of men's method use or male gender norms.⁵ Such institutional orientations that position SRH as a sole concern of women have been a critical limiting factor in advancing the focus on men's involvement in SRH (Sen, 2013). Given that existing power structures may impact women's ability to access contraceptive services, as noted above, it is arguable that a sole focus on increasing women's service

⁵ FP2020 aims to increase by 120 million the number of female contraceptive users by 2020. It is currently evolving to become FP2030. See <http://www.familyplanning2020.org/> [accessed 29 August 2017]

uptake – as is the case with the targets set by FP2020 – while critically important, could be less impactful or sustainable without simultaneously addressing male gender norms and power dynamics.

1.2.3 The challenge for Malawi

While Malawi has shown great success in increasing contraceptive use (from a low base), key challenges remain: Machiyama et al. (2015: 163) describes the Malawian ‘family planning’ context as “high fertility...accompanied by moderate use of contraception and a high level of unmet need”. Significant gender inequalities remain in the country, as I explore in chapter 4. Studies with Malawian women highlight that the expectations and approval of their male partners are an important influence on their contraceptive intentions and use, and in some cases, men are the primary decision-makers on such matters (Haddad et al., 2013; Evens et al., 2015). Malawi DHS data shows a high rate of method discontinuation among women not desiring to get pregnant (NSO and ICF, 2017), highlighting the importance of understanding the broader context in which method use takes place. Much of the knowledge base around contraceptive use in Malawi focuses solely on understanding women’s structural barriers to access, while less is understood around more nuanced barriers and facilitators (Bornstein et al., 2020a). Several studies in Malawi point to the need for a greater emphasis on male involvement in contraceptive programming (Ntata et al., 2013; Palamuleni, 2013; Furnas, 2016; Dral et al., 2018). Expanding uptake of male methods, particularly vasectomy, would help Malawi meet its family planning commitments and strengthen gender equality (Perry et al., 2016).

1.3 Conceptual and theoretical approach

In this section I outline the conceptual approach to my research, including the social construction of gender and its linkages to SRH, and contraception more specifically. I include an explanation of what drives gender norms, how gender is constructed in Malawi, and how gender norms are situated within a broader framework of what drives behaviour. I then outline the theoretical underpinning of my research, hegemonic masculinity (Connell, 1995).

1.3.1 Social production of men's gender

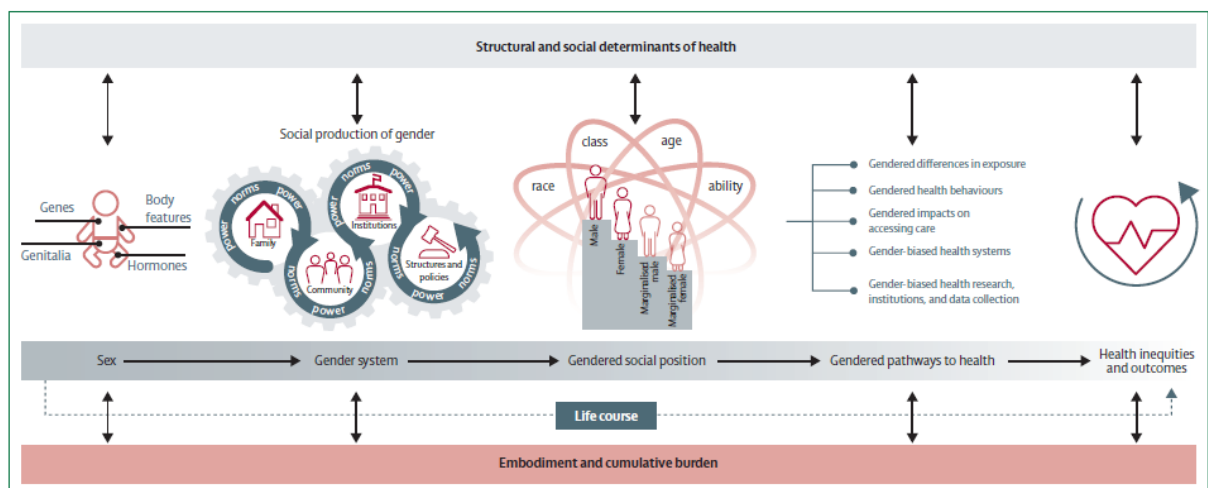
Gender is defined here as the socially constructed expectations regarding appropriate roles, responsibilities and behaviours among men and women in a given society (Gupta, 2002). It is both relational and structural, thus speaking to "power relations between women and men, and structural contexts that reinforce and create these power relations" (Barker et al., 2011: 14). It differs from sex, the biological categories (WHO, 2009) of men (and boys) and women (and girls). Male *gender norms* therefore refer to the "informal rules" (ODI, 2015: 3) and shared social and cultural expectations about behaviours for men, including roles in relationships (USAID, 2018), in contrast to women and girls (WHO, 2007). This includes ideas on being a man (manhood). *Masculinity* refers to the multiple ways manhood is socially defined across historical and cultural contexts, and the power differences between different versions of being a man (Connell, 1995).

Gender is often operationalised (specifically or implicitly) as relating to women alone. SDG 5 on gender equality contains targets solely in relation to women's empowerment (UNGA, 2015). Organisational Gender Audits, such as those that use the commonly employed International Labour Organisation (ILO) Participatory Gender Audit methodology (ILO, 2012), focus primarily on women's and girls' empowerment with limited focus on engaging men. While women's empowerment is critical, this accepted orientation of 'gender' being synonymous with women renders male gender invisible (Perry, 2016) and can have unintended consequences. Men are often not seen as having a role to play as allies in the movement for gender equality and women's empowerment (Edström et al., 2015). It may appear to men that all the problems are with 'other' men, a group they feel they do not belong to (Perry, 2016). Men can feel threatened by gender equality, perceiving its advancement of women's rights to be a zero-sum game (Dworkin et al., 2012b).

Men's gender, like that of women's, is constructed and reinforced through a gender system which interacts with other axes of power and privilege (Heise et al., 2019). Heise et al.'s (ibid.) conceptual framework below (figure 2) illustrates the impacts of gender on the social determinants of health. After

entering the world as biologically male, men’s gender is socially produced through the domains of family, community, institutions, and structures and policies, represented by the interlocking cogs (see left of figure 2), which each act to reinforce and often contest each other. These domains reflect the multiple levels which influence human behaviour within the socio-ecological framework (Bronfenbrenner, 1989). It is here that men learn to be men; where gender norms are “created, instilled and enforced” and power is distributed (Heise et al., 2019: 2443). These male norms and power relations then interact with other axes of power and privilege, such as age and other forms of intersectionality (ibid.), which represent an individual’s overall ‘gendered social position’ in relation to others (see middle of figure 2). At this stage, cultural practices are also important in the context of Malawi, as I will discuss in chapter 4. Differing social positions are reflected in multiple versions of manhood, or masculinities (Connell, 1995), which I discuss in the concept of hegemonic masculinities below. Restrictive male gender norms created through this process, and inequalities between men and women as a result of differing social positions, then create ‘gendered pathways to health,’ such as men’s gendered health behaviours (see right of figure 2). This then leads to health inequities and differential patterns of health and wellbeing, the final stage on the far right of figure 2. As Braveman et al. (2003) notes, health inequities are primarily a function of gender inequality and other axes, rather than biological sex.

Figure 2: Conceptual framework of the gender system and health



Source: Heise et al. (2019: 2443)

1.3.2 Men's gender in Malawi

Gender in Malawi is almost universally operationalised (and widely understood) to denote women, reflecting the necessity of advancing women's empowerment but equally reflecting an invisibility of men's own gender. As such, there has been an overall limited focus (comparative to other contexts) on engaging men or on the impact of masculinities in Malawi, as I explore in the next chapter. While the country's 'gender gap' has been highlighted in HIV programmes (Tiessen, 2005), education (Chisamya et al., 2012), and intimate partner violence (Conroy, 2014), among other areas, this relates solely to inequalities faced by women and not men's gendered roles. This orientation is reinforced by donor programmes in Malawi focusing on gender equality primarily as women's empowerment, in isolation from a focus on engaging men (DFID, 2012; USAID, 2016).⁶

Despite the lack of operational focus, men's gender in Malawi is nevertheless socially produced in line with each of the domains in the gender system model above. Our Malawi-wide research (see below), on which this study builds, found 58% of men and 72% of women agreeing that a woman's most important role is to take care of her home and family, with 59% of men and 71% of women agreeing that a man should have overall authority within the home (Zamawe et al., 2014). This reflects earlier literature that demonstrates that men are brought up to believe they are superior to women, have a culturally defined role as head of the household and as economic providers, and downplay the importance of new ideas originating from females, particularly if these touch on reproduction and family size which are perceived as affecting a man's social status (Kishindo, 1994). Research on cultural scripts also identify the individual and societal expectations on Malawian men to financially provide for families, with men who are unable to provide economically perceived to have failed as 'men' (LeClerc-Madlala, 2009). Marriage creates a status hierarchy among men, where conjugal status is prized. Equally a man is defined by his fertility and gains greater status from having children (Kishindo, 1994), a strong normative belief

⁶ I had several meetings with DFID Malawi, who were receptive to my study, but acknowledged that masculinities were not a gender equality funding priority.

constantly reinforced in Malawian society (Palamuleni, 2013). As a corollary, childlessness and infertility in Malawi is perceived as leading to significant gendered and social disempowerment, accompanied by infidelity and even divorce (Barden-O'Fakkib, 2005; de Kok and Widdicombe, 2008). Virility is a further marker of manhood (Kishindo, 1994). Sexual pleasure is regarded as synonymous with male sexual pleasure (John et al., 2015), and men's multiple sexual partners as a sign of their masculinity (Anderson, 2015), while men are socialised not to talk about their bodies and rely on myths rather than facts about sex and sexual health (Ntata et al., 2013). These gender norms are often reinforced through men's peer groups (Izugbara and Undie, 2008), and by broader structural inequalities between men and women which I discuss in chapter 4.

Manhood is associated with being heterosexual, and sexual relationships in Malawi are presented as almost universally heterosexual. The Malawi DHS does not measure sexual diversity. In our Malawi-wide research, over 90% of men and women stated they would be ashamed of being among homosexuals, with some participants (particularly men) believing it was acceptable to use violence should they suspect someone of being homosexual (Zamawe et al., 2014). There has been a documented surge in homophobic discourse in the country since 2009 (Biruk, 2014). Given the level of stigma, discrimination and criminalisation towards men who have sex with men (MSM) in Malawi (Ntata et al., 2008; Wirtz et al., 2013), it is argued that MSM cannot be included in mainstream interventions targeting men (Beyrer et al., 2012).

1.3.3 Male gender and its links to SRH

Different approaches have been posited to explain the relationship specifically between gender and SRH. As a reflection of the invisibility of men's gender, these have often focused solely on how gender inequalities impact on women's health and access to services and create vulnerabilities for women (Ehrhardt et al., 2009). While women bear the burden of SRH ill health globally (Ezeh et al., 2015), this orientation has meant that

mainstream global health programmes, policies and funding continue to largely exclude a focus on men (Higgins et al., 2010). When men are discussed within policy frameworks, it is often in negative terms (Keeton, 2007; Hawkes and Buse, 2013). This lack of focus on the social production of male gender within SRH may have unintended consequences that consolidate or reinforce male power or unspoken notions of manhood (Greene and Levack, 2010). For example, institutions, structures and policies focusing exclusively on women within the context of SRH reinforce women's responsibility for this issue, allowing men to abdicate their responsibility (Bila and Egrot, 2009). The fact that SRH services, particularly contraceptive services, are orientated by the health system as primarily female spaces (Cleland et al., 2011) may be both a cause and a consequence of men's objections to contraceptive use.

It is therefore argued that the current mainstream conceptual underpinnings of gender and SRH often fail to take account of how the social production of manhood can contribute to undermining the SRH and empowerment of women (Barker et al., 2010b) and the need to move beyond such approaches to gender which largely exclude men. This was recognised by the aforementioned Lancet Commission on SRHR, which stated that male gender norms exert a powerful influence on individual SRHR and highlighted a global gap in the focus on such norms within SRH responses, particularly with respect to contraceptive use (Starrs et al., 2018).

The literature base across sub-Saharan Africa highlights that male gender norms are associated with a range of male behaviours that can impact negatively on SRH, which have been particularly documented in the context of HIV and STIs. This includes perceptions of manhood that emphasise toughness, strength and prodigious sexual success (Jewkes and Morrell, 2010), encouraging risky sexual behaviours, particularly multiple concurrent sexual partners (Ndubani and Höjer, 2001) and men's unwillingness to use condoms or to use them consistently (Shai et al., 2012). These can be particularly reinforced through peer pressure among men (Selikow et al., 2009). Violent supportive norms (Kalichman et al., 2007) and gender and

power dynamics contribute to men's use of intimate partner violence and HIV risk behaviours (Dunkle et al., 2006). This has attendant risks for HIV/STI contraction and transmission (and unintended pregnancy), in a context where such gender norms limit women's ability to negotiate safe sex (Lindegger and Quayle, 2009). Inequitable gender norms also limit women's decision-making around their health-seeking (Watkins, 2014). These constructions also negatively impact on men's own SRH and support seeking, with gender norms of stoicism, self-reliance and being the economic provider discouraging HIV testing among men (Dageid et al., 2012), delaying men's treatment seeking for sexual health concerns (Pearson and Makadzange, 2008) and access to HIV antiretroviral therapy (ART) (Cornell et al., 2011; Siu et al., 2012). Boys may also be less likely than girls to admit ignorance around SRH matters or seek appropriate information (Varga, 2001) and schools further reinforce such norms, where the limited sexuality education that exists is often targeted at women and girls (Chege, 2005). Poor uptake of SRH services by young and adult men creates challenges to reaching them with SRH-related information (Dwadwa-Henda et al., 2010).

Male gender norms can also negatively impact on men's involvement in reproductive health (Onyango et al., 2010). Performing one's masculinity to male peers can lead to more sexually permissive attitudes among young men, compared to young women, impacting on adolescent pregnancy (Mchunu et al., 2012). Norms around male fertility within sub-Saharan Africa have also been associated with men's desire for larger families than their wives (Canning et al., 2015). Among adolescents in Mozambique, risk behaviours were used by men to test their fertility and prove their masculinity (Capurchande et al., 2016). These male gender norms can undermine women's SRHR and freedom to make their own reproductive decisions (Chege, 2005; McCleary-Sills et al., 2012).

1.3.4 Theorising masculinities: hegemonic masculinity framework

Raewyn Connell's theory of hegemonic masculinities (Connell, 1995) has arguably been the most influential framework in shaping understanding on men's gendered behaviours. Through this framework Connell argues that

men demonstrate a 'hegemonic' form of behaviours – an “ideal type of masculinity” (Connell, 1995: 47) - to impose their dominant social position and identity on others, and as a corollary the subordination both of women (Connell and Messerschmidt, 2005) and of less 'ideal' forms of masculinity. Being hegemonic represents a culturally idealised form of manhood, often associated with toughness and control (Lynch et al., 2010), sexual prowess (Jewkes and Morrell, 2010) and heterosexuality. Men, young and old, are encouraged to adhere, and constantly aspire, to such social norms so that they are legitimised as men (Flood, 2003; Shefer et al., 2007). Those who do not demonstrate dominant masculine norms are often seen as ‘feminine’ and marginalised by others (Jewkes and Morrell, 2010). Maintaining these hegemonic masculine ideals therefore can require men to behave in ways that have negative implications for equality between men and women and men’s own health and wellbeing (Campbell, 1995; Cohen and Burger, 2000; Courtenay, 2000). Given that adherence to these ideals produces hierarchies between men, this framework also recognises that men can have different power and privileges (Morrell, 2007). The social construction of masculinity is fluid (Petersen, 2003) and therefore norms are not static (Coles, 2009), with the most valued masculine ideals shaped also by one’s historical, social and cultural environment (Stern, 2013). This model is also ‘gender relational,’ so that “men and women are not postulated as polar opposites, rather ‘gender’ is understood as being about sets of relations between men and women, but also relations *between* men and *between* women” (Robertson, 2008: 4).

This concept therefore provides a useful lens through which to study the social construction of being a man within Malawi, and how these hegemonic masculine norms become ideals which men seek to live up to and influence the everyday realities of men and women. In Southern Africa, the framework has been previously applied to HIV (Skovdal et al., 2011; Morrell et al., 2012; Stern and Buikema, 2013; Leddy et al., 2016, among others), with no direct prior application found within empirical family planning and contraception research (see chapter 2). In Malawi, this theoretical framework has rarely been applied – except by Chikovore et al. (2014, 2015) on men’s tuberculosis care seeking – and not within the context of contraceptive use.

1.3.5 Limitations of hegemonic masculinities

Though Connell's remains an important theory, it has been critiqued in several areas. Although there is a recognition that men are not homogenous (Connell, 1995), the theory is often deployed to present a fixed character type among men. This one-set idea, as noted above, can lead to 'masculinities' itself being seen as the problem, rather than elements of masculine behaviour. A more predominant focus on men as the problem neglects a focus on men who may deviate from the norm (Stern, 2013). Given this, Morrell argues, hegemonic masculinities need to be seen not as a 'thing', but a way of understanding phenomena (personal communication with R. Morrell, 10 July 2015). In the context of SRH, it is necessary to reflect the complex social, cultural and gender norms that are influencing men's behaviour (Campbell, 1997).

A corollary of this singular focus of male gender is that being a man and male hegemony in Africa has come to be associated with "bad men" (Morrell et al., 2012: 24), creating a particular view of African masculinity. Hunter (2005) reminds us to avoid absolutist prescriptions of masculinity, which in sub-Saharan Africa may stem from a post-colonialist discourse, and which may characterise people as inherently 'diseased' or 'promiscuous.' Tracing back the roots of African masculinity, he argues that:

colonial rule and capitalist penetration significantly altered paths to manhood and reworked the meanings and practices surrounding multiple partners. (ibid: 391).

Hunter asserts that where there may have been greater space for contestation and fluidity between men and women around gender roles and sexual relationships, the colonial state and Christianity employed customary law to solidify patriarchal relations and religion to sanction a single, monogamous, moral code (ibid.). I explore post-colonial influences as it relates to Malawi further in chapter 4.

As part of the above, in essentialising masculinities there fails to be a recognition of the diversity among men, and prevents analysis, for example,

on how different groups of men may have different kinds of health-related behaviours. This would include an intersectionality approach, recognising the influence of race, ethnicity, religion, relationship status, among other factors, in shaping men's behaviour, and the influence of these factors across multiple levels of society. An intersectionality approach, Kapilashrami & Hankivsky (2018: 2589) argues,

.. sheds light on the fact that individual and group inequities are shaped by interactions between multiple sites and levels of power: institutions such as families, governments, laws, and policies; structures of discrimination...and broader processes of globalisation and neoliberalism.

A further limitation of Connell's theory is that it has a "tendency to portray men as either conceding to dominant gender norms or being marginalised by them" (Stern, 2013: 14). Men can simultaneously hold multiple identities, which may themselves be conflicting (Cornwall, 2007). The concept of men as both powerful and powerless (Cornwall, 2000) is a key example of this. Masculinities theory tends to assume men always hold power over women (personal communication with R. Morrell, 10 July 2015), failing to recognise that even men perceived to hold significant power may not do so, particularly where race, poverty, class and other social determinants can oppress them and impede their ability to fulfil male gender roles (Hearn, 2004). This limits the theoretical space to focus on positive masculinities, on men's own health needs in the context of SRH, and on how hegemonic masculinities can be deeply restrictive for men themselves (Lee and Owens, 2002).

In addition, despite its relational focus, this theory often lacks sufficient recognition of how women produce and maintain hegemonic masculine norms (Stern, 2013). As Hunter (2005: 398) argues, "It is too simplistic to suggest that masculinities are simply defended by men and challenged by women." Men and women's actions both maintain patriarchal structures (Hearn, 2004) and this concept can reinforce divisions between men and women, potentially *re-excluding* women, by presenting them as solely passive receivers of male gender norms (ibid.). In defence of Connell, Morrell (2007) argues that contrary to neglecting women, men's relationship with women is

central to the social construction of masculinity, and the application of this theory should focus beyond oppositional binaries.

Finally, in exploring SRH-related behaviours it is necessary to look at the institutional and structural level (Doyall, 2000, 2001; Scott-Samuel, 2009), which is also often absent from hegemonic masculinities theory. This includes understanding how the health system itself may perpetuate norms of masculinities, and the role of health services in shaping men's contraceptive behaviours.

In their paper, '*Hegemonic Masculinities: rethinking the concept*', Connell and Messerschmidt (2005) seek to take account of these limitations to the theory, particularly around women's participation and men's multiple simultaneous identities. As I discuss in chapter 3, reflecting these limitations, I have sought to reach a diversity of men, take a positive approach towards male involvement, including exploring men's own challenges and reflections, include both men and women's voices, and also explore structural level considerations.

1.4 Rationale for thesis and setting

The concept for this thesis is inseparable from my own personal and professional interest and growth, which as I explore in my discussion, arguably brings both advantages and challenges. Here I outline the rationale for my thesis and the study setting.

1.4.1 Personal and professional interest

I have long had a deep personal interest in questions of gender inequality and men's role therein. As an undergraduate I was inspired by reading bell hooks on feminism and Will Courtenay on masculinities and health. I volunteered as part of an outreach group of men speaking to other men about rape and its impacts on women and undertook a research project during my undergraduate studies on men's limited role in working to end violence against women in Scotland (where I grew up). Professionally, I've

worked in the area of SRH since 2004, sometimes as the only man in my department or division focusing on reproductive health. At the International Planned Parenthood Federation (IPPF) I became the torch bearer for exploring ways to address the fact that far fewer men were using services in the Federation's family planning clinics across the globe. In IPPF, the WHO, and other employment, I have often been struck by how peripheral (in my view) efforts were to address men's attitudes and norms in a context of programming to advance women's contraceptive uptake, or on gender and SRH more broadly. The organisational policies on gender equality in which I was involved often related almost entirely to women and girls. My passion for exploring men's gender led me to support the founding of the MenEngage Alliance,⁷ and to employment which has been more directly focused on programming to engage men, particularly around shifting masculinities as they relate to men's use of violence and engagement with SRH and to publishing a programmatic framework on men as partners and clients (Van den Heever et al., 2012) which informs how I define male involvement. My desire to do a PhD is a reflection of my broader personal interest in this field.

This story brings both personal nuances and potential biases within the context of 'engaging men', which are important for framing. The field of engaging men has been traditionally more comfortable on addressing men's gender-based violence (GBV) prevention and has been limited in its focus and conceptualisation (and often power analysis) of addressing masculinities within the concept of SRH, even less so as it relates to contraception. Many of my employers were implementing organisations, with a less rigorous research approach to their work and little or no discussion on conceptual approaches. Some of their interventions with men operated in isolation from work with women. These are limitations of work with men that I have critiqued (Shand et al., 2013). These factors were key drivers in my desire to explore the topic of contraception, listen directly to men's and women's own voices and to deepen my understanding, and to develop my research skills. At the same time, while my professional experiences confirmed to me the

⁷ MenEngage brings together organisations internationally to advance men's engagement for gender equality. See www.menengage.org [accessed 29 August 2017]

necessity of a greater focus on male involvement, and provided further impetus for my thesis, I had previously not interrogated my *own* investment in men's engagement for engagements' sake, and indeed whether we should engage men at all, not least given the aforementioned critiques around whether engaging men actually shifts men's overall position of power. I return to this in my discussion.

1.4.2 Choice of setting: Southern Malawi

Focusing on one context enables a deeper understanding of what goes on and why within that setting (Crowe, 2011; Denscombe, 2014), and how hegemonic masculinities manifest themselves (Hearn et al., 2012), from which broader inferences can potentially be extrapolated. Malawi generally, and Southern Malawi specifically, were selected as the focus of my research for a number of reasons.

Firstly, my work in South Africa, where I lived and worked for four years prior to moving to Malawi, involved the analysis of national policies in Malawi, which identified gaps in commitments to engaging men in SRH (Charles et al., 2014). I also interacted with staff in Malawian NGOs, UNFPA Malawi and the Malawian Ministry of Gender, and these conversations highlighted to me that issues of male involvement in contraceptive use had been historically neglected in the country, though were of increasing interest among Malawian stakeholders. Secondly, during this time I was able to move to Malawi a national household-based survey I was managing in Zambia, in order to undertake this in collaboration with the local Malawian UCL partner, Parent and Child Health Institute (PACHI),⁸ and thus combine with my PhD. This survey used a tool called the International Men and Gender Equality Survey (IMAGES), as I will discuss in chapter 3, the Malawi-wide findings of which (Zamawe et al., 2014) informed my more in-depth Southern Malawi analysis.

Southern Malawi was chosen specifically after being linked, by my primary supervisor, to the Malawi-Liverpool-Wellcome Trust Clinical Research

⁸ PACHI is a Malawi-based NGO working to improve health and wellbeing

Programme (MLW)⁹, based in Blantyre. MLW had the infrastructure and knowledge to support me in accessing my research sites and provided overall guidance. There are cultural differences between Malawi's three regions (Northern, Central and Southern) which can often reflect regional differences (Mbweza et al., 2008), and therefore I wished to ground my research in one particular area to aid my understanding and engagement. Southern Malawi itself also has variations in cultural practices among its different ethnic groups (MHRC, n.d.).

1.5 Data collection strategy

I undertook a community-based study using a sequential mixed methods approach (Tashakkori & Teddlie, 2003), composed of quantitative and qualitative research designs. My approach reflected the need for more mixed methods research on questions of gender and SRH in Africa (Schatz and Williams, 2012). The specific methods and rationale are explained further in chapter 3.

1.6 Research questions

My study research questions are as follows:

1. What is the understanding of and attitudes towards contraceptive use and family planning among men in Southern Malawi (including reported contraceptive method use)? (chapter 5)
2. How do social and cultural attitudes, norms and behaviours of Southern Malawian men (including those related to gender-equality) influence their approach to contraceptive use and family planning? (chapters 6, 7 and 8)
3. How do men perceive, experience and use contraceptive/family planning services, and how do these services, and the related Malawian institutions, respond to men's engagement? (chapter 9)

⁹ See <http://www.mlw.medcol.mw/> [accessed 29 August 2017]

1.7 Structure of the thesis

Chapter Two: This provides a review of the existing literature and evidence on which this study builds and outlines the gap in research which this thesis seeks to address.

Chapter Three: This describes the mixed methodology I used. The chapter covers my research phases and rationale, research design and instruments, data collection processes, data analysis, data prioritisation and integration, and my analytical framework. It also discusses my research principles, ethical considerations, and positionality.

Chapter Four: This provides details on Malawi's health indicators, colonial history and political situation, and on the status of women in the country. It also provides a historical analysis of family planning and men's involvement, and the related content of Malawian policies and efforts to engage men in gender equality. Finally, it provides an in-depth overview of my research setting and the contraceptive health system.

Chapter Five: This results chapter provides quantitative and qualitative data on men's understanding and use of contraception in Southern Malawi. The chapter explores men's reports on contraceptive use with their partner and condom frequency use, and then discusses men's understanding and attitudes towards male and female methods, and how men perceive current contraceptive information flows.

Chapter Six: This results chapter provides quantitative and qualitative data to explore how Southern Malawian men's attitudes, norms and behaviours related to gender-equality influence their contraceptive views and practices. The chapter explores indicators on men's support for gender equitable norms, and on men's decision-making on women's health seeking. It also discusses findings on how men perceive gender equality, contraceptive communication and decision-making within relationships, and on overall responsibility for pregnancy prevention.

Chapter Seven: This results chapter provides qualitative data on how men conceptualise being a man in Southern Malawi and how this impacts on men's approach to contraceptive use and family planning. The chapter explores male gender norms related to being strong, being fertile, being the economic provider, and being stoic and the countervailing ways these are said to influence male involvement.

Chapter Eight: This results chapter provides my quantitative and qualitative data findings on the meanings men ascribe to sex and how this influences their approach to contraceptive use. The chapter explores indicators on men's number of sexual partners and their description of their sexual satisfaction. It also discusses male gender norms and cultural influences around virility, sexual satisfaction, multiple sexual partners, the exchange of fluids and ownership over women's sexuality and how they influence the ways men and women perceive male and female methods.

Chapter Nine: This results chapter provides my quantitative and qualitative data findings on men's experience and use of contraceptive services, and how these services respond to men's engagement. The chapter explores secondary client data around men's use of contraceptive services, and the findings of my observations within health settings. It also discusses men's attitudes towards, and experiences of health services, and how the health system and broader health stakeholders perceive men's engagement.

Chapter Ten: This provides a discussion on my findings. I also provide personal reflections on my PhD and share strengths and limitations of my study. I end with the implications of my findings for research, methods, policy and future research.

1.8 Summary

This chapter has introduced the aim of my study, which explores how the gendered understandings, attitudes, norms and behaviours of men in

Southern Malawi influence their involvement in family planning and contraception. It provided background to this topic, and the importance of male involvement, and highlighted the links between male gender norms and SRH. I then explored the social production of gender, men's gender in Malawi and the theory of hegemonic masculinities. I outlined my professional and personal interest in relation to the study site, Southern Malawi, and explained my research questions. I now turn to my literature review.

Chapter 2: Literature Review and Research Gap

2.1 Introduction

The last chapter outlined the aim of my study, provided background to the topic of male involvement, and provided a rationale for my research. It also outlined the conceptual and theoretical approach to my study, and my research questions. This chapter provides a review of the literature on men, masculinities, contraception and family planning. I begin with the review methodology. Given limited research on this area in Malawi, the review of literature that follows is structured in two parts: 1) I discuss the literature for Southern Africa; 2) I explore what is known on this topic in Malawi. Informed by my findings, I have structured the literature as follows: men's contraceptive use; men's knowledge and attitudes towards contraception; the linkages between male gender norms (as discussed in the last chapter) and contraceptive use and family planning; men's engagement in contraceptive services; interventions in this area; and the methodological approach and gender framing of the literature. Based on this review, the chapter ends with outlining the gap which this thesis seeks to address.

2.2. Review methodology

An initial scoping exercise for literature on men, contraception and family planning and sub-Saharan Africa in July 2017 using Google scholar identified over 5,000 responses and highlighted the need to more tightly define research parameters. It also identified the benefit of looking beyond Malawi literature alone.

2.2.1 Focus of literature review

Based on my study focus, as discussed in the previous chapter – socially produced male gender norms as they relate to male involvement – my literature review sought to answer two specific questions, namely:

- What is known about men’s involvement in contraceptive use and family planning in Malawi, and how male gender norms and masculinities may influence men’s related understanding, attitudes and behaviours?
- What is known about men’s involvement in contraceptive use and family planning in other Southern African countries, and how male gender norms and masculinities may influence men’s related understanding, attitudes and behaviours?

2.2.2 Search criteria

The initial scoping exercise also informed the key word criteria. Given my desire to look beyond Malawi, I explored the literature from the broader region in which Malawi sits, Southern Africa,¹⁰ and with whom Malawi shares many cultural and economic similarities. My search key words were:

- (Masculinity OR men OR gender norms OR male involvement) AND (family planning OR contraception) AND (Malawi)
- (Masculinity OR men OR gender norms OR male involvement) AND (family planning OR contraception) AND (Angola OR Botswana OR Eswatini OR Swaziland OR Lesotho OR Mozambique OR Namibia OR South Africa OR Zambia OR Zimbabwe)

My searches using these terms were undertaken in PubMed, Scopus, Web of Science, Science Direct and JSTOR. The specific searches for each database are outlined in appendix A. This search was initially undertaken in July-August 2017, and then updated in June-December 2020. I also used the snowballing technique to identify further papers.

My inclusion/exclusion criteria for the literature are as follows:

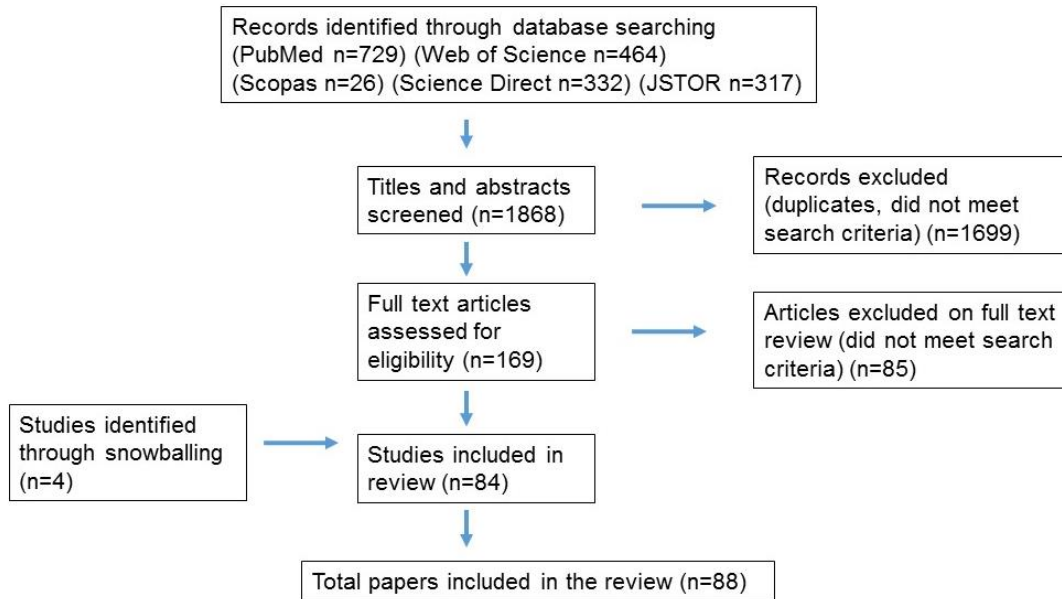
- Research articles, journals, book chapters, case studies, reviews
- Published between 1 January 2000 and present date

¹⁰ Southern Africa is a recognised region of the UN and Africa Union, containing 10 countries, and is the southernmost region of the African continent.

- Included data from men (individually or together with women) or a focus on male gender norms/male involvement. Data from women-only research was included solely where it was specific to my topic
- Focused specifically on family planning and contraception. Excluded HIV-specific or other health issues, where there was no substantive reference to contraception
- Included condom use as it related to pregnancy prevention or dual protection (for pregnancy and disease prevention)
- Included men's sexual behaviours where it related to family planning and contraceptive outcomes (excluding where the outcome was solely on HIV/STIs or non-health areas)
- Included infertility where it contained reference to male gender norms
- Included men aged 18 and over. Findings on adolescents and teenagers included where disaggregated data for 18+ was provided. Studies on school pupils excluded
- Focused on countries within Southern Africa
- Excluded maternal, newborn and child health (MNCH, see chapter 3)
- Excluded violence (see chapter 3)
- Excluded abortion (see chapter 4)

In June-December 2020, a total of 1,868 results were retrieved and screened, from which 169 papers were reviewed for detailed screening against the eligibility criteria. 88 of these papers were included in the review. Please see flowchart in figure 3 below.

Figure 3: Literature review flowchart



2.3 Findings from Southern Africa

This section presents the findings from nine countries in Southern Africa (excluding Malawi), namely Angola, Botswana, Eswatini (formerly Swaziland), Lesotho, Mozambique, Namibia, South Africa, Zambia, and Zimbabwe. I have categorised the literature to aid understanding and respond to my above literature review questions.

2.3.1 Overview

I found an overall limited focus on exploring men's views and behaviours as they relate to contraception and family planning, and research on this specific topic could not be retrieved from Angola, Botswana, Lesotho, Namibia and Zambia. The majority of studies found were from South Africa. A greater number of papers were identified focusing on male involvement in childcare, fatherhood, maternal health and prevention of mother-to-child transmission of HIV (PMTCT), rather than on contraception, or solely focused on women's behaviour, and were therefore excluded. Several studies on contraception used women's reports of men's behaviour as proxy, or engaged men as secondary to a female target group. Substantial differences were found in approaches used to explore men's contraceptive

behaviours, and in gender framing, as I explore. Only two papers specifically discussed vasectomy.

Much of the research which addressed masculinities, and men's gendered sexual behaviours, had a predominant focus on HIV. As noted, this review excluded HIV-specific literature, given my desire to look beyond HIV and explore an area where the literature is less well developed and for practical reasons. Given the importance of the HIV literature on masculinities, I include it here for comparative purposes and engage with it in the discussion of my findings.

2.3.2 Men's contraceptive use

Men's contraceptive reports: Research with men on their contraceptive use across Southern Africa is challenging to compare as target groups can vary (such as only students, young men, single adult men, or men in couples) and authors use different age ranges (for example, ages 15-29, 16-55, 17-24, 18-24, 18-40 or 18+). Authors also employ different measures to report men's contraceptive use, such as only asking men about male methods (Maja, 2007), conflating male condoms alone as contraceptive use in relationships (Ngcobo et al., 2019), or not separating out male and female reports on method use (Kraft et al., 2009). Studies with adult men on their contraceptive use may not ask about their relationship status (Van Rossem and Meekers, 2007), or include both married and unmarried men but not disaggregate their findings (Ngcobo et al., 2019).

Overall, men's reports on contraceptive use vary significantly and may be unreliable. Hoffman et al.'s (2017) analysis of students (aged 18+) in South Africa found only 17% of men (37% of women) reporting that their partner used a hormonal contraceptive method. In their study of students in 22 countries, Peltzer and Pengpid (2015) found 69% of men in Namibia and 47% of men in South Africa reported using a birth control method with their partner in the last 12 months (though specific methods were not provided). In a survey of South African youth, aged 18-24, Seutlwadi and Peltzer (2013) found 92% of young men reported currently using contraception, 87% of

which was male condoms. Only 10% of young men reported using dual or two methods¹¹ (data not disaggregated), which were associated with higher contraceptive method knowledge and sexual intercourse frequency among men (*ibid.*). Maharaj and Cleland's (2005) research with couples in South Africa found substantial discrepancies between husbands' and wives' reports of contraceptive use. Ngcobo et al.'s (2019) research with South African men, aged 18-40, also found their reports on contraceptive use to be contradictory (relationship status not disaggregated).

On condom use, while reports also differed significantly, I found younger and unmarried men were more likely to report condom use than married men, and men were more likely to report use than women. Maharaj and Cleland's (2006) research with students and Maharaj's (2006) research with young people, both in South Africa, found 65% of male students and 65-70% of young men 17-24 years (and 45-53% of young women), respectively, reporting condom use at last sex. Bankole et al.'s (2009) multi-country analysis of condom use among young men, 15-29 years, found 24% of men in Malawi, 22% in Mozambique, 74% in Namibia, 30% in Zambia and 39% in Zimbabwe reported using condoms at last sex. A later study in Zambia found 61% of men, 18-24 years, reporting using condoms, compared to 32% of women (Chowdhuri et al., 2019). By contrast, research with older men, 15-59 years, in Zambia found only 16% of men (and 11% of women) reporting condom use at last sex (relationship status not disaggregated) (Van Rossem and Meekers, 2007). A consistent finding across these studies was that being in a steady relationship or married reduced the odds of men using condoms (Maharaj, 2006; Bankole et al., 2009; Pinchoff et al., 2017).

Studies also find young men report using condoms to prevent pregnancy as well as for disease prevention. Maharaj (2006) found condoms to be the main method for pregnancy prevention among young men and women, with 63% of young men using condoms for dual protection, and only 4% using

¹¹ The authors did not define two methods. This has been defined in the literature as women's concurrent use of a hormonal method to prevent pregnancy and condoms to prevent STIs (Frohworth et al., 2016)

condoms with another contraceptive method. Maharaj and Cleland (2006) found only 10% of students saying they used condoms in conjunction with another method. Maja (2007) found 68% of South African adolescent males (ages not disaggregated) reporting condoms as their contraceptive method. These findings are supported by more recent research, with Hoffman et al. (2017) reporting 68% of students using condoms for dual protection (though data was not sex disaggregated). However, Bankole et al. (2009) found a greater proportion of young men reported condom use for preventing STIs alone than preventing pregnancy alone, with around one in three users reporting the method for both purposes.

This differed to condom use in the context of stable relationships. Maharaj and Cleland (2004) found condoms were primarily used for disease prevention rather than dual protection among married or cohabiting partners. Maharaj (2001a) also found the association of condom use with infidelity (see below) to be a major obstacle among men and women to using condoms for dual protection in relationships. Only 3% of male and female adults in Botswana (Kraft et al., 2009) were found to use condoms for dual protection, which was higher for those with concurrent partnerships (though data was not sex disaggregated).

I also found men use condoms inconsistently. Maharaj and Cleland's (2006) research with South African students found only 24% of men to report consistently using condoms, and the author's earlier research (Maharaj and Cleland, 2004) among married/cohabiting couples found only 2% of men reporting consistent condom use. Maharaj et al.'s (2012) study of condom use among married men in South Africa (and Uganda) found that consistent condom use reported by men had increased over time from 2.5% to 12%, though still remained low overall and increases were confined to urban populations and more pronounced among those defining themselves as cohabiting but not married (the author did not specify whether condoms were for contraception or HIV prevention, though the latter was implicit). In Gauteng province, 30% adult males and 50% male adolescents said they used condoms every time they have sex (Maja, 2007). The one exception

was Hoffman et al.'s (2017) research with South African university students (mean age 20), which found 73% of men to report two-month consistent condom use, which was higher for men who reported that their partner did not use (versus used) hormonal contraception and who reported using condoms for dual protection. However, explicit desire to prevent pregnancy was not associated with consistent condom use (ibid.).

Many papers retrieved explored men's condom-related behaviours, including consistency of condom use, solely in relation to HIV/STI prevention (rather than pregnancy prevention or dual protection) and with the underlying assumption that condoms were solely for use with extra-marital or casual sexual partners (such as Meekers, 2003; Foss et al., 2007; Moyo et al., 2008; De Walque and Kiline, 2011; Mantell et al., 2011; Jung et al., 2013; Reynolds et al., 2013; Chirinda and Peltzer, 2014; Manyapelo et al., 2017; Evans et al., 2018).

Vasectomy: The uptake of vasectomy among men is very low in the region, with reported prevalence at 0.3% in Eswatini, 0.4% in Botswana and 0.7% in South Africa (Shattuck et al., 2016).

Female condom use: Only 2% of married couples in Zimbabwe (data not disaggregated) reported use of female condoms, which were primarily used for pregnancy prevention (Meekers and Richter, 2005). The authors found men who had used male condoms had significantly greater odds of using female condoms, while men with two or more sexual partners had significantly lower odds (ibid.). Agha (2001) found no difference between men and women's intentions to use the female condom in Zambia, within the context of overall low use.

2.3.3 Men's contraceptive knowledge

Men's knowledge of contraceptive methods: Findings from DHS surveys across Southern Africa show the mean number of methods known by men, 15-49 years, to be high and range from 6.1 in Lesotho (MoH and ICF, 2016) to 8.2 in Namibia (MoHSS and ICF, 2016). In their global DHS analysis,

MacQuarrie et al.(2015) found contraceptive knowledge among men to be increasing over time in Namibia and Zimbabwe, and highest among men aged 30-44 and married. In both countries men's contraceptive knowledge was positively associated with their level of education (ibid.). Qualitative research in South Africa by Ngcobo et al. (2019) and Maja (2007) found men could name a range of contraceptive methods.

Despite these findings, research which explores men's contraceptive knowledge in greater depth finds only superficial understanding. In South Africa, Kriel et al. (2019) found men to have inadequate understanding of different methods and misunderstandings about side effects, which were associated with their opposition to use. Maharaj's (2006) earlier research in South Africa found young men to have less knowledge about female-controlled methods compared to the male condom. In Mozambique, despite naming different contraceptive methods, men could not verbalise what they understood about them, with young males showing more accurate understanding than older participants (Capurchande et al., 2017). Men were found to have poor knowledge about the female condom in Zimbabwe (Koster et al., 2015).

Male method understanding: DHS surveys in Southern Africa find a high percentage of men (97-99%) know about the male condom, (MoH and ICF, 2016; MoH and ICF, 2019), which mirrors Bankole et al.'s (2009) earlier multi-country DHS analysis. Qualitative and quantitative research with men across Southern Africa reinforces this finding (Maharaj and Cleland, 2005; Maja, 2007; Ngcobo et al., 2019). Maharaj (2006 and et al. 2006) found over 80% of men in South Africa were aware of the dual protective benefits of condoms. Knowledge on vasectomy is much poorer, with DHS reporting only 25-44% of men in Southern Africa (with the exception of Namibia) knowing about vasectomy (MoH and ICF, 2016; MoH and ICF, 2019). Shongwe et al. (2019) found men in Eswatini had very poor or non-existent knowledge about vasectomy, and Dunmoye et al.'s (2001) study of vasectomy clients in South Africa found 99% believed there was insufficient information available.

2.3.4 Men's attitudes towards contraception

Men's general attitudes to contraception: Quantitative data suggests increasingly positive male attitudes towards contraception. MacQuarrie et al.'s (2015) analysis of changes between 2000-13 to men's response to the DHS statement 'contraception is a women's business and a man should not have to worry about it' found over 50% of men disagreeing and increasing levels of disagreement in both Zimbabwe and Namibia. The authors argued these results represented broad acceptance among men of using contraception to avoid pregnancy (ibid.). Bietsch's (2015) seven sub-Saharan African country analysis of the same DHS question, including Mozambique and Malawi, found that over the previous two decades positive attitudes among men to contraception has increased across the region (country specific results were not provided) by around six percentage points and that higher approval was associated with older age and greater education.

Qualitative data from Southern Africa on men's attitudes presents a different perspective, highlighting the limitations of sole reliance on quantitative data, and in particular uncovering concerns among men about side effects of female contraception. Ngcobo et al. (2019) found men in South Africa had resistance to the contraceptive injection, believing it led to excessive weight gain and increased vaginal fluid. This reflects Maja's (2007) earlier South African research, finding men to express similar concerns related to the pill and injection. Raselekoane et al.'s (2016) study of male students' attitudes towards contraception, 18-24 years, in South Africa, found the majority had a negative attitude towards using methods. This author also found that while 67% of men acknowledged that it's good to use contraceptives, only 35% said that they liked to use them (ibid.). Men in Mozambique, particularly in union, expressed concerns about female contraceptive side effects (Capurchande et al., 2017) and Mozambican male adolescents objected to the Intrauterine device (IUD) and injections, preferring withdrawal and male condoms (Capurchande et al., 2016). Maja (2007) asserts that more accurate information could allay men's contraceptive fears and misconceptions.

On female condoms, for which I found limited research on men's views, Koster et al.'s (2015) analysis in Zimbabwe found men saw female condoms as more appropriate for a trusted than casual partner and were motivated by the fact that this method was less associated with HIV/STIs (compared to male condoms). Equally, however, unmarried men expressed a desire to remain "loyal" to the male condom and married men said female condoms were only applicable while women were menstruating (i.e. not an alternative to female hormonal methods) (ibid: 130).

Attitudes to male condoms: Many papers retrieved explored men's attitudes towards condoms within Southern Africa in terms only of HIV/STI outcomes (Maticka-Tyndale, 2012; Reynolds et al., 2013; Manyapelo et al., 2017; Zhang et al., 2017). The literature on pregnancy prevention or dual protection finds overall reluctant attitudes among men towards male condoms, and that men perceive this method as primarily for disease prevention (reflecting the bias within the research base itself). Ngcobo et al.'s (2019) research in South Africa found adult men to report a positive attitude towards condom use for both HIV and pregnancy prevention, though these men noted this did not translate into consistent usage and that they faced challenges in using condoms. Swartz et al.'s (2018) earlier qualitative research in South Africa, found young men (17-25 years) had a consistent reluctance to using condoms. Condoms are also seen by adult men in South African relationships as more effective for preventing HIV than pregnancy (Maharaj and Cleland, 2004), and though men may still approve of other contraceptive methods for fertility regulation not the condom given its association with promiscuity (Maharaj, 2001b).

I also found a strong belief that condoms are not an appropriate method in marriage (mirroring literature on use above). Research in South Africa finds most men (and women, though to a lesser extent) view condoms within marriage as taboo and a sign of infidelity. In Zambia, Chowdhuri et al. (2019) found being married negatively impacted on communication around condoms and intention to use. Across South Africa (Maharaj and Cleland, 2004),

Zimbabwe (Buck et al., 2005; Koster et al., 2015), Mozambique (Capurchande et al., 2017) and Zambia (Chowdhuri et al., 2019) research finds men to assert male condoms were more acceptable in non-marital or casual relationships, but not marriage, particularly given associations with infidelity and HIV. Both Maharaj (2006) in South Africa and Koster et al. (2015) in Zimbabwe found acceptability of male condoms among men decreases as relationships progress from casual to serious.

Attitudes to vasectomy: Reflecting its overall limited use in Southern Africa, research finds men have a negative attitude towards vasectomy. Capurchande et al. (2017) found significant opposition among men and women to vasectomy (and female sterilisation) in Mozambique, with men who had this procedure perceived as being emasculated. Men in Eswatini had strong objections, due to cultural expectations around having children, the potential of being abandoned by their current or future wife, and concerns about it causing impotence and ejaculatory problems (Shongwe et al., 2019).

Novel male method attitudes: Ngcobo et al.'s (2019) qualitative research found men in South Africa viewed the current methods for men as insufficient, and desired new non-barrier male methods. Modelling by Dorman et al. (2018) estimated that introducing a male oral pill or reversible vas occlusion would decrease unintended pregnancy 3%-5% in South Africa. Martin et al. (2000) found 55-83% of South African men said they would definitely/probably use a male pill, and 48-62% said the same for a male hormonal injection. Research on Mozambican men's willingness to use a male contraceptive pill found only one-fifth were either reluctant or unwilling to consider using such a novel method, although for many, willingness to use was dependent on side effects, costs and there being a strong medical reason (Vera Cruz et al., 2019).

2.3.5 Male gender norms, family planning and contraception

My review found an overall limited number of studies (particularly qualitative studies) exploring male gender norms and contraception, with a large number of papers focusing on men's gendered behaviour solely in the

context of HIV outcomes (such as Ndubani and Höjer, 2001; Montgomery et al., 2008; Mantell et al., 2011; Skovdal et al., 2011; Maticka-Tyndale, 2012; Shai et al., 2012; Stern and Buikema, 2013; Fladseth et al., 2015; Leddy et al., 2016; Chapman et al., 2019). The studies beyond HIV included here found male gender norms to have an important, more often negative, impact on men's contraceptive use and their support for use by their wives/partners. I have structured this section as follows based on the literature: communication and decision-making; male fertility; male virility; sexual pleasure and female infidelity.

Contraceptive communication: Analysis of DHS data finds positive associations between couple communication and method use. Becker and Costenbader's (2001) 23-country analysis of DHS couple data, which included Malawi, Mozambique, Zambia and Zimbabwe, found spousal discussion on contraception to be a predictor of couples' agreement on use and method used, which was mirrored by Bietsch's (2015) later DHS analysis across seven sub-Saharan African countries. The assumptions underpinning these associations were, however, questioned by DeRose et al. (2004) whose multi-country analysis using male and female DHS data, also including Malawi, Mozambique, Zambia and Zimbabwe, cautioned the link between spousal communication and contraceptive use, arguing that women may incorrectly conflate male partner willingness to discuss this issue as his approval of contraceptive use (while he may actually disapprove), and that the DHS discussion variable being used does not clarify the nature and quality of the discussion.

Multi-country quantitative analyses in this area, such as those above, may be limited (particularly given their reliance on DHS data), with national data found to provide a more nuanced picture, particularly the challenges of contraceptive communication in relationships. Maharaj and Cleland (2005) found a large proportion of South African couples had never discussed family planning together and had different perceptions of their attitudes towards use. Maja (2007) found that while 89% of married men said they wanted to discuss contraception with their partner, 74% wanted their partner to better

inform them about their method use. In Zimbabwe, Chikovore et al. (2002) found that there was little verbal communication between husbands and wives around contraception, a finding also mirrored in Angola (Prata et al., 2017). Capurchande et al. (2017) found Mozambican men were unaware of their female partners' family planning activities. In Zambia, men were less likely than women to report having discussed the use of contraception with their partners (Chowdhuri et al., 2019) but where contraceptive discussions took place it decreased non-use (Pinchoff et al., 2017). An exception was Raselekoane et al. (2016) finding 60% of male South African students had discussed contraception with their partner. Men's discussions on contraception and safe sex with other men (though infrequent) were also found to have an important (largely negative) role in men's contraceptive attitudes in Mozambique (Agadjanian, 2002), and were embedded in dominant patriarchal values (Capurchande et al., 2016).

Condom use communication was found to be minimal and gendered, with Maharaj and Cleland's (2006) research with South African students finding that men understood their role was to carry condoms, making it more acceptable for them to introduce the topic of use in a relationship. However, it was a women's role to request that condoms be used, and women who carried condoms were perceived as promiscuous (ibid.). Condom communication is further complicated by men's lack of comfortableness talking about sex with their partners, as Letshwenyo-Maruatona and Gabaitiri (2018) found in Botswana. These findings were mirrored in HIV-specific condom research (Mantell et al., 2011). In relation to the female condom, Koster et al. (2015) found married and single men in Zimbabwe were of the view that they should be the one to introduce the use of female condoms, as they would otherwise doubt their partner's fidelity.

Decision-making: Qualitative research points to men having a critical influence in contraceptive decision-making. In their research in rural Zimbabwe, Chikovore et al. (2002) found married men used threats and physical assault to prevent method use, reflecting their fear of loss of control. Ziyane and Ehlers' (2007) research in Swaziland found men reported

deciding when and how women use methods, and that women could not decide to do so independently. Capurchande et al.'s (2017) research in Mozambique found men reporting stopping their partners from using contraceptives because of irregularity of menstruation, and that female participants who consistently used modern contraceptives had their partners' approval. Kriel et al.'s (2019) research in South Africa on male partner influence found women to assert that men assumed ownership of women's bodies and female fertility, which could result in discontinuation of female contraceptive use. These authors also identified men's physical abuse towards women as an additional way men prevented their partners from using contraception (ibid.). Chikovore et al. (2002), Capurchande et al. (2017) and Kriel et al. (2019) all found men to be significantly concerned about women's covert method use, including outlining intricate strategies to catch their wives out. The one exception was Maharaj and Cleland (2005), who found that husband's disapproval of contraception did not have a significant net effect on use (based only on data from female partners), which may point to women still accessing methods regardless.

Quantitative studies on contraceptive decision-making also found men to be key decision-makers on contraceptive use. These studies focused solely on asking women about men's behaviour, identifying a gap in the quantitative research exploring decision-making dynamics with men themselves. In Angola, Prata et al. (2017) found that perceived husband's/partner's approval among women was associated with triple the odds of them reporting contraceptive use. In Mozambique, women who reported their husband/partner usually made the decision about their healthcare were 19% less likely to report intention to use contraception (Mboane and Bhatta, 2015). These findings mirrored Cau's (2015) analysis of Mozambican female DHS data, where women who lacked autonomy (defined as their husband/partner or someone else having the final say on visits to family or relatives) had significantly reduced odds of using contraception. In Botswana, Letamo and Navaneetham (2015) found unmet need was more likely among women who reported their partner disapproved of contraception. In an experimental study in Zambia, Ashraf et al. (2014) found

that women given access with their husbands to contraceptives (compared to given access alone) were 19% less likely to seek contraceptive services.

In terms of condom negotiation, men's role is also critical, reflecting the gendered nature of condom communication. Buck et al.'s (2005: 418) research in Zimbabwe with women and their husbands found both agreed there "was little a woman could do if her partner did not want to wear a male condom." Swazi male adolescents expected girls to refuse unprotected sex while maintaining they were the sole decision-makers on such matters (Ziyane and Ehlers, 2007). Pinchoff et al. (2017) found agreement regarding male condom use with a partner decreased non-use by 16% (though this figure was not sex-disaggregated). Among students, Maharaj's (2006) research found that while the majority of men said they had no greater influence over condom use than women, women had less control over condom use than men within inequitable or abusive relationships. HIV-prevention literature concurs with the view that males have greater self-efficacy in condom negotiation (Closson et al., 2018).

Responsibility for pregnancy prevention: Although men may make decisions regarding the use of contraception, research across Southern Africa - with male South African students (Maharaj and Cleland, 2006), husbands in Zimbabwe (Buck et al., 2005), Mozambican men (Capurchande et al., 2017) and men in Swaziland (Shongwe et al., 2019) – consistently finds men perceive pregnancy prevention and using methods as a women's responsibility. Maharaj and Cleland (2006) also found young men were far more concerned about HIV infection than pregnancy, compared to young women. Despite this, some studies found men acknowledge the need for their greater involvement. 72-90% of South African men interviewed by Martin et al.'s (2000) study on a male pill asserted that responsibility for contraception falls too much on women. Madlala et al. (2018) found South African young male nursing students expressed a desire to play a more active role in pregnancy prevention, while feeling constrained by reproductive health being perceived as a female domain. Vera Cruz et al.'s (2019) found a minority of Mozambican men believed that contraceptive use

should be a shared responsibility. A study of norms regarding women having sex before marriage in Namibia, Swaziland and Zambia found an increase in positive gender norms ('collective permissive attitudes' among male and female adults) regarding premarital sex led to increased odds of women reporting contraceptive use (Mejía-Guevara et al., 2020). However, this survey used only women's views as a proxy for male gender norms.

Fertility norms, breadwinner and contraception: Qualitative research in Southern Africa finds male fertility and men's breadwinner role as markers of manhood, but less is known about the connections to contraceptive use. Men in Swaziland reported that their wealth was measured by the number of children in their family (Ziyane and Ehlers, 2007). Young men in South Africa perceived having children as a way to demonstrate their masculinity (Swartz et al., 2018). This desire for more children was found to cause men in South Africa to resist contraceptive use in their relationships (Kriel et al., 2019) and Madlala et al. (2018) similarly found that South African young men experienced peer pressure to engage in unprotected sex which could lead to unintended pregnancy. At the same time, being a provider was part of masculinity (Swartz et al., 2018), and male norms around family size may be shifting due to men's provider role. Capurchande et al. (2017) found that while having many children was important to Mozambican men's self-identify, their kin and social networks, some men with a preference for more children had changed their fertility desires due to their economic constraints. Men's concern about the economic cost of large families, and not being able to support them, was also documented by Ngcobo et al.'s (2019) research with men in South Africa. There was limited focus on masculine norms related to infertility, with the exception of Zimbabwe (and Malawi, see below) where Folkvord et al. (2005: 242) found men regarding infertility as challenging the country's "male dominated culture" and blaming their wife as the cause of their childlessness.

Virility, sexual pleasure and contraception: Much of the research I excluded in Southern Africa on men's risky sexual behaviours, particularly multiple sexual partners, focused solely on the implications for HIV, and found this

behaviour to be common among men (such as Hargreaves et al., 2009; Onoya et al., 2015; Zhang et al., 2017). Similarly, Koster et al. (2015) in my review found over 50% of married men in Zimbabwe reporting an extramarital partner. Capurchande et al. (2016) also found male adolescents in Mozambique more likely (than female) to have unprotected sexual intercourse with multiple partners. Men's high rates of multiple partners may underly the association of condoms with disease prevention, with Bankole et al.'s (2009) research across Malawi, Namibia, Zambia and Zimbabwe finding men who had multiple/extramarital partners being twice as likely to use condoms for STI/HIV prevention only than pregnancy prevention.

Research on male sexual pleasure norms in Southern Africa has also been more widely documented within the field of HIV (such as Mantell et al., 2009; Scorgie et al., 2009; Adams and Moyer, 2015; Humphries et al., 2015; Kelly et al., 2015; Zulu et al., 2015; Wirth et al., 2016), and was beyond the focus on my literature review. I found sexual pleasure was seen by men as central to their manhood (Swartz et al., 2018). Despite the fact that contraception is believed by men to reduce their enjoyment of vaginal sex (Varga, 2001) there is limited research exploring the linkages between men's perceptions of sexual pleasure and contraceptive use. Smit et al. (2002: 1511) found South African men reported women who used the injectable to be "wet", "cold" or "tasteless." Raselekoane et al. (2016) also found decreased sexual pleasure as a key reason for South African male students' objections to contraceptives. Kriel et al.'s (2019) further found that increased vaginal wetness and decreased male sexual pleasure were the two main side effects South African men described, which made contraception (particularly the hormonal injection) unacceptable to them. Sexual pleasure concerns were men's primary objection to using condoms across several South African studies (Maharaj, 2006; Maja, 2007; Swartz et al., 2018), and in Zimbabwe (Buck et al., 2005), and the rationale for men's expressed preference for unprotected sex (Maharaj and Cleland, 2014; Kriel et al., 2019). Such concerns were found to be significantly greater among young men than young women (Maharaj and Cleland, 2006). Men also worried that condoms weakened their erection (Ngcobo et al., 2019).

Regarding female condom use, Koster et al. (2015) found that while some men found the length of time to insert this method meant they lost their erection, others (both married and unmarried) expressed positively that using this method felt like having natural, unprotected sex. However, Buck et al.'s (2005) earlier research found married Zimbabwean men reported concerns about sexual pleasure using the female condom, saying that the diaphragm had less impact on their sexual pleasure. Concerns about the negative impact of a vasectomy on their sexual lives has been raised by men in Eswatini (Shongwe et al., 2019). However, Dunmoye et al. (2001) found only 5% of vasectomy clients over a three-year period in South Africa reported a detrimental impact on their sexual activity and 3% said this had improved.

Female infidelity and contraception: Research identifies that men perceive contraception to facilitate female promiscuity. MacQuarrie et al.'s (2015: xiii) aforementioned multi-country analysis of male-only DHS surveys found a high level of agreement among men that “women who use contraception may become promiscuous,” with Namibia being only one of four countries (out of 18) to have less than 50% of men agreeing. In South Africa, Patel and Kooverjee's (2009), Raselekoane et al.'s (2016) and Kriel et al.'s (2019) research all found men believed that contraception increased women's promiscuity, with men expressing a view that the contraceptive injection gave women a licence to ‘sleep around.’ Swazi adult men have been found to similarly assert this (Ziyane and Ehlers, 2007). Chikovore et al. (2002) found married men in Zimbabwe objected to their wives' contraceptive use because it became more difficult to detect their wife cheating on them; this anxiety was more intense when men migrated away from home for work. Concerns about female infidelity have also been identified among men specifically in relation to condoms (Maharaj and Cleland, 2004) and men having a vasectomy (Shongwe et al., 2019).

2.3.6 Men's engagement with contraceptive services

Research finds men perceive contraceptive services as feminine spaces and therefore it is their wives'/partners' role to access methods, not their own

(Cleland et al., 2011). In Mozambique, men reported no engagement with family planning consultations or presentations at the health centre, and were concerned that they would be viewed as “dominated by their wife” if they were seen escorting them to such services (Capurchande et al., 2017:11). As a result, these men said they paid little attention to information their partner obtained at contraceptive counselling sessions (ibid.). The feminisation of contraceptive services also influenced service orientation, with Madlala et al. (2018) finding male nursing students in South Africa felt left out of reproductive health programmes and Kriel et al. (2019) finding South African health providers referred to a sole focus on women. As a result, men in Swaziland (Ziyane and Ehlers, 2007) and across sub-Saharan Africa (Vouking et al., 2014) complain that family planning services are not male-friendly. This orientation of services also influenced how condoms were positioned, with Maharaj and Cleland (2006) finding male and female students in South Africa preferring not to seek condoms at the health facility, and Kraft et al. (2009) finding fears in Botswana that condom use will erode gains in family planning. Concomitantly, Maharaj et al. (2012: 444) argue that family planning services in sub-Saharan Africa “have done little to legitimise condoms as a respectable method of dual protection.” There appears to be limited research on the challenges men experience using such services in Southern Africa – such as structural barriers which have been documented in East Africa (Kaida et al., 2005; Onyango et al., 2010) – or how family planning providers view male involvement.

2.3.7 Intervention research with men to increase contraceptive use

Interventions on male involvement in Southern Africa remain limited. Vouking et al.’s (2014) review of studies on male involvement in family planning decision-making in sub-Saharan Africa identified seven programmes, one of which was in Southern Africa (Malawi). Hardee et al.’s (2017) review of interventions reaching men as contraceptive users identified two within Southern Africa (Malawi and Mozambique). Both authors highlighted the limited, or missing, evaluation data among many interventions (ibid.). Vouking et al. (2014) also highlighted the different definitions used for male

involvement across studies, which was also evident from the literature retrieved in this review, which can create difficulties in making comparisons.

2.3.8 Methodological approaches and gendered framing of literature

A greater proportion of the country-level literature used qualitative methods, with only three studies found using mixed methods. Single forms of qualitative data (focus group discussions or in-depth interviews) were most common. Multi-country studies largely analysed DHS data, with no accompanying in-depth country analysis, which can be limiting given the constraints of some DHS measures (DeRose et al., 2004). Papers largely relied on women's reports of men's behaviour rather than men's own reports (also attributable to using DHS female data only). The majority of papers focused on the individual level, with limited focus on the community or structural level (such as health provider attitudes). As noted, several papers provide combined rather than disaggregated male and female method use reports, which limits understanding given reported differences. Most research was in an urban/peri-urban setting.

The papers presented a mixed picture in terms of gender framing. Among some, gender was used solely to describe biological sex. Several papers explored men's influence as it related to contraception, but not male gender roles or norms. Koster et al. (2015) acknowledged male gender and power norms, but how these related to their findings was not explored. Mejía-Guevara et al. (2020), while seeking to increase understanding on the impact of gender norms at the community level, did not distinguish male and female norms in their quantitative measure nor analyse their findings in terms of the social production and construction of masculine norms. The most comprehensive masculinities lens was employed by Chikovore et al. (2002) and Swartz et al. (2018), both of whom explored the construction of masculinities and gender power dynamics and discussed their findings in relation to those. No study employed Connell's hegemonic masculinities theoretical approach to specifically explore male involvement in male and female contraceptive methods and family planning.

2.4 Findings from Malawi

2.4.1 Overview of Malawi literature

There is a growing research base on family planning and contraception in Malawi, and my scoping suggested there to be at least three times more published papers specifically on women's behaviour in relation to this topic than men. While there has been a growth in couple or relationship-based research on contraception, my review found that men's inclusion in Malawi was often as default partners rather than programme beneficiaries in their own right, or as secondary research participants whose views and motivations were not specifically explored, and as such, women's reports of men's behaviours are used as proxy for men's (Palamuleni, 2013). Only one specific research study on male involvement in contraception was retrieved, focused on Central Malawi, using only qualitative methods (Dral et al., 2018). No study was retrieved specifically dedicated to male methods. This overlooking of men's roles in the Malawi family planning literature has been noted by researchers (Vouking et al., 2014), and the limitations it poses in being able to elucidate broader social and cultural understanding of contraceptive use (Palamuleni, 2013). Reflecting the Southern Africa literature, much of the research retrieved about men's gendered behaviours and masculinities in Malawi had a primary HIV focus, which I reference below, and provided important insights that I draw upon in this thesis. Only one intervention in Malawi has focused on male involvement to date (see below) with several interventions exploring engaging men in PMTCT (Sternberg and Hubley, 2004) and in antenatal or maternity care and childbirth (Aarnio et al., 2009; Kululanga et al., 2011, 2012a) but not looking at men's engagement in contraceptive use.

2.4.2 Men's contraceptive use in Malawi

The Malawi DHS 2010 found 42% of married men and 55% of unmarried sexually active men reported using a contraceptive method at last sexual intercourse (NSO and ICF, 2011). Among married men, 91% reported using a female method, particularly the injectable (21% of all married men), 8% reported using the male condom and 1% male sterilisation. Among

unmarried men, 50% reported the male condom as their contraceptive method, and 0.2% sterilisation. Men's use was almost exclusively modern methods, with only 3% and 1% of married and unmarried men respectively reporting using traditional methods. A limitation of this DHS data is that men's method use was asked for within the sexual activity part of the survey (section 4), not the contraception component (section 3), and therefore reports use at last sex, as opposed to use in relationships. This compares to women being asked detailed questions about their current method use in relationships within the survey's contraception section.¹² The 2015 Malawi DHS did not include equivalent data on men's contraceptive use.

Empirical research in Malawi finds a mixed picture on men's contraceptive use, reflecting the regional literature, and points to challenges in interpreting such reports. The IMAGES Malawi-wide research (2014), on which this study builds (see chapter 3), found 73.5% of men in relationships reporting current use of contraception with their partner (Zamawe et al., 2014). Qualitative research suggests potentially lower use, with Chipeta et al.'s (2010) focus group discussions with men and women in the Mangochi district of Southern Malawi finding that the majority were not using any method (though any sex differences were not made explicit). Among users, the most commonly-reported method was the injectable for women and male condoms for men (ibid.). Dral et al. (2018) later found husbands expressing that only their wives use (female) methods and they do not use any male methods. Studies also point to discrepancies in reporting, with Miller et al.'s (2001) husband-wife surveys finding men were more likely to report greater contraceptive use than their wives, and that this difference was further pronounced in the Southern region.

On condom use, more empirical studies explored men's gendered use solely in the context of HIV (such as Kaler, 2004a; De Walque and Kiline, 2011), reflecting the regional literature, and were beyond the focus of my review. Within the Malawi DHS, men's use of condoms in the last 12 months is also

¹² Men and women's contraceptive reports in DHS are therefore not comparable, and they arguably measure different sexual behaviours (last sex versus in relationships).

only measured within the HIV/AIDS section. No specific study (beyond DHS above) was found measuring Malawian men's use of condoms as a contraceptive method. In terms of consistency of condom use, a multi-country study among adolescents found only 27% of 18-19 year old Malawian men (exact region not specified) reporting consistent use of condoms during sex in the last three months (Bankole et al., 2007). The authors also found men in Malawi with higher education were more likely to report ever using condoms than men with no education (ibid.). Low levels of consistent condom use among Malawian men has similarly been documented in HIV research (Haddad et al., 2018).

2.4.3 Malawian men's contraceptive knowledge and attitudes

Men's knowledge: The most recent Malawi DHS reports the mean number of methods known among men aged 15-49 as 9.8 (NSO and ICF, 2017). The female condom and injectable were the best-known female modern methods (with 94% and 91% of men having heard of them, respectively). While 99% of men had heard of male condoms, only 69% had heard of male sterilisation (ibid.). Other studies in Malawi found equally high levels of knowledge of contraception among men (with the exception of male sterilisation) (Chipeta et al., 2010). The literature also suggests men's knowledge may have improved, as earlier research finds Malawian men to have lower levels of contraceptive knowledge than women (Kalipeni and Zulu, 1993; Bisika, 2008).

Mirroring the Southern African literature, in-depth analysis of men's understanding finds a more nuanced picture. Dral et al. (2018) found that, while men could name methods, they did not know how they work and often had misconceptions. Similarly, Self et al.'s (2018) qualitative research found male youth, 15-24 years, in Malawi more likely (than female youth) to express contraceptive misconceptions (for example that using methods cause sterility, illness and cancer). The gendered acquisition of knowledge was also found to be important, with Paz-Soldan's (2004) qualitative research with couples in South-eastern Malawi finding that men learn about contraception indirectly, based on observing others' behaviour, whereas

women's knowledge was based on actual discussions about contraception with other women. Dral et al. (2018) further found older men to be more knowledgeable on contraception due to their direct experience. These findings suggest that gendered behaviour has a considerable effect on the learning and spread of contraceptive information. Both Furnas (2016) and Dral et al. (2018) also assert that knowledge does not always translate directly into contraceptive practice for men in Malawi.

Men's attitudes: The IMAGES Malawi-wide study found men to be well aware of the importance of their partner using contraception (Zamawe et al., 2014), which was mirrored by Dral et al.'s (2018) qualitative research in the Central region. Shattuck et al. (2011) found men want to participate more in contraceptive processes, referring to their concern for the health and welfare of their families. A key reason for Malawian men's support for contraception has been found to be economic, with Shattuck et al.'s (ibid.) study also indicating that concerns about the financial burden of many children were particularly persuasive in changing Malawian men's attitudes towards contraceptive use.

Despite these positive attitudes, men in Malawi report significant concerns about female contraception. Both Ntata et al. (2013) and John et al. (2015) found that men expressed concerns about the side effects of hormonal contraception, including bloating, weight gain, and prolonged bleeding, which had a strong influence on their negative attitude to contraceptive use. A salient concern among Malawian men in multiple studies related to a prolonged menstruation period due to women taking the injection, limiting time available for sex (Chipeta et al., 2010; John et al., 2015; Bernstein et al., 2020a). Men further appeared to believe they themselves directly experienced side effects from female methods, such as impotence (Chipeta et al., 2010). Reported positive attitudes among men may also differ to their actual behaviours; Bornstein et al. (2020a) found that while men in Lilongwe see themselves as supportive of contraceptive use, women conversely frequently discussed men as barriers.

On condoms, research finds Malawian men to regard this method as for prevention of disease rather than pregnancy (Paz-Soldan et al., 2007; Chipeta et al., 2010; Ntata et al., 2013). As Bisika (2008: 80) notes, “The dual protection aspect of condoms has not been taken advantage of in many communities [in Malawi] and in general is not a popular family planning method.” Furnas’s (2016) qualitative research on relationship-level family planning trajectories in the South similarly found both condom use and dual protection to be rare. The author (ibid: 218) found condoms were “not a permanent tool that couples turn to for family planning; rather it is a transient solution employed in short-term relationships”, reflecting the unstable nature of its use. Condoms have also been associated with blisters and sores on male genitalia (Chipeta et al., 2010). HIV-specific research with men on acceptability of condoms, such as Anglewicz and Clark (2013), reflects the aforementioned research bias by focusing on condoms as solely for disease prevention.

Malawian youth expressed more positive attitudes towards condoms while couples expressed reservations. Self et al. (2018) found a preference for condoms over other methods among Malawian youth due to perceived side effects, though it was unclear if this was both male and female youth (as only females were quoted). In research with married couples, Chimbi’s (2007) mixed method study found the use of condoms to be unacceptable within marriage, which was mirrored by Bankole et al.’s (2007) research. A key reason is condoms being indicative of mistrust (Tavory and Swidler, 2009). Given that condoms are seen as primarily for disease prevention, men are supportive of their use during extra-marital or casual sex for the purposes of preventing HIV infection, but not in established relationships (Chimbi, 2007; Tavory and Swidler, 2009; Ntata et al., 2013). No specific research appeared to explore the potential contradictions relating to the pervasive perceptions among men that condoms are for HIV prevention while a large number of unmarried men report condom use as a contraceptive method in DHS.

Reflecting the almost non-existent use of vasectomy, I found no dedicated research focus on Malawian men’s views on this method. One study

exploring general perceptions on contraception found both men and women describing sterilisation as “self inflicted disability” (Ntata et al., 2013: 4). John et al. (2015) found objections to vasectomy related to the importance of male fertility, as explored below, and some men also worried that male sterilisation would increase female infidelity.

2.4.4 Men’s gender norms and contraception in Malawi

Reflecting the Southern African literature, the empirical research on male gender norms and contraception in Malawi remains overall limited, and much of this research is more than 20 years old. The research retrieved suggests male norms have an important influence on contraceptive behaviours, though several gaps remain in understanding. Several scholars explore men’s gendered behaviours principally in the context of HIV (such as Kaler 2003, 2004b; Dancy et al., 2006; Izugbara and Undie, 2008; Anderson, 2015; and Haddad et al., 2018).

Contraceptive communication: Studies in Malawi point to challenges around couple communication. As part of the only rigorous intervention to date focused on men and contraception in Malawi, The Malawi Male Motivator project, in Mangochi, Southern Malawi, Shattuck et al. (2011) – which was also identified in Vouking et al. (2014) and Hardee et al.’s (2017) aforementioned multi-country reviews – found more than one third of women had never spoken to their husbands about contraception. Similarly, Chipeta et al. (2010) found the reasons many married women had not done so was fear of physical violence from their husbands, and that they viewed contraception as a women’s matter and believed their husband wanted to have children. Poor communication was also compounded by men regarding women as responsible for initiating discussions on contraceptive use, while concurrently perceiving contraception communication to be a waste of time (ibid; Ntata et al., 2013). There was limited research identified exploring the impact of male peer group discussions on contraception (equivalent to the regional research). Paz-Soldan et al. (2012) analysis of social groups in Mangochi, Southern Malawi, found no association between men’s participation in social groups and their contraceptive intentions or use, while

this association existed for women's contraceptive intentions. The authors attributed this to the matrilineal system in the South (see chapter 4), which may lead women to have stronger communities than men (ibid.).

Improving couple communication was found to be critical for increasing contraceptive use. Palamuleni's (2013) analysis of DHS female data found that women's current method use in Malawi was directly related to the frequency of discussions between partners, with women who had never discussed contraception with their spouses four times less likely to be users than women who had done so more than twice. Ntshebe (2011) found women discussing contraception with their spouses to be over six times more likely to be users. The Malawi Male Motivator project, which used peer-led couple education, led to greater ease and frequency of communication between couples and was found to be a significant predictor of contraceptive uptake (Shattuck et al., 2011). The authors argue that addressing men's opposition to contraception through improved communication may be more effective than focusing on increasing men's knowledge (ibid.). No research in Malawi appears to have specifically explored the interplay between contraceptive communication and dominant masculine norms and how this may potentially impact on contraceptive use.

Decision-making: The literature identified Malawian men to have an important role in contraceptive decisions. The most recent Malawi DHS found 80% of married female users reporting that contraceptive use is a joint decision between husband and wife (NSO and ICF, 2017). Palamuleni's (2013) broader analysis of married women's reports in DHS found significant associations between women's contraceptive use and the approval of their spouse, with women whose husbands approved of contraceptives three times more likely to use methods than women whose husbands disapproved. No specific quantitative research appears to have used data from men themselves to measure their potential impact on contraceptive decisions.

A number of qualitative studies reinforce men's decision-making role, though also point to women having forms of agency, including accessing methods

secretly. Dral et al.'s (2018) research in Central Malawi found men to be the main decision-makers around method use, as well as method type and number of children. This was supported by research with Malawian women and their male partners, where men's explicit approval or objection was key to women using the IUD in Lilongwe (Bryant et al., 2015) and to using methods in general in Southern Malawi (Chipeta et al., 2010). Men's perceived refusal was also found to be a major reason for women not using methods (ibid.). Given men's influence, improvements in shared decision-making through greater couple communication in Southern Malawi have directly contributed to contraceptive use (Hartmann et al., 2012). Mbweza et al.'s (2008) earlier analysis of cultural scripts in Southern Malawi also supported the value of encouraging shared decision-making, but challenged the notion of husbands always dominating and wives always being powerless. While men were found to prevail in decisions on sexual relations, the authors found contraception was an area where women dominated decision-making or both husband or wife were involved in final decisions (ibid.). Despite men's decision-making authority, the literature finds many women may use methods secretly (Gipson et al., 2010). Indeed, a consistent finding was that one of the reasons for Malawian women's preference for the contraceptive injection is that it is easy to hide from their partner if they don't have spousal support (Bisika, 2008; Chipeta et al., 2010; Ntata et al., 2013; Anderson, 2015). Other than focus group discussions (Chipeta et al., 2010) no further qualitative analysis in Southern Malawi has been undertaken with men on their decision-making behaviour around contraception. There also appears to be limited analysis on the interplay between decision-making dynamics, women's covert use and dominant masculinities, and how this may impact on contraceptive use.

Concurrent with the literature in Malawi on men being involved in contraceptive communication and decision-making, Gipson et al.'s (2010) qualitative research with married couples asserts that men and women in Malawi mostly view contraception as 'ndizachizimayi', a Chichewa term meaning 'strictly for women'. Self et al.'s (2018) qualitative research with youth, 15-24 years, on their use of reproductive health services found girls

(more than boys) in Malawi to believe they had to bear the responsibility of unintended childbirth. There appeared to be limited analysis on perceptions of responsibility for pregnancy prevention among men, as documented in the broader regional research.

Fertility norms, breadwinner and contraception: An assessment of family size preferences in Southern Malawi among married women and their partners, found that wives may adapt their reproductive aspirations depending on the perceived wishes of their husbands (Yeatman and Sennott, 2014). A similar study in Northern Malawi, however, found both husband and wife were equally influential in the future probability of childbearing. Though this equal influence primarily applied when both partners wanted to cease rather than postpone childbearing, the authors note that it may challenge the perception of women being powerless should men have differing fertility preferences (Machiyama et al., 2015). The most recent Malawi DHS suggests a convergence of fertility desires among men and women, though women still desire to have fewer children (NSO and ICF, 2017). Men's future fertility desires, particularly should they remarry, were found by John et al. (2015) to be a particular concern men in Malawi's Central Region had with respect to vasectomy. No further research was retrieved exploring the salience of male fertility norms on contraceptive use, including no such research with men themselves in Southern Malawi. Though men's breadwinner role is fundamental to their identity (Anderson, 2015), no research was also retrieved exploring how this role may impact on their contraceptive behaviours, such as Sileo et al. (2017) has explored in Uganda.

The literature also found infertility in Malawi challenges masculinity (Bornstein et al., 2020b) and is seen as disrupting men's marriages, status and fatherhood identity (Parrott, 2014). Research in Central Malawi found that infertility-related stigma, and men's concerns about upholding their masculinity, impacted decisions around contraceptive use (Bornstein et al., 2020b). Earlier research with men and women in Southern Malawi found a barrier to contraceptive use was the association between contraception and long-term infertility (Ntata et al., 2013).

Norms of sexual pleasure and women's infidelity and contraception:

Literature on men's sexual behaviours in Malawi, including on multiple concurrent partners, has a predominant HIV focus (such as Paz-Soldan et al., 2007; Poulin, 2007; Clark, 2010), and data on these behaviours in DHS are only collected as part of the HIV behaviours section. Similarly, studies on male sexual pleasure in Malawi have a predominant HIV focus (Ngalande et al., 2006; Woodsong and Allemen, 2008; Shacham et al., 2014; Anderson, 2015). As noted, this was beyond the focus on my literature review. To date one study using focus group discussions in Central Malawi by John et al. (2015) has focused explicitly on the links between men's perceptions of sexual pleasure and contraceptive use. These authors found that any perceived changes in sexual pleasure among respondents or their partner "created a formidable barrier to contraceptive use or promoted contraceptive discontinuation." (John et al., 2015: 99). Contraception that limited the quantity of sex desired were deemed as impractical, with men speaking of how methods necessitating periodic abstinence due to reported side effects were likely to fail (ibid.). Chipeta et al.'s (2010) focus groups with men and women found similar abstinence concerns were a disincentive among men for method use. John et al. (2015) further found withdrawal was perceived to break the flow of sex, rendering prolonged sexual enjoyment difficult, and male sterilisation was associated with reduced sex drive, an inability to perform sexually, and embarrassment. Research with women and their male partners in Lilongwe (Bornstein et al., 2020a) and with Malawi youth in Central and Southern Malawi (Self et al., 2018) both found concerns among men on how contraceptives would weaken their libido and impact sexual pleasure. A significant barrier for condom use in Malawi is that it does not allow the mixing of fluids, seen as the signifier of ultimate sexual pleasure (Tavory and Swidler, 2009). Reflecting the Southern Africa literature, John et al. (2015) also found men viewed women who used contraception as promiscuous, an area arguably worthy of greater consideration in Southern Malawi.

The review did not retrieve any studies exploring the linkages between norms of male stoicism and contraception, such as how Chikovore et al. (2014, 2015) and Anderson (2015) have explored these areas in the context of tuberculosis and HIV respectively.

2.4.5 Men's engagement in contraceptive services in Malawi

The literature identified barriers to men's engagement with contraceptive services, though no dedicated studies explored this issue in equivalence to how Dovel et al. (2020) looked at barriers to Malawian men using HIV services. Dral et al. (2018) found Malawian men to be too shy or ashamed to go to contraceptive services. Gipson et al. (2010) argue that men are found to rarely seek health services in Malawi, particularly due to losing out on earning opportunities, creating low attendance among men that feeds a sense that men who go to services will stand out and be stigmatised. Poor health care providers' attitudes towards fathers in Malawi have been found within maternal health services (Kululanga et al., 2012b) but the views of health providers towards male involvement in contraception does not appear to have been documented. Gipson (2010) asserts that home-based sexual health services for men and women in Malawi provide a potential entry point for engaging men, though a pilot of combined home-based HIV and contraceptive services led to no significant impact on men's behaviour (Becker et al., 2014).

2.4.6 Methodological approaches and gendered framing of literature

The Malawi literature review found almost twice as many qualitative as quantitative studies. Two studies used mixed methods, one on condom use in marriage (Chimbiri, 2007) and one on couple communication (Shattuck et al., 2011). Only one study used multiple forms of qualitative methods (Bornstein et al., 2020a). No studies to date have used observational methods or asked the views of women in communities (as opposed to service users) when exploring issues of male involvement in contraception. Men were most commonly reached as couples, identifying a gap in research with unmarried younger men (with the exception of Self et al., 2018). Most research focused on the individual level, with no specific research exploring

healthcare providers' and broader stakeholders' views on male involvement in contraception. Differences between male and female responses were occasionally not disaggregated or sufficiently clear (such as Self et al., 2018; Chilinda et al., 2020). Studies included all three regions of Malawi and both urban and rural settings.

Many papers on Malawi did not perceive men as gendered or used gender as the term for biological categories. Paz-Soldan et al. (2012) and Bornstein et al. (2020a) explored differences between men and women's behaviour, and Shattuck et al. (2011), Hartman et al. (2012) and Mbweza et al. (2018) acknowledged male gender and power norms, but how men or women may condone or challenge masculine norms was not explored by these authors in their research findings. Gipson et al. (2010) more comprehensively discussed the construction of masculinities and gender power dynamics and explored their findings in relation to these. Similarly, Parrott (2014) and Bornstein et al. (2020b) both provide an in-depth analysis of masculinities as it relates to infertility, though this does not explore contraceptive methods. There was no explicit framing of research on male involvement in contraception using Connell's hegemonic masculinities theoretical approach.

2.5 Gap this thesis addresses

In light of the above review, my study will add to both the Malawi and Southern Africa literature around the relationship between men's gendered attitudes, norms and behaviours and family planning and contraceptive use. It will build on, and engage with, the existing body of HIV literature in Southern Africa, including Malawi, which provides significant insight into masculinities. I believe my study can contribute to knowledge in the following areas:

- Understanding how men's gender and contraception are both constructed and operationalized in Malawi.
- Exploring the influence of hegemonic masculine norms on contraceptive use and family planning, using Connell's framework.

- Foregrounding the voices of men themselves in communities in Southern Malawi, in terms of their own biases, contradictions, challenges, decisions, barriers and motivations as they relate to contraception and family planning.
- Understanding the relationship between masculinities, gender equality, communication and decision-making and women's reproductive autonomy in the context of contraception use, and adding new insight into men's views on responsibility for pregnancy prevention and how the changing dynamics within relationships on contraceptive uptake impact men's sense of manhood.
- Adding to the current literature on how male norms around being the breadwinner, strength, stoicism, fertility, sexual pleasure and conceptions of women's promiscuity may influence men's approach to contraceptive use.
- Adding to extant knowledge on condom use among men as a contraceptive method, particularly outwith married couples.
- Adding insight around men's use, views and behaviours regarding vasectomy
- Understanding how men view and experience contraceptive services, and the perspectives of health providers and stakeholders towards men's involvement (thus going beyond solely focusing on the individual level).
- Providing the first known mixed methods study exploring a breadth of questions on men's involvement in contraception and family planning in Southern Malawi, including through the use of multiple qualitative methods, beyond solely focus group discussions or in-depth interviews.

2.6 Summary

This chapter has explored the existing literature on men, masculinities, contraception and family planning, for both Southern Africa and Malawi, finding male gender norms to be an important influence on male involvement. Several gaps in the literature were identified, particularly in Malawi, in the context of which my study aims to contribute to existing knowledge. The next chapter will discuss the methodology I used for my

research, including my analytical framework informed by this literature review.

Chapter 3: Methodology and Research Principles

3.1. Introduction

In the last chapter, I reviewed the literature on men, masculinities, contraception and family planning in both Southern Africa and Malawi, and identified a gap in knowledge which this thesis seeks to address. The literature review also informed my methodology, particularly the limited use to date of mixed methods research and of multiple forms of qualitative methods.

This chapter provides an overview of my methodological approach and research principles. I begin with my rationale for using mixed methods, followed by a snapshot of each method used and my study setting. I then summarise my role and the principles of my research. I undertook my study in three phases, and I outline the data collection instruments and procedures for each of those phases. I then discuss quality control and ethical considerations, followed by my data entry and analyses procedures. I explore my approach to data prioritisation, mixed method integration and my analytical framework. I conclude with considerations of my position as the researcher.

3.2 Rationale for mixed methods and overview of methods and setting

3.2.1 Introduction and rationale for mixed methods

Mixed methods research “involves collecting, analyzing, and interpreting quantitative and qualitative data in a single study...that investigate the same underlying phenomenon” (Leech and Onwuegbuzie, 2009: 265). As Tariq and Woodman (2010) note, its central feature is the application of *both* quantitative and qualitative methods.

Both of these methods have advantages and disadvantages. Quantitative research is perceived as more reliable and objective, more generalisable, and allows for an exploration of the relationship between variables. Nevertheless, it is limited in its ability to focus on contextual factors that

assist in interpretation of results or variations in human behaviour (Denscombe, 2014). Qualitative research, Kaler (2004b) argues, is an essential method for understanding many of the ideas and concepts which underlie behaviour, and which cannot be sufficiently captured in pre-set categories within quantitative instruments. However, its limitations include that it is arguably more easily influenced by researchers' personal bias and it is more difficult to maintain, assess and demonstrate rigour (Denscombe, 2014).

The collection, analysis and combination of data from these two designs, using a mixed methods approach, into one study provides a more complete understanding of a research problem (Creswell, 2002). A mixed methods approach also enables comparison of findings to improve accuracy, and to investigate separate components of the same overall question (Denscombe, 2014). My interest in using mixed methods was to comprehensively explore and triangulate data on male involvement to answer each of my three research questions.

I used a sequential approach, beginning by analysing quantitative data followed by collecting and analysing qualitative data. As Hulme (2007) notes, sequencing is probably the most frequently used mixed methods approach. This was both for design and pragmatic reasons. I used an 'explanatory sequential' mixed methods design (Tariq and Woodman, 2010), which allowed analysis of the quantitative data (phase 1, see below) before beginning the qualitative research (phases 2 and 3). This enabled my qualitative research to explore 'why' and 'how' questions generated by the quantitative data (ibid.) and therefore deepen my understanding of the associated contextual factors. The funding was first secured for the quantitative survey. I then undertook the follow-up qualitative research once I was able to secure additional funding.

As part of the iterative process of my research (see below), phases 1 and 2 identified the need for additional research at health facilities themselves, and therefore during phase 3 I undertook further concurrent quantitative research

(collecting client service statistics) while completing additional qualitative research in these health facilities. This reflected my desire to mix methods to expand my breadth of inquiry (Greene et al., 1989) and better respond to my final research question on men's use of contraceptive services.

3.2.2 Overview of research methods and timeline

Table 1 below provides an overview of the methods used within each research phase, the related instruments, outputs included in the thesis, who undertook the research, language used – English or Chichewa, Malawi's national and most widely spoken language in the South (NSO, 1998) – timeline and funding sources.

Table 1: Snapshot of Research Methods by phase and timeline

Method	Instrument	Outputs for thesis	Undertaken by	Language	Timeline	Funding source
Phase 1: Quantitative International Men and Gender Equality (IMAGES) survey						
Household based questionnaire with men	IMAGES survey	417 male questionnaires in Southern Malawi	PACHI (I provided oversight)	Chichewa	April-Nov 2013 ¹³	Swedish International Development Agency
Phase 2: Qualitative research						
In-depth interviews (IDIs) with men	Interview guide, demographics sheet, summary	40 interviews & demographics; 40 summaries	Research Assistants (RAs). I provided oversight	Chichewa	July – Dec 2014 ¹⁴	University of Cape Town (UCT), South Africa Scottish International Education Trust
Focus Group Discussions (FGDs) with men	Focus group guide, demographics sheet	4 FGDs & brief demographics (48 participants); 4 summaries	RAs (I provided oversight)	Chichewa		
FGDs with women	Focus group guide, demographics sheet	2 FGDs & brief demographics (32 participants); 2 summaries	RAs (I provided oversight)	Chichewa		
Health Providers interviews	Interview guide, demographics sheet	26 interviews & brief demographics	Myself	English		
Key stakeholder interviews	Interview guide, bespoke questions, demographics sheet	12 interviews & brief demographics	Myself	English		
Community observation	Notes	Research diary entries	Myself	English		
Informal conversations	Notes	Research diary entries	Myself	English		

¹³ This timing of Phase 1 was dictated by the donor funding in which this research was a part

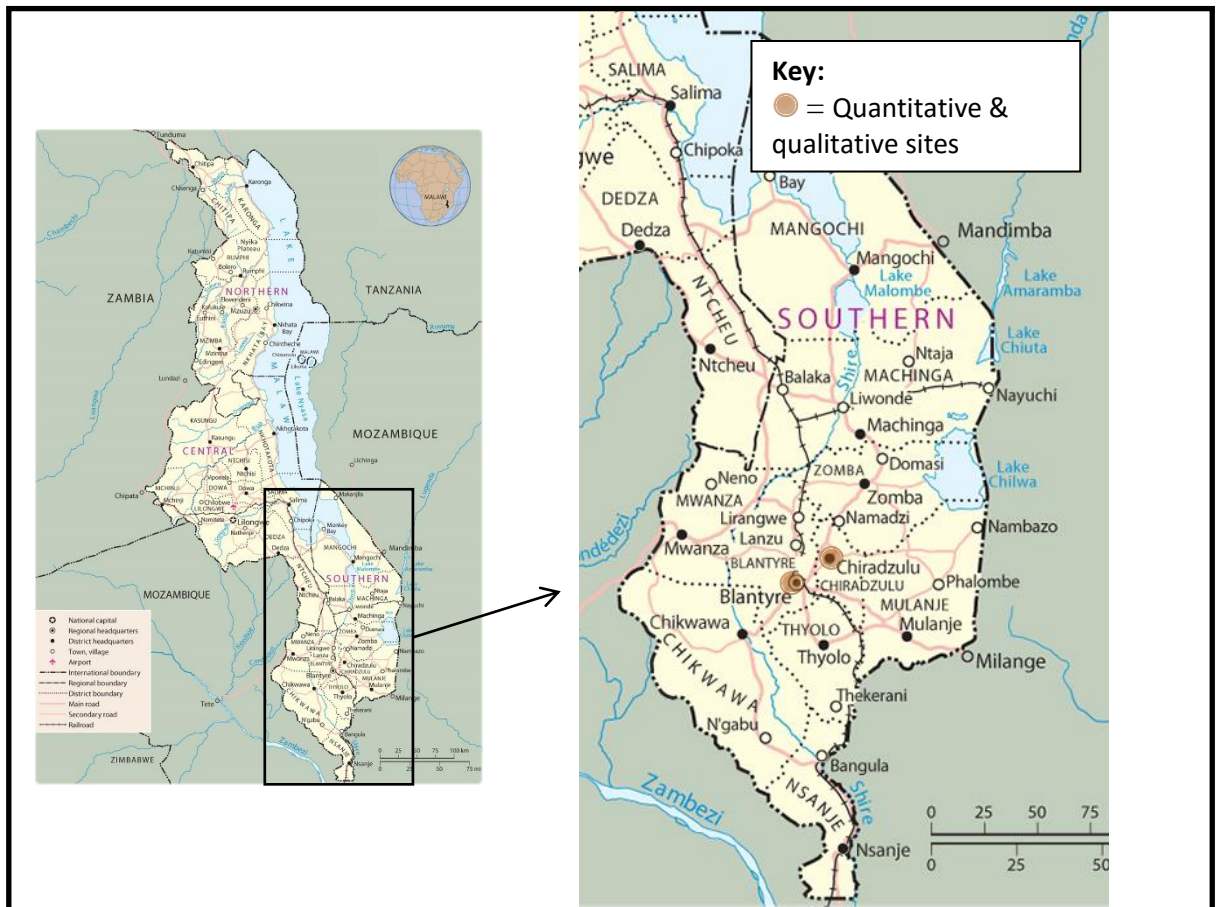
¹⁴ Phase 2 and 3 timing were reliant on me securing grants to cover the separate associated research and living costs

Phase 3: Qualitative and quantitative research						
Clinic observation	Template	27 observational sessions	Myself	English	July-August 2015	Follow-up funding from UCT, South Africa
Rapid male client interviews	Template	Not included. From 37 interviews, no male contraceptive client	Myself & RAs	English & Chichewa		
Secondary male client data from health facilities	Data matrix	16 clinics	Myself & RAs	English		
Community and national dissemination of preliminary findings	Summary of initial results	4 community meetings, meetings in Lilongwe and radio show discussion	Myself & RAs	English & Chichewa		

3.2.3 Locations in Malawi: Blantyre and Chiradzulu in the South

The sites for all phases of my research were in Southern Malawi, covering communities within both Blantyre (urban) and Chiradzulu (rural). The Phase 1 research was a national survey, from which I extracted data from the Southern region. The map on the right in Figure 4 below highlights the specific sites where I collected my quantitative and qualitative data.

Figure 4: Map of Malawi and Southern Malawi



3.3. Role of candidate

This section describes my role in each of the research phases. For phase 1, the IMAGES survey was part of a grant I secured from the Swedish International Development Agency (Sida) while employed at the NGO Sonke Gender Justice (Sonke) in South Africa and concurrently doing my PhD.¹⁵ Sonke allowed me to combine this survey with my PhD and relocate the research to Malawi to do so (as noted in chapter 1). I sub-contracted PACHI in Malawi to



Figure 5: IMAGES data collection team

undertake this research, given their connection to University College London (UCL), and oversaw the implementation of their work at all stages of the research, together with the local IMAGES Co-ordinator, Dr Collins Zamawe. IMAGES included both a male and female survey. I spent extended periods of time in Malawi during phase 1, including making three trips to co-facilitate the training of data collectors, be present in the field during data collection (see figure 5), co-facilitate the training and oversight of data entry staff and to support the development of the data entry database (each of which I detail below).

For the purposes of my PhD, I added a specific question to the IMAGES male survey prior to data collection on contraceptive use (which is not part of the standard questionnaire). I then created a separate Southern Malawi male dataset which I refined and analysed (see below). I did not work on the Malawi-wide male dataset, or the female dataset.

I was solely responsible for phases 2 and 3 of my research, including the research design, development of tools and implementation. Once I secured the

¹⁵ Neither Sida nor Sonke had any direct involvement in my research or choice of data for this PhD.

necessary funding,¹⁶ I left my employment in South Africa and relocated to Blantyre. While at Malawi-Liverpool-Wellcome Trust (MLW), I was provided with ongoing support from my supervisors and advisors at UCL, MLW¹⁷ and University of Cape Town (UCT), with whom I shared regular updates and sought feedback. I presented my research plans at both MLW and UCT, and also held a range of meetings in Malawi with students, academics, NGOs, UN agencies and donors to receive their feedback (please see a list of those in appendix B). I decided on semi-structured tools and observation as the primary qualitative methodologies, given my desire to deepen understanding of the emerging themes from phase 1, and sought to adopt an innovative and iterative approach to my qualitative research.

I recruited two Chichewa-speaking male research assistants (RAs) for the qualitative research, both of whom had been data collectors during the IMAGES study. I also recruited three Chichewa speaking transcription and translation (T&T) staff, who became based at MLW. In addition, I appointed three Chichewa speaking female research assistants based at MLW for my female



Figure 6: Qualitative male RA and the T&T staff

focus group discussions (FGDs).¹⁸ See figures 6 and 7. I provided one-day training to all these RAs, which was more in-depth for the male RAs given the multiple methods of data collection with men. I observed the first in-depth interviews (IDIs) by both male RAs (with the approval of the interviewee),

¹⁶ The qualitative research was funded by the South African Social Science and HIV programme (SASH) at University of Cape Town (UCT). SASH/UCT did not have any direct involvement in research implementation. SASH was a partnership with Brown University.

¹⁷ At MLW I was based in the Social Sciences Team, under the direction of Dr Nicola Desmond.

¹⁸ Names are as follows. Research assistants Joseph Mpimphila and Gospel Kanyama; Translation and Transcription Staff Sunganani Mtonga, Maxwell Khawela and Mwiza Sambo; and female Research Assistants Charity Gunda and Bernadetta Payesa.

following which I gave feedback (particularly on body language and probing). Being present also gave me insight into the context of the interviews.

I was together with the RAs throughout the fieldwork, though not in interview rooms/spaces. This enabled me to undertake a debrief with the RAs on emerging issues immediately following each interview, particularly on the basis of their written interview summaries (see below), and to spend time in the communities observing. Given the



Figure 7: Qualitative female RAs with local chief in Chitera

distance of some rural locations, we would often stay together in local guesthouses while undertaking the research. At specific points during the fieldwork I brought the whole research team together to discuss and reflect upon the emerging results, explore cultural nuances and areas that were unclear to me. This process also became a form of internal validation. I conducted and transcribed all the health provider and stakeholder interviews and created the clinic observation and client data tools based on emerging results and existing MWL tools (see below). I decided to hold dissemination meetings, and developed the outputs for this, re-employing the RAs to support the process. I undertook all qualitative data coding and analysis, and data integration (quantitative and qualitative) and analysis, details of which are below.

3.4 Principles of research

A number of principles were important to me as I undertook this research. Firstly, the need to look at what is done as well as what is said. Discourse analysis (Shaw and Bailey, 2009) helps to provide meaning to what people say, though does not explore their broader actions. By undertaking observations, and collecting secondary client data on behaviours, I was able to capture nuance,

better understand lived realities, and to explore connections between what men told me and how they actually behaved.

Secondly, it was important to me to listen to voices ‘on the ground’ in Malawi and their own opinions on the research topic. In the geopolitics of knowledge, intellectual ‘wisdom’ is often perceived to be housed solely within the global North (Connell, 2014). Accordingly, it was important to me to share my findings first within the research communities, reflecting my concerns about global North “extraversion” (Connell, 2014: 1). A concept developed by Connell (ibid.), extraversion reflects data from research undertaken in the global South being solely extracted to the global North and not informing the context from which it is taken. Connell (ibid.) argues this process then reflects how knowledge is constructed and shared, which can lead to scholars of the global South being marginalised and reinforcing the perception of ‘wisdom’ being housed within the global North (ibid.). The dissemination meetings I held were a reflection of my desire to feed back my research findings, to give back to the communities in exchange for the information they had made available for my research (Tubaro, 2019). My meetings with practitioners and policy makers in Malawi further reflected my desire to contribute to policy and practice.

Thirdly, I was speaking to men about their sexual behaviour, an intimate personal issue. Inherent in my approach is an assumption about what constitutes ‘responsible’ masculinities. While making a value judgement on the behaviour of these men, I am keen not to make a moralistic judgement. African men have often, whether advertently or inadvertently, been positioned as ‘bad’ men (Keeton, 2007) or inherently ‘promiscuous,’ particularly within the context of HIV (Hunter, 2005). In interpreting the voices of these men around sex, I do not wish to reinforce these moral positions and instead focus on the normative behaviours and not the individuals.

Fourthly, I sought to facilitate South-South¹⁹ linkages between MLW and UCT, including building connections between these academic institutions and writing a joint UCT-MLW research funding application. I also facilitated links between MLW and NGOs with whom I was in contact, such as Médecins Sans Frontières (MSF) in Malawi and Sonke. This was my attempt to contribute pragmatically to Southern perspectives (Connell, 2014) on practice during my research.

Fifthly, as I was learning and developing my own skills through my research, I was keen to support the capacity building of others, where applicable. The Executive Director of PACHI in Malawi, referring to the South-South nature of our collaboration during phase 1 (given IMAGES was being funded through a South African NGO), noted that he believed our work together had more broadly developed PACHI's capacity and had provided a model for other research projects. During phases 2 and 3, I also aimed to provide opportunities for my research team to build their broader skills, e.g. via training, enabling the T&T staff to sit in on FGDs to better understand this method, and supporting the RAs in securing further educational qualifications.

Finally, my approach to research acknowledges the co-production of knowledge (Pohl et al., 2010). As Jasanoff (2004: 3) says, "scientific knowledge, in particular, is not a transcendent mirror of reality. It both embeds and is embedded in social practices, identities, norms, conventions, discourse, instruments and institutions." Such co-production therefore exists between the researcher and participants, and between the doctoral student and research team. During phases 2 and 3 I sought to employ a collaborative approach to my research, engaging the research team not only as paid staff, but also as informants to my findings given their more direct understanding of the local context. In doing so, I was guided by the Participatory Research Framework developed by the Institute for Development Studies (IDS, 2010), which has been

¹⁹ South-South refers to developing countries working together to find solutions to common challenges

previously applied in Malawi (Stackpool-Moore, 2013). In Table 2 below I outline the key stages from that Framework, and how I sought to differ in my work from a more traditional approach.

Table 2: Adapted Participatory Research Framework, adapted from IDS (ibid)

Research stage in my Phase 2 and 3	Traditional approach	My research approach
Identifying research question	Researcher led	Researcher led
Development of approach	Researcher led	Researcher led, with refinement based on feedback with research team
Recruitment	Researcher led	Researcher led, with recruitment undertaken in Chichewa by RAs. I attended meetings with Chiefs, and as part of recruitment in the field. Where convenience sampling was used, this was informed by the research team
Entering community	Researcher led	Joint entrance into communities. Researcher introduced to community Chiefs by research team, who led those meetings. Researcher guided by research team
Data collection	Researcher led	Researcher led, with research team undertaking different elements (I undertook interviews in English; researcher team did interviews in Chichewa). Being present in the field gave me a better understanding of the communities that were being interviewed.
Data analysis	Researcher led	Researcher led, but informed by meetings with the RAs on my initial findings
Validation and dissemination	Researcher led	Initial plans discussed with research team and refined based on feedback

3.5 Phase 1: Quantitative Methodology

This section outlines the specific procedures for the quantitative research, including the instruments, sample size, and interview procedures.

3.5.1 Quantitative instrument and adaptation

My quantitative research used an anonymous household survey instrument called the International Men and Gender Equality Survey (IMAGES) (see appendix C), which was adapted to the Malawian context. The full IMAGES survey has been previously conducted in multiple countries on different continents (including across sub-Saharan Africa), though never in Malawi. It was

developed by the South African Medical Research Council, Instituto Promundo and the International Center for Research on Women. The survey covers several topics related to gender equality, including employment, education, household division of labour, attitudes towards gender equality, health related practices, sexual behaviour and use of GBV. The age range for the survey is 18-59 years old.²⁰ The survey instruments were designed to be relevant to men and women of different sexual orientations and practices, those in or not in relationships, and those with or without children.

The survey contains questions and Likert scales from a number of international sources. The primary one of interest for my study is the Gender Equitable Men (GEM) scale (Pulerwitz & Barker, 2008). The GEM scale has been used within surveys to assess men's support for a set of gender equitable norms (ibid.) and has been previously used to measure the relationship between male gender norms and SRH outcomes (Ghanotakis et al., 2016). A reduced version of the scale was used separately in Malawi in 2008 by Shattuck et al. (2011). My study employed the original 17 GEM scale items, covering areas related to gender norms including violence against women, masculinities, relationships with other men, domestic chores and household decision-making, sexual identity and relationships, and SRH (Levtov et al., 2014). Like other applications of GEM, I used a 3-point Likert scale (agree, partially agree and disagree).

The IMAGES survey was translated into Chichewa, and then each translated question was reviewed and reworked during the training workshop. A prior planning meeting with stakeholders was also held in Lilongwe in August 2012, which I attended. The survey tool was first pre-tested by PACHI in the town of Mponela in the Central Region.

²⁰ The lower age limit reflects the fact that 18 years old is the minimum age within WHO ethical standards for doing such research. Adolescents and teenagers also require a dedicated research focus.

3.5.2 Sample size calculation and sampling

The sampling process was undertaken at a national level, prior to my creation of the Southern Malawi specific dataset, and therefore I outline these processes nationally.

Sample size

The IMAGES male sample size in Malawi was 1,000 (417 for Southern Malawi). This sample size provided adequate statistical power to detect any relationships between explanatory variables within the target population. Based on the expected prevalence of men who display gender equitable attitudes – using previous IMAGES surveys (Barker et al., 2011) – and Malawi population figures, a minimum sample of 384 guaranteed that any proportion was estimated to be within plus or minus 5% of the true value, with 95% confidence (calculation using CDC Epi Info v7). The sample was from 50% urban and 50% rural areas. This total sample size, and geographical split, was on parity with prior IMAGES research (Barker et al., 2011). The survey did not seek to be nationally representative but to provide a picture of urban and rural Malawian men's attitudes, behaviours and experiences in selected locations. The inclusion criteria for the survey was men who self-identified as 18-59 years of age.

Sampling procedure

A multi-stage sampling procedure was used. Firstly, the country was divided into urban and rural. Two districts from the urban areas and three districts from the rural areas were randomly selected. Table 3 below shows the geographical sampling distribution for the total 1,000 male participants. The areas in red are in the Southern Region.

Table 3: Quantitative sampling distribution (per district)

	Urban		Rural		
Districts	Lilongwe (Central region)	Blantyre (Southern region)	Kasungu (Central region)	Mzimba (Northern region)	Chiradzuru (Southern region)
Male Sample size	250	250	167	166	167
Total	500		500		

Thereafter, using the probability proportional to size (PPS) sampling procedure (Lohr, 1999), within each of the two urban districts, five communities (wards/townships) were selected. And then, within each of the three rural districts, two communities (traditional authority areas) were selected. This PPS procedure involved creating a cumulative list of community populations (wards/townships or traditional authority areas) within each of the above districts and selecting a systematic sample from a random point on the list. This process ensured that each community within these districts had equal probability of being in the sample. Tables 4 and 5 below provides the sampling distribution for the areas that were selected following the PPS procedure. The locations in red are in the Southern Region.

Table 4: Sampling distribution per ward/township (Urban)

URBAN											
District	Lilongwe (Central region)					Blantyre (Southern region)					Total
Ward/ township	Area 18	Area 23	Area 36	Area 49	Area 56	South Lunzu	Likhubula ward	Ndirande south	Bangwe	Limbe east	
Male sample	50	50	50	50	50	50	50	50	50	50	500

Table 5: Sampling distribution per traditional authority/TA (Rural)

RURAL							
District	Chiradzulu (Southern region)		Kasungu (Central region)		Mzimba (Northern region)		Total
TA	Likoswe	Chitera	S/C Kawamba	TA kapelula	Mtwalo	S/C Khosolo gwaza jere	
Male sample	84	83	84	83	83	83	500

Finally, using the Malawi National Statistical Office (NSO) demarcated enumeration areas per ward/township or traditional authority, two enumeration areas were randomly selected within each.

Household Sampling Frame and selection

The projected household numbers for each selected enumeration area – based on the national Malawi household list from 2008 census data, provided by the Malawi NSO – formed the sampling frame, and allowed calculation of the nth number for each enumeration area. A random central starting point for data collection was then selected within each selected enumeration area, a bottle was spun to identify a direction (see figure 8), and a constant number of households in that direction (every nth number, generally where $n=3$) approached directly for participation in the survey. Every household within each chosen community, therefore, had an equal probability of being selected for the sample.



Figure 8: IMAGES data collector spinning the bottle

When households were approached, a household listing form was completed. The researcher would check if there was an eligible person available in that household. If two people were eligible, then the person with the earliest birthday in the year was selected (where household members did not know their birthdays, an eligible participant was randomly selected). If the household had no eligible respondent, or the person identified did not agree to take part, then the next household was approached instead (and then every nth household thereafter).

3.5.3 Interview process

The interviews took place face-to-face in a private location where the respondent's answers could not be overheard and were interviewer-administered using a paper-based questionnaire. Only one participant per

household was interviewed. In order to avoid biased results, male interviewers interviewed only male respondents. This approach is consistent with prior IMAGES surveys (Barker et al., 2011). I sat in on several male interviews from a short distance (with the approval of the participant), and I was able to observe the interview and get an appreciation for men's acceptance of the survey.

3.6 Phase 2 & 3: Qualitative Methodology

I undertook follow-up qualitative research to further interrogate and contextualise the phase 1 quantitative data. This section outlines the specific procedures for my qualitative research, including the instruments and interview procedures.

3.6.1 Qualitative data collection tools

I developed semi-structured (open-ended) questionnaires for the IDIs with men, FGDs with men and women, health provider interviews and stakeholder interviews (see below), which covered 10 topic areas. Overall, these explored the following topics in varying degrees:

- Motivations for, and communications around, men's health-seeking and factors informing men's poor SRH health-seeking
- Men's sexual identity, including sexual performance and sexual pleasure
- Men's SRH risk-taking practices, including around multiple concurrent sexual partners and unprotected sex
- Men's and women's use of and approach to condoms, perceptions and barriers to vasectomy, men's involvement in communication and decision-making regarding contraception and family planning, perceptions of family planning, knowledge of methods (particularly for men), and barriers to men's involvement
- Men's HIV testing motivations and barriers, disclosure dynamics & treatment use
- Experiences of STIs and sexual dysfunction, and related care seeking and communication

- Men’s experiences of public, private and traditional services, including for contraception
- Barriers to men using public SRH/contraceptive services
- Improving men’s SRH seeking behaviour and service use, including contraceptive services, and their recommendations around male involvement programming and service delivery.

Given the existing research on engaging men in maternal, neonatal and child health (Levtov et al., 2015) and on violence and contraception (Maxwell et al., 2015), these topics were not included. The exclusion of violence also related to my being unable to meet the ethical and methodological requirements of doing research on violence, such as offering referrals and follow-up support (Ellsberg and Heise, 2005).

These instruments were designed for any man (or woman, where applicable) irrespective of their relationship or marital status. The questions were informed by the literature, the phase 1 quantitative findings, consultations with stakeholders, and feedback from MLW researchers, my supervisors and my RAs.



Figure 9: Refining the research tools together with the RAs

These instruments were first developed in English, and then translated into Chichewa, following which they were further reviewed and refined together with my RAs (see figure 9). The IDI and FGD instruments were then pre-tested in Ndirande South for cultural relevance and comprehension. I also pre-tested the health provider and key stakeholder interview guides in Blantyre, and the tools were then further revised.

Iterative process

The role of the iterative process in qualitative research is “key to sparking insight and developing meaning” (Srivastava and Hopwood, 2009: 76). As such, once

the research began, additions and nuances were made to the qualitative tools over time. This reflected emerging issues from the IDIs and FGDs which I sought to explore further. A key example is that during IDIs men talked in greater detail than I anticipated about the barriers they faced within health services, and their lack of use of services for contraception. This led to more in-depth questioning and informed a closer exploration of these issues during phase 3 of my research, particularly the collection of client data on men's contraceptive service use.

3.6.2 Qualitative sample

A total of 195 participants were engaged during the qualitative research, of which 158 have been included in this study where their data relates to contraception. My research continued until saturation was reached on selected topics, and on the basis of feasibility. I believe that this sample size is sufficient for a study of this nature. Efforts were made to purposefully recruit men and women from a range of ages, educational backgrounds, and occupations (see research procedures below). The specific locations for the qualitative research in Southern Malawi mirrored those in phase 1 and were as follows:

- Blantyre: Bangwe, Ndirande South and South Lunzu
- Chiradzulu: Chitera and Likoswe

The total qualitative participants per location are outlined in table 6 below:

Table 6: Overview of qualitative research participants

	IDI participants	FGD male participants (# of FGDs)	FGD female participants (# of FGDs)	Service providers	Key stakeholders
Blantyre (urban)					
Bangwe	7	10 (1)	-	8	4
Ndirande South	9	11 (1)	16 (1)	7	
South Lunzu	4	-	-	2	
District Hospital	-	-	-	1	
Chiradzulu (rural)					
Chitera	10	14 (1)	16 (1)	3	1
Likoswe	10	13 (1)	-	2	
District Hospital	-	-	-	3	
National level²¹					
Lilongwe (capital)	-	-	-	-	7
Total	40	48 (4)	32 (2)	26	12

Inclusion criteria for male IDIs, FGDs and clients were sex (male) and age (18-59 years), matching the IMAGES criteria. Exclusion criteria were under 18,²² female, in polygamous relationships, and anyone unable to give consent. For female FGDs, the key criteria for selection were age (over 18) and sex (female). Locations in Chiradzulu were more difficult to reach than Blantyre, and the former has far fewer health services than the latter. This led to the inclusion of the District Hospital (which sits outside both Likoswe and Chitera).

3.6.3 Data collection procedures, phase 2

I now explain each of the data collection procedures I used during phase 2 of my research.

²¹ When approaching organisations in Blantyre, I was often referred to their head office in Lilongwe for an interview. Government departments are also based in Lilongwe.

²² In Malawi, people complete secondary education (if they attend) between age 15-18.

In-depth interviews (IDIs) with men

A total of 40 IDIs were undertaken (20 in Blantyre and 20 in Chiradzulu, as outlined above). These interviews enabled in-depth exploration around men's individual attitudes, behaviours and experiences.

Men were recruited by two means. Firstly, from a list, with contact details, of 79 male participants from the IMAGES survey in Blantyre and Chiradzulu who stated an interest in being contacted for my follow-up qualitative research. These participants were called by the research team to confirm they remained interested in participating, and if so, my study was explained to them and basic demographic details were collected (name, location, age, marital status, education level and religion) – to ensure inclusion criteria was met and a diverse study population – and their location was confirmed. From this IMAGES list, 21 men (of the list of 79) agreed to participate in my study. The majority of other men could not be contacted (due to their telephone numbers not working), and several did not respond (despite several calls) or were no longer interested. Secondly, to add to these 21 men, I undertook additional recruitment in the target communities. We visited each location and used random and convenience sampling to identify further participants. The same basic demographic details were collected of men who expressed an interest in participating.

These two methods provided a sampling frame of 62 men. From this list, I identified a group of 40 participants, ensuring diversity in demographic backgrounds (and therefore experiences). Those in this purposive sample were then called back, and the interview time/venue agreed upon, at which point they received further details. No one dropped out at this stage.

The IDIs were face-to-face and interviewer-administered based on the questionnaire (see appendix D). Each IDIs lasted around 60 minutes. Before the interview began, each man was asked to complete a two-page demographic

sheet in Chichewa (see appendix E) asking about both key demographics variables as well as sexual behaviours (use of contraception, method type, frequency of condom use, number of sexual partners, HIV testing, STI experiences and health service use). The use of a demographics sheet followed standard MLW practice. There were various settings for the IDIs, including under a tree, in a school, a community hall, or a convenient location for the participant (see figure 10). The interviews were conducted in Chichewa, and audio recorded.

After each IDI, the RA completed a two-page written summary in English using a template I developed (appendix F). This summary allowed me to have an immediate sense of the key issues and themes arising from the interviews, which was useful given that it could take several weeks for each full interview to be transcribed and translated. These summaries also enabled me to identify areas where I felt it was necessary for the RAs to probe further. They provided a useful basis for ongoing discussions with the research team throughout phase 2, including on areas of clarification.



Figure 3: Undertaking an IDI in a school in Ndirande South

Focus group discussions (FGDs) with men

A total of four FGDs were held with men (two in Blantyre and two in Chiradzulu), involving 48 participants in total. These FGDs took place in the same areas as the IDIs, to support triangulation of the qualitative data. They took place after the IDIs had begun, to allow for greater exploration of key themes emerging from those interviews. The FGDs allowed a greater understanding of the relational aspects of men's attitudes, behaviours and experiences.

Participants for the FGDs were also recruited through the above sampling frame collected for the IDIs. In addition, snowball recruitment techniques in the

communities were used to ask men to suggest the name of someone else they knew for the FGDs. It was important for me that the FGDs contained both men who had participated in an IDI, as well as men new to the research. For each FGD 10-12 men were selected to participate reflecting diverse demographics, though larger numbers presented themselves on the day and many had to be turned away. During consent processes, all participants were screened to ensure they met the inclusion criteria and that there was a diversity of participants.

The FGDs were led by an interviewer (research assistant) who asked questions based on the questionnaire (see appendix G). The FGDs took about one to three hours to complete, including a break. A demographic sheet, more basic than that used for the IDIs, was completed by each



Figure 4: Undertaking a male FGD in Chitera

participant at the start of the process. These FGDs were held in a community hall or church (see figure 11), undertaken in Chichewa, and audio recorded. A participant numbering system was used.²³ Another research assistant took notes of the discussion in English, using a specific format I developed. As with the IDIs, these notes allowed me to have an immediate sense of the key issues and themes arising from the FGDs and were used during follow-up discussions with the RAs. I sat in these FGDs, which allowed me to observe men's reactions to different questions and group dynamics.

Focus group discussions with women

Two FGDs were held with women (one in Blantyre and one in Chiradzulu), involving 32 female participants in total. These discussions sought women's views to confirm or counter men's responses, rather than an in-depth

²³ This is where each participant says their number before speaking, allowing their response to be matched to their demographic details.

exploration of women's own behaviours. The discussions were deliberately held in the same areas as the FGDs with men and took place after completing the research with men to allow for an in-depth exploration of women's views on men's attitudes, behaviours and experiences.

Random and convenience sampling were used by the female RAs to recruit the female FGD participants from their local communities. These methods provided a total of 48 names, and a similar sampling frame as to that used for men was created for women. From this list, I identified a group of participants ensuring diversity in demographic backgrounds. Far more women presented themselves on the day, many of whom were turned away, and this reflects the larger group of participants in the female FGDs.

These FGDs were led by a female interviewer (RA) asking questions based on the female questionnaire (see appendix H). Another research assistant took notes of the discussion in English. I did not attend these FGDs in order to create a safe space. The FGDs with women lasted around one to two hours (including a break). They took place in a school and community hall, were undertaken in Chichewa, and audio recorded. I similarly reviewed the notes of these discussions shortly after, providing me with a sense of key issues and themes, and to support my follow-up discussions with the female RAs.

Interviews with health providers and key stakeholders

26 interviews were undertaken with health facility managers, health providers and three traditional healers across the target districts. 12 interviews were also undertaken with government, NGO and UN stakeholders. After mapping services (see 3.7.2 below), convenience and snowball sampling was used to identify interviewees, with support from Health Surveillance Assistants (HSAs), the in-charge at Health Facilities, and recommendations from the DHOs.

These interviews explored the opinions of health professionals and stakeholders on male involvement, and the views of health providers on the availability of contraceptive services for men, and men's access to, and experience and use of, such services. A deliberate attempt was made to include health care staff at all levels of seniority, from management to junior staff. A greater number of urban than rural health providers were interviewed, due to there being fewer service providers in Chiradzulu and to practicalities – accessing some rural locations was challenging, often across long distances, and on several occasions the staff members in question were not available.

I undertook all these interviews myself (face-to-face), using my semi-structured guidelines (appendix I) as well as bespoke questions for stakeholders (appendix I & J). Each interview was in English, or using simultaneous translation, and lasted between 45-60 minutes. These interviews took place in the offices of those informants (or on the facility grounds). They were recorded, where possible, and transcribed verbatim. I am aware that both health professionals and stakeholders are not simply unbiased professionals, but individuals with their own biases and perspectives.

Community observation

I undertook observation within my research communities. I spent time in each community in the context of my IDIs and FGDs, and also alone before and after my health providers/stakeholder interviews, when I sought to observe daily activities (Hammersley et al., 2007). I also visited bottle stores and drinking places. My approach to community observation was unstructured and informed by FHI360's 'Qualitative Research Methods: A Data Collectors Field Guide' (Mack et al., 2005).

Observation provides a counter-balance to over-reliance on self-reports (Guest et al., 2013). Combining a variety of qualitative methods, including observation, allowed me to have a richer and more multidimensional dataset (Reeves et al.,

2008). My desire to use observational research was also informed by my undergraduate teaching on sociology and anthropology, which provided me with a grounding in the importance of this approach. The roots of participant observation are in ethnographic approaches to research (Denscombe, 2014).

Informal conversations

During my research, I held structured and unstructured conversations with my research team (as noted above) and also held informal conversations with men in my target communities, often chatting with them standing together in groups or separately working at stalls. I was occasionally invited by Malawian men to join them and their friends while they drank and chatted together. I also spoke with health providers informally during my visits to health centres. Informal conversations have been used in other research on contraception in Southern Africa (Capurchande et al., 2017) and are often part of observational research (Mack et al., 2005). As part of my participatory research approach, I discussed my interpretations of relevant informal conversations with my male and female RAs to gain their insights.

I am aware of the biases I brought into these situations, not least as a white man from the global North, and that this influenced what I decided to observe, discuss and record (Ambert et al., 1995) and how my own subjectivities undoubtedly influenced these data collection processes (ibid.).

Research diary

I kept a research diary during the whole process. This was used as a guide for my completion of activities, and to record relevant notes from my observations and informal discussions, as well as any other impressions, thoughts or conversations I felt were relevant while undertaking my research.

3.6.4 Data collection procedures, phase 3

I now explain each of the data collection procedures I used during phase 3 of my research.

Clinic observation

I undertook observation at the same health facilities (public and private) in which I had interviewed the health professionals. This was a more structured process than my community observations. I developed a clinic observation template (see appendix K), which ensured I recorded how the clinic worked, who attended, the number of attendees, and reactions of attendees and staff. The template was informed by other MLW tools and my emerging results. This observation did not take place in consultation rooms, given issues of confidentiality, but within the broader health facility and its environs on the basis of guidance (and approval) from the in-charge of the facilities. Twenty six observational visits took place at these facilities, the locations of which are outlined in table 7 below.

Collection of secondary male client data

I also collected male client data from 16 health facilities (public and private) across my research sites (see example in figure 12). This process sought to more systematically identify the services available for men and men's use of these services. As service statistics were not available electronically, they were



Figure 5: Malawi Health Centre, Likoswe

based on reviewing quarterly client records developed by the health facilities (for the quarter, April-June 2016), or estimates from clinic staff where those were not available. I developed a structured matrix to collect client data (see appendix L), which I completed together with the responsible health facility personnel. Data included men's use of contraceptive services, HIV and STI services, and other services targeted towards men. For practical reasons, this data collection

generally took place during the same time as clinic observation. Table 7 below also outlines the number of client data sites in each location.

Table 7: Number of clinic observation sessions and client data collection sites in Blantyre and Chiradzulu

Research site	Name of service	Type of service	Clinic observation sessions	Male client data collection
Blantyre (urban)				
Bangwe	Bangwe Health Centre	Public	6	1
	BLM Bangwe	Private	1	1
	Madinah Bangwe	Private	1	1
	Lungu Private Clinic	Private	2	1
	Muopa Private Clinic	Private	1	-
Ndirande South	Ndirande South Health Centre	Public	4	1
	BLM Ndirande South	Private	1	1
	Madinah Ndirande South	Private	1	1
	L&A Private Clinic	Private	1	1
	Malabada Private	Private	-	1
South Lunzu	South Lunzu Health Centre	Public	1	1
	Praises Private	Private	-	1
District Hospital	Queen Elizabeth Central Hospital	Public	1	-
Chiradzulu (rural)				
Chitera	Chitera Health Centre	Public	1	1
	Mbulumbuzi Health Centre	Public	1	1
Likoswe	Malavi Health Centre, Likoswe	Public	3	1
	CHAM Hospital	Private	1	1
District Hospital	Chiradzulu District Hospital	Public	-	1

Community dissemination of research results

I held dissemination meetings in four of my research communities to present my initial findings. Interested men, women, stakeholders and health providers and those interviewed (whom I could contact) were invited to attend. I developed a detailed overview and a four-page summary of my key findings, which were translated into Chichewa (see appendix M). During these meetings, the RAs made a presentation of the main findings based on a written overview and we

also handed out copies of the four-page summary (see figure 13). No individual was quoted directly as part of the shared findings.

After the presentation, participants were asked for their feedback and responses, and discussions took place on each of the areas of my findings, including around contraception and family planning. These meetings were held in Chichewa, with a note taker writing notes in English. A



Figure 6: Dissemination meeting Ndirande South

debrief meeting was held immediately after each event to summarise the key comments. These community meetings were well received and pointed to the resonance of the findings in the target communities. They also provided a form of validation of my data and raised other nuances on my data and responses which informed my overall findings.

In addition, I held a number of meetings with key national stakeholders that had expressed a prior interest in the study to explore opportunities for the research to inform their work. Finally, on my suggestion, a national radio discussion and call-in was held on Ufulu FM to discuss the research findings, which generated significant listener participation.

3.7 Quality control, consent, data security and ethical considerations

3.7.1 Quality control and reflection

PACHI developed a protocol for the IMAGES study, which included several quality control procedures. A five-day training was held for all IMAGES data collectors, to enhance their understanding and skills. A team of 17 data

collectors were recruited, including two supervisors. This training was also useful for reviewing the English and Chichewa translation of the survey side-by-side and addressing inconsistencies.

During data collection, completed surveys were collected at the end of each day and reviewed for completeness. PACHI also did spot checks on households interviewed to ensure the interviews took place and that the correct person was interviewed. PACHI also set daily survey targets, and immediately addressed emerging issues, to ensure continuation of data collection and a common understanding among researchers. I held a mid-point debriefing session with the whole IMAGES research team, to discuss their experiences and their perspectives on the reception towards the survey, which provided useful insights into the data collection process.

I developed a protocol for my qualitative research with several quality control procedures. This included the repeated review by the research team of the qualitative tools to ensure common understanding, which was particularly important given the evolving nature of the research, and as questions would change dynamically requiring immediate translation into Chichewa. My accompaniment of the RAs throughout enabled me to ensure we maintained momentum in completing the IDI and FGDs. I developed checklists for the RAs to aid both the IDIs and FGD process.

Half of the translated transcripts of the IDI audio recordings were randomly selected and cross checked by the research assistant that had undertaken the interview in question, who then highlighted any changes required. I also reviewed translated IDI and FGD transcripts and clarified any areas of misunderstanding with the team. The meetings I held with the whole qualitative research team also provided an opportunity for the T&T staff to provide feedback to the researchers on common mistakes they had identified or

challenges they had in undertaking their transcription and translation roles. The initial written summaries were also a critical part of quality control.

3.7.2 Entering the communities and health facilities

Entry into selected communities for all phases was through the local leaders, from whom verbal permission was sought. This was important so that other leaders and stakeholders within the communities were informed about the presence of the research in the study area. No local leader refused to grant permission. I sat in on those meetings, which were led by the RAs.

For health services, discussion first took place with the District Health Officers (of both Blantyre and Chiradzulu), who provided me a written letter of support. I created a mapping tool to document the available public and private facilities offering SRH and contraceptive services within my target areas (see appendix N) which informed who I then approached.

3.7.3 Informed consent, confidentiality and compensation

For both IMAGES and my qualitative research, eligible participants were given an information and consent form in Chichewa (see appendix O and P) at the beginning of the interview, which the interviewer discussed with them. Where necessary, the document was read out to people. This made clear that participation was completely voluntary, and the discussion was confidential and could be terminated at any time without penalty to the participant. No undue pressure was made on the participants to take part. Those participants who agreed to participate were asked for their consent to do so (through signing or thumb print) before the research began. No adults without the capacity to give informed consent were involved in the research. If the person did not agree to participate, then the interview did not proceed. The consent form also contained the local contact details of PACHI and myself.

For my FGDs, these procedures were discussed with everyone as a group before participants were asked to sign individually if they were willing to proceed. The RAs also made their own public commitment to confidentiality to the group, and all participants were requested to maintain and respect confidentiality around the discussion.

IMAGES participants received mobile phone airtime (urban areas) or soap (rural areas) as a reimbursement for their participation. This was recommended by PACHI. During my qualitative research, IDI and FGD participants received Malawian Kwacha (MWK) 1,000.²⁴ Records were kept of these payments. Those participating in FGDs were also given refreshments. I sought advice on the issue of reimbursement and followed standard MLW practice. While some advice was not to pay participants, I believed it was ethically important to acknowledge and recognise people's contribution in this way.

3.7.4 Data privacy and security

To ensure data confidentiality, an anonymous ID code was generated for each participant, which ensured that all completed questionnaires had no names or identifiers. Consent forms were separated from questionnaires (so that interviews could not be directly attributed) and were stored securely at the PACHI offices for IMAGES or in the MLW office for my qualitative research.

To maintain data security, paper questionnaires, consent forms and any notes were kept in a secure location and only accessible to personnel involved in the study. Electronic data was only available to personnel involved in the study, and was backed up regularly on an external hard drive. Personnel were required to sign statements agreeing to protect the security and confidentiality of research information.

²⁴ At the time of my interviews, this was equivalent to GBP 1.50

3.7.5 Ethical approval

Ethics approval for this research (see appendix AA) was granted by University College London Ethics Committee (UCL Project ID: 4259/001), the National Health Sciences Research Committee in Malawi (NHSRC, protocol reference #1058 for the quantitative research and protocol #1267 for the qualitative research), and the University of Cape Town Human Research Ethics Committee (UCT HREC, ref: 322/2014). The NHSRC and UCT HREC both provided extensions for the continuation of the qualitative research in 2015, and UCL provided an extension in 2019.

3.8 Analysis of quantitative and qualitative data

3.8.1 Quantitative data entry and analysis

Quantitative data entry

A Microsoft Access database was created for data entry.²⁵ Data entry staff were trained for two days on this database. Data was then entered into Access by these staff over a six-week period. As part of quality control, 10% of the questionnaires entered into the database every day were checked for accuracy. Once verified, the data was loaded into STATA.

Data cleaning and preparation

Initial data cleaning took place by PACHI in 2014, in which they categorised certain variables, removing the related individual entries.²⁶ A small number of entries were eliminated at this stage due to incomplete data, leaving a dataset of 998 men.

After creating a Southern Malawi specific dataset, I familiarised myself with the whole dataset and then undertook further data cleaning – removing missing data and identifying duplicate and erroneous data through cross tabulations with

²⁵ I developed this together with the PACHI IT Manager, Michael Msiska.

²⁶ The dataset I received had pre-established categories for income, employment status, age groupings and number of children, without the original raw data allowing me to recode these variables.

other data and running frequencies to look for any inconsistencies. Non-applicable items were removed from analysis and missing labels added. I also created a number of additional variables of interest, and recoded several variables, including GEM scores (see below). The proportion of missing data was only 0.5%.

Quantitative data analysis

I analysed the Southern Malawi dataset of 417 men using STATA version 13. The GEM scores were trichotomised (Pulerwitz & Barker, 2008), with one item reverse scored due to measuring a more equitable (rather than inequitable) norm,²⁷ in line with established procedures for this scale (personal communication with R Levto, 5 October 2015). I rescored the GEM scale, given this item had not been reversed in the original dataset. The contraceptive use variable within IMAGES used for analysis included only those men with partners (married or unmarried), and I undertook a range of in-depth analysis using this variable.

For logistic regression purposes, the Likert scale for always use, mostly use, occasionally use and don't use condoms was combined to a two-level scale of always/mostly and occasionally/don't use. Similarly, responses reporting 2-3 sexual partners and 4+ sexual partners were combined. In logistic regression analyses, the reference group was the category with the higher observed frequency (this gives the most stable odds ratio estimates).

I undertook the descriptive, cross-tabulations, t-tests and logistical regression tests included in this thesis. The key variables of analysis included:

- Descriptive statistics of key variables of interest, including demographic details (location, age, relationship status, education, number of children, employment status, ethnicity and religion), GEM scores, final say over women's health and sexual relationship description

²⁷ This item is 'A man and a woman should decide together what type of contraceptive to use'.

- Bi-variate analysis using Pearson's Chi-squared to explore relationships between demographic variables and sexual behaviours (ever HIV test, STI, frequency of condom use, number of sexual partners, contraceptive use in relationship)
- T-tests and regression to explore relationships between demographic variables and average GEM scores
- Multivariate logistic regression of the associations for the following variables: contraceptive use in relationship; frequency of condom use; and having 2 or more sexual partners. Unadjusted and adjusted odds ratios were presented, with confidence intervals for the latter. Significance was assessed using a likelihood ratio test. In all cases statistically significant differences were reported at the $p < .05$ level.

During my quantitative data analysis I sought advice from several other doctoral students at MLW and UCL, and received guidance from one of my secondary supervisors. I also presented my initial quantitative findings to colleagues at UCT and MLW, receiving feedback.

3.8.2 Qualitative data entry and analysis

Qualitative data entry

Each of the IDIs and FGDs were first fully transcribed into Chichewa by the T&T staff using the audio file, and then a full English translation was typed out next to each Chichewa response. These transcripts with both Chichewa and English were typed in Microsoft Word and uploaded to NVivo. This allowed simultaneous review of the languages side-by-side and facilitated language checks and clarifications with the RAs. All interviews I undertook in English I transcribed verbatim into Microsoft Word and uploaded to NVivo.

Qualitative data analysis

I used thematic analysis to reveal prominent themes or recurring issues (Attride-Stirling, 2001) to provide a rich, detailed and holistic account of the data (Braun

and Clarke, 2006). Whilst in Malawi, I manually analysed the completed Summary Forms for all IDIs and FGDs, and developed a list of emerging results, which I discussed further with colleagues and my RAs (see appendix Q).

Once I had the full transcriptions, I immersed myself in the data for the purposes of analysis and mapped out the most important themes that appeared to be emerging from, and shaping, participants' responses. I developed a coding frame (codebook, see appendix R) – a set of categories (themes and sub-themes) – *a priori* based on my review of 50% of the qualitative data. This included broad pre-theorised categories (e.g., men's sexual pleasure) and new themes emerging from the material. I then imported this codebook into NVivo and coded my qualitative data against these categories. This was an iterative process, with initial coding and organisation of the coded data to align to the categories to enable systematic analysis, followed by amendments to these categories as a result of further coding. This allowed new codes to emerge from the data, an approach borrowed from grounded theory (Charmaz, 2014).

After coding, each of the themes and sub-themes were explored to look for common trends and differing opinions. These categories were then reviewed again in order to identify quotes. Interviewee codes were used to ensure confidentiality. After initial write-ups of my results, I manually reviewed the raw data again to double check for consistency, and continued to do so throughout the process (see example of subsequent manual coding in appendix S).

I coded my notes from community and clinic observations and informal conversations by hand as this was more time efficient than transcribing them and entering them into NVivo. The demographic sheet data was entered into Microsoft Excel and coded. Secondary client data findings were analysed manually and added into a table in my results chapters.

Throughout my qualitative analysis I sought advice from other doctoral students undertaking qualitative research, particularly at MLW and UCL. I received helpful guidance from qualitative research staff at UCL, UCT and Brown University, and also benefited from a week-long training course on Nvivo at UCT. I presented my qualitative findings at MLW and at a number of conferences, receiving feedback.

3.8.3 Demographic details of participants

Please see appendix T - X for the demographic breakdown of IMAGES Southern Malawi participants and my qualitative participants, respectively.

3.9 Data prioritisation, data integration and analytical framework

3.9.1 Prioritising data

Given the breadth of data I collected, I decided to prioritise one specific health behaviour in order to deepen my analysis and most usefully synthesise and make sense of it. I chose to focus on contraception, given that it was most novel to the research context and the gaps in existing research on the topic. All research methods included data on contraception and family planning, and the intersection of these issues with men's gendered attitudes, norms and behaviours; therefore this data was specifically analysed for the purposes of my thesis. Additional data which did not respond to my research questions has not been included.

3.9.2 Data integration

After the data from both methods was separately analysed, I created a matrix for each of my research chapters with the relevant corresponding quantitative and qualitative data (see appendix Y). I received guidance on this process from one of my secondary supervisors. This allowed further analysis in which I compared, contrasted and then combined my data and findings (Tariq and Woodman, 2010). This is an established technique for mixed methods integration, using a mixed methods matrix (O'Cathain et al., 2010). This enabled

me to compare quantitative and qualitative responses to the same themes and variables. It enabled preservation of the integrity of each type of data, while benefiting from enhanced understanding through their combination (Tariq and Woodman, 2010).

As noted in 3.6.3, half of the men in my phase 2 in-depth interviews were not from the phase 1 IMAGES study population, meaning these data sources were not the exact same sample. Where men were from the same sample (both phase 1 and 2 participants), the IMAGES and qualitative data unfortunately could not be matched. This was due to the collection of phone numbers of men interested in my follow-up research being separated from their IMAGES ID code, and thus their individual IMAGES responses. This was compensated with the collection of additional quantitative data on each IDI participant (demographic sheet, see above) during phase 2. I was also able to compare this additional quantitative data with what these men told me verbally during their IDI, and explore whether there was concordance or contradiction.

Data integration of both methods was also an iterative process. I refined both my quantitative and qualitative findings as I wrote my results chapters and moved back and forth between those different types of data seeking to “make meaningful links between them” (Tariq and Woodman, 2010: 6). This included using diagrams to identify relationships between themes (appendix Z).

3.9.3 Analytical framework

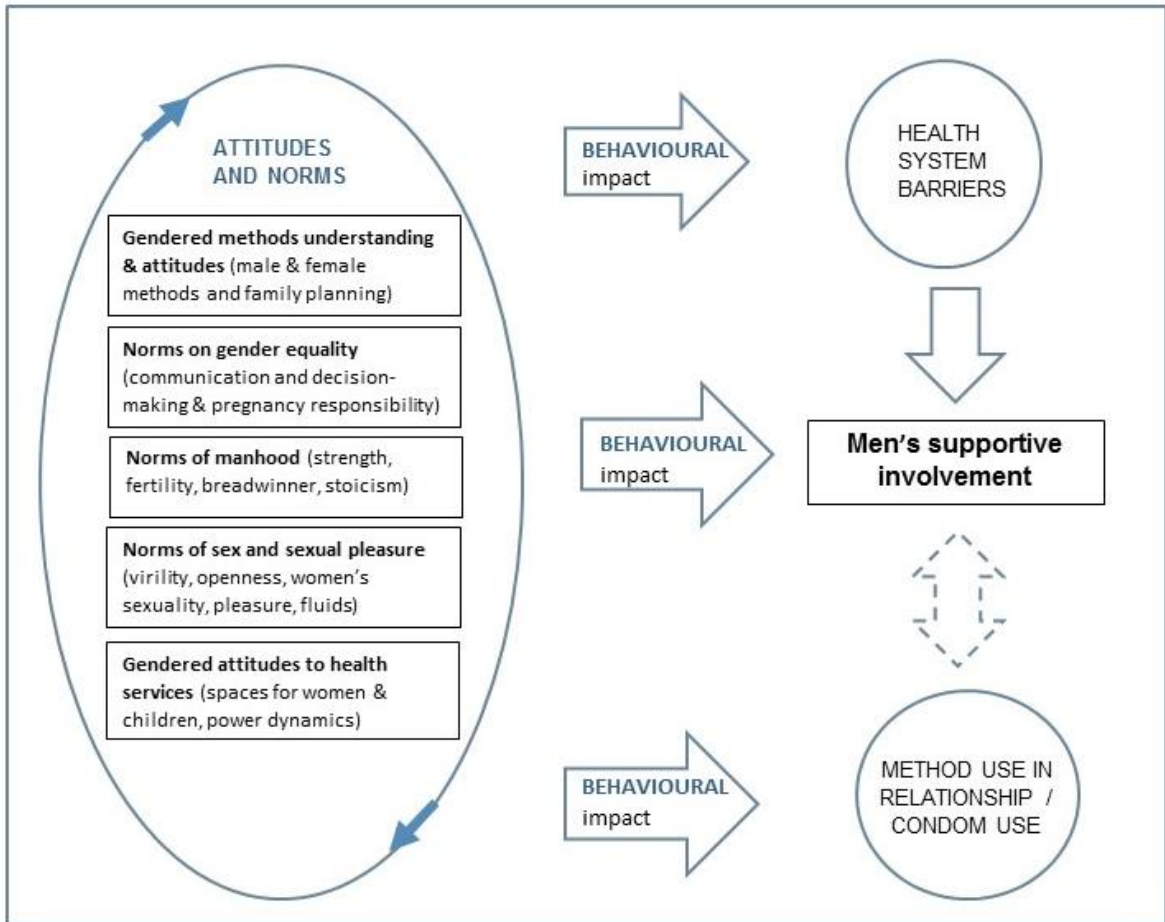
Based on the literature review, my conceptual approach and emerging findings, I developed the following analytical framework to guide analysis and structure my findings to respond to my research questions (see figure 14). This model asserts the following:

- Men’s gendered attitudes and norms across the following areas – method understanding and attitudes, gender equality, manhood, sex and sexual pleasure, and towards health systems – impact their behaviours. These

attitudes and norms also interact with each other, and may influence men's behaviours alone or in combination. Each of these areas (each box below under attitudes and norms) are discussed in a separate results chapter.

- Men's gendered behaviours directly impact men's supportive involvement in contraception and family planning, the primary outcome focus on my thesis, in positive or negative ways.
- Men's gendered behaviours also influence men's involvement via the health systems barriers men experience.
- Men's gendered behaviours also influence men's involvement by the extent to which men are contraceptive users (themselves or their partners). As men are often not users themselves, this may not be a direct relationship, as their partners may use a method while they are not supportive (or vice-versa).

Figure 7: Analytical framework for data analysis



In my research, I did not exclude anyone due to sexual orientation, nor make assumptions about their sexuality. All respondents spoke only in the context of heterosexual relationships, and as such this reflects the orientation of my analysis. More broadly, it reflects the aforementioned challenges in Malawi in relation to discussing sexual diversity.

3.10 Position of the researcher

Self-reflexivity is an important aspect of undertaking research (Finlay, 2009). My time in South Africa and Malawi was informative in exploring how I positioned myself as a white foreigner. They were also very different experiences for me. South Africa had an ongoing public discourse around racial equality, and I had

to reflect on 'my place' as a white educated man from the global North, working and living there. At the same time, I blended in. In contrast, in Malawi, I felt like an expatriate (I had never really felt this in South Africa), and was often more aware of my whiteness, but there was no public discourse (in the mainstream media, at least) on racial justice. I had many benefits in Malawi of what Peggy McIntosh (1989: 1) calls the "Invisible Knapsack of White Privilege."

This put me in a position of relative power and status. I had material resources that were unattainable for most Malawians. Given vast inequalities, I could make a big difference through actions that were inconsequential to me. When I visited rural districts, sometimes my car was the only vehicle in sight. I was often perceived as a philanthropist or donor. For example, men in Chitera asked me to fund local projects. There was an unequal power dynamic between myself and the RAs, who were deferential to me in a way that had not been the case in South Africa. The RAs equally had power; they were my brokers to the research communities, and research projects in Malawi have cachet, as did an association with MLW. This created power inequalities between the RAs and participants. It would be naïve not to presume that the communities' interest in my research was aided by these unspoken perceptions, and they influenced the interactions I and my RAs had. At the same time, Malawian men may have been more comfortable divulging sensitive information, such as on sexual dysfunction, to an outsider, as Gipson et al. (2010) also found.

In order to better familiarise myself with the context, and improve my understanding of my findings, I took weekly lessons in Chichewa. I also sought to immerse myself within the Malawian culture, to the extent possible, and attended St. Michael's and All Angels Church, a Presbyterian church in Blantyre, spent time with Malawian friends and also attended a traditional Malawian wedding.

I believe it is also important not to 'other' men in Malawi. Meisenhelder (2003: 100) writes that "othering is a symbolic framework that still haunts what is said and thought about Africans by Europeans and North Americans". Partly this requires me to be upfront regarding my own challenges around engaging in contraception. The behaviours being discussed here are not Malawian, nor regional specific, but universal. My wife and I, both well educated, discuss issues of contraception openly and constructively, and I have often bought condoms, but she is the one who has mostly accessed contraceptive methods. We are a married couple relying primarily on female contraceptive methods. I, too, have been worried about the impact of condoms on my sexual pleasure and performance. During the research I would therefore seek to present myself as also struggling with these issues. This approach reflects what Finlay (2002: 220) describes as "reflexivity as social critique" in trying to manage the power imbalances between researcher and participant. Nevertheless, there are clearly limitations, not least because of enormous power inequities, in my ability to 'level' with these men around understanding their sexual behaviour.

Finally, my background working in the field of engaging men may have coloured my coding, analysis and perspective. Though I am not an uncritical actor of this field, I may have unconsciously tried to 'prove' the value of engaging men in contraception. I often found the responses of participants resonated closely with my own views and values; sometimes they energised me. However, I believe my mixed methods and triangulation processes, and validation of results, ensured research rigour and allowed the data to speak for itself.

3.11 Summary

This chapter has provided an overview of my mixed methods approach, including outlining the rationale for mixed methods, introducing the research location, my specific role and the principles to my research. I then provided an overview of my methodological approach during each phase of my research and how I separately analysed the data within both my quantitative and qualitative

methods. I then explained how I prioritised and integrated the data sources and the analytical framework which guided the structure of my findings. Finally, I discussed my position as researcher. To build on this, the next chapter explores my study setting in greater detail and provides further background to the history of contraceptive use in Malawi.

Chapter 4: Background to men and contraception in Malawi and overview of Study Setting and health system

4.1 Introduction

In the last chapter I outlined my methodological approach and research principles. This chapter provides additional background on Malawi, and Southern Malawi in particular, in order to better situate my findings. I begin with an historical analysis to contraceptive use in Malawi and men's involvement therein (I use the term family planning here, as this is the language used in the literature), followed by an overview of key demographic and health indicators, and then explore the status of women. I then review the content of Malawi's policy documents as it relates to male involvement in contraception and reproduction, and present details on programming in Malawi on engaging men. Finally, I provide an in-depth overview of my urban and rural research sites, and the structure of the contraceptive health system in Southern Malawi.

4.2 Malawi history and context

4.2.1 Colonial history and post-colonial legacy and its links to family planning

Colonial history: Malawi was ruled by the British from 1889 to 1964. It was known first as British Central Africa (1889-1907) and then Nyasaland (1907-1964). The history of Nyasaland was marked by African communal lands being forcibly taken by the British, local inhabitants forced to seek work on white-settler plantations, favouritism of European agricultural interests and food shortages, leading to widespread civic unrest. The country, renamed as Malawi, achieved full independence in 1965 and was ruled as a one-party state until 1994 under its first post-independence president, Hastings Banda. British influence during the colonial period was significantly influenced by David Livingston, an explorer and Church of Scotland missionary, who heralded the growth of "Christianity and civilisation" as a precondition for European commercial exploitation (McCracken, 2012: 38-39).

Status of women and female sexuality: British colonial rule included replacing the existing matriarchal structure with European patriarchy (Kaarhus, 2010). These western ideas about social organisation created a hierarchy between men and women, and in particular reinforced men's role as the economic provider, and reinforced male dominance (Matinga, 2015). Similar impacts of colonialisation in reinforcing different male and female roles and men's power have been documented in Kenya (Guyo, 2017). Riley and Dodson (2016) argue that the post-colonial conceptualisations of gender roles and identities continue to have significant salience in Malawi today.

Banda's rule also saw the passing of legislation related to women's sexuality (though not men's). It became illegal for women to wear trousers or any kind of skirts which showed their knees. Banda has been described as a President whose practices were a complex interplay between "a more radical anti-colonial conservatism, and a more reactionary post-colonial conservatism" (Gabay, 2017: 1119). As a reflection of Banda's legacy continuing to inform the status of women, the matter of women having their trousers forcibly removed in public by men in Malawi made international media headlines in 2012.

History of family planning: Despite initial attempts to introduce a family planning programme in the 1960s, this was banned as a result of public misconceptions as to its intent (Palamuleni, 2013) with widespread speculation that modern contraceptives were being introduced to sterilise people (Kalipeni and Zulu, 1993). Following decades of dialogue, the National Child Spacing Programme was approved in 1982, though this was viewed with equal scepticism. As the name suggested, the programme's focus was on birth spacing and not limiting. As Kishindo (1994: 61) notes, in relation to that period, "The public then viewed family planning as a disguised attempt at birth control which ran counter to traditional cultural values which stress the value of children to society." The government invested little effort in this programme until the late 1980s (Paz-

Soldan, 2004), where a quickly expanding population and a food crisis led to the widespread creation of maternal and child health (MCH) clinics offering family planning services (Marshall, 1989). It was not until the 1990s that the country more openly approved family planning (Pulamuleni, 2013).

This history is also informed by HIV and AIDS. The onset of the AIDS epidemic in Malawi was initially blamed on the government and international community (Kaler, 2004a), and condoms – as they were being advanced by these same groups – were treated with suspicion and mistrust, including rumours that they contained oils and the HIV virus itself. As Kaler notes (ibid: 106), “population control looms large in the ways that potential condom users in Malawi think about the world, so that condoms, AIDS and population control become fused together in a symbolic nexus.”

History of male involvement: The role of men in family planning in Malawi is shaped by the above history. Once initiated, the National Child Spacing Programme limited its target population to childbearing women only and was coordinated out of the MCH programme (Kalipeni and Zulu, 1993). In approbation of men’s authority, this programme initially sought to provide contraceptives only when a husband accompanied their wife to the clinic (ibid.). Following complaints from women that their husbands did not wish to do so, the programme began giving contraception without men’s presence or consent (ibid.). This programme had overall limited emphasis on men and failed to consider Malawian men’s control over women’s reproductive capacities and family size decision making (Kishindo, 1994).

There is limited historical analysis of Malawian men’s perceptions of contraception. With respect to male condoms, Kaler (2004a: 105) argues that, for Southern Malawi, “condoms do not arrive in communities as natural, value-free objects” and that negative attitudes towards condom use among married Malawian men must be understood within a historical analysis of how rural

communities embedded within their discourses on condoms associations of HIV, coercive population control and malevolence.

4.2.2 Malawi's political situation

In 1994 Malawi adapted to a multi-party democracy. The country has experienced several political upheavals, including applying for debt relief in 2006, soaring inflation in 2011 and a large corruption scandal in 2013/14 which led to several donors suspending their aid. The shift to multi-party democracy created space for gender equality to enter the political agenda (Anderson, 2015). Equally patriarchy has remained entrenched within the political system post-1994 (ibid.), including around reproductive rights. Contraception is not restricted by law, though anecdotal evidence suggests adolescents require parental consent to access commodities and services. Abortion is legal only to save a women's life, and punishable by seven to 14 years in prison for any other reason (Malawi Penal Code, 2014). Analysis of statements by Members of Parliament (who are predominantly male) between 1994-2014 found most to be opposed to condom use (Muula, 2006), undoubtedly shaping broader male involvement norms.

4.2.3 Religious, ethnic and cultural context

Religion is an important part of Malawian society. Only 3% of men, and <1% women, report themselves as having no religion (NSO and ICF, 2017). Religion is ubiquitous in rural Malawi (Yeatman and Trinitapoli, 2008). As a result of its colonial history, Christianity remains predominant (85% are Christian). Contraceptive use among women in Malawi differs dramatically from the stated positions of their religion, and religious leaders rarely mention family planning during sermons (ibid.). Some religious leaders have been found to demonize condom use (Rankin et al., 2008). Ethnicity is equally important to Malawians, and the country is ethnically diverse. There appear no significant variations in contraceptive use across ethnic groups (NSO and ICF, 2017).

Villages in Southern Malawi also follow a matrilineal social organisation, where descent is traced through the mother's lineage (Kishindo, 1994), as opposed to the Northern region which practices a patrilineal system. In matrilineal structures, traditionally men, once married, leave their own villages to live in those of their wives'. A woman in this social system produces children for her own matrilineage (and these children remain with the women should the marriage end and the man leaves the matrilineal home). It is argued that despite the contemporary norms that women exercise power in matrilineal societies, this may not reflect actual practice (Matinga, 2015). Research on cultural practices by the Malawi Human Rights Commission (MHRC) found female chiefs interviewed testified to men dominating decision-making positions (MHRC, n.d.). Matrilineal societies are reported to have high rates of divorce and re-marriage (Matinga, 2015). A contemporary example of the differences between customs and practices is in the area of land rights. While matrilineal customary law in Malawi dictates that property is passed predominantly through the matrilineage (ibid.), in practice, as Kishindo (2010) notes, there is a growing tendency of people, especially men, acquiring land through purchase.

4.2.4 Malawi socioeconomic demographics

Malawi ranks among the world's least developed countries (World Bank, 2020), positioned 170 out of 187 countries in the 2016 Human Development Index (UNDP, 2016). It is also densely populated with an estimated 17.2 million inhabitants (PRB, 2016). Life expectancy at birth is estimated to be 62 years for men and 64 years for women (PRB, 2016). Reflecting its colonial history, the country's economy is mainly agricultural, particularly cash crops (tobacco, tea, coffee and sugar), which contributes 30% of Malawi's GDP and the vast majority of its revenues from exports (FAO, 2015), as well as 80% of its employment (NSO and ICF, 2011). The majority of people live in rural areas (NSO, 2008). Employment is unstable for large proportions of the population.

4.3 Relevant health and gender equality context in Malawi

4.3.1 Malawi SRH outcomes

Malawi has a national HIV prevalence of 8.8% (15-49 years old), which is higher in women compared to men (10.8% versus 6.4%) and most pronounced in the South at 12.8% (NSO and ICF, 2017). Malawi's maternal mortality ratio (MMR) is one of the highest in the world, at 439 maternal deaths per 100,000 births (NSO and ICF, 2017). Recent analysis has identified significant delays in women accessing a health facility during an obstetric emergency (Mgawadere et al., 2017). Reflecting the country's laws, abortion is socially condemned (Kalipeni and Zulu, 1993) and abortions are an important cause of maternal deaths (Polis et al., 2017). Malawians tend to experience first sex at 17, and first marriage at 18 (NSO and ICF, 2011). Sexuality education is poor, with Malawi ranking last in a four-country study with adolescents on access to sex education and condom demonstrations (Bankole et al., 2007).

4.3.2 Malawi family planning outcomes and men's perceptions

Malawi has seen a steep national rise in its contraceptive prevalence rate among currently married women, 15-49 years, from 28% in 2004 to 59% in 2015-16 (NSO and ICF, 2017). Nearly all married women who use contraception use a modern method (MacQuarrie et al., 2015). Injectables are the most common method among married women with 30% using them (NSO and ICF, 2017), reflecting several studies in Malawi (Gipson, 2010; Becker, 2014). Unmarried women, 44% of whom report currently using a method, state the injectable as their main method (15%), closely followed by the male condom (14%).

Despite the increasing use, 19% of currently married women, and 40% of sexually active unmarried women in Malawi continue to have unmet need for contraception, which is higher among rural areas (NSO and ICF, 2017). Thirty seven percent of women who began using a contraceptive method report discontinuation in less than 12 months, with side effects/health concerns the

primary reason given (ibid.). Donors have identified unmet need as a key challenge for Malawi (USAID, 2016). Polis et al. (2017) found more than half of all Malawian pregnancies to be unintended. Total fertility rate (TFR) in Malawi is 4.4, which is higher in rural than urban areas (4.7 versus 3.0) (ibid.). On average, women are having one child more than they want (ibid.). Researchers have questioned why fertility has not declined by the same magnitude as the increase in contraceptive use (Palamuleni, 2013).

In Southern Malawi, 54% of currently married women report using a modern method (NSO and ICF, 2017), which is consistent with the national picture (no figure is available for unmarried women). Unmet need is 20% among currently married women, slightly higher than the national average. The Southern region has the highest TFR in the country, of 4.6, and the largest gap between TFR and the wanted fertility rate of 3.5 (the level of fertility if all unintended births were prevented) (ibid.).

The Malawi DHS surveys also ask about men's perceptions on contraception. I analysed the datasets from the last three DHS surveys (2004, 2010 and 2015) on the question 'contraception is women's business and a man should not have to worry about it' finding around 70% of men have consistently disagreed (see appendix AB). On the question 'women who use contraception may become promiscuous,' my analysis of the same datasets finds men's agreement to this question has increased over time (from 27% agreeing in 2010 and 32% agreeing in 2015) (see appendix AB).

4.3.3 Status of women

Women's lower status than men in Malawi, which reinforces male domination in household and decision-making, is widely documented (Bisika, 2008; John et al., 2015). Prior comparative DHS studies have graded Malawi very low in terms of the status of women (Kishor and Neitzel, 1996) and the country currently ranks 172 (out of 189 countries) in UNDP's Gender Inequality Index (UNDP,

2020), which includes women's participation in parliament and the labour force. Malawi also ranks in the bottom quartile of the World Economic Forum's Global Gender Gap Index (WEF, 2020), reflecting the significant income divide between men and women (NSO and ICF, 2017).

Marriage is nearly universal, with only 1% of women and 2% of men not marrying by ages 45-49 (NSO and ICF, 2017). Marriage remains the most socially accepted means of procreation in Malawi (Kishindo, 1994). At the same time, marriage is a "fragile institution" (Reniers, 2003:198), with rates of divorces in Malawi's Southern region said to be the highest in sub-Saharan Africa (ibid.). Rates of divorce, separation and being widowed are much higher in women than men (ibid.). While overall rates of men and women currently in union are relatively similar (51% and 66% respectively), women, on average, marry five years earlier than men (NSO and ICF, 2017). This suggests a picture of Malawian women having relationships with older men, also discussed by John et al. (2015), which has been shown to limit women's agency (Luke, 2005). According to Kishindo (1994), divorce threatens the basis of women's economic support, rendering it challenging for them to go against the wishes of their husband. Premarital pregnancies among women are highly stigmatised (Levandowski, 2012).

4.4 Content on engaging men within Malawian national family planning policies

Building on my prior work in South Africa (Charles et al., 2014), I reviewed the content of key policies on contraception in Malawi at the time of my research, looking at the policy content on male gender norms, men's role in supporting their partner's contraceptive use and men as contraceptive users. I found that while there are positive references to the need to engage with men, the policies overall lack specifics or concrete commitments. In particular, there are key gaps in relation to male gender norms, and women are positioned as the primary

users of contraception (with the exception of male condoms, which are principally positioned as for disease prevention).

In terms of male gender norms, the National Condom Strategy 2005 notes how gender norms can lead to men's risky sexual behaviours, though this is mainly positioned within the context of HIV (MoH, 2005). The later National Reproductive Health Strategy 2006-2010 does not discuss male gender norms within the context of contraceptive use, and how these could both impact use and ways they could be addressed (MoH, 2006), which is arguably a significant omission given the Malawian literature in chapter 2. These policies do not contain any specific commitments on ways to engage men to shift restrictive gender norms, such as working with men as advocates for healthier behaviours. This is compared to more forthright assertions on the impact of male gender norms within Malawian HIV policies. For example, the National HIV Prevention Strategy 2009-2013 specifically references masculinities as a determinant of HIV and commits to challenging harmful gender norms. The later National HIV & AIDS Strategic Plan (NSP) 2012-2016 and Policy 2013 note that gender norms underpinning male dominance limit women's influence over SRH, the need for equitable environments where engaging men, and for gender specific programmes (though gender here in the NSP is presumed to mean women only).

In the area of men's role in supporting their partners' use of contraception, The National Reproductive Health Strategy 2006-2010 includes a reference to the importance of this, noting for example concern about men's lack of involvement in family planning practices (MoH, 2006). This is strengthened by the later National SRHR Policy 2009 (MoH, 2009), which includes a specific goal on male involvement in all SRH issues and services. There are limited specifics, however, in terms of ways men should be encouraged to be involved, or on related couple communication and decision-making processes, and nothing

which speaks to safeguarding women's autonomy in the context of engaging men (as found in the HIV policies).

In the area of men as contraceptive users, The National Condom Strategy 2005 notes that partner communication needs to be improved to ensure effective use of condoms for both HIV prevention and family planning, including changing men's perception and use of condoms (MoH, 2005). A similar commitment to condoms is not included in the later National Reproductive Health Strategy 2006-2010. There appear no specific commitments to increasing men's uptake of vasectomy. The subsequent Malawi Health Sector Strategic Plan 2011-2016 has only measures for women's contraceptive use (MoH, 2011), despite acknowledging the need for greater male involvement.

Finally, with respect to men's use of SRH services, the National Reproductive Health Strategy 2006-2010 refers to the need for services to specifically address men's own SRH needs, including being more male friendly, and to initiate behaviour change programmes and public education to increase men's demand for these services (MoH, 2006). This Strategy also highlights the need for infertility to be seen as a couple issue, and not just a women's issue. The later SRHR Policy 2009 goes further, specifically highlighting the need to 'empower men' to access services. There are limited specifics, however, on strategies to increase male client numbers within SRH services, nor discussions on male gender norms around service use.

4.5 Efforts on engaging men in Southern Malawi

Perhaps in recognition of the early acknowledgement of objections by husbands to the use of contraception, the 1990s heralded a small number of specific activities seeking to engage men in family planning, such as a Man-to-Man initiative and child-spacing clubs for men (Mason and Lynam, 1992) co-ordinated by the organisations Banja la Mtsogolo (BLM) and Christian Health Association of Malawi (CHAM) (see below) (Kishindo, 1994). During the time of

my research, I did not encounter any specific NGO activities on male involvement in contraception, which I explore further in chapter 9.

Malawi has a deeper history of activism by NGOs in relation to engaging men in the prevention of GBV and HIV. The most prominent actor in this area in Southern Malawi is an organisation called Men for Gender Equality Now (MEGEN) Malawi, which does not specifically focus on family planning. There have been over 20 years of social marketing of condoms in Malawi to men (Solo et al., 2005), though this appears solely to be within the context of HIV prevention. The Malawi National AIDS Commission (NAC) published a ‘study on the factors associated with male involvement in HIV related services in Malawi’ in 2014 (NAC, 2014) – which itself discusses condoms primarily in the context of HIV – but there was no similar focus on male involvement within the Ministry of Family Planning. The challenges created by men’s limited involvement in contraception were, however, the subject of national media coverage during my research, including a headline in The Nyasa Times, one of Malawi’s national newspapers, that ‘Men shun family planning as Malawi adds 400,000 people annually.’²⁸ My prior engagement with MEGEN while based in South Africa provided me with the perception that, though clearly committed to gender equality, their gender power analysis was limited, and their use of language to engage men could simultaneously reaffirm men’s decision-making authority.

4.6 Overview of research and health service settings in Southern Malawi

I now present a more detailed overview of my two research sites, Blantyre (urban setting) and Chiradzulu (rural setting).

4.6.1 Overview of Blantyre and Chiradzulu

Blantyre is the capital of the Southern Region, and the country’s financial and commercial capital. It has over one million inhabitants, and one of the fastest growing rates of urbanisation globally (Habitat, 2010), with 70% of its population

²⁸ The Nyasa Times, 4 March 2014

living within unplanned settlements (Habitat, 2012). The predominant religion is Christianity, and it has a broad ethnic diversity. MLW's offices are based in the centre of Blantyre.

Chiradzulu lies about 30 kilometres to the north east of Blantyre. The people of Chiradzulu are primarily subsistence farmers, living in matrilineally organised villages. Many men (and to a lesser extent women) from this area travel to Blantyre for labouring and other forms of work. There is limited road and electricity infrastructure. The communities have Chiefs (see below), and traditional courts that settle minor disputes. The predominant religion is Christianity, and the largest ethnic groups Lomwe and Yao. Far less empirical research has taken place in Chiradzulu, as compared to Blantyre. Figure 15 below provides a map of the area, showing both locations.

Figure 8: Map of Blantyre and Chiradzulu



4.6.2 Overview of my research sites

My research sites in Blantyre – the wards of Ndirande South, Bangwe and South Lunzu – are all urban/peri-urban settlements surrounding the city. Most people commute to and from central Blantyre for work using minibus taxis or, for a minority, by car. These settlements are accessible via tarmac road, though often the final part of the journey requires travelling on dirt tracks. Houses range from concrete buildings to mud huts (reflecting its unplanned nature). There is significant urban poverty, with only 11% of households electrified and 49% of people in formal employment (NSO, 2008). Each of these wards has a corresponding government Health Centre.

The research sites in Chizadulu – the traditional authorities (TAs) of Likoswe and Chitera – although only 30 kilometres from Blantyre, have a distinctly rural setting. Most of the people in these TAs do not have electricity. Families typically live in homes made of mud bricks, with a dirt floor and thatched roof (see figure 16). I often observed people repairing their home. People generally charge their mobile phones at charging stations (stalls) run by the companies Airtel or TMN (also a source of male employment). Accessing these communities requires travelling off the main tarmac road, and down long dirt tracks to reach the village centre (where the Health Centre is based for both TAs). A further local source of employment for men is bicycle taxis, which take people returning from Blantyre from the main tarmac road back to the village.

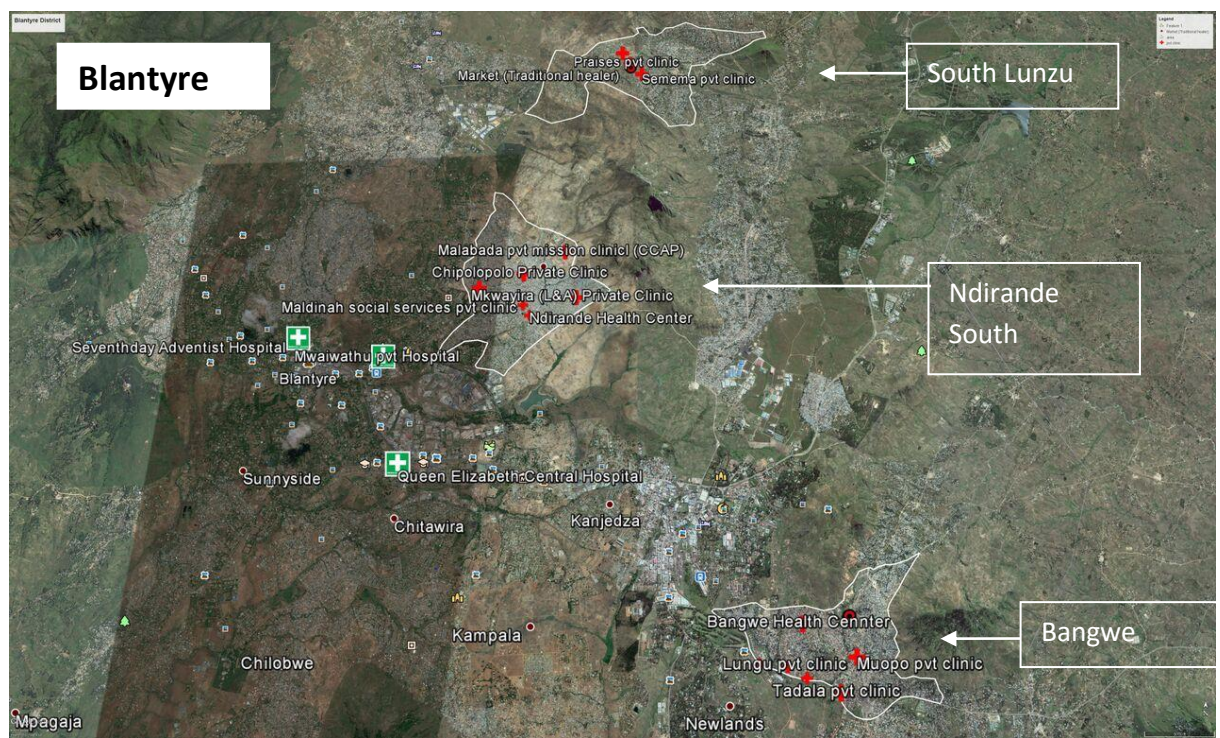
<1% of households are electrified and only 11% of people are in formal employment (NSO, 2008). A greater proportion of health expenditure in Chiradzulu, versus Blantyre, is through external sources outside government (Borghi et al., 2018).



Figure 9: Main road into Chitera, Chiradzulu

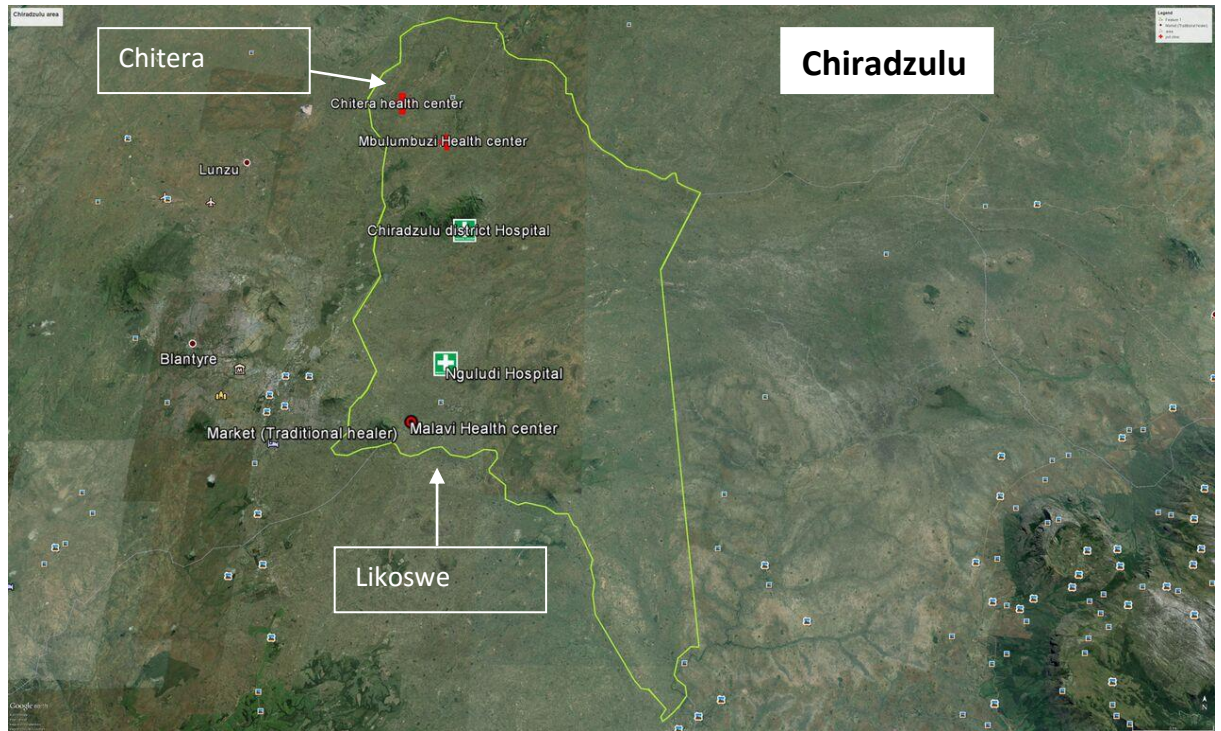
A distinguishing feature of rural Malawi is its social groups (Paz-Soldan et al., 2012). Both Likoswe and Chitera have a Chief (male and female, respectively). The Chief has a council group with whom he/she meets weekly. Monthly meetings would generally be held in each community, or meetings for specific reasons (such as when I disseminated my research findings). The regular meetings discuss issues concerning the community, and nominate or ask people to participate in groups related to various village functions or NGO projects (ibid.). For example, engagement in NGO-run women’s village savings schemes was discussed first at these meetings. Figures 17 and 18 below provide maps of both Blantyre and Chiradzulu created for my study²⁹ which highlight these wards/TAs and the corresponding health facilities (noted in chapter 3).

Figure 10: Map of my Blantyre research sites



²⁹ These maps were developed by Wisdom Shonga at MLW in July 2015, using Google Earth after collecting GPS coordinates of each facility

Figure 11: Map of my Chiradzulu research sites



4.6.3 Contraceptive health system and provision in Blantyre and Chiradzulu

The principal provider of contraceptive services across Southern Malawi (and Malawi as a whole) is the public sector (government), through a network of district hospitals (serving the broader population), health centres (for specific areas/villages) and health posts. Government services are also provided through mobile clinics, HSAs and community-based distributors. Seventy nine percent of all modern contraceptives used by women in Malawi are obtained from the public sector (NSO and ICF, 2017). Contraception is free, though there are often hidden costs (such as transport to clinics). In theory, a broad range of contraceptive methods are available, but in practice it appeared to me that options are often limited, particularly to the contraceptive injection or implant.

The public provision of contraceptive services is largely targeted towards pregnant women through ANC. During ante-natal clinics, women are counselled on contraceptive use, or couples are counselled jointly should male partners

also attend. After giving birth, women (or couples) are advised not to have sex for six weeks. At a six-week post-natal check-up, women are offered contraceptive methods. During my observational research I found public clinics generally have specific days allocated for women to access contraceptive methods during consultations (which were different from days allocated for HIV treatment), and this set-up was widely known among women and men. HIV and contraceptive services were combined for women through ANC, where women were encouraged to be tested and to bring their male partner for testing. There was no specific set-up for male contraception. Men could access condoms via consultation rooms (normally for HIV services) in public clinics.

The private sector is also a key service provider, often offering greater method choice and flexibility in timing of consultations for contraceptive methods, but is limited by regulations in what it can provide. The aforementioned NGO BLM is the second biggest provider of contraceptive services in Malawi, and a significant provider within Southern Malawi (mainly urban areas). Unlike public services, clients pay a fee for accessing BLM services (though these are often subsidised by government). Vasectomy is only available in Southern Malawi through BLM, via appointment, as in other areas of the country (Machiyama et al., 2015).

CHAM, an ecumenical NGO, is also a significant provider of contraceptive services in Malawi. Within Chiradzulu, the CHAM hospital is the sole health facility covering a broad radius. The CHAM network is smaller than BLM, and focuses on a broad range of areas, including female contraception. Clients also pay for contraceptive services, though these are often subsidised.

A range of private providers also offer services, including private hospitals, pharmacies, doctors and mobile clinics. Several NGOs, such as the Family Planning Association of Malawi (FPAM) also run clinics in Malawi. All private providers charge a fee. Condoms can be bought over the counter in many

private clinics. Not all private providers offer contraceptive services, due to government regulations, and also for religious reasons.

As the above maps highlight, Blantyre had a far greater range of public and private services than Chiradzulu. As such, the District Hospital in Chiradzulu serves many of the local areas which do not have health facilities. Fewer NGOs were also based in Chiradzulu. The one exception is MSF, which had a significant presence across the Chiradzulu health system. MSF trained and placed staff members within the Chiradzulu clinics and provided overall operational support to the local health administration and also ran women's community groups. I met regularly with MSF during my research to discuss my findings.

4.7 Summary

This chapter has provided additional background to male involvement in Malawi. I began with an overview of Malawi's colonial and post-colonial history, and how that has informed the lower status of women, and shaped family planning narratives and men's limited involvement, as well as the fusion of AIDS and population control concerns. I then discussed the country's political situation, religious, ethnic and cultural, and socio-economic context, which all inform male gender norms. I also provided details on the current SRH, family planning and women's empowerment outcomes in Malawi. Following this, I provided an overview of the content of relevant Malawian policies at the time of my research, and programme efforts to engage men, both of which are limited in their focus on male gender norms and male involvement, and present condoms as primarily a method of disease prevention. The final part of this chapter provided greater detail on my research sites and their socio-economic and cultural contexts, and on the contraceptive health system and its structures within these areas which reflect a primary focus on women. I now turn to my results chapters.

Chapter 5: Men's gendered contraceptive understanding, attitudes and use

5.1 Introduction

This first results chapter presents my findings on use, knowledge and attitudes towards contraception among men in Southern Malawi. I begin with my quantitative data on male reports of current contraceptive use with their wives/partners, and frequency of condom use when having sex in the last 12 months, and explore the quantitative relationship between contraception and condoms. I then discuss my qualitative findings on men's differing understanding of the term 'family planning', and related semantic considerations in Chichewa, following which I look at men's knowledge, perceptions and behaviours in relation to both male and female contraceptive methods. This analysis focuses principally on the only two male methods available in Southern Malawi, condoms and vasectomy, given the limited knowledge base regarding these methods and the need to increase their uptake (Perry et al., 2016). I conclude by discussing men's perception of current information flows on contraception, and men's desire to improve their understanding in the area of male involvement. This chapter sets the scene for the following chapters, where I explore a range of male gender norms, and how these impact on male involvement. It responds to research question one: What is the understanding of and attitudes towards contraceptive use and family planning among men in Southern Malawi (including reported contraceptive method use)?

5.2 Men's reported contraceptive method use in relationships

My quantitative and qualitative methods included questions to men in relationships about current contraceptive method use. As noted in chapter 3, existing quantitative research on contraceptive use and behaviours in Malawi, and more broadly, often use data from women as their base, including using female reports on men's behaviours as a proxy (Palamuleni, 2013). I aimed to

provide further nuance to this existing knowledge base through exploring male reports in my study.

5.2.1 Contraceptive method use and associations

I asked men in Southern Malawi to respond to the question 'If married/in a relationship, are you currently using any kind of family planning method with your partner (such as the contraceptive pill, contraceptive injectable, male or female condom).'³⁰ A total of 224 men responded. Among those men, the majority (72%) reported using such methods. Table 8 below provides associations of contraceptive use among men, including both demographic variables and sexual behaviours. Details on the types of methods used are included further below.

³⁰ The question was targeted at men in stable partnerships and allowed men to choose whether they wished to respond given their relationship status.

Table 8: Associations of men's reported current contraceptive method use with their wife/partner by demographic variables and sexual behaviours (men in relationships in Southern Malawi, n=224)

	No of men	No using contraceptive method (%)	Unadjusted odds ratio (OR) (95% CI)	Adjusted odds ratio (AOR) ³¹ (95% CI)	p-value ³²
Total	224	162 (72.3%)			
Location					
- Urban	112	73 (65.2%)	1	1	0.07
- Rural	112	89 (79.5%)	2.07 (1.13, 3.77)	2.14 (0.92, 4.96)	
Age					
- 18-24 years	38	26 (68.4%)	0.65 (0.29, 1.46)	1.33 (0.43, 4.12)	0.10
- 25-34 years	113	87 (77.0%)	1	1	
- 35-49 years	56	41 (73.2%)	0.82 (0.39, 1.71)	0.61 (0.23, 1.59)	
- 50-59 years	17	8 (47.1%)	0.27 (0.10, 0.76)	0.16 (0.04, 0.73)	
Relationship status					
- Married	167	119 (71.3%)	1	1	0.04
- Not married	57	43 (75.4%)	1.24 (0.62, 2.47)	2.85 (1.04, 7.86)	
Education					
- No education/ Any primary	99	71 (71.7%)	0.88 (0.47, 1.63)	0.95 (0.43, 2.09)	0.98
- Any secondary	105	78 (74.3%)	1	1	
- Any tertiary	19	13 (68.4%)	0.75 (0.26, 2.17)	1.05 (0.29, 3.85)	
No of children					
- No children	38	20 (52.6%)	0.31 (0.14, 0.67)	0.14 (0.04, 0.51)	0.004
- 1-2 children	102	80 (78.4%)	1	1	
- 3+ children	84	62 (73.8%)	0.78 (0.39, 1.53)	1.42 (0.57, 3.57)	
Employment status					
- Employed	132	96 (72.7%)	1	1	0.91
- Unemployed	83	60 (72.3%)	0.98 (0.53, 1.81)	0.95 (0.42, 2.16)	
Ethnicity					
- Lomwe	121	90 (74.4%)	1	1	0.71
- Yao	31	20 (64.5%)	0.63 (0.27, 1.45)	0.68 (0.25, 1.84)	
- Ngoni	25	18 (72.0%)	0.89 (0.34, 2.32)	1.50 (0.44, 5.15)	
- Chewa	16	13 (81.3%)	1.49 (0.40, 5.59)	2.24 (0.42, 11.96)	
- Other	30	20 (66.7%)	0.69 (0.29, 1.63)	1.14 (0.38, 3.41)	

³¹ Adjusting for all other demographic and sexual behaviour factors listed in the table.

³² This p value corresponds to the AOR.

Religion					
- Protestant	71	49 (69.0%)	1	1	0.49
- Catholic	55	41 (74.6%)	1.31 (0.60, 2.89)	1.24 (0.49, 3.16)	
- Pentecostal	59	44 (74.6%)	1.32 (0.61, 2.85)	1.96 (0.76, 5.05)	
- Other (inc Baptist, Anglican)	38	27 (71.1%)	1.10 (0.47, 2.61)	0.92 (0.34, 2.48)	
Ever HIV Test					
- Yes	179	135 (75.4%)	1	1	0.01
- No	45	27 (60.0%)	0.49 (0.25, 0.97)	0.35 (0.15, 0.81)	
Ever Had STI					
- Yes	24	19 (79.2%)	1.62 (0.58, 4.54)	1.75 (0.48, 6.30)	0.39
- No	191	134 (70.2%)	1	1	

These results show that rural men had twice the odds of being contraceptive users compared to those in urban settings (AOR 2.14, 95% CI 0.92-4.96, $p=0.07$) and men 18-24 years had greater odds of being a user than those aged 25-34 years (AOR 1.33, 95% CI 0.43-4.12, $p=0.10$) while those aged 35-49 years and 50-59 years were less likely to be users than their younger counterparts (AOR 0.61, 95% CI 0.23-1.59 and AOR 0.16, 95% CI 0.04-0.73, $p=0.10$, respectively), although neither of these results reached statistical significance. Men in a relationship but unmarried had almost three times the odds of being a contraceptive user (AOR 2.85, CI 1.04-7.86, $p<0.05$) compared to married men, a correlation which I discuss further below. Contraceptive use was strongly associated with the number of children a man has. I found those with no children were less likely to be users (AOR 0.14, 95% CI 0.04-0.51, $p<0.005$) and those with 3+ children had 1.42 times the odds of reporting contraceptive use (AOR 1.42, 95% CI 0.57-3.57, $p<0.005$) compared with those with 1-2 children. Contraceptive use was also associated with HIV testing, with those who had never tested being much less likely to report use (AOR 0.35, 95% CI 0.15-0.81, $p=0.01$) compared to those who had tested. Education, employment status, ethnicity, and religion had no significant impact on reported contraceptive use. Men who were not in a relationship (and therefore excluded from this analysis) were mainly urban, 18-24 years old, had secondary level education and no children.

The overall rate I found of men reporting contraceptive use in relationships (72.3%) is higher than the Malawi DHS 2010 (which found 42% married and 54.6% unmarried men reporting using a method at last sexual intercourse), but my findings mirror DHS on a greater proportion of unmarried men than married men reporting using a method (NSO and ICF, 2011). It also mirrors the national IMAGES findings (Zamawe et al., 2014). My data covers a greater age range than DHS (which is only up to 49 years) and I asked men about contraceptive use with one's partner/wife, rather than at last sexual intercourse as in the DHS. Men also opted to answer this IMAGES question if they were in a relationship. Men could be unaware perhaps of their partners' contraceptive behaviour, due to a lack of partner communication (discussed in the next chapter). There may have been measurement errors due to men's high number of sexual partners (discussed in chapter 8). These factors may have impacted the higher overall reported rates.

5.2.2 Types of contraceptive method use within relationships

The IMAGES survey did not ask further questions about the contraceptive method type among those men who reported being users. In order to increase understanding, I collected this data from my follow-up qualitative sample. I asked men in relationships whether they were using contraception and if so, what methods. The findings are outlined below in table 9. Thirty one men in my qualitative sample were in relationships (married or unmarried), among whom 26 men (83% of those in a relationship) stated they were using contraception with their partner.

Overall, female-initiated methods³³ accounted for 81% of all methods men in relationships reported using with their partner, of which the contraceptive injection was by far the most common method (62%), which was consistent

³³ "Female-initiated contraceptive methods help give women more control over their sexual and reproductive lives, their own fertility, and decisions about whether, when, and with whom they'll have children." (PATH, 2016: para. 1)

across urban and rural contexts, and reflects women's reports in the last two Malawi DHS surveys (NSO and ICF, 2011, 2017). All reported methods used were modern methods (no traditional method was stated by participants).³⁴ My observation and informal conversations within clinical settings found only the Depo-Provera brand of contraceptive injections (often called Depo for short) being administered, which lasts three months. Contraceptive injections were also commonly known as 'Jacksons,' slang based on the Chichewa word for injection, *jakisoni*. It was reported that Depo-Provera was not always available at clinics, and as such, long-term sub-dermal progestin implants – typically Norplant (levonorgestrel) – were beginning to be offered, the uptake of which was yet to be determined. No respondents reported using oral contraceptive pills, perhaps reflecting challenges with its availability, and people favouring Depo-Provera because it is more reliable, avoids the need to take a tablet every day and cheaper than the pill if bought privately.³⁵ No men reported having a vasectomy, availability of which is extremely limited in Southern Malawi as I discuss in chapter 9, and its use across Malawi has remained at less than 1% since 2010 (*ibid.*).

I found clear differences between married and unmarried men's reports of method type. All married men reported relying on female-initiated methods in their relationship (none were using male methods), with the vast majority (76%) using the injection, which mirrors DHS data on married men most commonly reporting the injection as their current contraceptive method (NSO and ICF, 2011). I found the IUD to be the second most commonly used method reported by married men (14%). Among unmarried men, all reported using the male condom as their contraceptive method. This also mirrors the Malawi DHS findings, which reported that the male condom is by far the most common contraceptive method used among sexually active unmarried men (*ibid.*).

³⁴ Traditional methods include the calendar or rhythm method and withdrawal (WHO, 2019).

³⁵ My discussions with public health providers also highlighted there was generally a push for women to take more long-acting reversible contraception (LARC), perhaps reflecting the priorities of USAID (a major donor in the country). LARCs have lower failure rate, and many women prefer Depo-Provera as it can also be concealed (as I discuss in chapter 6).

Table 9: Current contraceptive use by methods (men in relationships in Southern Malawi among qualitative sample, n=26)

Which contraceptive method are you or your primary partner/wife using? (n=26)	Location			Relationship status	
	Total (%)	Urban (n=12)	Rural (n=14)	Married (n=21)	Not married (n=5)
Injection (Depo-Provera)	16 (62%)	7 (58%)	9 (64%)	16 (76%)	0
Implant	1 (4%)	0	1 (7%)	1 (5%)	0
Intrauterine device (IUD)	4 (15%)	2 (17%)	2 (14%)	4 (19%)	0
Oral contraceptive pill	0	0	0	0	0
Male condoms	5 (19%)	3 (25%)	2 (14%)	0	5 (100%)
Female condoms	0	0	0	0	0
Vasectomy	0	0	0	0	0
Other	0	0	0	0	0

5.3 Frequency of condom use during sex

I also asked men in the IMAGES survey about the frequency of their condom use when having sex in the last 12 months, using a Likert scale with four options (always use, mostly use, occasionally use and don't use condoms), the results of which are in table 10 below.

Among sexually active men, 79% said they either occasionally use or didn't use a condom when having sex (43% and 36%, respectively), highlighting reported inconsistency of condom use among men in Southern Malawi. Only 10% of men reported that they always used condoms. There was no significant difference between reported condom use among urban and rural men. The likelihood of not using condoms increased with age, with 20% of men ages 18-24 years, 37% of 25-34 year olds, 52% of 35-49 year olds, and 67% of 50-59 year olds reporting not doing so ($p < 0.001$). Married men were more likely to report not using condoms (49%), followed by men in a relationship (31%) and then single men, among whom only 12% report not doing so ($p = < 0.001$). As men increased their number of children a greater proportion did not use condoms, with 17% of

men with no children reporting not doing so compared to 52% of men with 3+ children ($p < 0.001$).

Table 10: Men's reported condom use frequency when having sex in the past year, by demographic variables and sexual behaviours (sexually active men in Southern Malawi, $n=324$)³⁶

	No of men	I always use a condom	I mostly use a condom	I occasionally use a condom	I don't use them	p-value
Total	324	33 (10.2%)	35 (10.8%)	138 (42.6%)	118 (36.4%)	
Location						0.16
- Urban	178	23 (12.9%)	20 (11.2%)	78 (43.8%)	57 (32.0%)	
- Rural	146	10 (6.9%)	15 (10.3%)	60 (41.1%)	61 (41.8%)	
Age						<0.001
- 18-24 years	102	21 (20.6%)	10 (9.8%)	51 (50%)	20 (19.6%)	
- 25-34 years	137	9 (6.6%)	17 (12.4%)	60 (43.8%)	51 (37.2%)	
- 35-49 years	67	3 (4.5%)	8 (11.9%)	21 (31.3%)	35 (52.2%)	
- 50-59 years	18	0	0	6 (33.3%)	12 (66.7%)	
Relationship status						<0.001
- Married	175	4 (2.3%)	12 (6.9%)	73 (41.7%)	86 (49.1%)	
- In relationship, not married	74	10 (13.5%)	9 (12.2%)	32 (43.2%)	23 (31.1%)	
- Single/not in relationship	75	28 (25.3%)	16 (18.7%)	42 (44.0%)	47 (12%)	
Education						0.24
- No education/ Any primary	131	9 (6.9%)	14 (10.7%)	50 (38.2%)	58 (44.3%)	
- Any secondary	163	21 (12.9%)	18 (11.0%)	74 (45.4%)	50 (30.7%)	
- Any tertiary	28	3 (10.7%)	3 (10.7%)	14 (50%)	8 (28.6%)	
No of children						<0.001
- No children	115	25 (21.7%)	17 (14.8%)	53 (46.1%)	20 (17.4%)	
- 1-2 children	116	6 (5.2%)	10 (8.6%)	50 (43.1%)	50 (43.1%)	
- 3+ children	93	2 (2.2%)	8 (8.6%)	35 (37.6%)	48 (51.6%)	
Employment status						0.03
- Employed	167	14 (8.4%)	12 (7.2%)	71 (42.5%)	70 (41.9%)	
- Unemployed	145	17 (11.7%)	23 (15.9%)	61 (42.1%)	44 (30.3%)	

³⁶ I excluded men ($n=70$) who said they had no sexual partner in the separate question on number of sexual partners in the past year. An additional 45 men were excluded from the sample for not responding.

Ever HIV Test						0.10
- Yes	253	31 (12.3%)	28 (11.1%)	107 (42.3%)	87 (34.4%)	
- No	71	2 (2.8%)	7(9.9%)	31 (43.7%)	31 (43.7%)	
Ever Had STI						0.80
- Yes	30	3 (10.0%)	5 (16.7%)	12 (40%)	10 (33.3%)	
- No	280	27 (9.6%)	30 (10.7%)	119 (42.5%)	104 (37.1%)	

For the purposes of further analysis I combined these condom use frequency options into two categories (always/mostly and occasionally/don't use) to explore the associations of greater condom use when having sex in the last 12 months. The results are outlined in table 11 below. Overall, only 21% of men reported always/mostly using condoms. I found a less clear trend with respect to age, which was not statistically significant, and influenced by relationship status, as I explore below. Compared to married men, those in relationships but not married had almost four times the odds of always/mostly using condoms (AOR 3.86, 95% CI 1.63-9.15, $p < 0.001$) and single men (those not in a relationship) had seven times the odds of doing so (AOR 7.27, 95% CI 2.78-10.01, $p < 0.001$). Men's odds of always/mostly using condoms decreased as they had more children, reflecting the trend in table 10, though this was not significant. In addition, men who had tested for HIV had almost three times the odds of always/mostly using condoms (AOR 2.62, 95% CI 1.12-6.11, $p = 0.03$). Education, as well as employment status, ethnicity and religion (excluded from table) had no significant impact on predicting always/mostly using condoms.

Table 11: Associations of men's always/mostly using condoms when having sex in the past year, by demographic variables and sexual behaviours (sexually active men in Southern Malawi, n=324)

	No of men	No (%) always/mostly using condoms	Unadjusted odds ratio (OR) (95% CI)	Adjusted odds ratio (AOR) ³⁷ (95% CI)	p-value
Total	324	68 (21.0%)			
Location					
- Urban	178	54 (24.2%)	1	1	0.76
- Rural	146	25 (17.1%)	0.65 (0.37, 1.13)	1.11 (0.57, 2.16)	
Age					
- 18-24 years	102	31 (30.4%)	1.86 (1.02, 3.40)	0.67 (0.28, 1.60)	0.55
- 25-34 years	137	26 (19.0%)	1	1	
- 35-49 years	67	11 (16.4%)	0.84 (0.39, 1.82)	1.28 (0.48, 3.40)	
- 50-59 years	18	0 (0.00%)	-	-	
Relationship status					
- Married	175	16 (9.1%)	1	1	<0.001
- In relationship, not married	74	19 (25.7%)	3.43 (1.65, 7.14)	3.86 (1.63, 9.15)	
- Single/not in relationship	75	33 (44%)	7.80 (3.93, 15.52)	7.27 (2.78, 19.01)	
Education					
- No education/ Any primary	163	39 (23.9%)	0.68 (0.38, 1.2)	0.89 (0.44, 1.79)	0.26
- Any secondary	131	23 (17.6%)	1	1	
- Any tertiary	28	6 (21.4%)	0.87 (0.33, 2.3)	0.37 (0.11, 1.21)	
No of children					
- No children	115	42 (36.5%)	1	1	0.23
- 1-2 children	116	16 (13.8%)	0.28 (0.15, 0.53)	0.46 (0.18, 1.17)	
- 3+ children	93	10 (10.8%)	0.21 (0.1, 0.45)	0.43 (0.13, 1.43)	
Ever HIV Test					
- Yes	253	59 (23.3%)	2.10 (0.98, 4.47)	2.62 (1.12, 6.11)	0.03
- No	71	9 (12.7%)	1	1	
Ever had STI					
- Yes	30	8 (26.7%)	1.42 (0.60, 3.36)	2.39 (0.83, 6.89)	0.10
- No	280	57 (20.4%)	1	1	

The large difference between the unadjusted and adjusted odds ratio for the location and age variables indicates the presence of statistical confounding. I

³⁷ Adjusting for all other factors listed in the table

found that this was mainly driven by relationship status, with single men being much more likely to almost/mostly use condoms. Men in urban areas were almost three times as likely to be single compared to their rural counterparts (74% versus 26%). Seventy one percent of men aged 18-24 were single, compared to 22% of men aged 25-34, and only 4% of those aged 35-49 and 2% of those aged 50-59.

I explored the relationship between contraceptive use in relationships and frequency of condom use in the past 12 months (tables 8 and 10 above), which did not identify a clear pattern. Table 12 below highlights those findings.

Table 12: Cross-tabulations between men’s reported frequency of condom use when having sex in the past year and contraceptive use with their wife/partner (men in relationships in Southern Malawi, n=218)

	No of men	I always use a condom	I mostly use a condom	I occasionally use a condom	I don’t use them	p-value
Contraceptive use response						0.001
- Using a method	159	5 (3.1%)	14 (8.8%)	80 (50.3%)	60 (37.7%)	
- Not using a method	59	4 (6.8%)	5 (8.5%)	13 (22.0%)	37 (62.7%)	

This analysis shows that among men in relationships, both those using contraception with their partner and those not doing so, gave broadly similar responses on their frequency of condom use (that they primarily only occasionally or didn’t use condoms). The main difference was that a greater proportion of contraceptive users reported occasionally using condoms rather than not using condoms (50% versus 38%), while the reverse was true of non-users: a greater proportion of those not reporting using contraception said they did not use condoms rather than occasionally used (63% versus 22%). I then stratified only those who used contraception (n=159, excluding non-users) by relationship status to explore any differences in their condom frequency reports

(not shown). I found that a greater proportion of married male contraceptive users did not use condoms as opposed to their unmarried male counterparts (42% versus 27%). A greater proportion of unmarried contraceptive users reported always or mostly using condoms (compared to married men) (22% versus 9%). Overall, however, both married and unmarried contraceptive users reported poor condom use frequency, reflecting table 10 above.

These findings nevertheless reflect the trend of unmarried men reporting that contraception includes condom use (more so than married men), as also identified by DHS (NSO and ICF, 2011), but highlights this is in the context of overall inconsistent condom use. I explore this further qualitatively below. Exploring the relationship between contraception and condoms is complicated by the fact that my questions measure two different things – contraceptive use with one’s partner, and frequency of men’s condom use during sex – and is further challenged by men in all relationship status groups reporting multiple concurrent sexual partners, as I explore in chapter 8.

5.4 Qualitative research on men’s contraceptive understandings, perceptions and behaviours

Overall, my quantitative data found greater odds of unmarried men being a contraceptive user versus married men (table 8), different method reports among married and unmarried men (the former relying solely on female methods and the latter using male condoms) (table 9), inconsistent frequency of condom use among all men (table 10), and the lack of a clear trend between the measures for contraceptive use and frequency of condom use (table 12). Given the discrepancies or contradictions that have been found in men’s contraceptive reports in Malawi (Miller et al., 2001) and South Africa (Maharaj and Cleland, 2005; Ngcobo et al., 2019), I therefore sought to contextualise these quantitative findings with qualitative research and, in particular, add to extant understanding around male methods and the reasons underpinning men’s contraceptive practices.

My qualitative research begins with men's understanding of the concept of family planning, which provides important context to the subsequent findings. I then explore men's understanding of male methods, men's use of male condoms as a contraceptive method, contradictions and confounding factors in men's condom behaviours, men's perceptions and behaviours related to vasectomy, and men's knowledge and perception of female contraceptive methods. I then conclude by exploring my findings around men's gendered access to contraceptive information and men's desire for greater involvement.

5.4.1 Men's understanding of family planning

Despite the differences between the terms 'family planning' (considerations of family size) and 'contraceptive methods' (to avoid unintended pregnancy), in Malawi 'family planning' is often used as shorthand for contraceptive methods (particularly female methods). For example, the Malawi DHS Survey uses 'family planning' synonymously with contraceptive methods, as does much of the Malawi literature I found (see Gipson et al., 2010; Shattuck et al., 2011; Bornstein et al., 2020a, among others). In my conversations with Malawian men, however, I found they made a distinction between these terms, which informed their views about methods.

For most married men, whether they reported using contraception or not with their partner, I found their primary response was that family planning is a question of one's family size, not of methods. This related particularly to decision-making within marriage, as I discuss in the next chapter, and the financial implications of multiple children, as I discuss in chapter 7. For example, this adult married man, who reported that his wife used the injection, explained this understanding of family planning in a line of questioning intended to be about methods:

I: Are you involved in family planning methods at home?

P: Yes. Right now I have a firstborn who is six years old going on

seven. We are expecting our second-born. My wife is two to three months pregnant. So you can see the age range. It is something that we sat down and discussed. It is why our firstborn reached this stage and is now in standard 2. (IDI-NS-8 male, urban, married, 32yrs, 1child)

Informal conversations in my research communities confirmed that talking about the concept of family planning to married men elicits a primary consideration of family size. The history of contraceptive provision in Malawi is central to understanding this. As I noted in chapter 4, when the National Child Spacing Programme began in the 1980s, the main vehicle through which contraceptive methods became available, it was seen as a disguised attempt to control family size in a cultural context where child limiting was forbidden (Chintsanya, 2013). The Programme focused primarily on women with little, or no, emphasis on men (Kishindo, 1994). This historical legacy remains embedded in the culture and is reflected in the following quote from an older rural married man during a FGD in response to the question why Malawi is lagging behind compared to other countries in contraceptive use:

Teaching on these family planning methods came here late... During the time of our ancestors, when one would say, 'I want to practice family planning,' they [men] would say, 'We need a clan.'³⁸ So it has taken time for people to understand them. When talking about family planning, they say women should practise family planning, forgetting that both men and women are supposed to practise family planning. (FGD-CHI-9 male, rural, married, 52yrs, 2chldn)

Among unmarried men in relationships during IDIs, there was a perception that family planning was not relevant to them, although they used condoms with their partner to prevent pregnancy, the implications of which I discuss below.

During my research, much of the public discussion, including the media, used the term 'family planning' as synonymous with contraception. Men viewed family planning services (as they are called in Southern Malawi) which provided contraception as 'women and children' spaces, and they are orientated as such,

³⁸ Clan refers to a large family grouping or tribe.

as I discuss in chapter 9. My findings reflect those of Paz-Soldan (2004) whose qualitative research with men and women in South-eastern Malawi similarly found men to talk less about contraceptive methods, than the pros and cons of having smaller families. I did not identify more recent research in Malawi specifically asking men about how they perceive the term family planning. My findings reflect qualitative research in Kenya, finding married men's greater concern was family size rather than methods (Withers, 2015a).

In addition to the above, I found men would sometimes jump back and forth between the two different semantic interpretations of the term 'family planning' or speak about both family size considerations and methods in the same sentence. Here for example, an adult married man whose wife uses the injection, responds to the same question asked above to IDI-NS-8:

- I: Are you involved in family planning methods at home?*
P: Yes
I: What areas are you involved in?
P: We discuss the number of children we should have in our family. We discuss that to avoid unexpected children, she should go for the injection, so the other children we have can grow properly. (IDI-LIK-8 male, rural, married, 27yrs, 1child)

In discussing this matter with the research team, an important linguistic matter was raised: in Chichewa, there is only one word for family planning, *kulera*, and this word is used synonymously for contraception, meaning there is no distinction in the language between these concepts. Context was therefore critically important, and this could render interpretation of men's responses complex, both to IMAGES and the qualitative research.

In the presentation of these results, I employ contraception to refer to the methods, and family planning to considerations of family size. I have left the quotes as originally spoken, and added additional clarification, where necessary.

5.4.2 Men's awareness of male methods

Men were asked during IDIs which male contraceptive methods they were aware of, in response to which a quarter of men interviewed, mostly married, could not mention any methods, with rural men appearing to have the least knowledge. Condoms were mentioned by just over half of the men interviewed. Only a portion of married men could name a male method, among which condoms was the most common response. This differed from unmarried men in relationships who were all able to name condoms as a male method. The greater ease in which unmarried men mentioned the male condom as a method, compared to their married counterparts, is in accordance with their reported contraceptive use (table 9 above).

On vasectomy, only a small number of married or unmarried men mentioned this method initially and, on probing, around half of this group said they had only heard of its existence but could not provide many details about it, mirroring DHS findings on limited knowledge of vasectomy in Malawi (NSO and ICF, 2017). IDI conversations on this method solicited much greater confusion and hilarity among men, compared to asking them about condoms.

Reflecting men's limited knowledge of vasectomy, many married men who explained that they had heard of this method expressed their understanding in vague terms, such as this adult man whose wife used an IUD:

I just hear of them [male methods] but I really don't know them. They say that they incise the duct, that's all that I know. [laughing] (IDI-BAN-7 male, urban, married, 25yrs, 1child)

Some men reacted with surprise that this method would prevent pregnancy and asked whether vasectomy and tubal ligation were the same thing.

Reflecting married men's poorer understanding of male methods, some within this group appeared unsure about the rationale of the question, such as this older urban man, who said his wife used the contraceptive injection:

- I: Which family planning methods for men do you know?*
P: Um. But 90% of family planning methods are for women (IDI-BAN-2 male, urban, married, 50yrs, 4chldn)

Despite this man having 4 children, his broader responses presented a sense of contraception being something that he is a passive beneficiary of, rather than taking any meaningful role in. I found similar surprise to this question in rural areas, such as this younger married man, whose wife also took the contraceptive injection, reacting as follows:

- I: Which family planning methods for men do you know?*
P: Men can also undergo family planning? (IDI-CHI-8 male, rural, married, 23yrs, Nochldn)

Other married men responded that they only knew female methods or presumed the question related to female methods, for example this adult man who said he was not using contraception with his wife:

- I: Which family planning methods specifically for men are you aware of?*
P: I only know of one method where you are given an injection, I am not sure what they do, but that's the only method I know (IDI-BAN-5 male, urban, married, 27yrs, 1child)

A distinction that presented itself was that, while some married men mentioned condoms in the context of this question, it was not necessarily regarded as a male method as this adult married man noted, whose partner was also using the contraceptive injection:

- I: What family planning methods specifically for men are you aware of?*
P: For men?
I: Yes
P: No, there are not any family planning methods for men. The one thing I know about for men is condom use (IDI-SL-4 male, urban, married, 25yrs, 2chldn)

This conceptual separation between 'condoms' and 'male methods' reinforced the sense that contraceptive methods was a matter for women. Contraceptive

methods were therefore understood as feminine and incongruent with masculinities. This also links to the broader orientation of the male condom, as I discuss below.

Sexually active single young men presented a general lack of understanding on the question of male methods, with one asking:

Are there family planning methods for men? (IDI-LIK-5 male, rural, single, 18yrs, Nochldn)

These young men also reflected the fact that they may not know about methods for men, but they understand this is a matter for women, reflecting the early socialisation of women's responsibility for pregnancy prevention, such as this young man who reported not yet being sexually active and after responding twice that he did not know any male method, then said:

Hmm, I don't know. Maybe when I become a man. I just know that it's women who go for it [contraception]. I don't know about men. (IDI-NS-1 male, urban, single, 22yrs)

Throughout my qualitative research condoms were implicitly and explicitly discussed as male (not female) condoms, even if men did not make that distinction. During separate questioning, both men and women expressed attitudinal barriers around female condoms, as well as embarrassment around women seeking to access them. For example, this adult married woman explained during a FGD:

People are afraid to put on a female condom because they don't know how to put it on. They are afraid that it may go deep inside and cause some problems. That is why we let men wear condoms. (FGD-CHI2-6 female, rural, married, 34yrs, 4chldn)

In my other FGD with women, the group gave a collective response of 'mmmmmh' when questioned about female condoms, reflecting that they may not have previously been asked about this method. These findings reflect the Malawi DHS on female condoms being rarely used (NSO and ICF, 2017) and

given this, I focused my questioning primarily on male condoms.

During my time in Malawi there were several official campaigns in my research communities and nationally, particularly on billboards and radio, promoting the use of male condoms to prevent HIV. Unsurprisingly, therefore, men in my research understood the benefits of condoms for preventing HIV and other STIs. Despite this, while not all men may see the male condom as a male method, I found men to equally widely understand that condoms prevented pregnancy. This well-developed understanding of the dual protective benefits of condoms among married and unmarried men mirror's Maharaj's (2006 and et al. 2006) findings in South Africa, and does not appear to have been previously explored in empirical research in Malawi.

5.4.3 Male condom use as a contraceptive method

My study found clear differences in how married and unmarried men, who said they were contraceptive users with their partners, talked about and reported *actually* using condoms for pregnancy prevention. For married men, across both urban and rural contexts, condoms were universally not acceptable as a method of contraception with their wife. This reiterates my finding in table 9 above that no married male user reported condoms as the contraceptive method they used in their relationship.

One of the primary reasons for this was that, in the view of married men, their wives were the ones responsible for using contraception. As such, just as contraception was feminised, being a user oneself as a married man was not consistent with performing one's masculinity. For example, this adult married man, who reported not using condoms in the last 12 months and that his wife uses the injection, noted:

- I: Do you prefer to use condoms or not during sex*
P: I use family planning methods – my wife is the one who uses it
I: Which family planning method do you use?

P: Injection
I: You mean you do not prefer using condoms?
P: Yes, I do not use condoms with my wife. My wife uses the injection method of family planning
I: Ok, why do you not use condoms?
P: Because we are a family, we agreed on one thing, to use injection as a family planning method. If I use a condom, my wife will be surprised.
(IDI-LIK-9 male, rural, married, 31yrs, 2chldn)

This man (IDI-LIK-9)'s description of himself as a 'user', though his wife takes the method, while perhaps unsurprising in the context of marriage, may reflect why some men only named female methods when asked about their knowledge of male methods. It also reiterates that women being the actual users of methods in marriage, not men, is consistent with men's construction of masculinity. During FGDs, this broader sense among married men that they do not use methods directly themselves was reiterated:

Aaah, men do not adopt family planning methods, even condoms. There are very few and they are just rare. (FGD-NS-6 male, urban, married, 26yrs, 1child)

Married men also told me that condoms were not culturally appropriate in marriage. Here an adult married man, who said he had not used condoms in the last 12 months and his wife uses the injection, explained this:

I: Do you prefer to use condoms or not during sex?
P In my view I think using condoms is not in our culture
I: Okay
P: That is why I made a choice to have one partner
I: Okay
P: For someone who has many sexual partners it is good for them to use condoms
(IDI-BAN-6 male, urban, married, 36yrs, 4chldn)

The unacceptability of condom use in marriage was reiterated by multiple female FGD participants, in particular presenting the condom as a symbol of insufficient marital love and commitment. For example, this married adult women noted:

Most women want plain [unprotected] sex because plain sex signifies that love and affection is sufficient inside the home, but when the man uses a condom inside the home, it shows lack of love and commitment, and the woman starts to question the thinking capacity of the man. So it is like there is insufficient love because of that condom usage. (FGD-NS2-2 female, urban, married, 29yrs, 2chldn)

An underlying assertion here among these married respondents is that conjugal condom use is a sign of infidelity, an association I return to in chapter 8. Given that condom use with one's wife would undermine love within a relationship, not doing so was an important sign of trust, as this adult man whose wife also uses the injection and who reported not using condoms in the last 12 months stated:

We don't use condoms because we trust each other, and on top of that we use other contraceptive methods. (IDI-SL-4 male, urban, married, 25yrs, 2chldn)

I also found responses from married men connected to something even more fundamental; that using a condom with your wife challenged the essence of being a married man in communities and was therefore associated with stigma. As this young man stated during a FGD, reflecting a broader view:

For those that are married they think that using a condom will seem like they are not married. (FGD-CHI-5 male, rural, single, 24yrs, 1child)

As marriage is a key route to being a hegemonic male in Malawi (Anderson, 2015), condom use therefore undermined men's dominant position. These results support Chimbi's (2007) research analysing DHS surveys on condom use among married men in Malawi, which found that condoms were seen by men as "an intruder in marriage" (2007: 1102). As a further reflection of how hegemonic masculinities and conjugal status combined as a rationale for not using condoms, informal conversations in my research communities identified a common saying that, once married, 'men have the right to do it [have sex] without fear.' This concept of men's lack of fear arguably has implications for the burden of responsibility for pregnancy prevention, and for HIV, which I discuss in subsequent chapters.

As these findings suggest, it is not a lack of understanding among married men that condoms can prevent pregnancy which pose a barrier to use, but what condoms symbolise in the context of their relationship. In other words, in the context of hegemonic masculinities, understanding does not necessarily translate into use. In their research findings in Malawi, Ntata et al. (2013) similarly found that condom use is rejected by men once they enter marriage or a more committed relationship with a female partner, particularly as there is no longer stigma in having children, which is contrary to the experience of unmarried men, as I discuss.

Given these views, married men also told me that while “some use condoms as a contraceptive method” (IDI-BAN-6 male, urban, married, 36yrs, 4chldn), a further reason they did not do so was because they did not ‘mix’ contraceptive methods. As one adult married man noted, whose partner uses the contraceptive injection:

At home I don't use condoms because we follow only one family planning method. We don't want to mix up. (IDI-NS-8 male, urban, married, 32yrs, 1child)

An additional indication of married men’s practice of the separation of condoms and contraception was where they asserted that condoms *were* to be used with their wife. A small number, from both urban and rural settings, said they used condoms to have sex with their wives during their partner’s menstruation. As one adult man noted, whose wife was using the injection:

P: It happens that your wife is having her monthly menstruation, and you have that strong desire for sex either the day before finishing or after finishing the cycle. So we use the condoms for hygienic reasons.

I: Which means you don't like using condoms unless she has just completed her menstruation cycle?

P: Yes, we only use them then when we want to have sex [during menstruation].

(IDI-NS-5 male, urban, married, 28yrs, 2chldn)

For these men, it was clear this was for hygienic purposes, to protect against the perceived uncleanness of menstruation, and their principal concern was not for pregnancy prevention. I found cultural beliefs associating menstruation with being dirty and dangerous, and, as I discuss in the following chapters, menstruation was also linked to male infertility and men's sexual dysfunction. A younger married man further explained that after menstruation, couples resorted to relying solely on female methods, and again having unprotected sex:

It just depends on when my partner is menstruating. When she is about to menstruate three days prior to the date or four days, I use a condom and afterwards we have plain sex. (IDI-CHI-8 male, rural, married, 23yrs, Nochldn, injection)

Despite these exceptions for menstruation, both men (IDI-NS-5 and IDI-CHI-8 male) reported not using condoms in the last 12 months, reinforcing that the performance of hegemonic masculinities for married men is associated with non-condom use. Making an exception to use condoms in the context of menstruation appeared not to undermine married men's dominant status.

I found one example of more progressive masculinities by an HIV positive adult man, who said his wife was also HIV positive, and who spoke of using both condoms and the injection for contraceptive purposes:

Right now the method that I use most is condoms. When it comes to my wife, she goes for injections. (IDI-NS-2 male, urban, married, 32yrs, 2chldn)

As noted above, I found men from the IMAGES research who had tested for HIV were more likely to report being a contraceptive user with their partner and always/mostly using condoms, and this qualitative response would concur with these quantitative findings. It also highlights that engaging with one's HIV status may be a moment for reflecting on healthier masculine norms, consistent with Sileo et al.'s (2018) findings across sub-Saharan Africa.

In contrast to married men, I found men in a relationship (unmarried), in both rural and urban areas, who had reported they were using condoms as their contraceptive method with their partner (table 9), confirmed this behaviour during IDIs and did not refer to using any other method. These men were all under 30 years, and none had children, and explicitly talked of condom use for pregnancy prevention, such as this rural young man:

- I: Are you involved in discussions or decisions with your partner about contraception/family planning?*
P: I can say, I take part by using condoms during sex
I: Why do you take part?
P: To prevent unintended pregnancies and sexually transmitted infections
(IDI-CHI-6 male, rural, 21yrs, relationship, nochildn, condom)

This man also separately reported mostly and always using condoms during sex in the last 12 months. Chimbiri (2007) asserts that any changes in condom behaviour, if they are happening, are outside marriage, and my findings would suggest this to be the case. As I found in chapter 2, there is a gap in research on unmarried men's condom behaviour in the context of contraception in Malawi.

As a further indication of these differing behaviours, but equally as an assertion of dominant masculinities, unmarried men in a relationship suggested that they will use condoms with their partner for pregnancy prevention until they get married, alluding to the fact that thereafter they would mirror the behaviour of married men:

- As I said already, I am not married. Therefore, I just use condoms until I get married and have children. (IDI-LIK-2 male, rural, 27yrs, relationship, nochildn, condom)*

This quote further suggests that condoms are a transitory method among this group. It touched on something reflected in other unmarried men's responses, that using condoms was not seen as actively choosing a male contraceptive method over a female method. This reinforces the fact that contraception was

feminised. Informal conversations in my research communities identified that young men and women in relationships are afraid of getting pregnant before marriage, which is seen as deeply embarrassing to their family, and thus condoms are used to prevent pregnancy while dating. Premarital pregnancy was described by one unmarried young man, who explained the rationale for using condoms in his relationship as following:

P: I prefer using condoms

I: Why?

P: I do not want to ruin my future

(IDI-NS-9 male, urban, 25yrs, relationship, nochldn, condom)

Conversations with my research team identified a related stigma for unmarried women being seen to access female methods at health facilities, which would signify them as having culturally inappropriate premarital sex, reflecting Bornstein et al.'s (2020a) qualitative research findings in Malawi. As such, I found unmarried partners used condoms as they were more accessible to them and did not require going to health services, as this unmarried young man in a relationship said, reflecting this broader sentiment:

Often times this happens [using condoms] among youths maybe in fear of unwanted pregnancies and the like and also because it is easiest and a more affordable method compared to pills. (IDI-NS-6 male, urban, 23yrs, relationship, nochldn)

This context was undermined by poor communication between parents and young people around their sexual behaviours. Qualitative research in Southern Malawi by Limaye (2012: 121) found parents perceived talking about sex with their children as “shameful or immoral,” which mirrored the findings among Malawian youth and parents by Self et al. (2018). Self et al. (ibid) found parents to express negative opinions about youth accessing contraceptive methods, and young people to assert that service providers do not provide methods if you look young and will report them to their parents.

These findings show that married and unmarried men have a different approach

to condoms as a contraceptive method, even if both understand dual protection. Across my qualitative IDI sample I also found unmarried men to be far more likely to report always or mostly using condoms when having sex in the last 12 months and married men mostly reporting not using condoms during this period. These findings suggest that unmarried men (in relationships) were responding to the IMAGES contraceptive method use question (table 8 based on their condom use (and thus differently to married men, as discussed). While my quantitative research did not identify a clear relationship between condoms and contraception, my qualitative research would suggest this exists in the context of unmarried men in relationships. This picture is complicated, however, by both married and unmarried men showing contradictions in their reports.

5.4.4 Men's countervailing condom narratives

Concurrent with the above, I found clear contradictions in both married and unmarried men's reported condom use behaviour in my qualitative research, which indicated that men sometimes behaved differently to the way that they initially stated they did.

Among married men, while condoms were not to be used with their wives, and this group reported the lowest condom use frequency, some married men also told me they *did* use condoms for extra-marital sexual partners. This reflects the findings of Chimhiri's (2007) research in Malawi on rural married men's condom behaviours outside the marital home. In their responses, I found married men to present a more proactive approach to condom use with outside partners. For example, this young man, who had two sexual partners over the last 12 months and whose wife used the injection, said, reflecting a broader sentiment:

You prefer plain sex when your partner is yours and you are living under the same roof and you are not afraid to have plain sex. But when you've just met her like today it is not good [to not use condoms] because you don't know her status [HIV] so you can contract diseases. (IDI-CHI-8 male, rural, married, 23yrs, nochildn)

While married men did not fear the implications of unprotected sex with their wives, the corollary of IDI-CHI-8's quote is that men fear contracting HIV with outside partners as they do not know this person's serostatus. This was, therefore, their primary motivation for condom use in those circumstances. Married women in FGDs widely confirmed this behaviour in answer as to why married men use condoms outside their marriage:

They don't want to contract sexually transmitted infections and infect their wives. (FGD-CHI2-6 female, rural, married, 34yrs, 4chldn)

No married man referred to the potential risk of unintended pregnancy for these other sexual partners as a motivator for their use of condoms.

At the same time, while there was a clear narrative of condom use for extra-marital partners, reflecting Chimbi's (2007) and Tavory and Swidler's (2009) research in Malawi, married men also suggested that they may actually not use condoms at all during extra-marital sex. One adult married man who earlier said that his wife used contraception, and that condoms were for outside partners, later went on to qualify his assertion:

- I: *Okay, you've said that at home you don't mix. Meaning that there is also elsewhere you use it [condoms]?*
- P: *Sometimes you can just fall into a certain situation so you use a condom*
- I: *What are women's views towards condoms?*
- P: *There are different kinds of girls. Some are reckless just like other men. They don't want condoms. Some are responsible and say 'we cannot do anything without a condom.' Some girls will tell you not to use condoms*
- I: *Okay*
- P: *These reckless girls don't say no to condoms. But they accept whatever you want*
- I: *Okay. How does what women say affect your condom use?*
- P: *When you have a condom and meet a certain girl that you want to sleep with you can have intentions of using a condom, but if she doesn't ask for it you can have plain sex and can get infected (IDI-NS-8 male, urban, married, 32yrs, 1child, injection)*

Both married men quoted above (IDI-CHI-8 and IDI-NS-8) said they didn't use

condoms in their response to the condom frequency question despite their mixed message. Overall, my conversations with married men suggested unprotected extra-marital sex was potentially common. This aligns with the Malawi DHS, which found only 36% of married men reporting using condoms at last sex with a causal sexual partner (NSO and ICF, 2017). This quote also reflected the views of many married men in my research that the onus was often on women for condom use during extra-marital sex, reflecting dominant masculinities, otherwise condoms were not used. As I explore in chapter 9, unprotected extra-marital sex validated one's manhood, despite men's awareness of the attendant risks of such behaviour.

Among unmarried men in relationships, I found fewer qualitative examples than among married men, suggesting contradictory condom behaviour, which supports the IMAGES findings of the greater odds of consistency of condom use among this group when having sex in the last 12 months (table 11). Nevertheless, some responses alluded to non-consistent condom use when having sex, such as this young man:

- I: Do you behave differently inside the home and outside in terms of condom use?*
- P: By using condoms on other women outside my relationship, and not using condoms on my partner*
- I: Ok*
- P: Of course, you can have another sexual partner if your partner is far from you, but it is better to use condoms on both partners, because you cannot know how she was behaving when she was away from you, and how you were behaving when she was away (IDI-CHI-6 male, rural, relationship, 21yrs, nochildn, condom)*

This unmarried young man (IDI-CHI-6) reported using condoms in response to the question on contraceptive method use with his partner. He also reported his condom frequency as mostly using them. The responses from these unmarried men were also complicated by around a quarter of this group reporting two or more sexual partners with whom they may be using condoms, as I discuss in chapter 8.

Sexually active single men, who I found in IMAGES being the most likely to use condoms, equally highlighted they might not always do so. For example, this single man who said he always used condoms, also told me he had three sexual partners in the last 12 months, and said:

P: I prefer not using condoms

I: Not using condoms

P: Yes, with my partner that I can trust

(IDI-NS-4 male, urban, single, 26yrs, nochildn)

These responses highlight the significant challenges in both interpreting men's responses and in exploring correlations between the two concepts of reported contraceptive use in relationships and frequency of condom use. They suggest that this complexity is the reason why I identified no clear relationship between these concepts in my IMAGES results. Above all, they highlight that while HIV and STIs are very much in men's sights as they navigate the nexus of condom use and sexual partners, with the exception of unmarried men's concerns about the stigma of premarital pregnancy, the impacts on unintended pregnancy are largely not. As I discuss in the next chapter, concern for pregnancy prevention was not part of how men validated their manliness.

5.4.5 Vasectomy perceptions and behaviours

I also specifically explored the views of men and women on vasectomy. This method is an under-researched area, and one in which there is growing interest among Malawian stakeholders in exploring further potential.³⁹

Overall, I found vasectomy was regarded as anathema within Malawian culture given its irreversibility, and that men of all ages had nothing positive to say about this method. Many men expressed both misconceptions and fear relating to vasectomy, particularly around side effects on male sexual pleasure and performance, as I discuss in chapter 8. This was reinforced by men having no

³⁹ My discussions with government stakeholders in Malawi while developing my research questions identified a desire to expand vasectomy uptake. Globally, vasectomy has untapped potential for method expansion (Shattuck et al., 2016)

reference point: as noted in table 9, no man had had a vasectomy, and I found no man was able to mention knowing someone who had had the procedure, with very few men saying they themselves would consider it. Ntata et al.'s (2013) study on general contraceptive perceptions in Malawi found similarly strong opposition to male sterilisation, and such opposition has been found to be a significant barrier to demand among men across other low-income countries (Shattuck et al., 2016).

The primary objection among married men related to concerns of male fertility, a key marker of hegemonic masculinity that I discuss in chapter 7, which would be challenged by a man's inability to have children whatever his age. As one adult married man, who had four children, and whose partner used the injection said, he would never have a vasectomy, noting:

You can agree to go for vasectomy with your sexual partner but at the end of the day you can separate with your partner. The marriage can end, so getting into another marriage can be hard. If you decide to marry again, that means you cannot produce children. (IDI-BAN-6 male, urban, married, 36yrs, 4chldn)

Reflecting this view, I found women were as fervently against vasectomy, though it was clear that women also lacked detailed knowledge about the method. Women's principal objection similarly reflected the need for men and women to always be able to produce children, including should women need to remarry in the future. During the FGDs, women made nervous laughter about this issue as a sign of their embarrassment in discussing the possibility of male sterilisation. As one young married woman said, reflecting the importance of longevity of a man's fertility:

I don't think it [vasectomy] is a good method because if your husband dies, and you remarry, the man that you get married to needs a child, so what will you do. I think the best way is just using Jacksons [injection] in case your husband dies and you want to remarry because obviously that man will need a child. (FGD-NS2-8, female, urban, married, 23yrs, 2chldn)

My findings on vasectomy also identified a further view, which is worthy of reflection. Men's specific objections to vasectomy notwithstanding, men also reflected that contraception is a women's responsibility, a reassertion of dominant masculinities mirroring how married men viewed condom use. As one adult married man, who was not using contraception with his wife, responded once it was explained to him what vasectomy was:

I cannot do that method [vasectomy] if I am married, my wife has to do it. (IDI-BAN-5 male, urban, married, 27yrs, 1child)

These findings add to the broader picture on men's limited use of male methods. I also found one adult married man during a rural FGD to state a view that the current range of accessible male methods (condoms and vasectomy) is insufficient:

On the issue of family planning, there is a need for the methods [for men] to be more like those for women. There should be more methods for men so that we can also have a choice on what method we want to use. (FGD-CHI-14 male, rural, married, 27yrs, 3chldn)

Related to this, another adult married man during an urban FGD noted that female methods were 'better' than male methods and this was a reason why men don't use male methods:

The best family planning methods are those of women and that is reason most men do not adopt these methods. (FGD-NS-6 male, urban, married, 26yrs, 1child)

These comments, though not more broadly represented among FGD participants, could suggest that men's disinterest in male methods is partly related to their view that men don't have enough choice. However, other quotes from these same men point to their concern with current male methods being about the impact on their sex lives, as I explore in chapter 8. This picture requires additional nuancing through exploring men's broader understanding and perceptions of female methods.

5.4.6 Knowledge and perception of female contraceptive methods

Compared to male methods, I found men to be much less surprised by questions of female contraception, and much more eager to discuss their associated reservations. Given Malawi's family planning history, the existence and use of female contraception, particularly within the context of ante-natal and post-natal care, is widely understood. I therefore found men, particularly married men, were well aware of multiple female contraceptive methods, that these methods prevented unintended pregnancy, and that such methods were available at the health facilities in my research sites.⁴⁰ Married men would frequently explain in their responses which method their partner was using. However, these men often had limited specific understanding of how these methods work, which is important in light of the source of men's objections.

I found men provided few opinions on the relative merits of certain female-controlled methods versus others.⁴¹ The one exception was the contraceptive injection, which was clearly the best-known method among men and singled out during FGDs and IDIs, particularly for its side effects, including the following example for an adult man during a FGD:

Women have tumours in their uterus... women have bloating where they feel like they are already pregnant. (FGD-BAN-2 male, urban, married, 27yrs, nochildn)

I found the injection to be associated with a number of myths about its impact on male health, such as "injection causes back pains" to men (IDI-CHI-3 male, rural, single, 26yrs, nochildn). As this adult woman noted during a FGD:

Men complain that they feel unwell when they have sex with a woman who uses injections. If you stop using the Jackson the man gets better. (FGD-CHI2-15 female, rural, married, 59yrs, 6childn)

Particularly concerns were also raised about the impact of the injection on

⁴⁰ However, although men could say that women could receive methods at the local clinic, they could not say specifically which clinic or which methods were or were not available.

⁴¹ My research did not seek to explore men's views on each specific female method, but rather left it open for men to talk about which ever method they wished.

men's fertility and sexual pleasure, both markers of dominant masculinities, which I discuss in chapters 7 and 8, respectively. Conversations with health providers confirmed that rumours and urban myths surrounded female contraception, as this female provider noted:

Men also say they have abdominal pains, due to the women using family planning. That it is giving them pain... There are a lot of myths associated with family planning. This is why most men are against family planning. (HP9, female, urban, 48yrs, private service, manager)

I found married men to indicate that they were particularly irritated by the prolonged menstruation that appeared to accompany the use of the injection. As one adult man said during an urban FGD:

Women have menstrual fluids for a month rather than 2-3 days. (FGD-BAN-2 male, urban, married, age 27, nochild)

This then became presented as something that men perceived never ended, as another adult said on this topic during a rural FGD, which was followed by laughter from the group:

These days, women are having perpetual menstrual periods. (FGD-CHI-7 male, rural, married, 29yrs, 3child)

Women's menstruation, already seen as dangerous, was seen as even more problematic therefore by men given the extended periods due to the injection, and was raised during FGDs as something to be redressed, and a reason for men to be against using female methods:

Some [men] use problems they have encountered as a reason [not to use methods]. It could be possible that there is a woman who took a family planning method but because of her body and the way her blood works, the injection method gives her problems. Because they have seen that, they believe that it is a given fact that family planning is not helpful. That's why you just decide to be the way you are. (FGD-CHI-8 male, rural, married, 46yrs, 4child)

Men's view that "It is better for us to just remain the way we are" (FGD-CHI-10 male, rural, single, 24yrs, 1child) – in other words, to not use contraceptive

methods – was a common refrain in relation to side effect concerns. While irregular bleeding has been documented as a side effect of the Depo-Provera injection (Berenson et al., 2008), these quotes suggest men may not have an accurate understanding of the mechanisms and side effects associated with it, which clearly affects their views on women’s contraception. While some men highlighted their desire to prevent their partners from accessing contraceptive methods as a form of protecting them from these complications, ultimately prolonged menstruation was reducing the sexual availability of their partners, something which Chipeta et al. (2010) also found in their FGDs in rural Malawi, and thus challenged men’s ability to perform dominant masculinities.

My research findings suggest men have a broad but shallow knowledge on female methods, with misconceptions common. This mirrors the findings of qualitative studies by Dral et al. (2018) in Central Malawi and Self et al. (2018) among Malawian youth. At the same time, men had more in-depth knowledge on female than male methods. Men’s knowledge may not be the primary issue when it comes to use in my study, as Hartmann et al. (2012) also argued in their research. I found men still reported high levels of contraceptive use in their relationships despite their shallow knowledge and the fact that female methods challenged their ability to perform hegemonic masculinities. Nevertheless, these findings highlight that men have gendered misunderstandings due to rumours, myths and misinformation. These feed negative attitudes towards contraception that may pose challenges for women’s sustained method use.

As a further indication of this unsupportive environment, conversations with men on female methods would occasionally elicit general responses from men about their broader disinterest in contraception, such as this adult married man during a FGD:

Most men do not care about family planning methods. (FGD-NS-4 male, urban, married, 32yrs, 1child)

I found such statements to be at odds with many men's specific opinions on female methods, as noted above, and with their reported method use. It could reflect differences between what men say publicly, and what they do in practice, reflecting O'Brien et al. (2005). Equally, it arguably reflects how *kulera* is positioned within the context of masculinities: as contraception is feminised, married men's interest is ultimately not about methods per se, but control, as I further explore in the next chapter.

5.4.7 Men's gendered access to contraceptive information

In the context of ways to increase men's involvement, I found men during IDIs and FGDs to identify that their limited understanding about contraception was problematic, and that this meant they tended to look only at the disadvantages of contraceptive methods, as this adult married man said during a FGD:

I feel like understanding is the main problem here in Malawi because it doesn't mean we are refusing to practice family planning but it is difficult for people to understand... So the problem of understanding is what is making us [men] not look at the meaning of family planning. We just see the disadvantages only... It cannot be possible [to use contraception] unless you are with someone who understands the advantages of family planning. (FGD-CHI-4 male, rural, married, 26yrs, 2chldn)

Such quotes reinforced the fact that in the absence of proper understanding, men then learned about contraception from the rumours they heard, which made it harder to address their aforementioned myths and misconceptions.

Men highlighted that a key information source on contraception was speaking with friends. FGD-CHI-7, quoted above raising concerns about women's prolonged menstruation periods, went on to explain that his friends were a key knowledge provider for him on female methods, said to be a largely negative influence on use:

So you tell your friend, 'My wife is going through this and that. She went to a health facility to take a family planning method but then it seems that thing is not matching with her body.' So your friend has some fears and

says [to himself], 'Maybe that can also happen to my wife. I should just stop her from going there for that [contraception]'. (FGD-CHI-7 male, rural, married, 29yrs, 3chldn)

Health providers confirmed to me that men were having such conversations with their friends about side effects and that they had a direct impact:

When men discuss [family planning] with friends, one will tell them that this has happened to their wife, and the man will take his friend's word on the side effects of family planning. The man then tells the wife that he doesn't want her to use methods or go to the clinic for family planning. (HP9, female, urban, 48yrs, private service, manager)

As I note in chapter 6, couples often did not discuss these matters, with the result that men's misinformation as well as concerns about menstruation and side effects persisted. Paz-Soldan (2004) found that men and women in Malawi were more likely to discuss family planning with members of the same sex than with their partners. Male peer groups in Malawi have been found to be spaces that reinforce and validate men's masculine identity (Izugbara and Undie, 2008).

In seeking to understand this dynamic, it became clear that a key gendered barrier was that current contraceptive information is not orientated towards men. Observation in my research sites found there were no equivalent large-scale campaigns targeting men regarding contraception similar to those on HIV, and that NGOs working on contraception (such as on safe motherhood) undertook activities solely with women. Women were far more likely to be users in clinics, and receive more direct contraceptive information as a result, as I discuss in chapter 9. During the Radio Ufulu FM call-in discussion I held on my research results, the fact that men had insufficient contraceptive information and services targeted at them was a frequent comment made by male and female callers. My observations reflected the Malawian findings of Self et al. (2018), who similarly found family planning messages targeting females more than males, and Paz-Soldan (2004) who found women were much more likely than men to learn about methods at the health facility. In effect, contraception was not only feminised by men, but was equally operationalised as such.

In this context where women receive more direct information on contraception, men rely on their partners to pass on contraceptive teaching. Men expressed concern about these gendered contraceptive information flows, where women become the knowledge brokers; this appeared to undermine their interest in male methods, as this married older man whose wife uses the injection, noted:

I: Although you have said that 90% of family planning methods are for women, I wanted to know which family planning methods are meant for men?

P: Aaah, men don't use family planning methods. They just have to listen to what the nurse has told their partner about any methods (IDI-BAN-2 male, urban, married, 50yrs, 4chldn)

Such information flows challenged men's self-image as dominating power structures, represented here in being head of the household, and created broader mistrust among men towards the health system and challenges for couple communication. It presented masculinities as fragile (Izugbara and Undie, *ibid.*) and reflected men feeling emasculated, as I discuss in the next chapter. In response, arguably partly in defence of men's hegemonic identity, I found that they wanted to be directly targeted in their own right with first-hand information.

5.4.8 Men's desire for greater involvement and targeted contraceptive approaches

Despite men clearly having opinions about male and female methods, an ongoing theme through men's responses, young and old, was a desire for greater involvement. The need to increase men's involvement was also raised as an important priority among communities during the research dissemination meetings, in particular around contraceptive communication and decision-making, as I explore in the next chapter. Qualitative research on male involvement in Kenya similarly found male participants almost universally believing they should be more involved (Withers et al., 2015b).

I found men believed they would benefit from more formal targeted information themselves, as this adult married man who was not using contraception with his wife suggested:

I think men are too shy to go to health facilities. It just needs a thorough counselling of men that they should be taking part. At the moment that form of counselling is not enough, mainly because it is concentrated on women. (IDI-NS-7 male, urban, married, 30yrs, 1child)

This reflects research findings on female condoms in Zimbabwe. Koster et al. (2015) found that contraceptive information linked to formal teaching was more accepted by men than the information their wife would bring into the home.

I also found men eager to be reached more directly through the existing health talks and activities in their communities, reflecting a presumption that these were currently solely targeting women. During FGDs several men expressed a sense of discrimination in this regard, such as this married adult man:

The other thing is that men and women are treated differently. Women have the opportunity to receive counselling that helps their mind when they go to a health facility and there are many organisations that are working with women. If there had been organisations coming here and holding discussions with men on these issues, a lot of men would have been free to go to health facilities. We feel like we are discriminated against and we become adamant and stay on the same position [being against contraceptive use]. (FGD-CHI-13 male, rural, married, 42yrs, 4chldn)

Men's concomitant objection to contraceptive use speaks to the dangers of a limited operational focus on male involvement, as Greene and Levack (2010) argue. In requesting specific targeting towards men, it appeared men desired a separate space to come together as men that was not associated with being for 'women and children'. This could provide a space in which men could engage together, receive factual information about methods and learn, as another adult married man from the same FGD noted:

It reminds me of what one woman said, that most of the family planning

methods are for women because they go for antenatal and postnatal clinics. So if we men had time to be together like we are here, talking about family planning, a lot of us men can have our minds opened to the real truth. (FGD-CHI-6 male, rural, married, 25yrs, 1child)

During FGDs, men also highlighted they were able to talk freely only as men together, that male-only spaces to discuss issues could lead to positive changes in their communities (FGD-CHI-13 male, rural, married, 42yrs, 4chldn). As one adult male FGD participant noted in relation to the space created by the FGD itself:

This is a rare opportunity to have men gathered together and to talk about issues they have on their chest. (FGD-LIK-13 male, rural, married, 27yrs, 2chldn)

My conversations with men also highlighted the value of research with men themselves on contraception. Throughout my interviews and FGDs I found an openness, curiosity and eagerness among men to converse. Some married men, including those who did not use methods with their partners, said that the conversation had expanded their knowledge on methods. At the end or on the fringes of the IDIs several men mentioned that this was the first time they had ever had a structured discussion about contraception. For example, this young married man noted the following at the end of his IDI, reinforcing the fact that men lacked current spaces directed at them:

I'm just thankful that you are carrying out this research on people like us men who are in the villages. This is something that is scarce for us to speak out on ourselves about challenges we are facing in our community. (IDI-CHI-8 male, rural, married, age 23, Nochildn)

These findings challenge the often-asserted notion of men's disinterest in contraception, and further reflects more positive masculinities. They suggest benefits in creating spaces that acknowledge men's gendered experience of male involvement and in doing so shift contraception from being perceived as feminine and challenge the negative opinions men may have. Equally, while men's sense of exclusion was heartfelt, an important consideration here is

whether men's desire for male-only spaces is to reclaim information flows on which they feel emasculated and that such spaces could potentially reinforce hegemonic masculinities.

5.5 Summary

This chapter has explored the contraceptive use and understanding of men in Southern Malawi, seeking in particular to deepen understanding around male methods in this context. I found no distinction in Chichewa between the terms family planning and contraception, and while family planning is used synonymously in Malawi to relate to methods, for men, family planning was more a concern of planning one's family than an interest in the contraceptive methods to do so. Contraception and its use were portrayed as feminine and operationalised as such. Unmarried and married men showed different contraceptive behaviours, in a context of broader inconsistent condom use (only 21% reported always/mostly using condoms during sex). Unmarried men reported twice the odds of being a contraceptive user, condoms being the method they used with their partner, noting access barriers for other methods and the stigma of premarital pregnancy as the motivating factors for their use. Married men reported using only female-initiated methods, primarily the contraceptive injection, and that condoms were symbolically unacceptable with their wife and challenged their dominant masculine identity. Both unmarried and married men showed contradictions in their condom use reports, which questioned the reliability of their reports, and the utility of correlations between male reports of contraceptive method use and condom frequency use. While married men were more likely to report not using condoms, they said that they did so during extra-marital sex (for STI/HIV prevention), but then subsequently reported that they actually often had unprotected sex. Unmarried men, while reporting condom use with their partner, and having almost four times the odds of reporting always/mostly using condoms during sex (compared to married men), said they sometimes had unprotected sex with their partner or with another sexual partner. Single men who had seven times the odds of reporting

always/mostly using condoms, also provided examples where they did not use condoms. This behaviour among men brought attendant risks for both unintended pregnancy and HIV/STI infection.

In general married men did not have a well-developed understanding of male contraceptive methods, and all men displayed significant misunderstandings around vasectomy, and a very negative attitude towards this method. On female methods, while men had a greater general understanding, they also displayed superficial knowledge, which often led them to seek incomplete information from elsewhere and to focus more on negative rumours and the disadvantages of contraception, thus creating barriers to women's method use. In particular, the Depo-Provera injection, the most commonly-used female method, was perceived as problematic among men. Despite men's concerns, they asserted that the current provision of contraceptive information and methods target women primarily, reflecting a sense of discrimination, and a desire for greater involvement and to be more directly targeted within reproductive health programmes and initiatives.

My findings in this chapter highlight the need to look beyond men's reported use, and their knowledge, in understanding men's contraceptive behaviour, as Mbizvo et al. (1991) and Duze and Mohammed (2006) argue. In particular, given men's desire for greater targeting, they speak to the need to nuance our understanding of male involvement (and any strategies to further engage men) through exploring how use and knowledge are influenced by notions of male power, appropriate male and female roles and men's support for gender equality, matters to which I now turn.

Chapter 6: Men's support for gender equality, and its links to contraceptive use

6.1 Introduction

In the last chapter, I found married and unmarried men to report different contraceptive use behaviours (the former primarily relying on female initiated methods and the latter using the condom for pregnancy prevention), in a context of overall inconsistent condom use. Men showed limited in-depth knowledge around both male and female methods, provided a range of objections to use, and believed that contraceptive information and services should be more targeted towards them. Men's primary interest with respect to *kulera* (family planning) was around family size not contraceptive methods, with the latter being seen and operationalised as feminine.

This second results chapter specifically explores my quantitative and qualitative findings on Southern Malawian men's gender equality-related attitudes, norms and behaviours and their impact on male involvement. As discussed in my introduction, research across multiple settings has shown how the ways men and boys perceive equality between the sexes influence their practices around contraceptive use and household decision-making and communication. I begin by looking at men's support for gender equitable norms, as measured quantitatively through the Gender Equitable Men (GEM) scale within IMAGES, and the association between GEM and reported contraceptive use. I also look at the association between an IMAGES measure on women's health-seeking decision-making and contraceptive use. Using my qualitative data, I then explore men's conceptions of gender roles and gender equality, and whether family planning is a women's issue, which provides context for a more in-depth focus on communication and decision making on contraceptive use. Finally, I explore men's views on responsibility for pregnancy prevention, particularly whether they desire to access contraceptive services and are concerned about the impact of pregnancy on women's health. This chapter responds to research

question two: How do social and cultural attitudes, norms and behaviours of Southern Malawian men (including those related to gender-equality) influence their approach to contraceptive use and family planning?

6.2. Men's gender equality-related attitudes and its links to contraception

In order to better understand men's support, or lack of, for gender equitable norms in Southern Malawi, my quantitative research used a standardised and evaluated measure, the GEM scale, as explored in my methods. I now discuss the results of the GEM scale and its links to men's reported contraceptive use.

6.2.1 Gender Equitable Men scale results

The GEM scale within the IMAGES survey included 15 items, with statements seeking to capture men's attitudes towards gender equitable norms, particularly within the context of intimate relationships or differing social expectations for men and women. For each item, men responded to whether they totally agree, partially agree or disagree with these statements, and were provided a score (between 1-3) based on their response. The lowest score was given for the most inequitable response to the question, and the highest the most equitable response (see chapter 3 for further details). These items are outlined in table 13 below.

The 15 GEM items are considered together here as an overall measure of equitable or inequitable norms among men (Singh et al., 2013), and the specific item responses are also separately explored for more in-depth analysis. To aid understanding, I grouped these items below into those covering areas relevant to my PhD topic (items i. to x.) and those which were not the subject of follow-up qualitative research for my thesis (items xi.-xv.).⁴²

⁴² Household chores, childcare and homosexuality were outside the direct scope of my thesis and therefore not further explored qualitatively. Violence was also not further explored directly (see rationale in chapter 3), but was raised in my discussions with men, as I explore below.

Table 13: List of 15 GEM scale items

GEM items relevant to PhD topic

- i. A man and a woman should decide together what type of contraceptive to use
- ii. It is a woman's responsibility to avoid getting pregnant
- iii. I would be outraged if my wife asked me to use a condom
- iv. A man should have the final word about decisions in his home
- v. If someone insults me, I will defend my reputation, with force if I have to
- vi. To be a man, you need to be tough
- vii. Men need sex more than women do
- viii. Men are not open to talk about sex with their partners, they just do it
- ix. Men are always ready to have sex
- x. Men should be embarrassed if they are unable to get an erection during sex

Other GEM items

- xi. There are times when a woman deserves to be beaten
- xii. A woman should tolerate violence in order to keep her family together
- xiii. I would never have a gay friend
- xiv. A woman's most important role is to take care of her home and cook for her family
- xv. Changing nappies, giving kids a bath, and feeding the kids are the mother's responsibility

Results of specific GEM items relevant to PhD topic

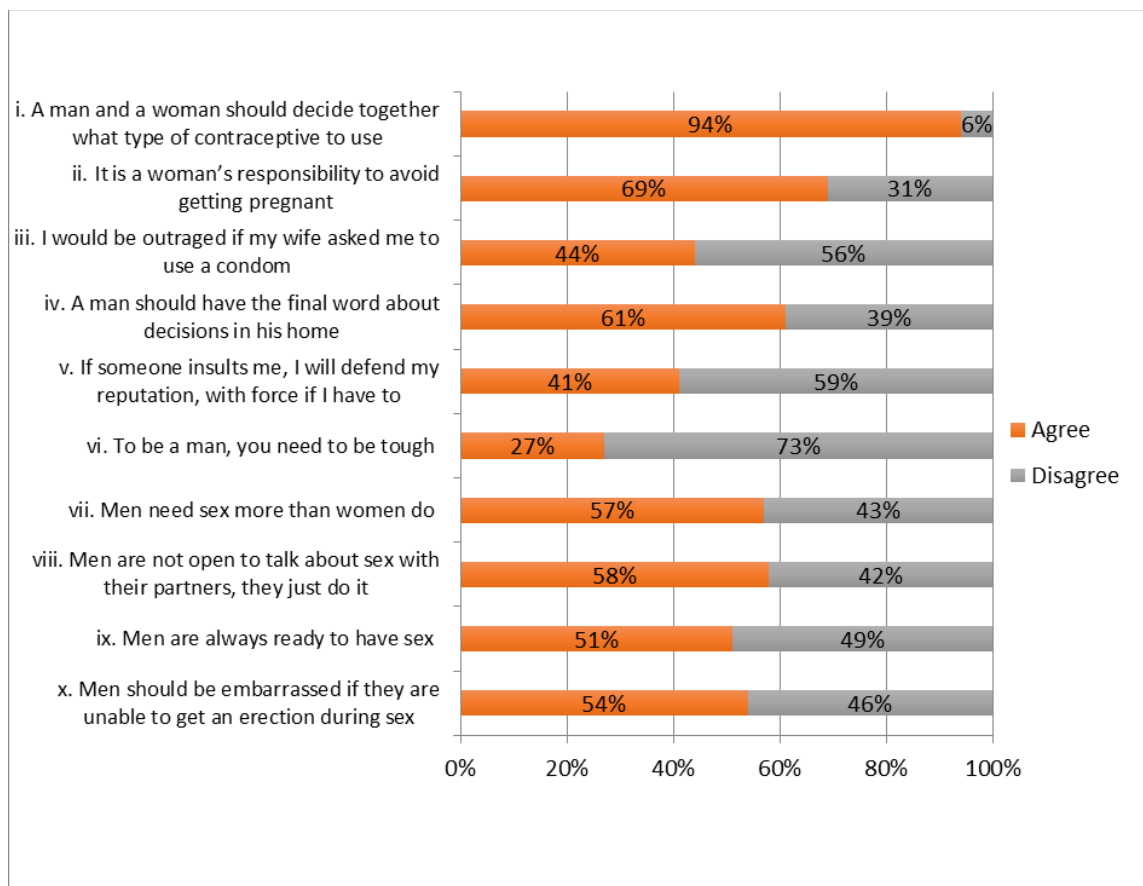
I begin by considering the responses to each of the first 10 items of interest. Figure 19 below provides an overview of the percentage of men (from the total of 415 interviewed) agreeing and disagreeing with each statement within these items. To aid interpretation, the percentage of men totally and partially agreeing were combined. With respect to items 1-10, I found:

- The vast majority of men (94%) agreed with the statement (item i.) 'A man and a woman should decide together what type of contraceptive to use'.
- Most men (89%) agreed with the statement (item ii.) 'It is a woman's responsibility to avoid getting pregnant'.
- Just below half (44%) agreed with the statement (item iii.) 'I would be outraged if my wife asked me to use a condom.'
- Two thirds of men (61%) agreed with the statement (item iv.) 'A man should have the final word about decisions in his home.'

- Just under half of all men (41%) agreed to the statement (item v.), ‘If someone insults me, I will defend my reputation, with force if I have to.’
- Only 27% of men agreed with the statement (item vi.), ‘To be a man, you need to be tough.’
- A majority (57%) of men agreed with the statement (item vii.) ‘men need sex more than women do.’
- 58% of men agreed with the statement (item viii.) ‘men are not open to talking about sex with their partners, they just do it.’
- Men were equally split on the statement (item ix.) ‘men are always ready for sex’ (51% agreeing and 49% disagreeing).
- 54% of men agreed with the statement (item x.) ‘men should be embarrassed if they are unable to get an erection during sex.’

I discuss individual GEM items i.- iv. further below and return to the remaining individual items (v.-x.) in results chapters 7 and 8.

Figure 19: List of relevant GEM scale items with percentage agreeing/disagreeing (all men, n=415)

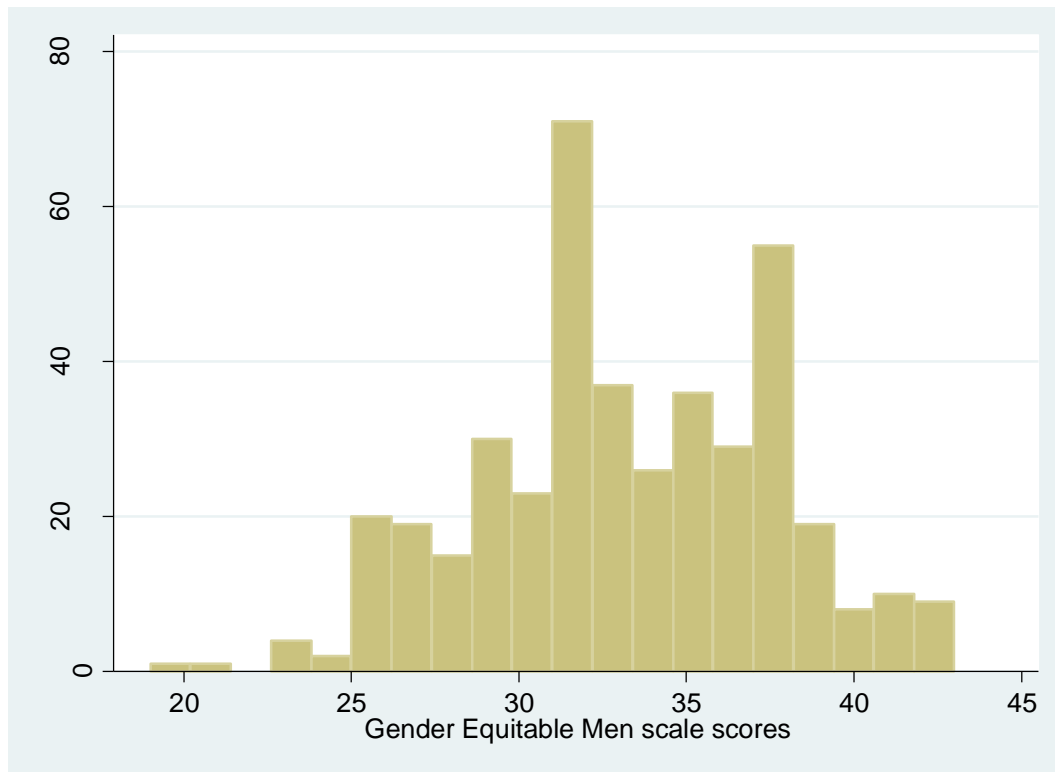


Overall measure of men's support for gender equitable norms

For the purposes of exploring men's overall attitudes towards gender equitable norms, I consider all 15 GEM scale items together, reflecting prior use (Barker et al., 2011). The alpha measure of internal consistency for the full scale is, $\alpha = 0.61$, a value acceptable in exploratory research (Nunnally and Bernstein, 1994).

In order to analyse the scores of the full GEM scale, I created a histogram covering total GEM scores across all respondents (where participants could receive between a minimum score of 15 and maximum score of 45). This is outlined in figure 20. The histogram shows that GEM score results are skewed right, reflecting a limited number of low scores. The results follow a standard distribution, with the exception of significant clustering around a score of 31-32 and 38.

Figure 12: Histogram of GEM scores (all men in Southern Malawi, n=415)



Analysis of the GEM scale results in other countries has included combining the scores across all 15 items, and categorising these into low, moderate and high

support for gender equitable norms (see Chapter 3). Low support for gender equitable norms would be understood as someone with the most traditional, rigid and inequitable view of a man's role within their relationships and social contexts (vis-à-vis women and other men), and high support would be the most progressive and equitable view of this role. Following categorisation, I found that in Southern Malawi a very small proportion (4.1% of men; 17 respondents) were found to have low support for gender equitable norms, almost two thirds (64.5% of all men; 267 respondents) were found to have moderate support for gender equitable norms, and just under a third (31.4%; 130 of all respondents) showed high support for gender equitable norms. This clustering of men around moderate or high support for gender equality, which can be seen in the histogram above, reflects GEM scale categorisation results in other countries (Barker et al., 2011).

I analysed the demographic factors associated with average GEM scores. Mean scores (i.e., without categorisation) were used in order to give the greatest statistical power. The results are provided in table 14 below. I found that rural men had marginally lower mean GEM scores than urban men. Age was inversely associated with GEM mean, with 18-24 years having the lowest scores and 50-59 years the highest scores. While these results were not statistically significant, my finding on age differs from other GEM findings where young men were consistently more equitable than their older counterparts (Barker et al., 2011); this may be related to the influence of young men's peer groups in Malawi (Izugbara and Undie, 2008). Education is strongly associated with GEM scores ($p < 0.001$), with more educated men providing more equitable responses, mirroring other findings (Barker et al., 2011).

Table 14: Average⁴³ GEM score among Southern Malawian men by demographic variable (all men, n=415)

	No of men	Mean (SD)	Unadjusted difference (mean)	Adjusted difference (mean) ⁴⁴	p-value ⁴⁵
Total	415	33.1 (4.4)			
Location					
- Urban	248	33.4 (4.4)	0.0	0.0	0.20
- Rural	167	32.6 (4.4)	-0.80 (-1.66, 0.07)	-0.69 (-1.76, 0.37)	
Age					
- 18-24 years	164	32.4 (4.2)	-1.21 (-2.16, -0.25)	-1.15 (-2.39, 0.08)	0.06
- 25-34 years	159	33.6 (4.2)	0.0	0.0	
- 35-49 years	71	33.6 (4.6)	-0.30 (-1.52, 0.93)	0.57 (-0.80, 1.93)	
- 50-59 years	21	34.0 (3.2)	0.46 (-1.54, 2.45)	2.07 (-0.26, 4.38)	
Relationship status					
- Married	178	33.4 (4.5)	0.0	0.0	0.59
- In relationship, not married	83	33.0 (4.6)	-0.46 (-1.61, 0.69)	-0.67 (-1.99, 0.65)	
- Single	154	32.7 (4.1)	-0.73 (-1.67, 0.22)	-0.54 (-1.94, 0.85)	
Education					
- No education/ Any primary	147	31.9 (4.8)	-1.64 (-2.54, -0.74)	-1.76 (-2.76, -0.76)	<0.001
- Any secondary	227	33.6 (4.0)	0.0	0.0	
- Any tertiary	38	34.6 (4.2)	1.00 (-0.49, 2.49)	1.17 (-0.42, 2.76)	
No of children					
- No children	195	32.8 (4.3)	0.0	0.0	0.56
- 1-2 children	123	33.7 (4.5)	-0.92 (-1.92, 0.07)	-0.38 (-1.91, 1.14)	
- 3+ children	97	33 (4.5)	-0.73 (-1.90, 0.44)	-0.72 (-2.05, 0.63)	
Employment					
- Employed	182	33.3 (4.6)	0.38 (-0.49, 1.24)	-0.45 (-1.50, 0.61)	0.41
- Unemployed	218	32.9 (4.2)	0.0	0.0	
Ethnicity					
- Lomwe	207	33.1 (4.2)	0.0	0.0	0.58
- Yao	63	32.3 (4.8)	-0.74 (-1.98, 0.51)	-0.73 (-2.04, 0.58)	
- Ngoni	46	33 (5.2)	-0.15 (-1.56, 1.26)	-0.67 (-2.18, 0.84)	
- Chewa	35	33 (3.7)	-0.09 (-1.67, 1.49)	-0.66 (-2.32, 1.01)	
- other	63	34 (4.5)	0.90 (-0.35, 2.14)	0.31 (-1.01, 1.62)	

⁴³ Please note that higher scores equate to higher support for gender equitable norms.

⁴⁴ Adjusting for location, age, marital status, education, no of children, employment status, ethnicity, and religion.

⁴⁵ This p value corresponds to the adjusted difference (test of heterogeneity).

Religion					
- Protestant	136	33.1 (4.5)	0.0	0.0	0.75
- Catholic	104	32.9 (4.1)	-0.15 (-1.28, 0.98)	-0.18 (-1.33, 0.37)	
- Pentecostal	97	33.5 (4.4)	0.39 (-0.76, 1.54)	0.49 (-0.69, 1.66)	
- Other (Baptist, Anglican)	77	32.8 (4.7)	-0.24 (-1.48, 0.99)	0.20 (-1.04, 1.44)	

6.2.2 Associations between GEM scores and contraceptive use in relationships

I analysed the association between total GEM scores (as a measure of men's support for gender equality) and reported contraceptive use, looking only at men in relationships. First, using categorisation of the GEM scores, I found that men with high GEM scores (greater support for gender equitable norms) had twice the odds of being a contraceptive user with their partner (AOR 2.03, CI 1.03-4.00, $p < 0.041$)⁴⁶ compared to men with low/moderate GEM scores.⁴⁷ Secondly, I looked at average GEM scores, and similarly found contraceptive method users in relationships to support more equitable gender norms as they had a +1.4 GEM point score difference than non-users (1.41, 95% CI 0.09-2.72, $p = 0.035$). The mean GEM values were 33.62 for users, and 32.21 for non-users. These relationships were found to be statistically significant, highlighting that men's support for gender equality is associated with contraceptive method use, and that shifting inequitable gender norms among men can have a positive effect on increasing contraceptive uptake, as Hardee et al. (2017) and others have argued.

I also undertook an analysis of the mean scores, among men in relationships, for the GEM statement (item iv.) 'A man should have the final say about decisions in the home' against reported contraceptive use. This is the only GEM item that provides an indication of men's views on norms relating to the balance of power within the home. I found that men who reported they were using contraceptive methods (compared to those who were not) had more equitable

⁴⁶ Adjusting for location, age, marital status, education, number of children, employment status, ethnicity and religion.

⁴⁷ For the purposes of logistic regression analysis, I combined low and moderate scores.

views (higher scores) on this statement (coefficient 0.28, 95% CI 0.03-0.52, $p < 0.05$), suggesting that increasing men's support for norms on more equitable decision-making within the home can have an impact on contraceptive method use.

6.3 Analysis of decision-making on women's health-care seeking and associations with contraceptive method use

As the GEM scale only explores men's support for gender equitable norms, it is also important to look at men's reported behaviours. I therefore analysed a separate item in IMAGES on men's self-reported behaviours around decision-making on women's healthcare seeking in the home. How decisions are made on women's health seeking was identified as of critical importance in the quantitative research with women in Southern Africa (Cau, 2015; Mboane and Bhatta, 2015; Prata et al., 2017), and I found a gap in empirical research asking men themselves about this.

I asked men the question of who had the final say in the home on decisions relating to women's health-care seeking, with the following options: you (the man himself); the women herself (his wife/partner); that women's health seeking was a joint decision between himself and his partner; or another person makes this decision. I found that overwhelmingly men reported that final decisions about women's health seeking were being made jointly by women and men (59% of respondents) or by men alone (29% of respondents). Only 2% of men (3% among married men, and 0% among men in relationships) reported that women alone had the final say in their own health seeking. These figures were consistent across all demographic variables.

I analysed the correlation between this question on final decision-making on women's health seeking and men's reported contraceptive use, the results of which are in table 15 below. To prevent the test for heterogeneity being diluted, I excluded the small categories of men reporting decision-making by women

alone (n=4) and by others (n=3) and focused on a direct comparison between men’s decisions and joint decisions on women’s health seeking. I found that men who alone had the final decision on women’s health seeking had 77% lower odds of reporting using contraception with their partners compared to where this decision was made jointly; which remained consistent after adjusting for other variables (AOR 0.33, 95% CI 0.14-0.77, p=0.01).

Table 15: Associations of reported contraceptive method use by men’s reports on who has final say on women’s health seeking (men in relationships in Southern Malawi, n=176) ⁴⁸

Who in your family usually has the final say regarding partner’s health-seeking at home?	No of responses per option (% of responses per option)	No using contraceptive method (%)	Unadjusted odds ratio (OR) (95% CI)	Adjusted odds ratio (AOR) ⁴⁹ (95% CI)	p-value
Total male respondents	176	162 (72.3%)			
- <u>Man</u> has final say	54 (30.7%)	31 (59.3%)	0.33 (0.16, 0.67)	0.33 (0.14, 0.77)	0.01
- <u>Women</u> (partner) has final say on own health-seeking	4 (2.3%)	4 (100%)			
- <u>Joint</u> final say/ decision	114 (64.7%)	93 (81.6%)	1	1	
-Other person’s say/decision	4 (2.3%)	3 (75%)			

This finding, together with my finding on the GEM household decision-making item iv. above, point to the impact of both household decision-making norms, as well as men’s authority, on contraceptive method use. These results highlight that approaches solely seeking to promote women’s health seeking and empowerment may lead to less sustainable change if they do not also work with

⁴⁸ This question was asked to men in relationships following a filter on living with their children.

⁴⁹ Adjusting for location, age, marital status, education, number of children, employment status, ethnicity and religion

men to question underlying inequitable male gender norms and behaviours (Edström et al., 2015).

6.4 Exploring men's attitudes towards gender equality, contraceptive communication and decision-making and pregnancy prevention responsibility

My quantitative results found men to be overall moderate or high in their support for gender equitable norms. Higher GEM scores (more equitable responses) were positively associated with reported contraceptive use, as were more equitable responses to the specific GEM item on household decision-making. Men's overall control of decision-making on women's health seeking was strongly negatively associated with contraceptive use.

Based on these findings, I used qualitative research to deepen understanding around how men's equitable or inequitable attitudes and norms impacted on male involvement. In particular, I explored men's views on gender roles, on gender equality, on contraceptive communication and decision-making, and where responsibility lay for pregnancy prevention; items both mirroring the GEM scale statements and identified across the Southern Africa and Malawi literature in chapter 2 as important components in exploring women's agency within the context of contraceptive use.

6.4.1 Men as household decision-makers and women as caregivers

Despite finding quantitatively most men to be moderate or high in their support for gender equitable norms, I found qualitatively that men did not see women as their equal, particularly in the context of relationships, holding positions that undermine the advancement of women's empowerment. For married men, they were the decision-makers in the family, reflecting women's lower status, as explored in chapter 4, and therefore had the final say at home, a position in congruence with hegemonic masculinities. This was particularly apparent during FGDs in rural areas, as reflected by this married adult man:

We are the heads of the families. Being heads of families, we are mostly self-reliant, saying 'There is no one who can tell me what to do.' (FGD-CHI-8 male, rural, married, 46yrs, 4chldn)

Another rural married adult man explained that these socially constructed power differentials between men and women, and men's position of dominance, are instilled in couples from the beginning of relationships:

We see this even during courtship that a man is the one who seems to be the decider and not the woman; she just helps in simple matters. (FGD-LIK-10 male, rural, married, 32yrs, 3chldn)

Within this hierarchy, women's role was within the domestic sphere. Men provided responses that clearly delineated their role as the economic provider, seen as more critical, and women's role in these 'simple matters' which were seen as of lesser importance, as this older married man from an urban FGD noted:

Women are the ones who take care of the household. They play a role in that they monitor the health of their husbands because most of the families here in Malawi depend on men. So if a man is frequently ill, a family cannot progress. So, a woman plays a big role by making sure that the husband is healthy and strong so that he can work and make the family happy. (FGD-BAN-10 male, urban, married, 50yrs, 4chldn)

As this quote also notes, women play an important role in men's health, which men confirmed, as part of supporting men's economic provider role. During FGDs married or widowed women confirmed their responsibilities as primary caregiver and over the domestic realm, explaining this must be achieved sometimes under difficult circumstances:

And when the children are born, you are the one who takes care of them, raises them, so maybe there is no food in the house. You face those problems alone as the man is not always at home. (FGD-CHI2-5 female, rural, widowed, 44yrs, 1child)

The separation of these roles, and the negative impact it has on gender equality, is a global concern (Levtov et al., 2015). Raising children is not in

congruence with dominant conceptions of masculinity. Implicit here is that women's role as primary caregivers is of lesser importance, a viewpoint arguably linked to the ways in which colonial actions shaped gender roles in Malawi, as I explored in chapter 4. My observational research findings supported this. While access to employment appeared to be changing in Blantyre for more educated women, this division remained pronounced in rural areas, with women the ones getting water from wells, looking after children, cleaning and running the household, while men often congregated together, sometimes under trees, ran stalls selling food or mobile phone airtime, or were out of the village at work or looking for work. Women came to my FGDs with their children, while no man brought his children to either an IDI or FGD.

As a result of these inequalities, men in both FGDs and IDIs told me that they reject information flows from women, as reflected by this married adult man during a rural FGD:

According to the tradition here in the village, we know that a man is great; a woman is under him. So it is difficult for a man to accept when a woman is telling him to do something or to assist him properly. (FGD-LIK-13 male, rural, married, 27yrs, 2chldn)

This supports the GEM item iv. finding above that most men agree that men should have the final word at home. Conversations with the research team identified a view that women who dominate decision-making within the family are seen as deviant. The family unit within marriage in Southern Malawi is often a location in which men construct and perform masculinities (Kapulula, 2015), and where the "husband assumes control of his wife's reproductive capacities and makes the reproductive decisions" (Kishindo, 1994: 64). As Malawian men need to continually prove their masculinity (Izugbara and Undie, 2018), public and private reassertion of this conjugal position of dominance was central to married men's construction of self.

Health providers supported this view, and reflected the importance therefore of

targeting men to improve family health, such as this private health provider in Bangwe:

Men are mostly the head of the household in Malawi. When you educate the head of household, it can impact on the whole family. It can improve the health of the family. (HP5, male, urban, 33yrs, private service, clinician)

As a reflection of how a nominally matriarchal society may not be reflected in practice (see chapter 4), though the village of Chitera had a female Chief, discussions with my research assistants reflected that her influence was often limited.⁵⁰ The existence of a female Chief also did not change the overall lower status of women in her community as evidenced by men's and women's responses from Chitera.

6.4.2 Gender equality is against men

I found that co-existing with these underlying inequitable power differentials between the sexes, and different gender roles, was a sense among men that women's advancement threatens hegemonic masculinities and that 'gender equality' in Malawi does not 'respect' men. In particular, I found men felt emasculated by women's empowerment, such as this married adult man from Chitera noted during a FGD, reflecting the views of many others:

The other thing is that women's rights are the ones that are being promoted very much. We just hear, 'women, women.' So we feel like men's rights should also be promoted so that men should take a leading role, for their role to be seen. (FGD-CHI-14 male, rural, married, 27yrs, 3chldn)

This mirrors Chikovore et al.'s (2014) qualitative research, which found men in Blantyre feeling threatened by any changes in traditional gender roles as a result of gender equality.

While men played the 'leading role' in the home, they felt the public focus on

⁵⁰ Matriarchy was not defined in Chitera as women holding the power (as in the opposite to patriarchy), but that the line of the Chief passes through the maternal line.

women's rights did not respect such family unit power dynamics. I found this fed into a broader context in which men's emasculation was said to feed relationship problems and men's risky sexual behaviours. In other words, men dealt with this threat to their preferred image by amplifying dominant masculinities (ibid.). As this married man noted during an FGD:

I just would like to comment on a family issue. Marriage is built by a man and a woman. So I don't think it is a wise thing for an organisation to come and just call for women or girls to discuss some issues. For those married couples it is better to call for a man and a woman and advise them together so that these people should be free to each other in their families and do things together to prevent them from being unfaithful to one another and doing things that are not good. (FGD-LIK-13 male, rural, married, 27yrs, 2chldn)

In rural areas I observed that there were several women-only groups run by NGOs meeting regularly, particularly focusing on women's empowerment and women's savings and loans schemes. I did not observe any similar activities specifically targeted at men, and informal conversations suggested that few, if any, did so. I found during FGDs men felt this disproportionate number of organisations targeting women was discriminating against them:

Women are benefitting a lot from organisations whether loans or whatever. So it is like men are being discriminated against, because whatever they say is for women. So men want to say, 'What about our part?' (FGD-CHI-13 male, rural, married, 42yrs, 4chldn)

Reiterating this sense of discrimination, FGD-LIK-13 quoted above went on to suggest during the FGD the need for organisations to specifically focus on reaching out to men, reflecting what I found men to say about the limitations of contraceptive information flows discussed in the previous chapter. Given that FGD-LIK-13 was also clear that men have higher status than women (see above), there is arguably a danger such male-only spaces would reinforce hegemonic masculinities:

I feel that this country has come to a point where it favours women more. Most organisations are fighting for women's rights and health. That's why

we see that it is women who are free when it comes to health issues. So there should have been some other organisations like we are doing here. We are men only and we are discussing freely. Those organisations should be found and they should be calling for men to gather in one place. Things would have [then] been progressing well. (FGD-LIK-13 male, rural, married, 27yrs, 2chldn)

Health providers and stakeholders confirmed that such a sense of exclusion was directly impacting on men's approach towards contraception, particularly given men were head of the household. A senior staff member from a national NGO running family planning clinics told me:

P: Men don't use our family planning services

I: Why is this?

P: There are several reasons for this. It was the way family planning was brought in. It was not presented as a family issue, but instead as a women's issue. We say healthy mother equals a healthy nation. But a mother is not healthy if her husband is not involved to support her... The driver of rural families and communities are the men. If women and children are sick, for the men to take the first step to take them to hospital [motivation] is so low. If men are motivated to seek help, it will improve women and children's health. Men will also not provide resources for their partner to access family planning services [such as money for transport] if not motivated.

(KS2, female, urban, 44years, NGO service provider, director)

These responses provide an insight into men not believing that gender equality benefits them, and that approaches to promoting women's rights are operationalised in a way that men perceive to be at odds with their decision-making power in the home. It supports the view that men have not been sufficiently informed of, and engaged in, the benefits of gender equality and male involvement, as Townsend and Shand (2009) argue. This is important because, as Chikovore et al. (2014) argues, men in Malawi feel a sense of failure in not fulfilling their dominant role, and in an absence of alternative more equitable roles, are reinforcing gender inequality. Indeed, as a reflection of this, a member of staff from a UN agency told me on the fringes of a National Gender Conference that she was attending:

Discussions on gender, such as the National Gender Meeting in Blantyre this week, are still predominately women in the room. We have not moved from the belief that power is finite – you have to take power away from men, to [give to] women. We have not presented enough on the benefits of gender equality to men, as well as the benefits for women and children to have men involved. We don't focus enough on why gender equality [is good] for men, as individuals, and within communities. (KS4, female, urban, 29yrs, UN agency, officer)

As I now explore, this macro level tension between men being the household decision-makers, though feeling excluded from gender equality interventions and threatened by women's advancements, played out at the micro level around family planning and contraceptive use.

6.4.3 Family planning is a family issue not a women's issue

I asked men during IDIs whether they considered family planning to be only a women's issue. Given that Malawian literature has presented family planning as *ndizachizimayi* (Gipson et al., 2010), Chichewa for 'strictly for women', and the principal focus on women within the country's national family planning strategy, I expected men to agree. Instead, I found men, with only two exceptions, to disagree, a common response being:

*I: Do you think family planning is a women's issue only?
P: No, Is it an issue for both men and women
(IDI-SL-2, male, urban, married, 35yrs, 3chldn, injection)*

I found this view was shared by married men, those in a relationship or single men, even if they did not see family planning as a matter of direct relevance to them given their current life stage. It appeared to touch on something more fundamental. As noted in the previous chapter, most men associated 'family planning', *kulera*, with considerations of family size not methods. As such, while methods were feminised, family size considerations were not. Men believed that family size considerations should be a joint decision, as this married adult man noted during a FGD:

When it comes to the issue of making a decision to say, 'We should have two, three children,' that needs sitting down as a family and discussing. (FGD-CHI-4 male, rural, married, 26yrs, 2chldn)

Married men highlighted challenges in family size decisions being seen as only about women, including “fights which cause the husband to leave the relationship” (IDI-CHI-4 male, rural, married, 48yrs, 6chldn). Such considerations are for the family unit, these men stated, “because of marriage you are one body” (IDI-SL-3 male, urban, married, 42yrs, 5chldn), and that “it is not good for only women to get involved” (IDI-CHI-2 male, rural, married, 32yrs, 4chldn).

While these married men said questions of family planning, as family size considerations, was a joint endeavour, one married adult man, who currently had three children, suggested that it may indeed be a matter for men alone:

I already made up my mind when I was young that I should have a maximum of four children and see how I can raise them. (IDI-SL-2, male, urban, married, 35yrs, 3chldn)

In answering this question, married men highlighted an important distinction for them. Many men who answered that family planning was a matter for both men and women, further told me that accessing methods was, however, mostly women’s business, such as this adult married man:

I: Do you think family planning is a women’s issue only?

P: Family planning is for both women and men. But in my family, it is my wife who goes to the health facility for family planning. This is what we agreed. She should not do it on her own or in secret. (IDI-LIK-3 male, rural, married, 30yrs, 2chldn, injection)

This reinforces the view that men’s concerns regarding *kulera* are with family size, and less so with methods. Indeed, the only two men, both married, who answered this question instead agreeing that ‘yes, family planning was a women’s issue’, referred in their rationale not to family size considerations, but to the fact that it is women who are the ones to take contraceptive methods.

Their response reflected the different semantic interpretations of *kulera* that I discussed in the previous chapter. That men's involvement in family size considerations were in congruence with hegemonic masculinities, but taking contraception was not, informed their approach to contraceptive communication and decision-making, often in inequitable ways.

6.4.4 Communication around contraception

I asked men about their involvement in communication around contraceptive methods within their relationship. Among married men, I found many to provide detailed examples of different ways in which they discussed this matter with their partner, and the positive benefits of them doing so. An example of a supportive male partner included this rural adult married man who explained that it enables him to support his wife to remember to take a particular method:

Taking part in family planning methods such as injections, they say that the injections last for about three months so we remind each other about the dates to go for another injection when three months elapses. (IDI-CHI-2, male, rural, married, 32yrs, 4chldn, injection)

Another adult married man, from an urban context, highlighted that one of the benefits of his involvement in communication around contraception was being aware of potential side effects that his wife may face, even if she may not see the matter the same way:

It is at home then we are a group. Only that a lot of women consider it personal. But it is not personal. It is for both of you because if she has gone to get a family planning method then it can affect her. If something like a loop [IUD] has affected her then you don't know anything because she didn't talk to you in the first place. But if you are aware then you will be able to help each other. (IDI-NS-8 male, urban, married, 32yrs, 1child, injection)

This man went on to suggest that his education was the reason why he supports method use, which would concur with the GEM findings:

- I: But why did you allow your wife [to use contraception]?*
R: I'm educated. I went to school that's why I'm always open to my family. I'm not the head of the family as people say. We are one. (IDI-NS-8 male, urban, married, 32yrs, 1child, injection)

Another married adult man whose wife had an IUD spoke of supporting her with method switching as an additional benefit of supportive male involvement:

- I: In which way are you involved [in family planning]?*
P: In the past I used to encourage her [his wife] to go for family planning methods, she was using injections then, that one for three months and above. So when family planning organisations came, they said that there is another method for three years, so she went again for that method. (IDI-CHI-7 male, rural, married, 29yrs, 2chldn)

These findings point to the emergence of responsible forms of masculinity around men's engagement in contraceptive communication, and men's desire to advance such models of engagement. Positive couple communication has been found by others to yield a range of benefits within Malawi, including Shattuck et al. (2011) finding it facilitated method switching, men being aware of the potential contraceptive side effects, and making it easier for the wife to negotiate safe sex.

An important reason for men's desire to be involved in contraceptive communication was for considerations of family size, given their primary concern related to this. For example, this adult married man who had four children, whose wife used the injection:

- I: Why are you involved?*
P: The reason is that, ah, if you have many children you struggle to sustain them due to constrained resources. But if you have a good number of children you can take good care of them. That is why I am involved in discussions so that we manage the family. (IDI-BAN-6 male, urban, married, 36yrs, 4chldn)

As this quote noted, men had concerns about the cost of many children. This speaks to their role as breadwinner, which I will discuss in the next chapter.

Despite these positive examples, challenges around contraceptive communication were presented as a critical barrier to use, particularly in rural areas. One particular concern among men was how gendered contraceptive information flows, which, as noted in the last chapter, passed from the health system to women and then to men, challenge the power structures within the household. As one single man with a child said during the Chitera FGD, explaining how men react when women broach the subject with their husband:

Most of the time, what happens is that the message gets to women, but we say that the head of the family is a man. When the woman goes and tells the husband about what she has learnt, he slackens and shouts at the wife. So she says, 'It is better for us to be just living in this house without practising any family planning method.' That's why the number [of children] keeps increasing. It is because most of the things are done by women. (FGD-CHI-10, male, rural, single, 24yrs, 1child)

Here we see the corollary of married men's sense of emasculation due to their lack of direct access to contraceptive information, responding by using verbal harassment to reinforce their dominant masculinity: leading them to either not support, or even deliberately prevent, contraceptive method use by their partner.

In rural FGDs I found men to further present feeling powerless due to the gendered contraceptive information flows and to connect this to a broader mistrust of the health system, as this married adult man describes:

When somebody comes to tell you [about contraception], it feels like she is lying... we don't know the counselling or teachings that take place at the health facility because we don't go there. (FGD-LIK-2 male, rural, married, 40yrs, 3chldn)

Informal conversations in my research communities identified that men perceive women as being taught to be 'rude to their husbands' by the health facility, as they return home conveying instructions to men from health providers on the need to use methods, or to use condoms until women receive their next method. Health providers confirmed to me that they encourage women to do so:

We empower women who come here for family planning. We talk to women about how to discuss this issue [with their husband]. For the women to take the messages home, and negotiate with their partner, it is difficult. (HP11, male, rural, 47yrs, public service, manager)

This view that health providers are indirectly 'demanding' things of the male head of the household, infused men's suspicion of health systems and their objections given they did not control such information flows. This echoes the findings of Kalipeni and Zulu's (1993) research on contraception in Malawi, who found men to feel excluded by such information flows and then become suspicious about the details that they received from their partners. I also found this was compounded by men then communicating with their friends instead, who may further discourage contraceptive use. One solution to this advanced by the health system was couple approaches, as I discuss in chapter 9.

Married women during FGDs confirmed such communication challenges, where their attempts to discuss contraception with their husband were rebuffed:

P: When you talk to men about family planning, they tell you that you will see it for yourself.

I: Why do they refuse?

*P: They say it reduces sexual potency
(FGD-CHI2-11 female, rural, married, 26yrs, 4chldn)*

Despite men (such as IDI-NS-8 above) noting a concern of women seeing contraceptive use 'as personal', that women did not sufficiently communicate with men on this issue, this married woman's response suggests that the challenge may not be women's insufficient communication but with contraceptive communication flows challenging male hegemony.

In my conversations, neither men nor women proposed shifting the existing power dynamics around contraceptive communication, and instead that the existing provision of information should better respect men's authority as head of household. Indeed, as a reflection of how women also reinforce hegemonic

masculine norms (Connell and Messerschmidt, 2005), married women told me during FGDs that it was *their* approach towards discussing the use of contraception with men, not men's behaviour, that was at fault:

Let me just comment on what my friend has said. When asking a man to be taking family planning, we must persuade them so that they understand that it will help both of you in managing your family well, because it is the man's responsibility to provide for his family. So I think you must persuade him to let you go for family planning methods because sometimes men refuse to take part because of the approach that we women use. Maybe we are coming from drawing water and we find a man sitting resting, we just tell him anyhow that I have heard that so and so uses family planning methods so I want to do likewise. That is undermining the authority of the man. Basically, with the state of things nowadays I think we must encourage them to let us start using family planning methods. (FGD-CHI2-6 female, rural, married, 34yrs, 4chldn)

My qualitative findings also suggested poor couple condom communication, despite the fact that only 44% of all men (and 43% of those married) agreed with the GEM scale item iii. on men being outraged if their wives asked them to use a condom. This was attributed to the belief that condom use in marriage would undermine marital trust, as discussed in the previous chapter. It was also linked to the aforementioned power dynamics, where men use their power to force women to have sex without a condom, as this adult man in a relationship noted:

Men get furious when women demand use of condoms. They claim that they hold power over women. (IDI-SL-1 male, urban, relationship, 29yrs, no children)

Married women confirmed during FGDs that they faced challenges getting their husbands to use condoms:

We want them to be using condoms because it is so risky nowadays, we don't know how they behave when they are out there, but men are the ones who refuse to use condoms. (FGD-CHI2-1 female, rural, married, 36yrs, 5chldn)

Conversations also identified challenges in couple communication around

vasectomy, with women stating it would be very difficult to encourage men to go for this method. During a FGD on vasectomy, a married man reflected this in stating on the topic:

For a woman to tell me, 'Do you know that there is a method at the health facility you can chose?' I will tell her, 'You smoke marijuana and you are childish.' (FGD-LIK-10 male, rural, married, 32yrs, 3chldn)

Chipeta et al. (2010) found Malawian men to perceive discussions with their partner about contraceptive use a waste of time. During my community dissemination meetings, a key point made by participants was the need to focus beyond men being involved in contraceptive communication, to improving the *quality* of those discussions.

While contraceptive communication was an area in which men may not respect women's views, both urban and rural men noted that women's communication around men's broader health was acceptable, reflecting women's domestic responsibilities noted above. For example, this married man noted during a FGD, reflecting a common theme:

A woman is supposed to look after a man...she is supposed to tell her husband, 'Ah my husband, you are supposed to go to a health facility. You are coughing. What is happening?' That is the encouragement that comes from a woman to a man. (FGD-BAN-6 male, urban, married, 26yrs, 2chldn)

When asking men who they speak to first about their health in general, married men all said their wives, highlighting the acceptance of different topics of conversation. This further suggests that it is not communication *per se*, but the terms and perceptions of the topic when it comes to contraceptive communication which is particularly challenging. Improving the quality of communication is arguably inseparable from also shifting male gender norms and power dynamics in relation to method use.

As noted in the previous chapter, unmarried men in relationships reported that they used condoms as pregnancy prevention with their partner. However, these unmarried men said this was not an issue that they discussed with their partner; they simply ‘took part’ through using condoms, as one such adult man explained:

- I: Are you involved in discussions and decisions at home or with your partner about contraception/family planning?*
- P: We have never had a discussion about family planning, but I just use condoms.*
- I: Why?*
- P: Ah, it is not yet time to talk about it with my girlfriend.*
- I: Condom use is one of those family planning methods, so have you not discussed it?*
- P: It is just the same as family planning.*
- I: So how do you take part in making decisions on condom use?*
- P: We agreed we should be financially stable first before we have a child. We have to start working to earn money first. I told her that it is not right to impregnate her while we don't have anywhere to get money to meet our basic needs, we have to plan our future first. (IDI-BAN-3 male, urban, relationship, 20yrs, nochildn)*

Reflecting the performance of hegemonic masculinities being about concern for family size, and not methods, these unmarried men were most likely to tell me they were not involved in contraceptive communication or decision-making. As noted, the use of condoms, for them, was not about considerations of using male methods or not, but to prevent pregnancy using the most easily available method.

6.4.5 Decision-making around contraception

My qualitative research found married men to assert that they played a critical role in contraceptive decision-making, reflecting my quantitative findings. I found men's responses in this area were less focused on the specific advantages of their involvement in decisions, and more on the importance of such involvement. Here an adult married man, whose wife uses the injection, reflects on the need for decisions around method type to be made by the family unit, highlighting the potential for misunderstandings should women make decisions alone:

P: It is not good for women to decide alone on which family method to adopt, because it supposed to be done as a family. I heard that when a woman has received the injection method, she is not supposed to have sex for a few days.

I: Why?

P: It is an instruction from the health staff, they say people should wait two to three days before they have sex. So if you do not agree as a family, the instructions from the health facility might not be followed by the husband with the mentality that the wife is trying to punish him.

(IDI-LIK-9 male, rural, married, 31yrs, 2chldn, injection)

Punishment, for this man, refers to being denied sex by his wife, a matter to which I will return in chapter 8.

Reflecting the above quote, I found married men said they were often involved in decisions about specific methods women will take. This reflected the finding of the related GEM item that most men are believe that decisions around contraceptive type used should be a joint decision (item i.). Reflecting this role, one rural adult man, whose wife had an implant, provided an example of supporting method switching, though in a slightly disparaging way:

The method that we used to like was injections. But knowing that method may confuse women, maybe the woman can forget the day that she is supposed to go for an injection, so we just made the decision to go for norplant [implant]. (IDI-CHI-5, male, rural, married, 26yrs, 3chldn)

During IDIs some married men expressed specific preferences for particular contraceptive methods, and that this overrode the preferences of their wives:

At first my wife said we should use condoms as a way of family planning but I told her that it will not work. So we discussed whether she should use pills, and I told her she should use the injection method. She said she should use a norplant, and we ended up going for the injection. (IDI-LIK-3 male, rural, married, 30yrs, 2chldn)

Discussions with married women during FGDs confirmed that men's role in decision-making at home on contraceptive methods was critical:

When a man and a woman want to start practicing family planning, you are supposed to agree that we want to start using this method. Women go to collect family planning after they have agreed with their husband to go for that family planning method. (FGD-NS2-4 female, urban, married, 31yrs, 2chldn)

I also found during IDIs that married men were not only jointly involved in decision-making, but arguably often had the overall decision, reflecting their inequitable attitudes and going further than the above GEM item i., for example, men giving their partner permission to seek a method in the first place:

I told my wife that we should start family planning, and she asked me which method should we follow. We agreed to use the injection method and I told her that she can go and do it. (IDI-LIK-9, rural, married, 31yrs, 2chldn)

This also supports the associations I found in IMAGES between norms around household decision-making and who had the final say on women's health seeking and reported contraceptive use. These findings differ from DHS (which finds mostly joint decision-making) but reflect Withers et al.'s (2015a) qualitative research in Kenya, similarly finding that men's authority was a critical factor to women's contraceptive use.

Reflecting the aforementioned concerns men had about the injection, during FGDs men raised the fact that they had a direct impact on women choosing or not to take this method, such as this married adult man:

The woman listens to the advice given by her husband, and she goes on to take family planning pills, shunning injection by labelling it a bad method. (FGD-NS-6 urban, married, 26yrs, 1child)

Health providers confirmed that, although women generally came to the clinic alone, they came with the specific consent and method preference of their husband, as this public provider stated in relation to this matter:

Most women, when they come for family planning services, say this is what my husband would prefer. (HP1, male urban, 36yrs, public service, in-charge)

These findings show that the hegemonic structures of power within research sites meant many men had control over methods, and therefore arguably women's bodies. Differing from Shattuck et al.'s (2011) findings in Malawi who found men to have less overall decision-making on the methods used, my findings above suggest that men appear to have strong preferences and decision-making power in this area. Some of this related specifically to sexual pleasure concerns around the contraceptive injection, as I will explore in Chapter 8.

Equally, I found sometimes men's involvement in decision-making was to refuse the use of methods at all, such as this adult married man, who reported not currently using contraception with his wife, reflecting the views of others in both urban and rural contexts:

I: Are you involved in discussions or decisions at home about contraception/family planning?

*P: Yes, my wife told me to use family planning methods, but I refused because we have only one child
(IDI-BAN-5 male, urban, married, 27yrs, 1child)*

As I will explore in the next chapter, often men's objection to contraception related to a desire for more children. Only one married man, who had also provided a positive example of communication, reflected emergent forms of more positive masculinities indicating that men should not refuse method use:

I don't know why they [men] deny their wives family planning methods. But it is not a good thing to do. (IDI-CHI-2 male, rural, married, 32yrs, 4chldn, injection)

In the context of contraceptive decision-making, I found dominant masculinities were not only defined by men's desire for control but equally men's fear of not being in charge of contraceptive decisions. In conversations, it was apparent that this was an area where men felt concern, where masculinities were fragile, should their wife make a decision alone to access methods:

If a woman decides to adopt a family planning method on her own without informing you then she has gone behind your back. But when you discuss various contraceptive methods and decide together which one to adopt, it means you've agreed on one thing. (IDI-BAN-6 male, urban, married, 36yrs, 4chldn, injection)

Informal conversations in my research communities and with health providers, identified that this was often associated with the fact that women were given methods, particularly through ANC/PNC, sometimes without men's knowledge.⁵¹ It was unclear whether this was automatic, or a routine offer only.⁵² This situation was highly objectionable to men, the ultimate sign of emasculation, as this married man explains during a FGD after his wife has returned from PNC:

The wife wants to tell you what she has got [contraception] from the health facility. Instead of you answering the woman in a just manner, you fail to do so. You tell her, 'That's foolish! Don't tell me that!' The woman... wants to tell you the truth. You shout at her. It seems like the woman wants to rule over you. So to make the woman not rule over you, that's when you become angry. So most of the time women dodge and go for family planning services without us knowing about it. (FGD-CHI-3 male, rural, married, 51yrs, 5chldn)

As we see here, women's access to contraception without the man's authorisation was seen to be empowering women, and challenging men's hegemonic masculine role within their community. Reflecting the rejection of information flows from women to men, as noted, men sought to reassert their dominance and prove their masculinity through verbal abuse and refusing to engage in the matter. I found that this perceived loss of control added to men's sense of exclusion from contraception, and frustration among men, creating further challenges for women, as Kalipeni and Zulu (1993) similarly found earlier in Malawi and Chikovore et al. (2002) found in Zimbabwe.

⁵¹ As noted, women are offered contraception during post-natal care six weeks after birth and often receive whatever method is available at that time. Men understood this process.

⁵² Though theoretically women have a choice over whether they accept methods, it appears they are strongly encouraged. Women may also say they were automatically given the method to appease their male partner who could accuse them of making decisions without them.

6.4.6 Women must access methods alone

While men desired to be, or are, involved in contraceptive communication and decision-making, and wished to be more directly targeted by information and services, I found men to make a clear distinction in both interviews and FGDs around their role: locating methods and going to a health facility is for women not for men. As one male adult whose wife used an implant and had provided an example of supporting method switching (see IDI-CHI-5 above) said:

- I: Do you think that family planning is a women's issue only?*
P No, it also concerns men, but I don't think it is necessary for me to go for family planning methods.
(IDI-CHI-5 male, rural, married, 26yrs, 3chldn, implant)

Another married adult man highlighted that, while he is involved in discussions, his role beyond that is limited, including not accompanying his partner:

I have never gone to health facilities for family planning with her, but we discuss it at home. (IDI-LIK-1 male, rural, married, 30yrs, 3chldn, injection)

During FGDs, men highlighted that in the context of women encouraging them to discuss using contraception, men tell them they are the ones to access the methods, as this older married man noted:

She says, 'The children are enough.' So when the man is refusing, she says, 'Let's go and learn about family planning together' and he says, 'You be the one to go there' [to the health centre]. (FGD-CHI-9 male, rural, married, 52yrs, 2chldn)

As I explore in chapter 9, client data found few men accompanied their partners to ANC/PNC, which would corroborate their views, and that men did not want to be seen in clinics.

As a reflection of the performance of hegemonic masculinities, men can play a deciding role, but ultimately leave the details to women, as this urban adult married man reflects upon during another FGD:

Most men play a role in family planning but it is not much because they just push it to the woman. If there are any discussions, they just discuss the fact that the woman should do it on their own. Playing a role in family planning, it doesn't happen that much. (FGD-LIK-2 male, rural, married, 40yrs, 3chldn)

In their research with women and their partners around IUD use in Lilongwe, Bryant et al. (2015) equally found men to give their permission but not accompany their female partners to any clinic visits.

One man explained during a FGD that the fact that men have fewer methods, as discussed in the previous chapter, was the reason why women are responsible for accessing methods:

Most of the time, women lead on this issue because they seem to be the ones that have many family planning methods at the health facility. When we come to men, there is the condom one and vasectomy. So women go there [to health facilities] because they have the opportunity to choose the method they feel is better. (FGD-CHI-4 male, rural, married, 26yrs, 2chldn)

As these results show, while men expressed concern where they lacked involvement in contraceptive communication and decision-making, I did not find men making an equally commensurate desire to actually *want* to go to contraceptive services with their partner. The use of such services, to access something seen as feminised, was incongruous with their dominant masculine self-identity. This poses challenges for considerations of increasing men's uptake of services. In the context of men's rejection of current information flows, and men's ability to exercise restrictive control over contraceptive decision-making, I found this could also leave women with no option but to secretly access methods to prevent pregnancy.

6.4.7 Ultimately responsibility remains with women

Whilst men's IDIs provided examples of ways men were involved in contraceptive communication and decision-making, my FGDs presented a picture of men being mostly disengaged, that they ultimately left the

responsibility for pregnancy prevention with women:

A lot of men run away from practicing family planning. They take it as the responsibility of a woman. If we can be discussing family planning, there will be more women. Men say, 'Family planning is the responsibility of women.' (FGD-CHI-9 male, rural, married, 52yrs, 2chldn)

Reflective conversations with the research team revealed their interpretation that men perhaps were not as involved as they claimed during IDIs and were giving the expected response during my interviews that they played a more involved role, in line with their socialised position as head of family matters and therefore performing hegemonic masculinities. I found women to equally reflect during FGDs that perhaps men's involvement in contraceptive processes was currently insufficient:

They [men] are supposed to take part because it is everyone's responsibility to contribute to making decisions on the number of children to have. So it takes a man and a woman to discuss on how to go about using family planning methods. If only one person is taking part in the family planning methods, it means that the responsibility rests on you alone and not the two of you. (FGD-NS2-4 female, urban, married, 31yrs, 2chldn)

My qualitative findings supported the GEM scale item finding, noted above (item ii.), on most men agreeing with the statement that pregnancy prevention is primarily a women's responsibility. I found that one rationale presented by men during both FGDs and IDIs was given that women get pregnant, they therefore face the burden of pregnancy and its outcomes on health and wellbeing. As one adult married FGD participant said:

Most men feel that since it is a woman who gets pregnant, the greatest responsibility regarding family planning should be in her hands. (FGD-LIK-10 male, rural, married, 32yrs, 3chldn)

As such, it followed for many men, both urban and rural, that women are therefore expected to shoulder the responsibility of ensuring that they do not get pregnant. Here, one of the two adult married men who asserted that family planning was indeed a 'women's issue', uses this rationale for his response:

Here in the village it is only a women's issue. Because it is women who suffer if you are not doing family planning, so they make sure they play a big role. (IDI-LIK-1, rural, married, 30yrs, 3chldn, injection)

Pregnancy, like contraception, was therefore feminised. While some men may have been responding to the GEM scale item ii. based on how they see things are – the physiological realities – my qualitative data suggests the primary driver was that the domain of pregnancy prevention was not in congruence with the performance of hegemonic masculinities. In the hierarchical nature of masculinities (Connell, 1995), pregnancy prevention was of lessor concern. Men's role is simply to impregnate. For example, this married adult man whose wife uses the injection, noted, in response to a question on vasectomy:

Most men... say that the task of bearing a child, I mean being pregnant, is for women. For them men's role is just to impregnate. So most men say that the main challenge is with women, so they prefer that women are the ones going for sterilisation and not men. (IDI-LIK-6, rural, married, 32yrs, 3chldn, injection)

During a FGD, another rural man spoke to men's ignorance towards the fact that they have a role in reproduction, reflecting an almost invisibility to the reproductive process:

What causes family planning to be for a woman is ignorance on the part of us men...Seeing as it is a woman who reproduces. She goes to a hospital to deliver, we say, 'It is a woman who delivers and she should be the one to practice family planning.' What we don't know is where the child comes from before reaching that stage. If we had realised that it is us men who reproduce, a woman is just like the one who incubates the eggs; this behaviour [not using methods] wouldn't have spread here. (FGD-LIK-8 rural, married, 20yrs, 1child)

These statements were arguably also used by men as a way to absolve themselves of responsibility. As men are not impacted directly by pregnancy, they ultimately leave pregnancy prevention to women. I found this to be confirmed by women in both rural and urban settings who asserted that men perceive pregnancy and childbirth to be largely a woman's issue, reflected in the barriers to male involvement in maternal health in Southern Malawi (Kululanga

et al., 2012a). During my observational research I was told a story of a man (who did not want more children) divorcing his wife who became pregnant because she had not fulfilled her 'responsibilities' to prevent pregnancy.

Implicit in these statements from men also is that women must deal with the consequences of unintended pregnancy. This lack of focus by men on this issue is a matter which Kalipeni and Zulu (1993) has highlighted as problematic given the high levels of maternal mortality in Malawi. Only one married man, whose wife was using the injection, referred to men having a responsibility to engage around contraception given the risks of pregnancy on women's health, reflecting more positive masculinities in this regard:

It is important to sit down and talk about it because a woman's life becomes safer and I'll also be financially stable when we don't have a lot of children. (ID-NS-8, urban, married, 32yrs, 1child)

These views on responsibilities were also the antithesis to how many men reported their condom behaviour, given their focus for condoms being on HIV prevention rather than pregnancy. One married adult man, who said he currently has two sexual partners, described how he carried condoms wherever he went:

- I: Do you take part in your family to discuss issues concerning family planning methods or condom use?*
- P: The issue of family planning, no, because we have just got married, we only have one child. But then on the issue of condoms I am on the forefront, because everywhere I go I carry a condom with me in my wallet.*
- I: Why?*
- P: I use condoms because I am not sure of the health [HIV]⁵³ status of that particular person so I can't be sure whether to do it plain with her, maybe she is already infected (IDI-NS-7 male, urban, married, 30yrs, 1child)*

A significant theme that emerged from my data was that in this context, I found that women, out of necessity, would secretly access contraception without their husband's knowledge; that they, as one women said, "just sneak out and go for

⁵³ "Health status" was a common synonym men used for their HIV serostatus.

family planning methods” (FGD-CHI2-6 rural, female, married, 34yrs, 4chldn). In the rural FGD, women were unanimous in their assertion that men’s disapproval didn’t prevent them from accessing the contraceptive services they needed. In the urban female FGD, women talked of going to a health facility without their health passport, so their husband wouldn’t know they had gone. My conversations with health providers confirmed that female clients often tell them their husbands have objected to contraceptive use, and that they wish to hide the method from them, and ask not to have the method noted so that their husband doesn’t find out. Providers also confirmed that men can use violence to discourage women accessing methods. As this nurse in Ndirande South told me:

Men don’t want wives to get family planning services. If a woman comes, when she goes home, the man can even tear up her health passport and beat her...Some women, when they come here for family planning, keep the health passport at the hospital. Women often hide their family planning methods in a bucket of flour...Some women come here for the implant. If the man sees the implant, they force them to remove it. (HP18, female, urban, 40yrs, public service, nurse)

This highlights that women were not powerless when it comes to contraceptive use, and speaks to the contradictory nature of masculinities (Connell, 1995). The provision of methods secretly to women has historical roots in Malawi, as I discussed in chapter 4, and covert use of contraceptives due to partner disapproval was documented by both Paz-Soldan’s (2004) and Gipson (2010)’s qualitative research in Malawi.

Among men, women secretly accessing methods was highly problematic. It appeared to go to the very heart of men’s perception of themselves as hegemonic, given their misgivings about contraception and more importantly that it bypassed their ability to have overall control. This action was described by one man as “ruining most families” (IDI-NS-9 male, urban, relationship, 25yrs, nochildn). Though men showed awareness of this, it was not a major theme of men’s discussions, and unlike the FGDs with women, was not

mentioned during the male FGDs. Arguably its public acknowledgement among men in FGDs could be to validate something seen as deeply emasculating.

6.5 Summary

This chapter has explored how equitable or inequitable attitudes, norms and behaviours among men impact on contraceptive use. Using the GEM scale, I found two thirds of men to have moderate support for gender equitable norms. Men with high support for gender equitable norms have twice the odds of being contraceptive users, than those with low/moderate support, pointing to the potential influence of supporting greater gender equality among men to improve contraceptive uptake. Men being less likely to have the final say on decision-making in the home and less likely to have the final say on women's health seeking was positively correlated with contraceptive use, highlighting the necessity of engaging men, and not only targeting women, in approaches to addressing unmet need.

Despite the overall moderate GEM scores, I found men did not see women as their equal in the home and broader society. Men responded negatively to advancing gender equality, perceiving this as only of benefit to women and as a challenge to hegemonic masculinities. Given men's focus on family planning being a question of family size more than methods, the majority of men said family planning was a joint issue (not a women's issue alone), while matters of contraception were overall women's business. I found examples of men supporting effective contraceptive communication and decision-making with their partner, reflecting forms of positive masculinities. However, this masked a deeper picture of men feeling threatened by contraceptive communication flows, and desiring to not only make joint decisions (as the GEM item found) but to control overall contraceptive use decision-making; reflecting their concern of not being sufficiently involved and that women may access methods without their approval. I found that this decision-making authority could directly impact on women's use. While men wanted to be involved in (and often control)

communication flows and decision-making, it was a women's role to access methods, and ultimately pregnancy prevention remained a women's responsibility. Within this context, women were secretly accessing methods, a matter which was a significant challenge to men's perceived dominant role within families.

A key building block to advancing more gender equitable approaches among men towards contraception is understanding how men's current conceptions of what it means to be a man impact on family planning and contraception. This is the topic of my next chapter.

Chapter 7: Men's conceptions of manhood and its links to contraceptive use and family planning

7.1 Introduction

In the previous chapter, I found that men's gender equitable and inequitable attitudes, norms and behaviours, as measured quantitatively and qualitatively, particularly around contraceptive communication and decision-making, had an important influence on male involvement. In order to advance more supportive and equitable forms of male engagement, it is necessary to explore more deeply the gender norms that shape what it is to be a man; that is, the learned socially enforced gendered 'rules' around masculinities in Southern Malawi. Where masculine norms are found to be more rigid, these are often associated with a range of negative SRH-related behaviours (Starrs et al., 2018). As such, an important component of promoting healthier and more supportive male engagement is seeking to better understand and shift these norms (Stern et al., 2015).

In this chapter, I present my qualitative findings on five key areas in which I found Southern Malawian men themselves to conceptualise what it is to 'be a man' and the impact of these rules on men's approach to male involvement. I take each area in turn, exploring their salience and contradictions, and then their influence on male and female contraception (and where applicable, notions of family planning and considerations of women's agency). This chapter does not explicitly address masculine norms associated with sex, such as virility, which are discussed in the next chapter. This chapter responds to research question two: How do social and cultural attitudes, norms and behaviours of Southern Malawian men (including those related to gender-equality) influence their approach to contraceptive use and family planning?

7.2 Construction of masculinities

In my conversations with men, I found that five areas in particular were highlighted as associated with manhood in Malawi and that impacted on contraception and family planning: 1) being strong not weak; 2) having many children; 3) not being infertile; 4) being the economic provider; and 5) being stoic in terms of health-seeking. I now discuss each of these areas in turn.

7.2.1 Men are physically and emotionally strong

As noted in the previous chapter, only 27% of men agreed with the GEM scale statement that ‘To be a man you need to be tough’ (item vi.), which would suggest that men eschew the dominant norm of masculinity being associated with strength. In my qualitative research, I found the opposite to be true: that manhood is intrinsically linked to being strong and tough, not weak, in congruence with these dominant norms. I found Southern Malawian society reinforced the perception that to be a man meant one was not free to show signs or feelings of weakness, as this married adult man noted during a FGD:

Our culture is so deep rooted. Here most men are not free to talk about the problems they have faced or encountered [to show weakness]... They are not free to reveal their problems. (FGD-BAN-1 urban, married, 42yrs, 2chldn)

One frequently cited sign of a man being weak was showing emotions. Several men during interviews, and as part of informal conversations, reflected a common saying that ‘a man doesn’t cry’, even with their closest family or at sad times.⁵⁴ As part of the hierarchy between men and women reflected in hegemonic masculinity, men are meant to repress forms of emotions and vulnerability which are associated with the expressions of women (Buck, 1984), with such ‘feminine’ behaviour used to distinguish between a man’s ‘strength’ and woman’s ‘weakness.’

⁵⁴ I was told, for example, that men don’t cry even if they go to funerals, or in their relationships.

During IDIs, men highlighted the ways this perception is instilled through upbringing, reflecting Kishindo (1994) on childhood socialisation, as an important process in the construction of men's gender as unemotional and 'tough.' As one single young man noted:

I think it is the way one is brought up...maybe some men were taught when they were young that men don't get sick, men don't feel cold, so men grow up with that mentality. (IDI-NS-1 urban, single, 22yrs, nochildn)

These gendered norms of strength were also performed by men in order to adhere to the expectations of others. This gave substance to masculinity and enabled men to construct themselves as masculine (Connell, 1995). In particular, I found men were worried about the perception of significant others in their life perceiving them as weak (Farrimond, 2011), should they show cracks in the armour of strong manhood. During FGDs, another urban young single man said with regard to socialising with his friends when feeling unwell:

This [concern about what others think] makes you pretend to be strong when you are with your friends chatting, though you are not feeling okay. (FGD-NS-1 male, urban, single, 22yrs, 1child)

One particular area of concern for men was not to show signs of vulnerability related to their family. During FGDs men also talked about not being trusted and respected within the family if they were seen as 'weak', as this married rural adult man noted "They should know that you are strong, [even] when you are feeling pain somewhere" (FGD-LIK-2 male, rural, married, 40yrs, 3childn).

When I presented my GEM results on 'being tough' (that only 27% of men agreed), male qualitative respondents asserted it was response bias, and that it is true men 'need to be tough'. Conversations with the research team also identified translation issues within the IMAGES survey around the Chichewa word for 'tough', *ovuta*. This word presents a sense of a man who is difficult, and perhaps men did not want to show themselves in a potentially negative light when responding to this GEM question.

These quotes also show men willing to express their vulnerability in the context of hegemonic masculinities. It challenges notions of masculinities being fixed and highlights that some men recognise the inherent contradictions in fulfilling dominant norms (Barker, 2005).

I found that an important factor in men's reluctance to engage with health services was their aforementioned status as the head of the household, and the fact that they wished to retain the respect of their community and not be seen as weak. This reflects the concept of 'gender policing' which is central to upholding hegemonic masculinities: men's concern about being rejected by others due to non-normative behaviour meant their lack of engagement with health systems gave further substance to their own masculine identity (Courtenay, 2000). Health services are seen as female spaces, and dominant masculinity is policed by men perceiving other men who access such services as feminine. As a corollary, even accompanying one's partner is rooted in embarrassment and shame and could have repercussions for men's standing amongst their peers, as this urban married adult man said during a FGD:

We men feel shy because we say we are heads of families. We also have the mind to say, 'With my status should I go to a health facility?' I feel like I will meet some other people and this is embarrassing. (FGD-BAN-5 male, urban, married, 30yrs, 3chldn)

Informal conversations identified that this concern had an impact on men's engagement with contraceptive use and ANC/PNC services. Conversations with the research team further confirmed that manhood being constructed as strong, and contraception as feminine and therefore weak, meant men did not see contraception as worthy of serious male engagement. As Kimmel (2004) notes, the repudiation of femininity is key to the masculine identity. As I will also explore, the concept of not being weak was also central to men's narratives around fertility and stoicism.

7.2.2 Masculine norms of fertility

I found strong cultural and social expectations regarding the importance of men having children in Southern Malawi, reflecting findings from sub-Saharan Africa (Barker and Ricardo, 2005). As one married adult man said, reflecting how manhood is defined through its association with fertility:

A man is defined by the ability to have children, being able to impregnate. (FGD-NS-11 male, urban, married, 32yrs, 2chldn)

That fact that a man in Southern Malawi is clearly defined by his ability to have children, often irrespective of his number of current children, was reinforced during FGDs with men and women as an important performance of hegemonic masculinities. It reflects findings by Kishindo (1994) that a Malawian man's socially accepted role is to impregnate women.

Masculine norms of fertility fused with the cultural importance of large families, also creating barriers to acceptance of contraception. This was particularly the case in rural areas, where men had a larger number of children than their urban counterparts (see demographics in appendix U & V). One rural married adult man during a FGD, reflecting a notion that having children is important to increase the size of the tribe, said:

I should talk about what my friends have said. Family planning is difficult maybe because of culture or beliefs, because children in the home is like bread. It is a joy when you have children in the home. When a tribe is not producing children, it gets smaller. So our parents taught us that children are like treasure. You boast a little bit when they are here. So when you haven't had children, you say you should have a few of them. (FGD-LIK-2 male, rural, married, 40yrs, 3chldn)

This quote demonstrates how children are seen as being at the heart of family life, and that progression of manhood is the performance of fertility.⁵⁵ This then became a barrier for contraceptive use, as an urban married adult man

⁵⁵ In Southern Malawi, particularly in rural areas, children could also be seen as providing financial or non-financial support to their parents, such as agricultural work, though this was not mentioned by men as a motivation for fertility. Lobola is not paid in Southern Malawi.

explained during another FGD:

And you also tell the woman, I don't want those things [contraception]. Our parents gave birth to us and if you practise that shall we bear like they did? Such things cause men not to practice family planning when women want to. (FGD-BAN-5 male, urban, married, 30yrs, 3chldn)

Among male respondents, the desire (or potential) to have more children, as part of the masculine norms of fertility, was the primary reason for non-use of contraception within relationships. Several statements were made suggesting men have differing fertility desires from their partner, causing them to object to using contraception. This was particularly the case among men with one or more children, who desired a larger family size. As one married adult man in this situation, who reported not using contraception with his partner, stated:

*I: But, did you take part in discussions with your family?
P: Yes I do take part, but sometimes I feel we should not take part.
I: Why?
P: We have one child, why should we do family planning when we have one child? People do family planning because they have three or four children.
(IDI-BAN-5 male, urban, married, 27yrs, 1child)*

Another married adult man, who already had three children and wanted one more, reflecting the aforementioned concerns of women deciding to take contraception without the man's knowledge, stated that different fertility desires can cause the end of marriage:

If women and not men are involved in family planning then the marriage cannot last when the man finds out. When the man finds a partner who cannot bear children the marriage does not last. (IDI-SL-2 urban, married, 35yrs, 3chldn, injection)

Indeed, reinforcing the challenge for women to use contraception in the context of men's fertility desires, one married adult man highlighted during a FGD that women must stop using methods the moment the man wants a child, presenting a view to which there was no objection from the group:

As a man, when it is time for you to impregnate her, it is time to tell her, 'Stop it. I would like to set fire. People should know that the firstborn child is mine.' That's what it is like. (FGD-LIK-7, rural, married, 30yrs, 2chldn)

This quote also presents a sense that women are just a uterus, for the man to impregnate when he is ready, reflecting men's ownership of women's sexuality that I will discuss in chapter 8. It is for this reason, even where men did not want large families, they appeared to desire to control decisions around family size. Women acknowledged during FGDs that, as a result of men's fertility desires, some men would not agree to the use of contraception:

Sometimes men prevent their wives from taking family planning methods because they want their generation to continue. (FGD-NS2-13 female, urban, single, 31yrs, 1child)

My informal discussions with health providers provided a view that men's differing desires to their partner to have more children was an important reason for their disengagement with contraceptive use. These findings suggest women may have less agency in this respect than other studies in Malawi have identified (Machiyama et al., 2015), though they support qualitative results in East Africa on the negative impact of men's fertility preferences on women's reproductive behaviour (Withers et al., 2015b; Okigbo et al., 2015).

These hegemonic male norms around fertility provided further barriers specifically to the use of male methods, with one young man in a relationship stating in relation to condom use:

If you want something that you claim is yours it becomes difficult to use a condom. (IDI-NS-6 male, urban, relationship, 23yrs, nochldn)

With respect to vasectomy, dominant male norms around fertility were a significant barrier to use, with a young married man saying that while "There is no problem with it [vasectomy]...The only problem that comes is when you are not able to bear children." (IDI-CHI-8 rural, married, 23yrs, no children). Reflecting this central association with hegemonic masculinity, an adult married

man notes in relation to vasectomy:

I've already said I wasn't aware of this method. But it is hard to carry it out because you cannot be a real man. (IDI-CHI-2 rural, married, 32yrs, 4chldn, injection)

In seeking greater understanding of male fertility norms, I also found that manhood was not only defined by having children, but men were respected due to their *number* of children, as this younger man noted reflecting on his culture:

We Africans believe that having many children is being a real man. In other countries they can have two children and get satisfied that they are enough. Here we got used to our grandparents having fifteen children. We also want to have fifteen children and family planning becomes difficult. (FGD-BAN-8 male, urban, single, 19yrs)

In the last two quotes we see also not only the dominant norms of masculinity asserted in terms of having children, but the construction of a hierarchy (Connell, 1995) between those who do (real men) and those who don't (weak men). In a context where men expressed reservations about engaging with the health system, there was no equivocation in the association of masculinity and fertility, highlighting how fertility is seen differently and is not about health. During FGDs, married women informed me that these male fertility norms meant that they had to take responsibility for encouraging contraceptive use:

Men's interest is to have as many children as they can, so it takes a woman to bring up the issue of family planning. (FGD-NS2-11 female, urban, married, 36yrs, 4chldn)

I found norms around fertility associated with hegemonic manhood were defined as married men not only having children with their wife, but by producing additional children through extra-marital affairs. This was particularly evident in rural areas, though not exclusively, as this young man with two sexual partners noted talking about married men:

Nowadays when people say that you are a real man it means they bear children elsewhere and also with their wife. They go around having children with many partners. (IDI-LIK-4 male, rural, single, 24yrs,

nochldn)

An extension of this particular performance of hegemonic masculinity I found that men may exploit women just to get the children they want and then leave them, as this married adult man noted during a FGD:

Because you can have a sexual partner for three months or three years and all you want is to just give her three children and dump her. (FGD-BAN-10 male, urban, married, 50yrs, 4chldn)

Women confirmed during FGDs that their husbands can abandon them just because they don't have 'enough' children, and marry someone else, such as this widowed adult woman:

The man can also abandon you just because you have children and get married to someone with no children. (FGD-CHI2-5 female, rural, widowed, 44yrs, 1child)

My informal conversations in the research communities identified this to be linked to men's perception around the attractiveness of women with children: those with many children may not have time to 'take care of themselves', and as a result are less desirable to men. Instead the husband leaves for a more 'attractive' woman, who presumably does not have children. Hegemonic masculinities therefore dictate not only that responsibility for children is feminine, but that this female responsibility must not interfere with men's ability to enjoy their dominant role.

Men's fertility was seen as desirably lengthy, an intergenerational marker, as reflected by the common Chichewa phrase, *mamuna saguga*, that "a man never gets too old when it comes to fertility" (IDI-NS-8 urban, married, 32yrs, 1child), even aged 50 years or above. In their qualitative study on male involvement in Uganda, Kabagenyi et al. (2014) similarly found male fertility to be an intergenerational marker. My informal discussions found that, given Southern Malawian matriarchal culture, in the event of a divorce, or a man becoming a widower, he moves out of the family home leaving the children behind with the

mother or her immediate family. Should this man marry again, he would move in with the family of his new wife, who would have an expectation of him producing children in his new relationship.

Norms of masculinity being associated with fathering children inside and outside the marital home, and that fertility embodies male dominance irrespective of age, were both significant barriers for vasectomy. Both urban and rural men spoke with concern of the prospect of not being able to produce children in the future, and the impact on social standing, such as this adult married man:

I hear that in Malawi men don't get old. So don't make yourself old by going for this method [vasectomy]. So in that sense you can look at other men and see that they are old but don't give up [having children]. (IDI-NS-8 male, urban, married, 32yrs, 1child, injection)

Not being able to have children in a new relationship due to vasectomy, “will cause quarrels in the family,” (FGD-CHI-3 male, rural, married, 51yrs, 5chldn), married older men told me. This barrier to vasectomy due to Malawian men’s inability to demonstrate fertility as part of hegemonic masculinity does not appear to have been previously documented.

By extension, if anyone should go for a permanent method, men thought this should be left to women alone, leaving men the option of seeking another partner in the future if they want more children, as this married adult man noted:

Most men don't use this method [vasectomy] because they do not want to risk it. They would rather have their wife perform such an operation knowing that they can go elsewhere and have a child. That is why this method is usually undertaken by women and not men. So in families there is need to understand each other so that you should go perform it. (IDI-SL-2 male, urban, married, 35yrs, 3chldn, injection)

Reflecting how male fertility norms were universally important, and how women can embody hegemonic masculinities (Connell, 2012), during FGDs women, young and adult, were found to be as fervently against vasectomy given the need for men to always be able to produce children. This method also had to be

explained to the female participants and there was nervous laughter while discussing vasectomy. Many women reflected a perspective that men's 'right' to have children would be undermined, and women will also suffer if the man isn't able to always produce children. Women were of the view that it was better therefore that they instead go for contraceptive methods:⁵⁶

I: What are your perceptions and attitudes towards men that use this method [vasectomy]?

*P1: If the man may go for sterilisation and the children die, you will have no other means to replace them [group all laugh]. So they can't go for sterilisation.
(FGD-NS2-9 female, urban, married, 21yrs, nochild)*

I: Okay, what are the others saying? Let's be open.

All: [Laughing]

*P2: It is not good for both of you to go for sterilisation as my friends have said, as the children may die and you will end up lacking children because you are sterile. So it is better to be using other family planning methods like Jacksons [injection].
(FGD-NS2-13 female, urban, single, 31yrs, 1child)*

In discussing men's fertility, I also found emergent alternative masculinities, with some men deliberately choosing to challenge the norm of large families and encourage their partner to use contraceptive methods, as this married adult man with two children asserts:

Yes, I take part. This is because if I do not take part in these family planning issues, we will be bearing children persistently and we will encounter financial difficulties. But if we adopt family planning, we will have few children. (IDI-SL-4 male, urban, married, 25yrs, 2child, injection)

Another married adult man from a rural context highlights this motivation:

I: Why did you make an agreement?

*P: We agreed to do family planning because we agreed not to have a high number of children
(IDI-LIK-3, rural, married, 30yrs, 2child, injection)*

⁵⁶ Here women also express reservations on female sterilisation, reinforcing the cultural importance of fertility

Comments from health providers also suggested that this norm was changing to facilitate method use, through more was needed to be done to shift these expectations around fertility. As this private provider from BLM in Bangwe noted:

We need to give proper counselling to men. Men need to be equipped to explain to the next wife that because I already have children, I don't want to bear more children...More people are [now] coming for family planning than before. They have seen their own failures. The climate is changing, as the economic situation is tough, and it is difficult to find jobs. (HP9, female, urban, 48yrs, private service, manager)

The motivation for these Malawian men, as these quotes suggests, is the economic cost of multiple children, as Parrott et al. (2020) also found. These dialogues speak to the contradictory nature of masculinities (Connell, 1995). They also speak to the fluidity of masculinities when two dominant norms, breadwinner masculinities and male fertility, collide, as I discuss below.

7.2.3 Men are not infertile

As an extension of male norms of fertility, I found that manhood was incongruous with infertility, with men who were unable to produce children seen as weak, reflecting the hierarchy of masculinities (Connell, 1995). For example, this young man noted in the context of discussing contraception:

Men want to be seen as fertile, not to be seen as weak to women. (IDI-NS-3 male, urban, single, 22yrs, nochildn)

While men often used the first person when talking about fertility, as a reflection of the associated embarrassment men only used the third person in IDIs and FGDs to talk about infertility. I found that married men that were not bearing children, particularly those not conceiving quickly, could feel stigmatised by the community as impotent, and their sense of manhood (and therefore status and dominance) would be challenged. This male shame associated with infertility was found to be much stronger in rural contexts, where distinctions were placed during conversations between two types of men: those that can conceive and by implication are 'real men' and those that cannot, as this point from an adult

married rural man during a FGD elucidates:

It seems like there are two types of men. There are some who take time to make a woman to conceive...and there are some who do not take time. So what happens is that maybe when the woman desires very much to become pregnant but it is taking a long time, the man gets worried and says, 'Since I am delaying like this, I have to do something else.' (FGD-CHI-4 male, rural, married, 26yrs, 2chldn)

Infertility thus challenged men's ability to uphold hegemonic masculine norms. Parrott (2014: 177), in her research on male infertility in rural Northern Malawi, argues that a positive infertility diagnosis should be seen as "deeply embodied" gendered disempowerment among men. Given such concerns, I unsurprisingly found the stigma of infertility and hegemonic manhood combined as an enormous challenge for vasectomy, something which does not appear to have been previously documented in Malawi. For example, this adult married man noted during a FGD, reflecting a widely held view across my research sites:

When they see that a man is not reproducing they give him names, 'He is impotent.' They talk a lot and that brings a reproach. That's why a lot of people hate that method [vasectomy]. (FGD-LIK-13 male, rural, married, 27yrs, 2chldn)

Men also referred to how male virility (as I discuss in the next chapter) was associated with fertility, and that male ejaculate was weak where contraceptive methods were used, compared to ejaculate that can impregnate and is therefore 'strong', such as this older married man during a FGD:

There are different types of sperms. There are sperms that are under family planning and there are other sperms that are strong. (FGD-CH-13 male, rural, married, 51yrs, 5chldn)

The assertion here is that 'weak' sperm emasculates the man as he cannot bear children. It also conflates notions of virility and fertility, highlighting how these factors combine to undermine contraceptive prevalence. In their FGDs in Central Malawi on infertility, Bornstein et al. (2020b) similarly found that weak sperm was a negative stereotype associated with suspected causes of infertility.

It also reflected a view that if a man takes too long to ejaculate he can't impregnate (also found by Bornstein, *ibid*) and links to perceptions of sexual performance that I discuss in the next chapter.

Men were therefore keen to avoid this social stigmatisation, and often doing 'something else' referred to by FGD-CHI-4 above involved seeking another relationship in order to satisfy the need to reproduce. One adult married rural man explained this during a FGD using a local idiomatic expression:

P: There are some people who think that if a man is not bearing children then he has fallen off a pawpaw tree⁵⁷ [is infertile]. These people would like him to make a clan. They say, 'We don't have a clan, so should he just stay [with that partner]?'

I: Okay

*P: When things are like that, you force yourself to find another woman so that you bear children with her in order to end the reproach [negative perception of others].
(FGD-CHI-9 male, rural, married, 52yrs, 2chldn)*

Another married man in this same rural FGD spoke after him, reiterating that men are mocked in the community for not bearing children, and these men therefore had extra-marital affairs to "see whether the problem is you or the wife" (FGD-CHI-12 male, rural, married, 40yrs, 4chldn). Implicit in their responses were that married women were to blame for male infertility. This was a way for men to reassert their masculine identity in the face of potential disempowerment. It may be that some women's secret use of contraceptive methods, as discussed earlier, meant that their husbands are unaware of the reasons for 'challenges' in having children. As discussed in the next chapter, men's threat of having extra-marital relationships was said to discourage women from using contraceptive methods, and therefore gendered notions of infertility may provide further barriers to women's continued use.

⁵⁷ 'Fallen off a pawpaw tree', '*kugwa mu mtengo wa papaya*' in Chichewa, is a local expression used to mock people, particularly relating to men, who are perceived to be infertile or barren.

Given the stigma around infertility, concerns that female methods would impact on the ability of men to bear children in the future was also highlighted as a critical barrier, as this adult man noted:

Most men do not allow women to use family planning methods because they think that they will not be able to bear children in the future. This is because most men think that having a child is a symbol of being a real man. (IDI-CHI-10 male, rural, married, 46yrs, 6chldn, IUD)

One married man raised concern about female infertility specifically in the context of the injection, that his wife was concerned about this:

[She was] scared with the rumours that she might become infertile if she takes injection as a family planning method. (IDI-LIK-6 rural, married, 32yrs, 3chldn, injection)

My conversations found that these concerns reflected a common myth, particularly in rural areas, that contraception, especially the Depo-Provera injection, could cause long-term, even indefinite, infertility. There appeared no understanding among men of temporary fertility challenges for women after they stop using Depo-Provera,⁵⁸ despite this being the most commonly used method (see chapter 5).

One of the causes of male infertility was said to be female menstrual fluids, which required treatment using a traditional herb called *mchape* available from traditional healers. Some men believed male fertility challenges were due to having sex with women during her menstruation period, and that this herb would help by cleansing one's body of women's menstrual fluids so men could conceive. As one adult married rural man explained:

When they say mchape it means that your body is not functioning properly. When you want to have a child privately, you go there [to a private healer] so that they can help you by giving you medicine which, when you drink and have sex with another woman, she gets pregnant. So people call that medicine mchape. (FGD-LIK-12, male, rural, married, 30yrs, 3chldn)

⁵⁸ Depo-Provera can cause temporary infertility (potentially up to one year, though this is rare).

As noted, women's menstruation was seen as dangerous, even that having sex with a woman menstruating can cause death. In my conversations with traditional healers, they confirmed that they provided *mchape* for men to 'cleanse' themselves (including if they've had sex with a woman who is pregnant), and that they advise men on their concerns around contraceptive methods (prescribing sexual enhancement herbs, as I discuss in the next chapter).

7.2.4 Breadwinning masculinities

Another area in which I found a clear assertion of Malawian men's identity was that of breadwinner and provider. Throughout my qualitative research, across both urban and rural settings, men talked in detail about their primary responsibility to provide financially for their family, to ensure their family could eat and cover its costs.

Men's role as breadwinner was not only key to one's self-identification, but the successful enactment of this role was central to being an adequate man (reflecting Chikovore et al., 2015). This was particularly the case among men who were married or in relationships, especially where men had children:

Here in our home village... a woman depends mostly on a man. I will do everything possible to go and find food so that we should eat in the home. (FGD-LIK-13, male, rural, married, 27yrs, 2chldn)

During FGDs married women confirmed this breadwinner role among men:

Men are responsible in providing for the needs of their family. (FGD-NS2-2 female, urban, married, 29yrs, 2chldn)

The fulfilment of breadwinning masculinities elicited a strong sense of pride among men during the research, and generated detailed responses during the male FGDs. Men were concerned for others to see them fulfil this role, as a reflection of the performance of hegemonic masculinities. As one adult married man with 4 children said:

When we say a real man it means the person has the responsibility of his family and people surrounding him. He should be able to give his life for other people. (FGD-CHI-13 male, rural, married, 42yrs, 4chldn)

The focus of men promoting the needs of others in this way over their own needs challenges the common perception of men as uncaring, reflecting positive constructions of manhood, though it requires further contextualisation.

Despite sole responsibilities for domestic and caregiving tasks resting almost exclusively with women, as I noted in chapter 6, men expressed a view during FGDs that as breadwinners they had a far greater responsibility within the household:

We men assume a very big responsibility in the family. Our wives do not have a big responsibility...because we just take all the responsibility to be ours. (FGD-LIK-10 male, rural, married, 32yrs, 3chldn)

Men's rationale appeals to their culturally defined roles as family heads and providers. This provides a further example of the hierarchal nature of hegemonic masculinities (Connell, 1995), where all women's responsibilities are relegated to be of lesser importance.

In order to fulfil one's breadwinning responsibilities, I found a critical role for men was to be in paid employment. In the IMAGES Malawi-wide results (Zamawe et al., 2014) we found men, particularly those that were married and had children, were overwhelmingly providing the main source of income in the home. Employment as fundamental to manhood has been documented by Anderson's (2015) research in Malawi.

Many men in my qualitative sample were self-employed or vendors,⁵⁹ or unemployed, and they told me that they, and men in general, spent significant amounts of time and energy on trying to earn a living or find money. It

⁵⁹ Vendors sold goods along the street, pavements or other public spaces, particularly mobile phone airtime, newspapers, fruit and vegetables, and second-hand clothes

highlighted that many men in my study struggled to consistently fulfil this expectation of manhood. My community observation found that work is precarious in Southern Malawi, with groups of men often waiting in specific locations each morning to be picked up for labour or other work where they would be paid by the hour, and often men had multiple jobs to earn enough money to provide. This focus on securing daily income constrained men's desire to engage more broadly in accessing health services. As this adult male who worked as a manual labourer noted:

When you go to health facilities, you leave behind some work you would like to do. (IDI-BAN-7 male, urban, married, 25yrs, 1child)

Such disengagement was further amplified by men's performance of the provider role. One area in particular where I found men expressing concern was how failing to meet this standard would look to neighbours, who may not wish to see them prosper financially. For example, this married man noted during a FGD:

You are much concerned with looking for money to buy the basic necessities for your family, because if you pay too much attention to being ill, your wife might start begging salt from neighbours. (FGD-NS-8, male, urban, married, 35yrs)

Women agreed that fulfilling the breadwinner role impacts on men's engagement with the health system. A large proportion of women spoke of the challenges for self-employed men, or those busy looking for money for their family, and that the working hours of clinics were often not conducive nor employers flexible. One married woman noted during a FGD:

They [men] don't go to a public health facility when they have no money. (FGD-CHI2-11 female, rural, married, 26yrs, 4chldn)

Health providers gave a mixed response on this matter, with one of the view that men use their provider responsibilities as an excuse for being unsupportive. Another provider asserted that indeed, due to being the breadwinner, men do

not see considerations of family planning, and going to related services, as a good time investment, and that this impacts their involvement:

Men refuse to be involved. They say they are busy. They are the breadwinners in the homes. They say they can't spend time going to hospital for family planning services. They think family planning is an issue only for women. (HP18, female, urban, 40yrs, public service, nurse)

The impact of men's provider responsibilities on their health seeking is an understudied area in Malawi. Chikovore et al.'s (2015) analysis of men's tuberculosis-care seeking in Blantyre found the pressure on men to continue work, coupled with job scarcity and low earnings, led men to neglect their health considerations and that of their families. My findings suggest men's gendered responsibility as primary breadwinners being at odds with taking time off work to engage in preventative behaviours, including going to contraceptive services. As IDI-BAN-7 quoted above also had three sexual partners, including his wife, my findings may also support Chikovore et al.'s (ibid) that in struggling to fulfil their preferred image as provider men may compensate with the amplification of other dominant masculinities.

I also found that men's role as breadwinner provided a counterbalance to how male fertility desires may undermine contraceptive use. Given men were responsible to provide financially for the family, I found that ensuring a desirable family size was the primary reason men who were users in their relationship stated for supporting their partner to use contraceptive methods. This was raised across my research sites, though more frequently in urban areas, such as this adult married urban man working as a vendor:

I am involved because it is not good to have a lot of children and with the way life is at the moment, we shouldn't bear children anyhow. (IDI-CHI-2 male, rural, married, 32yrs, 4chldn, injection)

A smaller family size was more financially manageable and predictable for men, especially given the financial challenges of feeding and paying secondary

school fees for many children, as this unemployed adult married man noted:

If a man does not approve for family planning methods, he is the one to take care financially of the pregnancy, the little children. All financial challenges will be upon him because he did not plan well. (IDI-LIK-8 male, rural, married, 27yrs, 1child, injection)

Male FGD participants also reflected the view that family planning was an issue of financial planning, given men are the ones in employment, such as this adult married man from a rural area noted:

It is true that men play a role because if we take Likoswe as an example, a lot of women are jobless. It is men who are employed. So it is you as a man who is supposed to play a role, telling your wife, 'We should have this number of children because of our financial standing.' If you don't play a role, you can have more children than the resources you find in your family. (FGD-LIK-10 male, rural, married, 32yrs, 3chldn)

Men's role as breadwinner and economic provider was a key rationale for family planning being a family issue (not only a women's issue) in men's opinion, with some men, particularly urban, speaking of wanting to have only two or three children at most, challenging the male norms of high fertility, as this young man working as a driver told me:

I think family planning is the issue of both men and women given how life is nowadays. Let's say you have five kids, you may be facing difficulties somewhere...Maybe there was no family planning involved...yet instead of that you could have just had two or three kids so that you didn't face any problem. (IDI-NS-6 male, urban, relationship, 23yrs, nochldn)

In responding, I found men framing this issue in terms of ensuring longer-term economic development for their families and Malawi. This is where men showed greatest interest in male involvement. In other words, concern that the financial cost of having too many children restricts progress of one's family, thus preventing men from performing their dominant breadwinner role. As the same unemployed married man quoted earlier noted:

I want my family to have a good future, we have to do good family planning. (IDI-LIK-8 male, rural, married, 27yrs, 1child, injection)

These findings reflect Shattuck et al.'s (2011) research with married men in Malawi, who similarly spoke of using contraceptive methods to improve family development. That such responses were also evident in my research from younger men without children, such as IDI-NS-6 above, may signal shifting masculinities across generations, and more positive norms emerging among Southern Malawian men.

During FGDs women agreed that men's role as economic providers should be a central reason for their support for contraceptive use. However, women's responses suggested that this rationale might not be as compelling for men as they present it to be, as this married woman, quoted above speaking about secretly accessing contraception, noted:

Men are supposed to agree to contraceptives and family planning because the whole responsibility lies in his hands. So he has to agree to these methods because if the woman might want more children, then the man will have difficulties to provide food for them. (FGD-CHI2-6 female, rural, married, 34yrs, 4chldn)

The financial benefits of avoiding unwanted pregnancies as the primary motivation among men to use contraception also mirrors Shattuck et al.'s (2011) research. How this motivator for contraception is underpinned by men's self-identification as breadwinner does not appear to have been documented in the Malawi literature, and my findings suggest a potential entry point here to increasing men's support for contraceptive use. Equally, neither men nor women spoke of the patriarchal structures on which breadwinner masculinities are based. Men's focus was more on performing their gendered role, than on women's rights. My results would therefore point to the need for a focus on economic benefits to be nuanced by attention to power imbalances and women's agency.

7.2.5 Men are stoic

Improving men's own health-seeking behaviours can have an important impact on their engagement in the health of their partners and families (Etienne, 2018). In this final section of the chapter, I discuss my findings around masculine norms of stoicism and how they impact men's health seeking and their perception of the health system, including for HIV and contraceptive services.

Research asserts a connection between dominant masculinities and men's poor health seeking (Courtenay, 2000), and my research confirmed this link. While many men initially contested the notion that a 'real man' does not look after their health, as my interviews progressed with men I found them to more clearly acknowledge that men should be stoic, not weak, and that health-seeking behaviour, or being seen to be unwell, contravened masculine norms (ibid.), as this adult man in a relationship noted:

Mostly we men think that we can't go to a health facility because we are men. (IDI-SL-1 male, urban, relationship, 29yrs, nochildn)

These assertions contested the quantitative GEM item finding of most men (73%) disagreeing with the statement that men need to be tough (item vi.). My qualitative research also identified that, as a reflection of the contradictory nature of masculinities (Connell, 1995), while reasserting dominant masculinities men were also aware of its dangers, as this married adult man noted:

P: Yes, here in the village we believe that if a man goes to health facilities frequently, it shows that he is not wise enough
I: Ah
P: While, in a real sense, it is not like that
(IDI-LIK-1 male, rural, married, 30yrs, 3childn, injection)

Though this man had previously had an STI, he didn't initially go to a health facility due to embarrassment in doing so. Given that health facilities, including accessing contraceptive information, was seen as entering a women and children's space, the repudiation of femininity as part of reinforcing one's

hegemonic masculine identity (Kimmel, 2004), was a barrier to men's engagement in the health of their partners and families.

The majority of conversations with men during FGDs across both urban and rural areas also reflected the normative association between masculinities and not accepting health concerns. In particular, accepting illness instead of adopting a stoic approach and weathering it out, would be stigmatised and was not congruent with the masculine representation men wanted to project to others (Courtenay, 2000). This was the case even where men knew that they should seek medical attention, as this adult married man noted:

According to Malawian culture, most men have that spirit of endurance. A woman can suffer from the same illness and go to a health facility after two days. As for a man, because of that spirit of saying, 'I am a man', within the same two days he can say, 'I am healed' [without doing anything]. (FGD-BAN-2 male, urban, married, 27yrs, nochild)

This was corroborated by women, as well as participant observation which found low health-seeking behaviour among men. In addition, male strength and power is also demonstrated through the innate ability of the male body to heal itself, whilst the woman's body is seen as inferior and weak by comparison. Another young rural married man noted during a FGD the need for men to overlook minor health concerns without attending healthcare services:

Maybe men believe themselves to be powerful. So sometimes when they [men] go to a health facility with minor illnesses, they feel like they are weak. So it is like being able to endure...A man endures. You don't just go to a health facility. (FGD-LIK-1 male, rural, married, 23yrs, 1child)

Reflecting such endurance, during my conversations I was told a local Malawi saying, '*Pamene mphongo yagona pansi ndiye kuti pavuta,*' meaning 'when a man has laid down to rest, then it must be serious.' Part of this belief is that men may think they are invincible or immune from health problems, as one adult married man noted reflecting others across urban and rural settings:

We think we can't suffer from any sickness by virtue of being a man. (IDI-NS-5 male, urban, married, 28yrs, 2chldn)

During FGDs, women concurred with these sentiments, with one adult married female participant noting:

Most men feel embarrassed to disclose their sickness. They don't feel free to open up about their sickness. (FGD-CHI2-4 female, rural, married, 31yrs, 2chldn)

These findings also speak to how men's sense of adequacy as men was permanently threatened, as Chikovore et al.'s (2014) research also found, with men worrying about how any challenge to their stoicism would question their dominant position in the home and society.

My study also found that HIV provided a lens through which stoic men viewed the whole health system, which often created a reluctance among men to engage with it, including in relation to contraception. Given its high prevalence in Southern Malawi, HIV was a central part of the everyday narratives among men during my research.⁶⁰ I found a perception that many men would assume they were HIV positive due to engaging in risky sexual behaviour, which Kaler (2003) also found in her research in Malawi. I found that men's fear of their perceived serostatus, and that it would require behavioural change around condom use and their number of sexual partners – thus challenging their manhood - made them reluctant to test, which female respondents also confirmed. As one young man who had not been tested for HIV and reported three sexual partners in last 12 months noted:

Most men know how they have behaved in the past, so they don't want to go for HIV testing because they know they will end up being disappointed with the results. (IDI-NS-4 male, urban, single, 26yrs, nochldn)

A common response among men during my research was that this context had an impact on men avoiding public health facilities more broadly, for fear of HIV

⁶⁰ Throughout my interviews men often presumed questions on health related to HIV (even when not specifically stated).

testing, as this adult married man who had two sexual partners noted:

Most of the time, most men fear going to health facilities [in general] because these days when you go to a health facility with a concern, they test you for HIV. Because men fear to know their HIV status, so they desire to find treatment on their own by taking panado [acetaminophen]. (IDI-BAN-5 male, urban, married, 27yrs, 1child)

During my research there was a government drive for men to accompany their partners to ANC/PNC where women receive contraceptive information and methods and couples are tested for HIV. Given men's concerns, this was a reason for them to avoid such services. Health providers and stakeholders confirmed the challenges of men not testing for HIV, that far fewer men than women did so, and the potential dangers of couple testing within the context of contraception and ANC/PNC:

If a woman discloses her status, it is ok if negative, but if she is positive it can break the marriage. This is because men say the wife brought the infection into the relationship, even if it is them. Being HIV positive means you are promiscuous. Men would rather get divorced than get tested for HIV. Men will then go elsewhere [leave the relationship for someone else] where you don't have to think about such issues. (KS2, female, urban, 44years, NGO service provider, director)

I found men telling me that they assumed the HIV status of their partners, and that HIV was further imbued among men with an association of death because, as this adult married man noted, "They [men] go to health facilities late when they are too sick" (IDI-BAN-6 male, urban, married, 36yrs, 4chldn). This was the ultimate sign of stoicism, where men only took action when it was too late, as this young man concurred during a FGD:

That's why most men die; their health is not good. They go to a health facility when their condition is worse. (FGD-BAN-4 male, urban, single, 24yrs)

Health providers told me stories of male friends they had that had died due to their sense of invincibility and reluctance to establish their HIV status, and thereby accessed services and diagnosis too late (for treatment to be effective),

and this was clear from my own clinic observations.⁶¹ In the context of contraceptive use, this fatalism and the association of mortality related to HIV became yet a further barrier to men engaging in health services, and a reluctance to accompany their partners.

As noted in chapter 5, I found in the IMAGES research that men who tested for HIV were more likely to be contraceptive users with their partners, which would indicate that the integration of HIV and contraceptive services may proffer a way to increase male engagement. At the same time, my qualitative findings suggest HIV compromised men's manhood, as Skovdal et al. (2011) also found in Zimbabwe, pointing to the need for careful consideration of male gender norms within such integration.

The impact of these aforementioned norms among men was compounded by structural challenges within the public health system, such as long waiting times and short opening hours, and related preferences of men for alternative sources of care, which were identified through my clinical observation. This barrier was reaffirmed during the research dissemination meetings, particularly by poorer men. Several quotes reflected these structural challenges, for example this unemployed adult married man noted during a FGD:

When we go to a health facility, it is hard to inspire you to go there when you are ill. You find that instead of operations starting at 7:30am or 8:00am, you find that they start at 11am or midday. So these are the reasons that you say, 'Should I go there this time? I better do something else.' (FGD-LIK-10 male, rural, married, 32yrs, 3chldn)

As this quote also highlights, there was a clear narrative that time is money for men, and reflecting Watson (2000), I found that while public health centres are free (though often some distance away, requiring funds to get there) health seeking by men may not be seen as an efficient time investment and remains

⁶¹ My observations of the male ward at Queen Elizabeth hospital in Blantyre confirmed that many men would arrive sick and undiagnosed, and that this was a significant cause of male mortality.

an abstract concept. It is argued that men need to establish ways to legitimise engaging with healthier norms and “cannot just be seen to be ‘doing health’ for its own sake” (Robertson, 2008:9). This would arguably not include prioritising preventative behaviour, of which accessing contraception would be included.

A key example of men needing a legitimate reason, in their view, to engage with the health system was the exception I found men made around STIs. In contrast to how they negatively viewed contraceptive services, my research found that men, across both urban and rural contexts, would generally consider accessing treatment for STIs, from both public and private facilities, and sometimes traditional healers, as a priority requiring prompt action, particularly as it was associated with future infertility. A common assertion during FGDs reflected the following:

Some say, ‘I will not be fertile if I delay.’ They say the end result of that infection is that you can no longer be fertile. So they rush to seek treatment [for STIs] so that they should be fertile. (FGD-CHI-9 male, rural, married, 52yrs, 2chldn)

There is limited analysis on how men’s broader health seeking impacts on their approach towards contraceptive use. As Baker and Shand (2017:3) argue, “Improved sexual and reproductive health for men would have immediate and obvious benefits for women as well as men themselves.” One area of opportunity is that men’s aforementioned ‘responsibilities’ have also been documented as a facilitating factor for their approach to their own health, and then the engagement in the health of others, particularly fatherhood, as a potential moment where men reassess restrictive male norms (Robertson, 2008). This may provide positive opportunities to further engage men around contraception, coupled with steps to address the aforementioned stigma around men accessing healthcare, the concerns around HIV testing and structural issues.

7.3 Summary

This chapter has explored five areas relating to how I found manhood to be defined in Southern Malawi – namely, being strong not weak, male fertility, not being infertile, breadwinner masculinities, and being stoic – and found them all to have an important, and often detrimental, as well as countervailing, impact on male involvement. Hegemonic masculine notions related to fertility, and the emasculation of infertility, negatively impacted on men's desire to use male and female contraceptive methods, providing formidable barriers for vasectomy. I found that dominant masculine norms around being the breadwinner, while creating barriers to men's broader engagement in contraception through their need to prioritise providing economically for their family, also provided positive forms of masculinities that were supportive of contraceptive use – reflecting Connell and Messerschmitt's (2005) concept of cracks in these traditional gender norms. In particular, men were concerned about the cost of providing for a larger family, pointing to a potential entry point for increasing men's support for contraception, albeit one that does not challenge the underlying gender power differentials. Finally, norms around stoicism, and the concomitant concerns around structural barriers to health services, and avoiding HIV testing, negatively impacted on men's desire to supportively engage in the health of their family, though it also offers entry points for engaging men worthy of greater exploration.

A critical part of concluding the picture of how Southern Malawian men's gendered attitudes and behaviours influence male involvement is to explore the linkages with men's approach to sex and sexual pleasure, matters I turn to in the next results chapter.

Chapter 8: Meanings men ascribe to sex and sexual pleasure and its links to contraception

8.1 Introduction

In the previous chapter, I explored the connections between five key masculine norms men identified in Southern Malawi and their influence on male involvement. That chapter provided insight into how men, and women, report that these socially constructed ‘rules’ of manhood impact on use of male and female methods, and family size considerations, in largely negative ways.

In this chapter, I share my quantitative and qualitative findings on the meanings and social and cultural expectations that men in Southern Malawi ascribe to sex and sexual pleasure; areas which are rarely researched within the context of contraception. I begin with my IMAGES data on men’s number of sexual partners and its related associations, and how men report satisfaction in their primary sexual relationship. I then use qualitative findings to contextualise these quantitative results, exploring male norms around virility, the superiority of male sexuality, sexual pleasure and male sexual behaviours. I present each of these areas and explore their impact on use of male and female contraception. This chapter responds to research question two: How do social and cultural attitudes, norms and behaviours of Southern Malawian men (including those related to gender-equality) influence their approach to contraceptive use and family planning?

8.2 Quantitative results on number of sexual partners and sexual satisfaction

The IMAGES data included a question on men’s reports on their number of sexual partners. Men’s number of sexual partners is generally only measured within the context of STIs and HIV (it is included as part of the HIV behaviours section of the Malawi DHS, for example), and rarely explored in the context of contraceptive use.

8.2.1 Number of sexual partners in last year

I asked men about their number of sexual partners in the last 12 months, the results of which are in table 16 below. Seventy men (17% of all men) said they had no sexual partner and have been excluded. Of those that are sexually active, 70% reported one partner, 21% reported 2-3 sexual partners and 9% reported 4 or more partners. A greater proportion of rural than urban men had only one sexual partner (77% versus 65%). Twenty two percent of married men and 26% of unmarried men in a relationship reported 2 or more sexual partners, which mirrored our Malawi-wide findings (Zamawe et al., 2014). Earlier research in Southern Malawi by Paz-Soldan et al. (2007) found unmarried men to have a higher mean number of sexual partners compared to married men.

The most recent Malawi DHS (NSO and ICF, 2017) finds 14% of men (and 1% of women), aged 15-49, in Southern Malawi reporting having 2 or more partners during the last 12 months, and 29% having sex with a person who was not their wife/the main person with whom they lived. In neighbouring Zambia and Mozambique, DHS finds 15% and 29% of men respectively to have had multiple sexual partners in the last 12 months (MoH and ICF, 2019; MISAU et al., 2011).

Table 16: Number of sexual partners in last 12 months among men in Southern Malawi (sexually active men, n=336)⁶²

	No of men	One partner	2-3 partners	4+ partners	p-value
Total	336	236 (70.2%)	70 (20.8%)	30 (8.9%)	
Location					0.04
- Urban	187	121 (64.7%)	45 (24.1%)	21 (11.2%)	
- Rural	149	115 (77.2%)	25 (16.8%)	9 (6.0%)	
Age					0.10
- 18-24 years	105	69 (65.7%)	23 (21.9%)	13 (12.4%)	
- 25-34 years	144	95 (66.0%)	37 (25.7%)	12 (8.3%)	
- 35-49 years	68	56 (82.4%)	8 (11.8%)	4 (5.9%)	
- 50-59 years	19	16 (84.2%)	2 (10.5%)	1 (5.3%)	
Relationship status					<0.001
- Married	178	139 (78.1%)	28 (15.7%)	11 (6.2%)	
- In relationship, not married	80	59 (73.8%)	17 (21.3%)	4 (5.0%)	
- Single	78	38 (48.7%)	25 (32.1%)	15 (19.2%)	
Education					0.97
- No education/ Any primary	133	93 (69.9%)	29 (21.8%)	11 (8.3%)	
- Any secondary	171	119 (69.6%)	35 (20.5%)	17 (9.9%)	
- Any tertiary	30	22 (73.3%)	6 (20.0%)	2 (6.7%)	
No of children					0.10
- No children	122	75 (61.5%)	34 (27.9%)	13 (10.7%)	
- 1-2 children	120	88 (73.3%)	22 (18.3%)	10 (8.3%)	
- 3+ children	94	73 (77.7%)	14 (14.9%)	7 (7.5%)	
Frequency of condom use in last 12 months					0.01
- Always use	32	24 (75.0%)	4 (12.5%)	4 (12.5%)	
- Mostly use	35	17 (48.6%)	14 (40.0%)	4 (11.4%)	
- Occasionally use	138	90 (65.2%)	36 (26.1%)	12 (8.7%)	
- Don't use	118	93 (78.8%)	16 (13.6%)	9 (7.6%)	

I undertook an analysis of factors associated with having multiple sexual partners in the last 12 months, comparing men with one partner to those reporting 2 or more sexual partners. The results are in table 17 below. I found

⁶² The concept of sexual partner is challenging in Chichewa, as there is no direct translation. This question may have been interpreted as more targeted to married men, than about men with casual sexual partners.

rural men had almost 50% lower odds of having 2 or more partners than their urban counterparts (AOR 0.53, 95% CI 0.31-0.93, $p=0.03$). Compared to married men, unmarried men in a relationship had 1.47 times the odds of having multiple partners (CI 0.71-3.02, $p<0.001$) and single men had 4.87 times the odds of doing so (CI 2.09-11.39, $p<0.001$). There was no clear trend between multiple partners and condom use. Compared to men reporting always using condoms, men who mostly used had the greatest odds of having multiple partners (AOR 4.86, CI 1.55-15.26, $p=0.02$), followed by men who occasionally used (AOR 2.97, CI 1.12-7.87, $p=0.02$) and men who report not using condoms (AOR 2.05, CI 0.71-5.93, $p=0.02$).

Table 17: Factors associated with men having multiple sexual partners (2 or more partners) in the last 12 months, by demographic variables and sexual behaviours (sexually active men in Southern Malawi, n=336)

	No of men	No (%) with multiple partners	Unadjusted odds ratio (OR) (95% CI)	Adjusted odds ratio (AOR) ⁶³ (95% CI)	p-value
Total	336	100 (29.8%)			
Location					
- Urban	187	66 (35.3%)	1	1	0.03
- Rural	149	34 (22.8%)	0.54 (0.33, 0.88)	0.53 (0.31, 0.93)	
Age					
- 18-24 years	105	36 (34.3%)	1.01 (0.60, 1.72)	0.58 (0.27, 1.24)	0.08
- 25-34 years	144	49 (34%)	1	1	
- 35-49 years	68	12 (17.7%)	0.42 (0.20, 0.85)	0.39 (0.17, 0.88)	
- 50-59 years	19	3 (15.8%)	0.36 (0.10, 1.31)	0.40 (0.10, 1.62)	
Relationship status					
- Married	178	39 (21.9%)	1	1	<0.001
- In relationship, not married	80	21 (26.3%)	1.27 (0.69, 2.34)	1.47 (0.71, 3.02)	
- Single/not in relationship	78	40 (51.3%)	3.75 (2.12, 6.63)	4.87 (2.09, 11.39)	
Education					
- No education/ Any primary	133	40 (30.1%)	0.98 (0.60, 1.61)	1.37 (0.77, 2.44)	0.39
- Any secondary	171	52 (30.4%)	1	1	
- Any tertiary	30	8 (26.7%)	0.83 (0.35, 1.99)	0.74 (0.27, 1.98)	

⁶³ Adjusting for all other factors listed in the table.

No of children					
- No children	122	47 (38.5%)	1	1	0.93
- 1-2 children	120	32 (26.7%)	0.58 (0.34, 1.00)	1.03 (0.45, 2.38)	
- 3+ children	94	21 (22.3%)	0.46 (0.25, 0.84)	1.19 (0.43, 3.23)	
Frequency of condom use in last 12 months⁶⁴					
- Always	32	8 (25.0%)	1	1	0.02
- mostly use	35	18 (51.4%)	3.18 (1.12, 8.98)	4.86 (1.55, 15.26)	
- Occasionally	138	48 (34.8%)	1.6 (0.67, 3.83)	2.97 (1.12, 7.87)	
- don't use	118	25 (21.2%)	0.81 (0.32, 2.01)	2.05 (0.71, 5.93)	

An analysis for confounding variables for the responses on age, education, children and condom use frequency found that this was mainly driven by relationship status. As noted, significantly more men aged 18-24 years were single (the group reporting being most likely to have multiple partners), compared to the other age groups. 25% of unmarried men (the second most likely group to have multiple partners) and 31% of single men reported having no education/any primary, compared to 55.8% of married men. Both of these groups were also significantly more likely to have no children, compared to married men. Finally, only 12% of single men reported not using a condom, compared to 31% of unmarried men and 49% of married men.

I undertook a separate analysis to explore the relationship between multiple concurrent partners and men reporting using contraception with their partner, which did not find a clear trend. Twenty five percent of those reporting contraceptive use said they had 2 or more partners (compared with 23% of non-users), thus reflecting a slightly greater proportion of contraceptive users reporting multiple partners. Exploring associations, contraceptive users had 1.16 times the odds of having multiple partners (AOR 1.16, CI 0.54-2.48, p=0.69) but this did not reach statistical significance. The fact that unmarried men, compared to married men, had overall greater odds of being a contraceptive

⁶⁴ The largest category has not been used as the reference group for this variable in order to compare against always use

user (table 8) and reported greater odds of multiple partners above (table 17), additionally complicates this analysis.

8.2.2 Sexual satisfaction with primary partner

I also asked all sexually active men in IMAGES, in relation to their main sexual partner, how they would describe their current sexual relationship, and how they would describe the frequency of sex. Men were offered a Likert scale of: very satisfying; satisfying; more or less satisfying; somewhat unsatisfying; or very unsatisfying.

With respect to their sexual relationship, 91% of men said it was very satisfying, and 5% said it was satisfying, meaning 96% of all men describing satisfaction with their sexual relationship. With respect to the frequency of their sex, 87% said it was very satisfying and 6% said it was satisfying, meaning 93% of all men describing satisfaction in terms of frequency. There was no variation across demographic factors, and as such, the lack of variability meant no further scope for analysis.

8.3 Qualitative narratives on masculinities and sex

Overall, my quantitative research found a large proportion of men reporting multiple concurrent partners, that men had greater odds of doing so if unmarried or single (compared to married), and that there was no clear relationship between multiple partners and contraceptive use. Men overwhelmingly described their sexual relationship, and their frequency of sex, with their main partner as satisfying (mostly very satisfying).

In order to deepen understanding around these findings, my qualitative research explored masculine norms associated with sex and how these influenced men's approach to use of contraception, including condoms. I found men presented the following key areas to be critical in this regard: 1) virility; 2) the superiority of male sexuality; 3) the taboo of sex; 4) men's multiple concurrent partners; 5)

narratives on female infidelity; 6) male ejaculation; and 7) the importance of mixing fluids. I now discuss each of these in turn.

8.3.1 Virility

Male sexual strength, or virility, was noted by multiple respondents in my research as an essential marker of manhood in Southern Malawi.⁶⁵ This link between masculinities and virility is both a regional (Varga, 2001) and global construct (Fleming et al., 2016), and similar normative associations have been documented through qualitative research in Mozambique (Macia et al., 2011) and South Africa (Stern and Buikema, 2013).

In Southern Malawi, I found male sexual performance was a central part of successful sex and important to one's sense of manhood. This ensured, as this married adult man said, "That you all [him and his partner] get sexually satisfied" (IDI-BAN-6 male, urban, married, 36yrs, 4chldn). Men referenced feeling a sense of pride if they felt they had performed well through sex. Sexual performance was equally performative hegemonic masculinity, defined by external approval, with manhood measured by popularity associated with being publicly known as 'good' at sex, which reflects Izugbara and Undie's (2008) findings in Malawi with young men (12-19 years). FGD conversations on sexual performance with men also generated a lot of laughter, perhaps a reflection of associated bravado.

Given the important association between masculinities and virility, men's concerns around how female contraception affected their sexual strength presented itself as a formidable barrier. As one adult married man with six children who was not using contraception with his partner, including not using condoms, explained:

⁶⁵ Throughout the qualitative research sex was clearly perceived and described to be a heterosexual act, although this was never explicitly stated by the respondents.

P: When it comes to family planning there are challenges towards men. When the woman is using family planning methods, when you sleep with her you see strange signs, so instead of doing it frequently you do it once in a while.

I: When you say doing it once in a while you mean having sex with your wife?

P: Yes

I: When they carry out family planning methods you have sex once in a while?

*P: Yes, my sexual strength declines.
(IDI-CHI-4 male, married, 48yrs, 6chldn)*

As a result, this man, who said his wife was previously using a contraceptive method, told his wife to stop using contraception completely. Similar sentiments were reflected during FGDs, such as one married man asserting:

“Contraceptives kill a man’s engine” (FGD-BAN-2 male, urban, married, 27yrs, nochildn). Another married man in the same FGD spoke of a loss of libido as a result of female contraceptive methods:

And also when we meet for sex I do not have the energy. So you just tell her [his wife] that you don’t want to have anything to do with those things [family planning]. (FGD-BAN-5 male, urban, married, 30yrs, 3chldn)

Married women across rural and urban areas confirmed during FGDs that such concerns among men were a cause of their objection to use, particularly in relation to the injection:

When a woman goes for an injection, men say that the tip of their penis droops and they can’t perform well during sex. (FGD-CHI2-6, female, rural, married, 31yrs, 4chldn)

This was also confirmed by service providers, though they disagreed that such an impact was due to contraceptive use, a matter to which I later return:

Another objection from men to family planning is the loss of libido. But it is not true. It is in their imagination. (HP18, female, urban, 40yrs, public service, nurse)

One particular notion of sexual performance that I found to be important among men (and women) was having multiple “rounds during sex” (IDI-LIK-1 male,

rural, married, 30yrs, 3chldn, 2 sexual partners).⁶⁶ Implicit in this notion was a man's ability to perform masculinities through multiple rounds. Men made comments alluding to feeling a pressure or expectation from themselves and from women to perform well through multiple rounds, even if this may be unspoken with their partner. As an extension of this, women's sexual desires often related to a man's number of rounds of sex, as this young man said:

Most people are not able to fulfil a woman's desires. It may be possible that a woman says, I need two or three rounds. When a man does it only once it doesn't fulfil a woman's desire very much [all laugh]. (FGD-BAN-9 male, urban, single, 20yrs)

As further reflection of the vulnerability of masculinities, men talked about their perception that women discuss their partner's sexual performance with their friends, and compare notes, particularly on the number of rounds during sex. Should men not perform appropriately, they worried their partners would "expose" them as not being "real men" (IDI-NS-6 male, urban, relationship, 23yrs, nochildn). Women confirmed to me that they do speak to their friends in such a manner and that they knew men were concerned about it. During FGDs women also made fun of men's sexual actions, perhaps as a way of reclaiming some agency.

The desire for multiple rounds was presented as a further barrier to female contraceptive use. Among men whose partner was using contraception, they said they could previously do three rounds with their partner, and now due to contraception could only do one or two. As this married man said during a FGD:

Maybe you haven't discussed the family planning method you are going to use but she has already got an injection...So you don't know that your wife has got family planning. You are just surprised that when you want to play, you play fewer rounds. You used to play three rounds but you only manage to do two. (FGD-CHI-12 male, rural, married, 40yrs, 4chldn)

Men also explained that this became a reason for their objection to

⁶⁶ A round is understood as sex until male ejaculation, and several rounds in this context refers to multiple orgasms during one period of sexual intercourse with the same person.

contraceptive use. For example, this younger single man explained what was said in his community about the impact of contraception on the number of rounds during sex:

Some men tell their wives that they should not use any method of family planning because these methods, taking pills, reduces sexual performance in men during sex. If a man was having three rounds of sex at a time, he is no longer able to perform like before and he may have problems to get erect. Because of these beliefs men refuse to let their wives use family planning methods. (IDI-CHI-9 male, rural, single, 24yrs, 1child)

Conversations with men, in both urban and rural settings, also identified a cultural preference “to ejaculate within a short time,” (IDI-LIK-1 male, rural, married, 30yrs, 3chldn), enabling more rounds to take place. In this respect, married men raised concern about the injection – the most widely used method – and singled this out as weakening a man’s ability to quickly ejaculate. These married men spoke about women’s menstrual fluids connected to the injection which were believed to “enter into the penis and cause problems that weaken the sexual performance of men” (IDI-CHI-5 male, rural, married, 26yrs, 3chldn).

A further notion of virility I found to be important in Southern Malawi was that men’s sex drive was often in control, and they needed to act upon that, as this older married man said during a FGD:

What makes you have sex with a woman are the sperms in the body. When sperms in the body command you, you have sex with a woman. If the sperms don’t command, you cannot have sex with the woman. (FGD-CHI-3 male, rural, married, 51yrs, 5chldn)

I found several male FGD respondents stated that, with respect to their sexual behaviours, they had limited self-control: “The main issue is lust and lack of self control” (FGD-LIK-12, male, rural, married, 30yrs, 3chldn). This was linked in another FGD to men’s strong desire for sex by a married adult man:

Eeeeeh what is making men to live risky sexual behaviour nowadays is women’s beauty and the way they are dressing. For instance, if you go

watch football or wherever you go you find that there's a lot of beautiful women. Not that those men are not satisfied sexually in their respective families, but lack of control is the main problem. You just have that strong desire to have sex with almost each one of them. (FGD-NS-6 male, urban, married, 26yrs, 1child)

This above quote arguably runs counter to my GEM scale quantitative findings in chapter 6 of only 51% of men agreeing to the statement 'Men are always ready to have sex' (item ix.), which could reflect social desirability bias in men's GEM responses.

Men's strong sex drive was also noted by women to lead to men objecting to them being given the contraceptive injection after childbirth, as men stated they cannot wait the advised period of postpartum abstinence after it is administered.⁶⁷ I also found men expressing concerns about maintaining their erection when using a condom. These factors of married men's unwillingness to practice abstinence, or use condoms, creates an environment that works against women being able to use contraception. This provides further context to my findings in chapter 6 of women concealing contraceptive use, which may be the only option for them to avoid further pregnancy.

Although no man had had a vasectomy, men perceived this method would equally have significant impacts on their virility. I found men to raise concerns that vasectomy would cause them to perform fewer rounds and to ejaculate late. Men were also concerned about their ability to sustain, or even have, an erection, as this married adult man noted:

With vasectomy most men fear that when they go to the hospital it may lead to no erection. Most men fear that they will stop having erections. (IDI-NS-2 male, urban, married, 32yrs, 2chldn)

The corollary for men would be not being able to have sex, which men linked to concerns around being unable to have relationships or get married, markers of

⁶⁷ Couples are advised to abstain or use condoms for seven days after the injection is administered.

manhood in Malawi (Kishindo, 1994), given the expectations around sex and sexual performance therein.

Men's concerns that contraception impacted their virility were further imbued with a cultural humiliation, I found, relating to male sexual problems. As one young man noted, losing one's erection was "a shameful issue" (IDI-NS-6 male, urban, relationship, 23yrs) and an adult married man further explained that "if I go to a health facility with these concerns they [service providers] will laugh at us" (IDI-LIK-1 male, rural, married, 30yrs). This concurred with the GEM scale item x. in chapter 6 of a greater proportion of men agreeing with the statement that they should be embarrassed if they are unable to get an erection during sex.

Indeed, while the IMAGES findings on sexual satisfaction presented a picture of men's widespread contentment, 25% of men in my qualitative research told me they had experienced challenges with losing erections, and that this issue was not discussed with their partners.⁶⁸ As a corollary, I found that 60% of men in my qualitative research had used traditional herbs for sexual enhancement, particularly *mthubulo*, available from traditional doctors or market drug stalls. While Morris (2011)'s research in Malawi found impotency to be a reason for men's use of such herbs, I found a deeper reason: these men wanted to boost their sexual strength to have more rounds and thus prove their manhood, as this young man explained:

P: Yes I have used mthubulo only.

I: Why?

P: I used it when I feel that my energy to perform well is not enough...so that she [his causal partner] should know that I am a real man.

(IDI-CHI-9 male, rural, single, 24yrs, nochildn)

⁶⁸ During FGDs women did not express an awareness of men having sexual problems. It may be that men are holding themselves to unrealistic standards of sexual performance.

There appeared little compassion among other men or women for a man to have such challenges, highlighting how men can equally feel disempowered in the context of dominant norms on male sexuality. As a further indication of men's reassertion of masculinity, I found men using traditional herbs also fed into men potentially forcing women to have sex, as I discuss below, which became a further barrier to contraceptive use in relationships.

8.3.2 The superiority of male sexuality and desires

All but two of the male IDI participants reported being sexually active (95% of qualitative sample), mirroring the high proportion in the IMAGES results. My qualitative research found men's views to be in concordance with the GEM item vii. results in chapter 6 of more men agreeing than disagreeing that 'men need sex more than women do', such as this young man with three sexual partners:

Men are the ones that mostly have much desire for sex [compared to women]. (IDI-NS-4 male, urban, single, 26yrs, nochildn)

In this respect, positioning men's sexual desires as a counterpoint to women's was not only a performance of masculinities but a hegemonic positioning of the domain of sex.

Reflecting the primacy of men's sexuality over women's, I found a perceived hierarchy existed in terms of who is allowed, privately at least, to initiate sex. Informal conversations in my research communities pointed to sex being a man's domain, an area where men asserted authority where women were supposed to follow. This is confirmed by the following married woman's response during a FGD:

Men have authority over their own bodies. They make their own choices to find a woman to have sex with. Women are just followers and they can't have sexual desires without a man. The man is a key player in this context unlike women. (FGD-CHI2-6 female, rural, 34yrs, 4childn)

Men's language during interviews was often used to convey this aforementioned sense of authority, such as describing the penis as a 'weapon' and 'engine', and the vagina as the 'site'. The fact that sex is seen as a man's domain, to be primarily initiated by them, also reflects Stern and Buikema (2013) and Kriel et al.'s (2019) findings in South Africa of male sexuality being premised on being superior to women's sexuality. This sense of superiority also meant men had double standards with respect to infidelity, as I discuss below.

I found that this hegemonic positioning of male sex meant that men assumed ownership over women's sexuality. In particular, sex was expected in relationships, as this young man reflected:

The reason you have a partner is to have sex with her. (IDI-CHI-6 male, rural, relationship, 21yrs, nochildn)

In this context, men's greater control of decision-making in the household extends to the domain of sex, and women should not refuse. Female respondents were of the view that they agreed to have sex with men by getting married. Conversations with my female research assistants suggested a view that many women often are not able to deny men sex. This mirrors the findings of Evens et al. (2015) who reported Malawi women are of the belief that they cannot refuse their husbands request for sex.

I found that a small number of men, married and single, said that women who do not want to have sex should force themselves. In this context, the man's desire to have sex overrides the women's wishes, as stated by this adult married man:

I: Okay. So you've said...that it is natural when having sex with your wife right? Do you strive for your partner's satisfaction or yours only?

P: No. Before I sleep with my wife I see if she is willing or not. If she is willing then we do it together. If she is not willing when I really want it then I ask her to try it for my sake to remove my desire. But if we do it together then we look at satisfaction for both parties. But

if I want it when she does not want to, then I just ask her to force herself.
(IDI-NS-8 male, urban, married, 32yrs, 1child)

In this context I found men suggesting that women must abide by men's sexual needs, and do what men want sexually, including, for example, women agreeing to different sexual styles, including 'jiggling their buttocks'. As this adult married urban man, with three sexual partners, said in relation to sex with his wife:

She does what I want her to do. (IDI-BAN-7 male, urban, married, 25yrs, 1child)

During FGDs a young man suggested that he used force to have sex against a partner's will, and that in this context a man can be satisfied with just one round of sex:

You might have done it by force. You have sex and release but your partner doesn't get satisfied, she didn't want it... You have the desire to have sex, I want to have sex. You have two or one rounds. You can even be satisfied by one round. (FGD-BAN-4 male, urban, single, 24yrs)

In a sign of men feeling emasculated by women who refused them sex, several men in the rural Chitera FGD talked about using traditional sexual enhancement drugs, as discussed, in order to 'punish' these women through hard sex:

I feel like often most of those men that use medicine during sexual intercourse depend on having sexual desires over a woman. Maybe you try to propose [sex with] a certain woman and she rebuffs you. So one day he says, 'I want to punish that one.' So when trying to punish her you go and get these things [traditional herbs] so that when you insert your member you don't remove it. [Some people laugh.] (FGD-CHI-10 male, rural, single, 24yrs)

These quotes indicate sexual coercion and sexual violence, which has been documented in Malawi (Decker et al., 2018), and are barriers to women accessing contraception. One health provider confirmed this, noting:

They [men] don't know safe sex with their wives when they are in bed. In this area they are raping women knowingly day-in, day-out. (HP7, male, rural, 43yrs, public service, clinician)

These forms of control by men have an impact on how they view women's sexuality as a whole, and pregnancy prevention within that. Women not only have limited negotiating power around method use (and challenges communicating with men on this issue), but must introduce contraceptive use into the male domain of sex where their own needs are of lesser importance. Marital rape did not appear part of the lexicon within my research sites, but arguably the threat of violence by men adds to the context of difficulty for women to access methods and a disincentive for their use.

8.3.3 The taboo of sex and communication

Co-existing with the above, my research identified challenges in men discussing sex with their primary sexual partner. This is in accordance with my GEM results in chapter 6 of the majority of men agreeing with the statement 'I am not open to talk about sex with my partner, I just do it' (item viii.). As one adult married man asserted:

I fail to communicate freely with my wife about sex. (IDI-SL-4 male, urban, married, 25yrs, 2chldn, injection)

These limitations in communication on sex within relationships were confirmed by key stakeholders:

Men will rarely discuss sex issues with their partners. They will speak to friends. Those that are educated are more likely to discuss. Rural men see these issues as taboo. (KS2, female, urban, 44years, NGO service provider, director)

My discussions identified that one of the challenges related to couple communication around sex was the broader cultural embarrassment in discussing this topic, as this key stakeholder noted:

Talking about sex is a taboo among partners. We need to deal with this issue as a country. (KS5, male, urban, 32yrs, NGO, manager)

This was confirmed by my research assistants, who told me that sexual partners

pretend to know about sex even though they don't discuss it. During the IDIs I often found men embarrassed to talk about sex, using euphemisms for the penis (such as calling it their member), and FGDs were often punctuated by nervous laughter on this topic. This creates a challenge in which sex is socialised as a male domain where men are expected to be the leader and where there is associated masculine bravado, whereas in reality men may have limited confidence. Despite men's concerns around what women thought of their sexual performance, this appeared an area that was not openly discussed between couples. My informal conversations in both urban and rural communities found that men, young and old, felt most comfortable confiding in their friends on matters to do with their sex lives.⁶⁹ This context of poor communication on sex underpinned the challenges couples reported in discussing contraception, and influenced men having multiple sexual partners, as I discuss below.

8.3.4 Narratives on men's multiple sexual partners

In congruence with the IMAGES results, my qualitative research found that Southern Malawian masculinity was open to, and permissive of, multiple sexual partners, including if married, even discussing this as something *expected* of men. As one young man noted, "With multiple concurrent partners you live a happy life" (IDI-CHI-6, male, rural, relationship, 21yrs). My discussions presented a sense of this behaviour being common, and women confirmed their awareness of the practice. This aligns with Limaye et al.'s (2013) qualitative study across Malawi, which focused on HIV, that found men having multiple sexual partners to be highly prevalent.

Sexually active single young men in particular spoke of the normalcy of having multiple partners, reflecting the IMAGES findings of this group having the highest level of multiple sexual partners. This also reflects Izugbara and Undie's

⁶⁹ These discussions would often take place among male friendship groups while playing *bawo* (a Malawian game) or in drinking places.

(2008) study with male youth in Malawi where the authors found young men used masculinity scripts to assert their power over other men and women as a justification for their multiple partners. It also provides further context to these young men having the lowest GEM scores (chapter 6). For the young men in my research, across both urban and rural areas, peer pressure from their friends was raised as a key reason for having multiple sexual partners, reflecting Izugbara and Undie (ibid.). As this young single man noted:

Friends affect me in such a way that they may say something that rouses my curiosity to know what they mean on what they are saying about sex, so I need to know either way. Maybe it can be right or wrong. (IDI-BAN-4 male, urban, single, 19yrs)

Unmarried men in relationships spoke of casual sexual encounters as a game men want to succeed at, a performance of dominant masculinities in which they “wanted to win over women by proposing sex to them” (IDI-NS-9 male, urban, relationship, 25yrs, 1 sexual partner), saying, “If one refuses sex today, I can go to the other”, (IDI-LIK-2 male, rural, relationship, 27yrs, 2 sexual partners). These men spoke of pride in receiving praise for being known as sleeping with many women.

A key difference in the qualitative research compared with IMAGES findings, was that multiple partners appeared to be just as prevalent among married men. Among my qualitative research participants, more than half (52%) of married men said they had two or more sexual partners in the last 12 months, which compared with 22% of married men in IMAGES research. Reflecting this view of multiple partners being *normal* in marriage, and the expectations from others to do so, one rural married man said during a FGD:

We should go to our culture and traditions. Some believe that a man cannot have one wife. When he is married he is supposed to have other women out there also. (FGD-CHI-8 male, rural, married, 46yrs, 4chldn)

I found that married men would not be seen as sufficiently male, and would be mocked in their communities if they only had one partner, reflecting infidelity

being a performance of masculinities policed by others. The aforementioned superiority of male sexuality also provided a rationale during FGDs for married men's multiple concurrent partners, given that women were created to support men's needs and desires:

The greatest thing is what my friend has said that these women were made for us. If we had not been here, they wouldn't have been here. So they say they are ours for us to deal with. There are some also that say, 'Women are flowers. When they come today, they will go tomorrow, and others will come.' So they would like to deal with the ones that may come. (FGD-LIK-10 male, rural, married, 32yrs, 3chldn)

During both rural and urban FGDs I found an unexpected honesty among men to explain why they had multiple partners. At the same time, these discussions provided a performance of masculinities themselves, with men keen to show off and make others in the group laugh.

During IDIs I equally found married men being open about their current or previous multiple sexual partners. One married man with three sexual partners talked about wanting to “differentiate” between women (IDI-BAN-7 male, urban, married, 25yrs, 1child), an expectation of sexual variety among men Paz-Soldan et al. (2007) also found in their research in Malawi. Another such married man reflected the aforementioned sense of sexual entitlement:

I like more than one girl and want to have them all. (IDI-NS-8 male, urban, married, 32yrs, 1child, 1 sexual partner)

During the interviews, some men, such as IDI-NS-8 above, would sometimes give contradictory responses around their multiple partners, beginning by saying they only have one partner, and then talking about other current sexual partners as the discussion progressed.

As a reflection of the aforementioned male expectation of sex, married men, in both urban and rural contexts, told me during FGDs that being denied sex by their partner was sufficient justification to have extra-marital partners:

We men do not come out in the open and talk about family problems. In families there are problems where, when a man wants to have sex with his wife, he has to beg. The man is staying there because of patience. [Some people laugh]. A man spends two weeks without doing it while he is being denied. So when that man is being denied like that, he does it where there is a little chance of being denied. The chance to engage in an extra marital affair. (FGD-CHI-13 male, rural, married, 42yrs, 4chldn)

In a re-assertion of dominant masculine norms, married men talked about being denied sex as corresponding with a lack of respect: “women do not respect their husbands” as (IDI-LIK-3 male, rural, married, 30yrs, 2chldn) noted, who had two sexual partners. This was in counterpoint to married men saying outside partners better responded to their sexual needs. As such, married men told me they would engage in extra-marital sex because they felt emasculated:

*I: Have you ever had multiple concurrent sexual partners?
P: Yes
I: Why?
P: We had problems with my wife.
I: Mmm
P: I wanted to prove [to my wife] I am a worthy man, and not to be taken for granted.
(IDI-LIK-1 male, rural, married, 30yrs, 3chldn, 2 sexual partners)*

Rural women reflected men’s views during FGDs, noting that men’s extra marital sex was due to “the behaviour of us women, we don’t respect men” (FGD-CHI2-14 female, rural, divorced, 28yrs, 3chldn) and particularly as a result of a wife denying her husband sex:

And when it is time to have sex, some women refuse to have sex or they are reluctant to have sex, so that is why men have multiple concurrent partners. (FGD-CHI2-2 female, rural, married, 28yrs, 3chldn)

A key theme that emerged across my research, which both linked to poor communication around sex and to men’s emasculation on being denied sex, was that there was insufficient openness among couples around sex leading to poor male sexual pleasure, which was a driver of men having multiple partners.

As one adult married man said in the context of an FGD discussion on men's multiple partners:

All that has been said rests on openness. If sexual partners were open to each other on sex either in marriage or a relationship, it would then be very easy to tell your partner that I am not sexually satisfied. (FGD-NS-8, male, urban, married, 35yrs)

This challenge of insufficient openness between couples in communities, adult men told me, was women's fault:

A woman may not be open to her long-time husband, being shy. She may switch off the lights when having sex, or she may take off her clothes inside the blanket because she is shy with her husband. That is why most men go to have sex outside the home. (IDI-CHI-6 male, rural, 21yrs, relationship, nochildn)

In a context where women were not seen as having authority around sex, and where there was widespread taboo, women were nevertheless responsible for preventing male infidelity, which reflects Stern and Buikema's (2013) research in South Africa. As one married rural woman said during a FGD:

In the family, if the man gets involved in extra marital affairs because you don't open up to him, it is high time you start being open to him and feel comfortable when you are having sex. That can make him change his behaviour. (FGD-CHI2-6 female, rural, 34yrs, married, 4childn)

I found for many men a lack of openness was a euphemism for being denied sex. These responses are in contradiction to the IMAGES findings on men reporting widespread sexual satisfaction with their primary partner. Indeed, the matter of insufficient openness leading to poor male sexual satisfaction was a key focus during my research results dissemination meetings, where wives in particular called on fellow women present to be more open to their husbands and not deny men sex. This reflected how hegemonic masculinities are also reinforced by women (Connell, 2012), solidifying men's position of authority in relation to sex. Given the presence of the wider community in these meetings,

and the approval of women being at fault by the community leaders present,⁷⁰ it reflected a broader norm of women attributing men's actions around sex to their own behaviours.

Despite broad acknowledgement of men's multiple partners, men understood this behaviour to be problematic and expressed their desire not to be caught by their wives. In particular, men understood the associated risks for STIs and HIV. As this married man explained during a FGD in relation to men's multiple partners:

We men are failing to control ourselves. That's why infections are just spreading because we are failing to be patient. When you just look at the woman's leg, just looking here, your member [penis] gets erected, 'I will deal with that woman,' while you are bringing problems to yourself. (FGD-CHI-12, male, rural, married, 40yrs, 4chldn)

I found married men to express during FGDs the hope that they did not then get infected and potentially infect their wives. One married adult man explained the negotiation he had with himself in the context of having extra-marital sex:

When you go to a sex worker you know that it is wrong to do so, you break marriage vows. If I contract an infection I will transmit it to my wife. You make a decision to say 'I must not get weak, I have to use a condom. My wife I love you' because when you are using a condom you don't just protect your life but that of a woman as well. (FGD-BAN-6 male, urban, married, 26yrs, 2chldn).⁷¹

The connections between men's multiple sexual partners and HIV risks are well documented in Malawi (Clark, 2010), and worthy of concern given my research findings. While men referred to HIV risks, the potential risk of unintended pregnancy in the context of their multiple sexual partners was not discussed by

⁷⁰ During the dissemination meeting on the results in Chitera, the female chief made a specific point of addressing the females present and highlighting that they should be more sexually open with their husbands, in order to prevent men having multiple partners.

⁷¹ My informal conversations, including in drinking places, found that there were two rates applied by sex workers: for protected or unprotected sex, with the latter being more expensive.

men. This reinforces the view that while HIV could challenge one's manhood, a lack of concern for pregnancy prevention did not.

As noted in chapter 2, there is a gap in the Malawi literature on men's multiple sexual partners in the context of contraceptive use. My qualitative research identified that exploring this relationship was more complex than simply looking for associations between quantitative variables. Men told me that they used the 'threat' of having multiple sexual partners, particularly in marriage, which created a context that arguably was not conducive for women to easily use contraceptive methods. This married man, whose wife was using the IUD, explained how he used this threat to stop his wife using contraception:

At that time I wanted a child, so my wife was on family planning methods, she got injected and the effect was to last for three months, but then the period elapsed and there was no sign of pregnancy. Then I started to have multiple concurrent sexual partners. And when she discovered that I started having multiple concurrent sexual partners, she stopped going for family planning. (IDI-CHI-7 male, rural, married, 29yrs, 2chldn)

This reassertion of dominant masculinity through engaging in multiple sexual partners to prevent contraceptive method use, and to assert control over reproductive decision-making, was also found by Withers et al. (2015a) in their research with men in Kenya.

During FGDs, married men also referred to how the negative impacts of contraception on their virility justified their infidelity:

Maybe you married the woman when she was a girl and you were able to have three rounds of sexual intercourse with her. When she delivers a baby, the day she goes for check-up she is forced to start practicing family planning because we men of today do not wait for six months. You start troubling her after just one month. When a man is troubling her like that, he says, 'Then I will go outside.' [be unfaithful] So when a woman sees that, she says, 'Should my husband leave me and go outside?' She starts accepting [not to use contraception]. (FGD-CHI-12 male, rural, married, 40yrs, 4chldn)

The negative impact of female methods on men's aforementioned preference for quick ejaculation was another rationale for their infidelity, as this married man noted, whose wife used the injection and who had two sexual partners in the last 12 months:

As I said, a woman who uses the injection method for family planning affects the man's sexual performance. You may have problems in ejaculating so maybe I will look for someone outside the home who is not using this family planning method. I will ejaculate within a short time. (IDI-LIK-1 male, rural, married, 30yrs, 3chldn)

For male condom use, the challenge was different: the very use of condoms by married men was a sign of male infidelity. As noted in chapter 5, I found a clear separation between condoms being inappropriate in the marital home, but appropriate outside with extra-marital partners. Given men sought to hide their infidelity, in FGDs men said condom use in marriage suggested a husband was having extra-marital sex:

This is the reason [why we don't use condoms]; the home is different from outside. It is better for you to move with condoms when going outside but you should never bring them inside the home because when you do that then you bring in quarrels. You started a long time ago having sex with your wife. So for you to bring a condom home, your wife will ask you and she will have some doubts about you saying, 'My husband has started leading an unfaithful life'. (FGD-CHI-3 male, rural, married, 51yrs, 5chldn)

This stigma of male infidelity associated with conjugal condom use was also advanced by married women during FGDs as a reason for their preference not to use condoms with their husband:

Sometimes we women are the ones who initiate the plain sex thing because we say that we can't have sex using a condom. If you put on a condom, it shows that you are not faithful and there is something that you are scared of, so that also makes men have plain sex. (FGD-CHI2-6 female, rural, 34yrs, 4chldn)

Reinforcing how condoms were imbued with related notions of promiscuity, married men stated that their wives believed that "prostitutes are the ones that

use condoms” (IDI-CHI-7 male, rural, married, 29yrs) and that they were therefore fulfilling their *wife’s* preference (not their own) in not using condoms in marriage. These quotes highlight how married men and women jointly reinforce hegemonic masculinities through their collective objection to condom use. Equally, as noted in chapter 6, married women may prefer their husbands to use condoms, but these notions of promiscuity serve to reinforce hegemonic masculinities in ways that undermine use.

8.3.5 Contrasting narratives of female infidelity

An area that emerged during my research was how men perceived women’s infidelity to be fostered by contraceptive use. While men’s dialogues around their own infidelity focused on the negative impact of contraception on their sex lives, narratives around women’s infidelity in the context of contraception related to men’s aforementioned desire to control women’s sexuality. It stemmed from a position that while men can be unfaithful, women cannot, and conversations with my research assistants identified men to feel emasculated should their female partner be unfaithful.⁷²

Though this area was not widely discussed by men, a small number expressed concern that female contraceptive methods would encourage their partners to be promiscuous or to leave them. As one married man said during a FGD:

We men get worried because at the time we are having sex with our wives...we think, ‘Since I am practising family planning, if my wife can leave my house and meet someone in the bush and find that the person is more powerful than me, will she not run away from me?’ So we get worried. (FGD-CHI-3 rural, married, 51yrs, 5chldn)

Implicit in this quote is that their wife’s infidelity would undermine men’s sexual dominance and challenge men’s ability to perform their hegemonic masculinity.

⁷² I found a clear view that women cannot cheat on men. Should a man accept a woman doing so he would be the subject of mockery in his community.

Men's concerns here related to a view that by using contraception women 'would not get caught' being unfaithful, and therefore by not using contraception their sexual misdemeanours would be 'found out', as this adult man explained:

If she doesn't use contraceptives, if she gets pregnant I will know that she was doing this [having sex] with another man when I'm not there. So I won't approve her use of family planning. (IDI-NS-9 male, urban, relationship, 25yrs, nochildn)

Rural women confirmed during FGDs how men's views of their infidelity affected contraception, and that this provided a barrier to their method use:

But they [men] also have the mindset that you will start looking good once you start to use those family planning methods. So they think that you may start prostituting and not be dedicated to your children in terms of taking care of them so they tell you not to use contraceptives so that you must be busy with children. (FGD-CHI2-12 female, rural, divorced, 30yrs, 5childn)

The perceptions that contraceptive access enables women to be promiscuous was found by Paz-Soldan (2004) in her work with social groups in Southern Malawi, who also found it a threat to notions of the primacy of masculine identity as sexually vigorous. These concerns that contraceptive use would facilitate their wife's infidelity arguably further reinforced their view that female contraception was emasculating.

8.3.6 Manhood is male ejaculation

My qualitative research also sought to further explore men's notions of sexual satisfaction and their links to male involvement. As potential further rationale for the significant numbers of men who quantitatively reported being sexually satisfied, despite qualitative comments suggesting otherwise, I found that sexual satisfaction was innate to manhood, and therefore expecting and presenting a sexually satisfactory relationship with one's primary partner was part of men's self-identity as dominant.

As a reflection of this dominance, I found that sexual satisfaction was positioned almost exclusively by men as male ejaculation, that, as a married man with three sexual partners told me, “ejaculation defines real sex” (IDI-BAN-7 male, urban, married, 25yrs). As one younger man in a relationship, who has two sexual partners, said, in response to what sexual satisfaction means to him:

I should reach the extent that I have released all my energy. (IDI-NS-6 male, urban, relationship, 23yrs)

And as an older urban man put it, using a metaphor:

This desire ends when you eat meat and finish it. So when it comes to sex, the same happens. (IDI-BAN-2 male, rural, married, 50yrs, 4chldn)

Within this context, male ejaculate embodied masculinity itself. It was described by one man as their “manhood” (IDI-LIK-2 male, rural, relationship, 27yrs). I explored with men whether they were concerned mostly for their own sexual pleasure. Reinforcing hegemonic masculinities, I found many men were not concerned for women’s pleasure, as this young man explained:

P: Once I have ejaculated that’s fine with me, I am satisfied. According to me I know that by just ejaculating then I am in fact satisfied.
I: Meaning that you have nothing to do with a women’s enjoyment?
P: No, nothing
(IDI-BAN-4 male, urban, single, 19yrs)

Other men did not know whether sex was pleasurable or not for their partner, as this dialogue with this adult married man highlights:

P: So when you say you are satisfied, is it mainly focused on you or satisfying your partner?
I: [Laughter]. I focus on my enjoyment because I wouldn’t know what she is thinking. She can say that ‘this guy only does one round’ without you knowing.
(IDI-SL-2 male, urban, married, 35yrs, 2 sexual partners)

When pressed further on this issue during IDIs, some men then said that it was important that their partners, as well as themselves, experienced sexual

pleasure. However, reflecting the comments above, where women's sexual enjoyment was discussed it was generally presented in terms of being fulfilled ultimately when the man has ejaculated. These men also expressed limited understanding of women's sexual pleasure.⁷³

One adult married man highlighted the need for greater male understanding and education in this area. As he was quoted earlier in the context of sexual coercion, and given he had three sexual partners, his suggestion may speak more to upholding standards of appropriate male sexual performance than a concern for women's sexual pleasure:

There is a need for special awareness for us men in relation to these sex issues, because you might think that you have satisfied your sexual partner without knowing that she is starving sexually. (IDI-BAN-7 male, urban, married, 25yrs)

I found women confirming that male sexual satisfaction centred around male ejaculation, and women often appeared more concerned with men's sexual pleasure than their own, reflecting how hegemonic norms of male sexuality also affect how women viewed their own pleasure; which Stern and Buikema (2013) also found to be the case in South Africa.⁷⁴

Two men challenged the current greater focus on men's sexual pleasure, reflecting positive forms of masculinity, advocating for more equitable sexual behaviour, and for greater respect of women's sexuality. These men were not yet sexually active, pointing to opportunities for engaging younger men before they begin sex. As one of these single men said:

Sex is not about having intercourse only, but you can also be caressing your sexual partner while she is cooking in the kitchen, that is part of sex. You do not need to do something special or perform in a certain

⁷³ During the interviews, men asked how one can tell whether a woman was sexually satisfied.

⁷⁴ The research did not directly explore women's perceptions of their own sexual pleasure in depth, as it did with men, for reasons of focus and positionality.

way...you can just have a romantic talk with your partner and be satisfied sexually. (IDI-CHI-3 male, rural, single, 26yrs)

Building on my findings around sexual performance, I found that a significant objection raised by men, both those who reported using contraceptive methods with their partners and those who didn't, was the perceived negative impact of female contraception on their sexual pleasure, which related in particular to the injection and its perceived side effects. John et al. (2015) similarly found that the negative impact of contraception on sexual pleasure has been associated with non-use in Malawi. One adult married man who was not using contraception described contraceptive use as:

Women's bodies being contaminated with chemicals...so the way you people used to do it in the beginning and how you are doing it now changes because of such medications. (IDI-NS-7 male, urban, married, 30yrs, 2 sexual partners)

Women confirmed that taking contraception negatively affected their own sexual desires. Women talked about men comparing the sexual openness of their female partners when speaking with friends, as noted above, leading men to conclude that women who use contraceptive methods do not have an interest in sex. Married women suggested during FGDs this leads to them stopping use of the injection:

Some men say that they don't enjoy the pleasure of sex when a woman carries out a family planning method, more especially the Jackson one. (FGD-NS2-8 female, urban, married, 23yrs, 2chldn)

In conversations with health providers, they acknowledged that such sexual pleasure concerns exist, but were largely dismissive of them, such as this private provider (a matter which was also expressed in the public sector):

They say that the husband isn't satisfied. Menstrual bleeding also, which affects their sexual life. It is not true, but they just think this. Some men say that when the wife takes a family planning method, the husband doesn't get erect and enjoy sex. (HP9, female, urban, 48yrs, private service, manager)

These differing views on the impact of female methods on sexual pleasure between men and women on the one hand, and providers on the other, played out during one of my research dissemination meetings. In Bangwe, health providers publicly disagreed with women asserting that contraceptive methods affect sexual desires and therefore could be a barrier to uptake, while women and men asserted that it did.

Men's concerns around female methods impacting their sexual pleasure was not universal. One rural married man whose wife used the implant said he had not experienced any effect on his sexual pleasure (IDI-CHI-5 male, rural, married, 26yrs, 3chldn). This could suggest that the normative assumption of the impact of female methods on sexual pleasure is method specific (given most wives used the injection) or it may be more prominent than how men actually experience this impact on their sex lives.

I also found men to express specific concerns that condom use created challenges for them to ejaculate or limited the number of times they could ejaculate. This was also further complicated by men asserting that the mostly widely available free condoms, from the Malawian government, were poor quality and negatively impacted their sexual pleasure.

Across urban and rural areas, young and old, men expressed significant concern around the effect of a vasectomy on their sexual pleasure. A particularly strong concern was a belief that a man would no longer be able to ejaculate. Given male ejaculate is seen as central to manhood, this perceived impact of vasectomy was problematic, as this married adult man whose wife used the injection noted:

All I can say is that naturally we were given manhood power, so it is not good to terminate that manhood [through a vasectomy]. (IDI-BAN-6 male, urban, married, 36yrs, 4chldn)

These statements were supported by adult married men during the FGDs, causing laughter among the group:

God created sperms in men's body. So should they cut a ligament with an aim of making the sperms not to come out? There is no man who can accept that. [laughter] (FGD-BAN-1, male, urban, married, 42yrs, 2chldn)

Such assertions were made irrespective of whether someone had children or not, and the number of children, reflecting a fundamental dislike of the method. Among men who may be a primary candidate for a vasectomy (already had three or more children), such as this urban married adult man, this appeared a critical objection:

Because they see they will not ejaculate if they use this method [vasectomy], most men will rather not use this method because they believe that sex is about ejaculation [laughter]. (IDI-BAN-1 male, urban, married, 39yrs)

Similarly, a rural married adult man noted the following with respect to vasectomy:

It means that there you have ruined yourself. You won't also be enjoying the pleasure of sex. (IDI-CHI-7 male, rural, married, 29yrs, 2chldn)

These quotes also demonstrate a widely held misunderstanding among men with respect to vasectomy. Only a handful of men were aware that they could still ejaculate after vasectomy. During IDIs others asked what happens to one's sperm, such as this young man:

But I have a question right there. Since one has slept with a girl, for you to reach the point...when you want to release those sperms. So when they operate on you and remove the vas deferens duct, will you feel the pleasure of sex? [laughing] Because releasing the sperms is where the whole story of sex lies. (IDI-NS-6 male, urban, relationship, 23yrs)

Conversations with the research assistants also found this concern was compounded by the fact that, in Chichewa, the difference between the terms 'sperm' and 'ejaculation' is not well understood, particularly among less well-

educated people. For many people, there is no distinction. This fed into the broader sense that a man would no longer be able to ejaculate after having a vasectomy. Given women would then know the man had not ejaculated, this was seen as the ultimate sign of emasculation, therefore exposing them to ridicule, as this young man noted:

Most of them [other men] have the same thinking as mine [about vasectomy]. If this happens to a man like me, if I have slept with a girl and did not ejaculate, I will think that it's going to be a secret. But then I may hear of it somewhere, maybe after break up, that you just see him as such but there is nothing that he does [he can't ejaculate]. (IDI-NS-6 male, urban, relationship, 23yrs, 2 sexual partners)

Informal conversations in my research communities reflected widespread derision of vasectomy given that men would no longer have sexual desires. On one occasion while interviewing in Likoswe, my research team were amused and eager to recount a story from one adult man whose wife used the injection, who compared a man who has had a vasectomy thus:

Castrated cattle just pulls an oxcart, it gets fat, and when it sees a cow that is on heat, it does not react in anyway or move closer. (IDI-LIK-6 male, rural, married, 32yrs, 3chldn)

Married men suggested that women should instead go for sterilization, as this would not undermine male sexual desire and women's availability for sex, reinforcing the primary concern among men. These findings point to a central challenge for vasectomy use among men in Southern Malawi, in addition to fertility norms: that there would no longer be sexual pleasure and therefore manhood.

8.3.7 Pleasurable sex is plain sex

My research also identified a cultural importance around mixing fluids during sex, and in particular male fluids, which further negatively impacted on contraceptive use, particularly condoms. This essence is captured by this adult married man:

When we [men] ejaculate inside the woman during sex, you feel good. But when you use that paper [condom] we do not feel anything, even women do not feel anything. (IDI-LIK-3 male, rural, married, 30yrs, 2 sexual partners)

I found that the principal reason was that unprotected, plain sex was more enjoyable, reflecting the strong preference for 'skin-to-skin' sex that Anderson (2015) also found in her research in Malawi. This was reflected by the well-known Chichewa saying about condoms many Malawian men repeated to me: *sweet sadyela mu pepala* (IDI-NS-2 male, urban, married, 32yrs), meaning 'you don't chew a sweet in its wrapper.'⁷⁵

Men regarded the experience or 'feel' of sex as 'being sweeter' for everyone without protection, reinforcing the fact that male and female sexual pleasure is centred around male ejaculation or orgasm inside the women without a barrier.

As male ejaculate embodied masculinities, to fully express this manhood, it was therefore necessary to ejaculate inside the women's body, as this young married man noted during a FGD as part of conversations frequently punctuated with laughter:

You release the sperms and she knows that he has released the sperms into me. That's when we know that I have really been satisfied. [laughter] (FGD-LIK-6, male, rural, married, 22yrs)

Skin-to-skin was therefore constructed as a sign of hegemonic masculinity. As an expression of dominance, this married man explained in his rationale for preferring unprotected sex:

They [women] should know who I really am [laughter]. (IDI-SL-2 male, urban, married, 35yrs, 3chldn, injection, 2 sexual partners)

⁷⁵ In this phrase, the penis is the sweet and the condom the wrapper, highlighting the fact that direct body contact without a barrier is considered best.

In counterpoint, the use of condoms, preventing men from ejaculating inside a woman's body, therefore, was to deny the full expression of one's dominance:

If I ejaculate in the condom, all the important things have been left in the chishango [popular condom brand]. (IDI-CHI-7 male, rural, married, 29yrs, 2chldn, IUD)

With casual sexual relations, men also spoke of notions of the mixing of fluids affecting women's preference not to use condoms during these encounters:

There are other girls whom, when you have worn a condom, tell you to take it off. They say 'I want to experience the pleasure in this sex so we must have plain sex or skin to skin'. So that is why you find that someone is buying a condom but they are having plain sex. (IDI-NS-9 male, relationship, 25yrs)

Pleasurable sex was therefore unequivocally unprotected sex. During my IDIs I asked men 'do you prefer to use male condoms or not during sex,' in response to which the majority of men, over half of whom were married, said they preferred not to use condoms, the primary rationale for which was due to unprotected sex being more pleasurable. When I also asked these men their views on the findings of the IMAGES research results of men reporting poor condom use frequency (table 10), almost every man said the reason for most men saying they only occasionally or don't use condoms was this preference for unprotected sex.

The fact that women were responsible for contraceptive use in marriage was used as further justification for men's preference for unprotected sex, thus enabling adult married men to further assert hegemonic masculinities:

If it is my wife, we have plain sex because we are married. My wife gets injections from a health facility. (IDI-SL-2 male, urban, married, 35yrs, 3chldn)

Married men also said women desire to 'feel' men's sperm: "even a woman does not feel anything" (IDI-LIK-3 male, rural, married, 30yrs, 2chldn) if you use

a condom, one said. As IDI-SL-2 above continued explaining in the context of sexual pleasure:

Very few women enjoy sex with condoms. Those that can tell you that we can't have sex without a condom are very few. (IDI-SL-2 male, urban, married, 35yrs, 3chldn)

As a result, another adult married man talked about “being forced by women” to have unprotected sex as those women said “I want to have sperms released into me” (FGD-CHI-14 male, rural, married, 27yrs, 3chldn).

During FGDs, women confirmed men prefer unprotected sex and refused to use condoms, highlighting the issue of men talking about unprotected sex being more pleasurable for them and their partner. Women, themselves, also said universally that they themselves preferred unprotected sex, as it was more pleasurable, with rural women being more forthright. This preference was reiterated by female participants during the research dissemination meetings. Kishindo (1995) highlights that in Malawi women have unprotected sex to please the man for fear of repercussions or financial necessity, and given my findings on men’s dominance in sexual decision making in which women arguably cannot deny men unprotected sex, reinforced by the negative associations of condom use in marriage, this broader context is of critical importance.

8.4 Summary

This chapter has explored how men’s conceptions of sex and sexual pleasure impact on contraceptive use, finding notions of masculinity and culture to strongly inform men’s approach and have a strong negative impact on men’s (and women’s) willingness to use male and female methods. I found 30% of men had two or more sexual partners in the last 12 months, with rural men having 50% lower odds of doing so. Compared to married men, unmarried men have 1.5 times the odds of having two or more partners, and single men have almost five times the odds of doing so. I found strong support for the importance

of virility, including men (married and unmarried) having multiple sexual partners, which impacted on contraceptive use. A context of taboo in discussing sex within relationships related to the view of insufficient openness among couples around sex. At the same time, men expressed a sense of ownership of women's sexuality, including entitlement to sex within relationships. They displayed double standards as women's infidelity was not tolerated, while women arguably had little choice but to accept men's infidelity.

Men were primarily focused on their own sexual pleasure, in which unprotected sex was seen as preferable by men and women, and mixing of fluids was seen as culturally important and central to hegemonic manhood, which provided barriers to condom use in particular. Male and female contraceptive methods were seen to impact on men and women's sexual pleasure and men's ability to perform well sexually, including sustaining an erection. While alternative more equitable male behaviours existed, these were in the minority, with these sexual scripts remaining pervasive within Southern Malawi, making the adoption and continuous use of contraceptives by women extremely challenging.

I now turn to my final results chapter which explores in greater depth men's engagement with contraceptive health services in my research sites.

Chapter 9: Men's engagement and perception of contraceptive services

9.1 Introduction

The last chapter explored my findings on male gendered and cultural norms related to sex in Southern Malawi, finding that virility, men's multiple concurrent partners, perceptions of ownership over women's sexuality and sexual pleasure, and a desire for plain sex and to share fluids, impacted in largely negative ways on men's approach to contraceptive use.

In my final results chapter I present my quantitative and qualitative findings on men's engagement with the contraceptive health system in Southern Malawi. I begin with data from the public and private clinics in my research sites on the contraceptive services available to men, the health service environment and client data on men's attendance at these services (alone or with their partners). I then explore men's views of these health services, and the perception of health service providers and of NGO and government stakeholders regarding men's engagement. The inclusion of more detailed data from these clinics reflects a consistent finding in phases 1 and 2 of my study that in order to more fully understand the challenges related to male involvement it was necessary to further explore structural factors. This chapter responds to research question three: How do men perceive, experience and use contraceptive/family planning services, and how do these services, and the related Malawian institutions, respond to men's engagement?

9.2 Contraceptive services targeting men and male client data

I collected data from the public and private clinics in the catchment areas of my research sites on the contraceptive services available to men and analysed secondary client data on men's use of these services. I also undertook observation on the environment of these clinics. As noted in chapter 4, health

service coverage was uneven across my research sites (for example, only one rural area had a private clinic), and services used different data management processes, and these inconsistencies are thus reflected within the client data. Only public services offered ANC/PNC, which as noted is a key route through which women access contraception.

9.2.1 Contraceptive services offered to men

I asked each clinic whether they offered male methods (vasectomy and male condoms), how condoms were accessed and whether they provided any other male engagement services. The results are outlined in table 18 below.

I found that most public services provided male condoms for free, and all private services (see caveat below) had male condoms for sale. Several public and private services also had female condoms, though uptake was limited. Across public facilities, with one exception, male condoms were only available on request through consultation rooms or specific services (and not in waiting areas) while in private clinics male condoms were more easily accessible (and could be purchased at the clinic reception). Only one private provider offered vasectomy services, reflecting men's comments on this method being mostly unavailable. No in-clinic or outreach groups or activities specifically targeted men to better engage them in clinic services as contraceptive users or to support women's contraceptive use, reflecting men's views on the lack of contraceptive programming targeting them.

While religion was not associated with men's reported contraceptive use (table 8), it was a factor in the male methods private services provided. Several private providers, such as CHAM, did not offer male condoms for religious reasons (these have been excluded from table 18). One private provider asked me to advocate to their headquarters for a change in their policies to enable them to provide male condoms. These clinics provided female contraceptive services under the banner of family planning, but did not want to be perceived as

providing services associated with risky sexual behaviours.

9.2.2 Environment of contraceptive services

My observation of public clinics found they appeared to be overwhelmingly a female-only environment, given that women, mainly those who were older or had children, made up the majority of those attending, and often I found no man was present. The majority of staff were female. These services were often overcrowded. Few men appeared to attend contraceptive and ANC health talks or were at the clinic on days when women would receive contraceptive methods, which differed from a much greater proportion of men visible during days when HIV treatment was provided, corroborating men's views on the gendered access to contraceptive information. Male condoms were not visible in public clinics, and were sometimes also found to be unavailable, but I was told they could be accessed through one-to-one consultations, primarily in conjunction with HIV testing, reinforcing the predominant focus of condoms for disease prevention. Public clinics solely targeted women in their advertising and information, for example with posters encouraging women to adopt different methods, while none focused on couples or men.

A 'health passport' is the primary booklet used by all Malawians to access public health services and contains all information about services accessed. Only the female health passport has a section on 'family planning' and antenatal care, not the general health passport that men used, which reflected the health system orientation of those services. Informal conversations in clinics corroborated the finding from health providers that, at a women's request, they agree not to include contraceptive methods within this passport so that their male partners do not find out.

In the private clinics, though women remained the majority, these spaces appeared more male-friendly, with more information targeted at men, such as leaflets. They also had a larger number of male employees. There were fewer

people in these services, which had a much calmer feel to them. Unlike public services, contraceptive provision (where offered) was available any day of the week. The service orientation towards men in private clinics was principally focused on STIs and HIV, with only one setting, a BLM clinic in Blantyre, having male-specific contraceptive service promotion via billboards offering vasectomy services and couple counselling. Men could purchase condoms at the reception. My informal discussions with men and health providers also highlighted that men often purchased condoms through shops, pharmacies, and bottle stores.

9.2.3 Male client data

I asked clinics for data on the number of male vasectomy clients, men's use of contraceptive services alone and with their partners, and men's accompaniment to ANC services. The results are also outlined in table 18 below.

I found that use of vasectomy services was extremely low (two users during the data collection period), reflecting the limited availability of the procedure and men's concerns. Men rarely used contraceptive services alone, and if they did this was for accessing male condoms. Condom access was higher in private clinics than public, and conversations with providers pointed to more young men accessing those services, often buying them at the reception.⁷⁶ A very small proportion of women (1-2%) were accompanied to contraceptive services, with the exception of one private clinic finding 10% of women to be accompanied. Men's engagement with ANC services was overall low, with the exception of two public clinics where 10% of female ANC clients were accompanied, based on estimates.

These findings corroborate the IDI responses from men on their poor engagement with these services. They are also further evidenced by the fact that in my undertaking of rapid male client interviews while at these clinics (see

⁷⁶ Often health providers did not consider male condoms when answering the question on male only contraceptive use, so a follow-up question needed to be asked to check that data.

table 1) no single man I spoke with was attending to participate in contraceptive or ANC services.

Table 18: Clinic data on men's use of contraceptive services between April-June 2016

Name of clinic	Services offered to men?				Male client data			
	Vasectomy	Condom	How condoms are accessed	Any specific meetings/ activities for men/male involvement?	Vasectomy clients	% men using contraceptive services alone	% men accompanying wives to contraceptive services	% men accompanying wife to ANC
Public Services								
Chitera Health Centre (rural)	No	Yes, male and female	Requested via ANC & VCT consultation rooms	Health club for STI & HIV on Thursdays (for everyone)	N/A	0%	2%	2%
Mbulumbuzi Health Centre (rural)	No	No, male or female	From HIV Treatment clinic	No	N/A	0%	0%	0%
Chiradzulu District Hospital (rural)*	No	No, male or female	Requested via consultation rooms	No	N/A	0%	0%	1%
Bangwe Health Centre (urban)	No	Yes, male only	Requested via ART/VCT/STI clinic	No	N/A	0%	<1% (not documented)	10% (not documented)
Ndirande South Health Centre (urban)	No	Yes, male only	Requested via consultation rooms	No	N/A	0%	<1%	Unknown

Malavi Health Centre, Likoswe (rural)	No, refer to Queens	Yes, male only	Requested via consultation rooms	No	N/A	4% (only condoms)	0%	10% (estimate)
South Lunzu Health Centre (urban)*	No	Yes, male only	Through pharmacy & in toilets	No	N/A	Unknown	2%	5%
Private Services								
BLM Bangwe (urban)	No	Yes, male & female	On sale	No	N/A, referred 1 man	10% (only condoms)	10%	N/A
Lungu Private (urban)*	No	Yes, male & female	On sale	No	N/A	0%	0%	N/A
Malabada Private (urban)*	No	Yes, male only	On sale	No	N/A	0%	0%	N/A
L&A Private Clinic (urban)	No	Yes, male only	On sale	No	N/A	0%	2%	N/A
BLM Ndirande South (urban)*	Yes	Yes, male & female	Requested via consultation rooms (free)	No	2 clients	0%	Unknown	N/A
Praises Private (urban)*	No	Yes, male & female	On sale	No	N/A	0%	2%	N/A

* Figures also include July

9.3. Qualitative data on men's and health service views on male involvement

My qualitative research included questions to men, health providers and key stakeholders relating to men's engagement with the health system, which provided further context to the data collected from public and private clinics.

9.3.1 Men's perception of the health system

During IDIs I found adult married men expressing a range of concerns about, and barriers they faced in relation to their local public health services, particularly that "They open health facilities late, and they close early" (IDI-LIK-8 male, rural, married, 27yrs, 1child, injection), that "You wait for a long time due to long queues" (IDI-LIK-3 male, rural, married, 30yrs, 2chldn, injection), and that "There is a lack of confidentiality and privacy" (IDI-LIK-1 male, rural, married, 30yrs, 3chldn, injection).

In particular, reflecting my client data and observations, men perceived these facilities as primarily feminine spaces, as this adult man in a relationship noted:

Most of the time they [services] are seen as for women and children, that is how men look at them. (IDI-LIK-2 male, rural, relationship, 27yrs)

During FGDs married men expressed concern that this orientation meant the health system solely concentrated on women, impacting on men's limited understanding:

The other problem is that medical service providers only concentrate on women when it comes to the family. Instead of teaching both sides (men and women) they are one sided. (FGD-NS-11 urban, married, 32yrs, 2chldn)

The reflected men's sense of discrimination noted in chapter 5.

Conversations with married men regarding health providers further reflected a view of them being "badly treated by health staff" (IDI-BAN-2 male, urban, married, 50yrs, 4chldn, injection). This manifested in these men feeling

emasculated, that their dominant status was not sufficiently respected by these providers:

Doctors and nurses should listen with patience and nicely to men when they explain their concerns. They should not just concentrate on women, they should not just shout at men and tell them to go away. Men have a problem if you shout at them, they will never come back. (IDI-LIK-1 male, rural, married, 30yrs, 3chldn, injection)

Men's concerns about the orientation of the health system also related to the aforementioned emasculation associated with women becoming the contraceptive knowledge brokers, as this adult married man noted during a FGD:

We should go back because most of the time we men feel like most of the things are done by women. When you go to health facilities you find that there are more women than men. Men just hear when the story is over that those things [methods] cause cancer or whatever. (FGD-BAN-5 male, urban, married, 30yrs, 3chldn)

I also found some married men to assert during FGDs that they were not comfortable meeting with female health providers, and desired more male providers, reflecting both men's dominant self-identification and their embarrassment discussing issues relating to sex with female providers:

On the issue of counselling there is need for change so that a man can meet his fellow man, because most of the time we are not free for we say, 'What will I tell this woman [female provider]?' I can just say, I'm having body pains and know what is making me feel the pain but fail to say it just because it is a woman. (FGD-BAN-5 male, urban, married, 30yrs, 3chld)

Married men also confirmed during FGDs that they avoided ANC/PNC services given their concern that they may get tested for HIV. As a result, they also then missed out on contraceptive information and the opportunity to support their partners:

You are supposed to go to ANC together for HIV testing, I can say only 30% of men go. Most men fear that if my wife tests HIV negative and me positive it will not be a good scenario. You think of the risky sexual behaviours. (FGD-NS-8, male, urban, married, 35yrs)

In exploring with men how male involvement could be improved, men of all ages highlighted that the health service could better sensitise men and reach them more directly. For example, one young man recommended:

I: How could we encourage men to be involved in family planning?

*P: By having discussions with men and explaining to them the importance of family planning. Telling them that they will not have challenges in raising their children. Educating them that if they have a number of children they are able to look after them. Explaining to them that their wives will have a good health and even they themselves will have good health and be able to look after it, if they follow family planning.
(IDI-CHI-9 male, rural, single, 24yrs, 1chld)*

Married men suggested that they could be more directly reached at home through the health system visitors in their communities, which could enable them to better support their partner. In doing so, these men could uphold their dominant status of head of household despite the more feminine focus area:

We can encourage men by telling them the advantages of being in groups and health advisors should be visiting them. These health advisors can give men insights into the advantages of family planning and what can be done to assist your partner. (IDI-CHI-5 male, rural, married, 26yrs, 3chldn)

I also found married men talked about the need for contraceptive services and counselling to be provided to couples as a way to better engage men:

Men must be encouraged to go to the health facility in the company of their wives so that they both receive counselling and family planning methods. (IDI-CHI-7 male, rural, married, 29yrs, 2chldn, IUD)

This desire for greater engagement of male partners was also recognised more broadly during my dissemination meetings. In Chitera, an in-depth conversation on my research results led to a decision by the Chief and community to trial prioritised access for women who are accompanied by their partner for contraceptive visits. A similar strategy had started being tested elsewhere in Malawi, with mixed success. Given my findings on men's control over women's sexuality, such action could potentially have unintended negative consequences.

I also found some married men during FGDs reiterated the view that they wanted to have their own space, reinforcing their feelings of emasculation with women being the sole knowledge brokers:

When talking about the issue of family planning, they [health providers] should never combine us with women because women have heard enough. They should come and talk to us men because, such as on the issue of vasectomy, I have never heard anything. They should come and conduct a meeting telling us, 'We want you to go for vasectomy and these are the advantages.' (FGD-LIK-10 male, rural, married, 32yrs, 3chldn)

Such comments underscore men's own desire for greater male involvement. It also speaks to the benefit of male only spaces to constructively reach men in the context of a health system perceived as feminine. Equally, given this man's (FGD-LIK-10) earlier quoted views about the superiority of male sexuality, it serves to underline the dangers in any spaces which may reinforce male hegemony.

9.3.2 Perceptions of health system on men's use

I found health providers in both public and private services corroborated the client data that few, if any, men come to contraceptive services alone or with their partners, and that most contraceptive clients are female. As one public provider said:

We see an average of 80 women per day (Monday-Friday) for family planning. Sometimes this can be more than 100. In a month, only one man might come. (HP18, female, urban, 40yrs, public service, nurse)

Providers noted that the only time that men would seek contraceptive services was to take condoms, or occasionally through ANC, which is also in line with my client data.

Health providers also confirmed that men rarely took up vasectomy services, and even where this was offered very few men came for such services, as one private provider noted:

We have only had one man since we started offering that service in 2010. (HP15, male, urban, 39yrs, private service, clinician)

I also found one health provider reinforced the misconception that a man could no longer ejaculate once they had a vasectomy (HP32, male, urban, 50yrs, private service, director). A senior staff member in Malawi's Ministry of Health (MoH) responsible for reproductive health underlined the cultural barriers to this method:

On vasectomy this is something that is very difficult in Malawi. Most people don't accept it (KS10, female, urban, 47yrs, MoH, co-ordinator)

Health providers across both public and private clinics identified men's limited engagement in contraceptive services as a challenge, and that more had to be done to address this issue, as this rural public provider explained:

We have some male involvement issues at the clinic. We ask ourselves why are men not coming? It is a big problem. You can come and see in the clinic register. There are always fewer men. (HP12, male, rural, 28yrs, public service, in-charge)

Another public provider reinforced this, highlighting that men's perception of the orientation of services was at the heart of the problem:

It is very important that we reach men. Men are the natural leaders of households in our communities. If men are encouraged to be involved in health services, we will have a healthier country. They say family planning is women's business, not men's business. They say 'nzazi amy' – health services are mostly including women and children. (HP10, male, rural, 42yrs, public service, nurse)

A private provider at BLM, whose organisation undertook door-to-door outreach providing contraceptive services, highlighted also that they rarely reach men, reinforcing that women therefore receive information alone:

We need to involve men in family planning by giving them information. Women already have a lot of information – we meet more women than men at our services. Most men are at work during the day. We have reproductive health assistants who go door to door. During the week they meet women, not men. Men lack the necessary information. (HP9, female, urban, 48yrs, private service, manager)

Given that the main focus of information provision is through services, or via outreach during times men may be working, health providers stated it was important to find alternative ways to reach men, particularly through different entry points and at different hours. One public provider described the following:

Our health officer goes to communities during working hours, and they do not find men. We need to reach people through churches. 8am to 4:30pm are the working hours. We are leaving men out, as they are not around during these times. (HP11, male, rural, 47yrs, public service, manager)

Another public provider suggested home or workplace visits to reach men, mirroring suggestions from men themselves:

We can do home visits, especially during weekends. We should go to men's working places to talk about family planning. (HP18, female, urban, 40yrs, public service, nurse)

My community observations of health talks in communities on contraception corroborated that men were rarely present, if at all. Men's role as economic provider clearly impacted on their participation in these forums, as noted in chapter 7. My observational research also suggests an equally important barrier to men's presence was prevailing perceptions about pregnancy prevention being feminised and a women's responsibility. I found that some men were available in communities to attend at the times of these talks but did not do so given that participation in such spaces was antithetical to the performance of dominant masculinities. The potential for engagement in the health system to undermine men's masculine identity was not identified by health providers.

A further recommendation mentioned by many health providers, and reflecting that of men, was encouraging men to accompany their partners to the clinic when they receive contraceptive methods:

We should be providing services to couples together. If men are involved, they can remind women to come for family planning methods. Men can also then get information on family planning, the importance of taking methods, and when to space children. Involving

men would be better for women. (HP18, female, urban, 40yrs, public service, nurse)

The head of one local public health service suggested regulations should be put in place to compel women to bring their partners:

We could have by-laws put in place by community leaders whereby if a woman has come to a hospital without her partner she would be sent back until she brings her partner. I have heard this has assisted and that a lot of men are then taking part. (HP13, male, rural, 38yrs, public service, in-charge)

Another public provider highlighted that the health system can then more easily address some of the aforementioned power dynamics that undermine contraceptive use:

Men have power in the family. If they come together as a couple to the health service it is easier to provide them information. We can get over power challenges between men and women. (HP11, male, rural, 47yrs, public service, manager)

Public health providers also confirmed to me that they did encourage men to attend ANC with their partners in order for them to be tested for HIV together, something that men had expressed to me they were reluctant to do:

We encourage pregnant mothers to take husbands on the initial visit, so they get tested together. (HP4, female, urban, 29yrs, public service, nurse)

These comments from health providers sought to address the aforementioned asymmetry of contraceptive information. Providers were not blind to men's authority in the family, and also told me that couple approaches would enable men and women to make decisions together. However, with the exception of HP11 above, in advancing couple approaches there were no references to how the health service could redress power imbalances, nor the dangers of by-laws in the context of men's socialised dominance, or the risks I found men feared of being tested positive for HIV while their wife was negative. This reflects how health providers themselves can reinforce hegemonic masculine norms, and illuminates potential challenges in both involving men while upholding women's autonomy.

This was further concerning in light of challenges public health providers told me with current counselling:

We need to have better counselling. If you give them [men] proper information, someone can understand. We can explain why we want them to use condoms, to stick to one partner. Many counsellors just say use condoms, without expanding. We need to say what do you want to achieve at the end of the day – what is the benefit. We need to explain all these things. To counsel someone to understand, it takes a long time. Not just 15 minutes. (HP9, female, urban, 48yrs, private service, manager)

In my conversations, I found the health providers themselves to be far greater advocates for male involvement compared to senior staff or higher-level stakeholders. This perhaps reflects the daily reality they witnessed and talked to me about of the challenges among women whose partners were not supportive. In sharing men's aforementioned concerns about structural issues in the health system, however, most providers contested that there were issues. I also did not find providers to reflect an understanding that men themselves wanted to become more involved or that men had a particular gendered interest in family planning. I found some public health providers exhibited a negative attitude towards men and their engagement in health services:

Men are difficult, men are very difficult. (HP21, female, urban, 36yrs, public service, nurse)

My clinical observations also identified a further reflection of masculine norms in the health system set-up: while the majority of health providers in public facilities were female, the majority of management were male. In my meetings with District Health Officials to discuss my research, all participants were male. These male District Officials, who set the overall health priorities for the area, equally did not seek to prioritise male involvement. They were arguably blind to men's own gender. Many of the mostly female health providers also spoke to me about their own concerns to pay for their bills and their low pay, and that they were clearly overstretched dealing with large client numbers.

My discussions with NGOs working on contraception in Southern Malawi identified that their work focused solely on women and that male involvement was not a priority. One NGO that ran a large programme promoting condom use and contraceptive outreach, reflected on the need to broaden their focus and the limitations of their current women-only orientation:

We haven't positioned our programmes to make men interested or to involve them. A lot of women are in the queue at health services. We haven't questioned the lack of male involvement. Men don't have enough information about family planning. No one is targeting men to challenge their misconceptions about family planning. They just go on with their objections to family planning as a result. (KS8, female, urban, 39yrs, NGO service provider, co-ordinator)

Despite the initial focus on engaging men in family planning at BLM and CHAM (see chapter 4), my discussions with these NGOs identified that these programmes no longer existed and that the accompanying knowledge appeared to have been lost. These organisations reflected on this being partly as a result of donor funding priorities. These organisations also positioned condom use as primarily for HIV prevention, not dual protection, as was also the case with KS8 above.

While health providers advocated for greater male involvement, I found that this was at odds with the focus of the Malawian government priorities, and that gender was still operationalised as relating solely to women. For example, a junior government official noted the following:

The Malawi government has focused much on the reproductive health system through only focusing on women and children and leaving men out. (KS12, male, urban, 28yrs, MoH, officer)

Reflecting the fact that men's engagement in HIV was a greater priority for the Malawian government, I found greater receptivity to advancing the issue of engaging men in HIV in my discussions with the Malawi National AIDS Commission, who subsequently held a national conference on men and HIV. Among family planning officials there was a less clear strategic focus on this matter.

This lack of focus on male involvement was represented at a senior level of the Malawian government by my interview with a Director within the MoH, who said engaging men was not a priority, though she did later acknowledge this need within the context of HIV:

Our health indicators are mostly about women and children. Our funding is really channelled towards this... In term of national priorities, men are a luxury. There is a saying that you can't deal with the penis until the vagina is fine. (KS3, female, urban, 40yrs, MoH, director)

These comments appeared to be in line with the limited policy commitments which Malawi had in the area of male involvement. Informal conversations with organisations identified that developing and implementing policy commitments around male involvement were not prioritised given that donors did not prioritise this. This highlights that male involvement is not only a health services matter, but requires greater understanding and prioritisation both at the policy level to address the gaps I identified in chapter 4, and in the context of development funding priorities.

9.4 Summary

This final results chapter has looked at data on men's engagement in contraceptive services, their perception of those services, and how the services themselves relate to men. I found limited contraceptive services targeted at men, with a very low rate of male users, either alone or accompanying their wives/partners. Men perceived health facilities to be primarily orientated to women and children, disrespectful of men's status and with a range of structural barriers, including concerns about HIV testing in the context of ANC/PNC. Men expressed a desire to be more directly targeted by these services, and for a greater emphasis on reaching men alone and couples. Health providers confirmed that few male clients attend, identifying this as a critical challenge, and the need to do more on male involvement. Providers simultaneously expressed a negative attitude towards men's engagement, which was reflected more broadly in the limited focus on men's role in reproductive health among health system management and Malawian

NGOs implementing contraceptive services. While not perceiving men as gendered in the context of contraception, nor acknowledging the construction of hegemonic masculinities, the health system inadvertently reinforced existing patriarchal power dynamics. The limited policy focus on male involvement was found to relate both to government priorities and to the priorities of donors.

Chapter 10. Discussion and Conclusion

10.1 Introduction

This chapter considers my study findings and their implications. I begin with a discussion of my findings, with reference to my analytical and conceptual approach. I then provide my personal reflections on this thesis. Thereafter, I explore the strengths and limitations of my study and summarise its contribution to knowledge. I then provide implications of my findings for research, methods, policy and programming. I end with a final conclusion.

10.2 Discussion of findings

This study explored how men's gendered understandings, attitudes, norms and behaviours influence male involvement in Southern Malawi. Based on my analytical framework (chapter 3), I explored men's contraceptive use, men's understanding, attitudes and access to information on contraception and family planning, how male norms of gender equality, male norms of manhood (strength, stoicism, fertility and breadwinner masculinities), and male norms of sex (virility, multiple partners, sexual pleasure, and control of women's sexuality) influenced male involvement and how health services were used and perceived by men and how they informed men's contraceptive behaviours. I found that how male gender is produced, and how hegemonic masculinities are performed and enforced (Connell, 1995), are critical considerations for male involvement, the use of male and female methods, and for the advancement of gender equality. There are other behavioural, cultural and historical drivers of contraceptive use beyond the focus of my research. I situate my results within the context of those, but this thesis did not seek to explore nor explain those broader factors. I begin with a broader discussion on the social production of gender, contraception and hegemonic manhood in Southern Malawi, followed by discussion on the ways in which my study contributes to an understanding on each of the above areas of my analytical framework.

The social production of gender and contraception as female

Much of the research on Malawi provides an unspoken assumption that gender is about women; an orientation that has been problematised by Mbweza et al. (2008) and Anderson (2015). My study found gender to be operationalised as such, despite the multifaceted ways I found men's attitudes and practices to be gendered. Through conversations on gender in the community, the focus of national bodies and policies on gender, donor conceptualisation, or local health initiatives, men's gender, and male gender norms, were rendered invisible. In light of this orientation, men did not perceive themselves as being gendered. This is important, as due to patriarchy, men's privilege concomitantly makes their position of status and power invisible, including to themselves. This is arguably a global phenomenon. Perry (2016:13) describes talking to men about gender as the same as "asking fish about water." By extension, therefore, the concept of gender equality in Malawi was seen as primarily a 'women's issue,' with limited conceptualisation among actors of what men's investment would be in such advancement. My findings that men then perceived gender equality as a zero sum game against men, reflects Riley and Dodson's (2016) findings on food security in Malawi and Dworkin et al.'s (2012b) findings on women's rights in South Africa. My study would suggest, as Barker et al. (2010a) assert globally, that the benefits of gender equality have not been sufficiently sold to men in Malawi.

My study also finds contraception in Southern Malawi is equally gender-specific; introduced and socially constructed as a female domain, bounded by notions of feminine roles and responsibility. Through families, peers and other community members, the health system and government policies, men as gendered contraceptive actors is largely rendered invisible (Jooste and Amukugo, 2013; Croce-Galis et al., 2014): what Greene and Barker (2011) describe as a unilateral 'gendered' approach to SRH. For example, only the women's health passport in Malawi has a section for 'family planning' and the health system largely abdicates all responsibility to women. Men are not directly targeted by, nor assumed invested in, contraceptive information and services, which take place largely within health system structures that men

rarely visit. There was no trace of the prior male involvement initiatives from the 1990s. In other words, contraception has become (and remains) synonymous with women's health (Wegner et al., 1998). A critical reason for this is contraception being solely conceptualised at the individual level in Malawi (Furnas, 2016), as opposed to something which is imbued with meaning by both actors in relationships and through structures. Just as men have not been sold the benefits of gender equality, nor have they been deliberately reached with the benefits of contraceptive use, which can limit their engagement and support (Flood, 2003; Campo-Engelstein, 2013). This positions contraception as both threatening and disempowering to men. This feminisation of contraception coexists with men's socially accepted position of power in Malawi and their influence on a matter directly impacting on women's bodies. Where men were gendered I found this was generally instrumentally with a focus on working with them to improve uptake by women of services (Greene et al., 2006) from a perspective that sees men as exclusively a barrier to women's reproductive rights (Withers et al., 2015a), rather than seeking to understand men's own interests, desires and narratives as a way to garner their support (ibid.). In Southern Africa, research around contraception by Mejía-Guevara et al. (2020) and others has relied on women's reports as a proxy of men's views and behaviours, and this study therefore makes a contribution in adding to the limited research base globally that listens directly to the voices of men themselves regarding contraception, and explores their own motivations (Townsend and Shand, 2009), as well as looking beyond solely individual level factors to better understand male involvement.

The roots of this gender-specific approach to contraception in Malawi are also historical and colonial, which informed the genesis of focus in the country's 'family planning' programme and in the language used. President Hastings Kamuzu Banda's objections to contraceptive use and his positioning of birth control as foreign (Messac, 2020), meant that contraception was viewed with suspicion (Kaler, 2004a). Banda's celebration of female fertility (Robinson, 2017) marked clear gender roles where manhood was based on having children, not the process by which pregnancy

takes place. As discussed in chapter 4, the national child spacing programme was set up to focus only on women and children. To gain Banda's assent, the Chichewa term, *kulera*, was chosen to mean 'family planning', as it can be translated both as child spacing (which could happen through alternative methods and does not appear to undermine male fertility) and modern contraceptive methods (Robinson, 2017). This provided cover on the one hand for those who wanted to provide methods to women (given Banda's objections to this) but rendered methods as something women received invisibly. My study found differing understandings of *kulera* to remain in the present day, with men's primary interest regarding 'family planning' as a matter of their social status around family size and in the decisions around having and spacing children, rather than the matter of responsibility for methods (in other words, how family planning is carried out). The legacy of this historical phenomenon as it relates to men's understanding of *kulera* and male involvement in Malawi does not appear in the literature. This is important, as in Malawi today I found that among health professionals and the health system more broadly, rather than these dual meanings, *kulera* has become synonymous with female contraceptives, meaning that men's gendered interest in this area was equally invisible. The conflation in the Malawian language and family planning discourse of the term family planning with contraception both reinforces women's primary responsibility for methods themselves, and the social construction of contraception as feminine.

My study also points to the social construction of the most widely available male method itself, the male condom, as *not* a contraceptive method in Malawi. Firstly, this is because it is presented primarily as a tool to prevent HIV. Much of the orientation and methodological approaches of condom research and interventions in Southern Africa, including Malawi, assume that condoms are principally (or solely) for HIV/STI prevention (such as Foss et al., 2007; Benefo, 2010; Weaver et al., 2011; Reynolds et al., 2012; Evans et al., 2018). One Malawian study specifically on contraceptive use among HIV positive men excluded condoms from available methods as the authors' assumed condoms were only for disease prevention (Tang et al., 2016). By

extension, research on masculine norms around condom use in Southern Africa by Ragnarsson et al. (2009), Shai et al. (2012) and Fladseth et al. (2015), among others, explore condoms solely in the context of HIV, with limited focus on masculine norms as they relate to condoms in the context of contraception. The lack of explicit or implicit acknowledgement that condoms are also for pregnancy prevention reflects a global bias within condom research (Hardee et al., 2016). This paradigm was embedded in how health actors in Malawi provided and promoted condoms and stigmatised them as promiscuous, reflecting historical suspicions among family planning providers towards the use of condoms for risky sex and HIV prevention, not family matters (Robinson, 2017). I found while this paradigm held true with respect to men's primary concern around condom use, it was at variance with how men in Malawi also understood the dual protection benefits of male condoms, and unmarried men's condom behaviours. Secondly, there is a perceived separation between male condoms and contraception. Despite men clearly knowing that condoms also prevent pregnancy, many, particularly married men, did not perceive it as a male contraceptive method. This reflects the broader feminisation of contraception, reinforced by research in Malawi which presents *kulera* as only about female-controlled methods (such as Bornstein et al., 2020a). Ultimately condoms are situated in a paradigm where men's responsibilities are not about being contraceptive users (Hook et al., 2018).

The production of hegemonic manhood in Malawi

A limited number of scholars to date have explored the social production of masculinities in Malawi, comparative to other countries in Southern Africa. Consistent with Gipson et al. (2010), Shattuck et al. (2011), Anderson (2015) and Mbweza et al. (2018), I found manhood in Southern Malawi to be associated with power and control over one's partner, with being the breadwinner, and with stoicism, fertility and sexual pleasure. I also found Malawian manhood was consistent with hegemonic masculinities theory: through their role as the de facto head of the household, and the main income earner, men assert their position as hegemonic, with concomitant socially sanctioned control over communication and decision-making with

their wives and partners. Men see their sexual needs as superior to women's. Men demonstrate these standards to others by not showing 'weakness' to neighbours and friends, such as that their wives are in charge or that they seek health-care. When men gain employment, marry and/or have children, this creates a social hierarchy where these men have higher status. Men's zero-sum understanding of gender equality means that hegemonic masculinities are defined as in contrast to women's autonomy and agency, thus challenging men's sense of authority. My study shows the utility of this theory to the Malawian context, complementing its prior use in the context of tuberculosis (Chikovore et al., 2014, 2015), and highlighting the fact that women and health systems also reinforce male hegemony.

An exploration of what drives these norms in relation to the gender system (chapter 1) is also instructive. Despite Southern Malawi's matrilineal system, women in practice often have limited agency (Matinga, 2015), as I found to be the case. Women's nominated male *nkhoswe* (see chapter 4), a guardian who is usually an older brother or maternal uncle (Robinson, 2017), can in effect make decisions for her. President Banda named himself '*Nkhoswe No. 1*' (ibid.), and despite his steps to promote women's education, Banda believed that women remained subordinate to the male guardians in their family (Forster, 2001). Colonialisation and Christianity also impacted on customary laws, and informed western ideas about social organisation that reinforced male hegemony (Matinga, 2015). The family home is where men's dominant role is both instilled and enforced, and where being the provider and shunning the domestic sphere upholds one's masculinity (Chikovore et al., 2015). Sex is constructed as masculine across all levels of society (Anderson, 2015). In local areas, most Chiefs are male (MHRC, n.d.). While most Malawians are economically poor, money and social status are linked, and money can provide access to fulfilment of other masculine norms, namely marriage, children and sex.

While my qualitative findings reflected a clear demonstration of hegemonic masculinities and gender-inequitable norms in Southern Malawi, the quantitative Gender Equitable Men (GEM) scale found most men in Southern

Malawi have moderate or high support for gender equitable norms. These GEM questions ask men directly about areas related to gender equality, and it can be argued that men know the 'correct' thing to say in response given the campaigns in Malawi on women's rights. The IMAGES Malawi-wide research found overwhelming support among men for statements on women's rights, despite also finding strong acceptance of a patriarchal division of roles between men and women (Zamawe et al., 2014). This may indicate that social desirability causes men to support gender equality in the abstract, while ultimately not changing patriarchal behaviours in practice. In a male involvement intervention in Uganda which I implemented we found men were more willing to display equitable behaviours towards their partner in the home, but less willing to publicly challenge other men's behaviours and patriarchy (Stern et al., 2015). Barker et al. (2011) assert that similar GEM scale results to my findings show that men support gender equality, while Flood (2015: 14) argues that "this support can be only superficial or tokenistic." My research would support Flood and suggest these moderate/high GEM scores, while potentially a positive sign, can mask men's inequitable behaviours. This also questions the survey's sensitivity and categorisation process (which I discuss further below), and highlights the strength of mixed methods research.

Hegemonic masculinities in the context of feminised contraception: the tension and opportunity of male involvement

My study suggests an inherent tension that is central to understanding male involvement in Malawi, and which adds nuance to assertions that men simply see matters of contraception as solely 'women's issues' (Gipson et al., 2010). On the one hand methods are understood through their incongruence with hegemonic masculinities: they are controlled and used by women, they are part of the domestic sphere and lower status. Equally, while clear physiological reasons dictate why women are more responsible for pregnancy prevention, few men, in sex with their wives/partners or causally, showed interest in the broader impacts of unintended pregnancy on women or how they could mitigate this (which mirrors Greene et al., 2006 and Campo-Engelstein, 2013). This was reflected by the majority of men

agreeing in my study that it's a women's responsibility to avoid getting pregnant.

On the other hand, my findings show that men clearly have an investment in what happens in relation to contraceptive use. Many are already involved, and most desired to be more involved. My study adds to extant knowledge through finding that men wish to be involved principally because female contraceptive methods interrupt their ability to exercise or project their authority and dominant status in community and culture. This may not necessarily manifest itself in preventing women using methods, but men feel that their masculinity is under threat if they do not have oversight of women's behaviour, as Chikovore et al. (2002) found in Zimbabwe. Married men want to rely on women taking methods, but do not wish these methods to interrupt their desires for children and for sex. As noted in chapter 4, Malawi DHS surveys since 2004 find most men disagreeing with the statement 'contraception is a women's business and a man should not have to worry about it,' which has been the basis of assertions by MacQuarrie et al. (2015) that men accept using contraception for pregnancy prevention. My study would suggest that these DHS results instead speak more to Southern Malawian men's concern that without their control contraception may challenge their hegemonic masculinities, than to a broader concern for pregnancy prevention.

My study also points to the potential pathway of gender equitable norms among men. The GEM scale can be understood as a way of measuring hegemonic masculinities (Leddy et al., 2016), and my finding that men with greater support for equitable gender norms (higher GEM scores) were twice as likely to report contraceptive use in their relationship highlights the importance of promoting gender equality among men in order to increase uptake (Kaida et al., 2005; Nalwadda et al., 2010; Nanda et al., 2013). This adds to the Malawian literature by building on Shattuck et al.'s (2011) findings on small positive correlations between equitable communication norms and contraceptive uptake (using a modified GEM scale), strengthening the gender norms and contraceptive use association, and is

the first time that this relationship has been measured in Southern Malawi using the full GEM scale. This quantitative finding was reflected in my qualitative research where men expressed a desire to shift gender roles, be more supportive, and receive more targeted information and services, as well as those who themselves already reported equitable behaviour. This reflects emergent positive masculine norms in the context of contraception in Southern Malawi, and points to possibilities for change. Masculinities are not static, and my research suggested shifting norms and men's role in flux, and opportunities to tap into these cracks in these traditional gender norms (Connell and Messerschmitt, 2005). Where men in relationships were found to be more supportive of contraceptive use, their responses suggested this co-existed with other equitable behaviours, such as on couple communication, highlighting the wider benefits of male involvement (Shattuck et al., 2011).

Despite these pathways to gender equality among men, interventions seeking to empower Malawian women to use contraception, such as women's groups (Rosato et al., 2012), while identifying the need to improve women's limited self-efficacy, rarely focus on how addressing patriarchal power, and challenging hegemonic masculinities, can prevent the undermining of contraceptive uptake (Phiri et al., 2015; Hook et al., 2018). Instrumental approaches to male involvement in Malawi, such as by Kululanga et al. (2011), can equally backfire if they do not focus on shifting gender norms.⁷⁷ Indeed, many of the critically important recent developments or commitments to advance contraceptive use, such as FP2020 or the 2017 Family Planning Summit, have not sufficiently incorporated approaches to shift male gender norms and power. My study adds to the body of research highlighting the blindness of many mainstream contraceptive approaches to the fact that men can change (Howse et al., 2010), but also to how gendered inequitable structures of power are reinforced and normalised at the individual, relational and structural level (Edström et al., 2015).

⁷⁷ Women who brought their husbands to ANC visits were allowed to skip the queue at health facilities. As their husbands refused to attend with them, many women would ask or hire a man in their community to attend as their pretend male partner for the ANC visit.

Men's gendered understanding and use of contraception

The Malawi DHS reports a high level of knowledge of contraceptive methods among men (NSO and ICF, 2017), which is based on providing a list of methods and asking men whether they have heard of each of them. Edström et al. (2015) and MacQuarrie et al. (2015) argue that such findings show that men are not disinterested in contraceptive use and are important for understanding whether men will use contraception. My findings highlight the need for greater interrogation of these assumptions, supporting Chipeta et al. (2010) that a high level of knowledge of modern methods among Malawian men alone does not determine whether they support contraceptive use. Men have heard of methods, but have less in-depth and accurate understanding of contraception given that it is women, not they, who receive direct information from the health system. Mirroring Dral et al.'s (2018) findings in Malawi, I found men focusing more on the rumours, myths and perceived side effects and disadvantages of male and female contraception that they absorbed, particularly in relation to the injection. While men may not be disinterested, my study would suggest there are important ways, worthy of greater attention, in which contraceptive information is gendered. My findings support Chilinda et al.'s (2020) call for more contraceptive education for men in Malawi. It also questions research focusing solely on contraceptive misunderstandings among women, such as Gueye et al. (2015), without similarly building the knowledge base on how men's poor contraceptive understanding interplays with a broader context of their negative gendered attitudes towards methods.

Existing research in Southern Africa with men on their contraceptive use is variously measured and reported. For example, men are only asked about their use of male methods, not all methods they/their partner may use (such as Maja, 2007) or men's condom use reports are conflated as their contraceptive use without exploration of other methods (such as Peltzer and Pengpid, 2015). Research data may not be sufficiently sex disaggregated (such as Kraft et al., 2009) and often relies on women's reports of men's use (Ross and Hardee, 2016). This creates challenges with comparisons. My study builds on the existing single methods research on men's use to date in

Malawi (Miller et al., 2001; Chipeta et al., 2010; Dral et al., 2018), providing mixed methods data that seeks to deepen understanding of how men themselves report contraceptive use. In understanding my finding that 72% of men in relationships reported contraceptive use, this context is important, as I specifically asked men and did not restrict my questioning to only male methods. It may be that men in my survey have over-reported their contraceptive use, as Miller et al.'s (2001) Malawi-wide quantitative research also found. It is also likely some married men may not know whether their wives are using a method. Men's reports are also broadly mistrusted; Miller et al. (ibid.) notes that the fact DHS surveys give primacy to women's method use reports over men's reflects an early belief among demographers that men's reports were less useful and accurate. My reported rate is nevertheless consistent with the broader Malawi study results (Zamawe et al., 2014) and my qualitative research.

Increasing men's use of existing male methods has been found to have a range of benefits for gender equality and can increase overall couple use (Hardee et al., 2017). The Southern Africa literature on contraceptive use can treat men as one homogenous group (such as Van Rossem and Meekers, 2007; Seutlwadi and Peltzer, 2013; Ngcobo et al., 2019), and my study adds to extant knowledge on the need to better understand the use and perception of male condoms by relationship type, particularly the need to explore unmarried men's use. My finding that unmarried men were almost three times more likely to report being a contraceptive user, compared to married men, reflects the Malawi DHS on higher contraceptive use among unmarried men (NSO and ICF, 2011). That unmarried men solely reported condom use to prevent pregnancy in their relationship also reflects Malawi DHS (ibid.). Due to the stigma of premarital pregnancy in Malawi (Levandowski, 2012), and structural challenges unmarried women can face accessing other methods (Bornstein et al., 2020a), the condom is the most accessible method. While these challenges for unmarried women have been documented in Malawi, their corollary – that condoms are used by young couples for pregnancy prevention – does not appear to have hitherto been a focus of empirical research in Malawi. Greater use of condoms among

unmarried men compared to married has been more commonly documented in sub-Saharan Africa in the context of HIV (De Walque and Kiline, 2011). In identifying this specific use of condoms to prevent pregnancy among young unmarried men, I also found a complexity: ironically, these unmarried men do not necessarily internalise the condom as a male method, or as a deliberate action of choosing a male method over a female method, but as a function of practicalities. This further reflects the social construction of *kulera* as only female methods.

My finding that married men solely reported using female-initiated methods in their relationship concurs with the Malawi DHS (NSO and ICF, 2011, 2017) and Ntata et al.'s (2013) qualitative research in Malawi. Among married men, the social construction of contraception as female, fused with hegemonic norms, means the condom is a taboo and an intruder in marriage, associated with infidelity and HIV. That I did not find a single married man reporting using a male method for pregnancy prevention speaks to the deep symbolic unacceptability of condom use within Malawian marriage, as Chimbiri (2007) also reports. This obstacle to using condoms as a contraceptive method in marriage was identified in South Africa almost 20 years ago (Maharaj, 2001a) and arguably remains formidable. Despite such challenges, however, given unmarried men's reports, the married men in my study arguably did previously use condoms for pregnancy prevention before getting married. This is supported by my findings, mirroring Koster et al. (2015) in Zimbabwe, that as soon as men enter marriage, condoms are then rejected, with a presumption that men then rely solely on their wife's contraceptive use. These findings support the calls for greater focus on the benefits of condoms for dual protection in Malawi (Bisika, 2008), and for the repositioning of condoms beyond disease prevention within the Malawi health system and policies. They speak to a need to better understand men's transition away from using condoms in marriage, and ways to maintain such use. Given that I equally found married women desiring to use condoms when their husbands did not, and men being key decision-makers around condom use, as Ziyane and Ehlers (2007) also found in Swaziland, dual protection

approaches in marriage must be undertaken in ways that do not entrench inequitable gender norms (Stern et al., 2015).

This picture on men's contraceptive use is also inseparable from another factor. I found overall low condom use frequency reports among men, with the majority of unmarried and married men reporting only occasionally or not using condoms at last sex, which has hitherto been documented quantitatively among young men in Malawi (Bankole et al., 2017). At the same time, I found around a quarter of men reporting multiple concurrent partners and unmarried men having slightly greater odds of doing so than married men. In the context of multiple partners, the validity of men's method reports have been questioned (Becker and Costenbader, 2001). In conversations with men with multiple partners, HIV/STI prevention was their primary driver of condom use rather than pregnancy prevention, which would reflect the prevalent orientation of condoms. Mirroring HIV research in Malawi (Anderson, 2015), I found both inconsistent condom use and multiple sexual partners to be associated with hegemonic masculine norms. Men's inconsistent condom use does not negate my earlier assertion that unmarried men are using the condom for pregnancy prevention in their relationships. Given I also found unmarried men having four times the odds of reporting always/mostly using condoms during sex (compared to married men), it suggests these unmarried men are using condoms across stable and casual partners. But it also suggests this behaviour does not represent emergent more positive masculinities, as unmarried men's condom behaviour is influenced by a complex interplay between concerns around the stigma of premarital pregnancy with their main partner and around HIV with casual partners, both of which would threaten hegemonic masculinities, rather than the attendant risks of pregnancy for women and girls.

There has hitherto been limited analysis of how men and women in Malawi perceive vasectomy. Reflecting findings from Eswatini (Shongwe et al., 2019) my study found men adamantly opposed to this method. A combination of pro-natal beliefs among men, women and health providers, infused with hegemonic norms, meant that vasectomy was considered a

form of castration, making men feel weak and unable to perform sexually. In effect, it represented the neutering of their manhood as it linked to their fertility, as Kabagenyi et al. (2014) and John et al. (2015) have also noted in Malawi, closing down their future options regarding sexual partners. Reflecting Shongwe et al. (2019), there was clear misinformation among men about how the procedure would impact on them, reinforced by myths and misperceptions, in a context of distrust where men have never met anyone who has had a vasectomy. Reflecting Perry et al. (2016), this inaccurate understanding contributed to men's objections to vasectomy. The low prioritisation of this method was socially constructed by a health system in which there was no provision of vasectomy services, except at one private clinic. My findings also reflect the poor use of this method globally (Ross and Hardee, 2016). Equally, I found men expressing a desire for further information, pointing to the potential that a further focus and expansion of this method could have in Malawi (Perry et al., 2016). My study would suggest the need to equally address men's concerns of emasculation, and Chichewa language semantics (see below), in any future expansion.

This study also adds to the knowledge base on men's views of the current method mix. Men were of the opinion, as Ngcobo et al. (2019) also found in South Africa, that there are not sufficient male methods available, and that current female methods are better than male methods; an issue not just for Malawi but requiring global attention (Hardee et al., 2016). My findings support the call for a broader range of male methods made by USAID and the recent Lancet Commission (Starrs et al., 2018), particularly a method which falls between a short acting and permanent method for men (Hardee et al., 2016). An international study that found 55% of men would be willing to use a new hormonal contraceptive method did not include any parts of Africa (Heinemann et al., 2005). In a three-country study on women's views about a male pill, which included South Africa, Glasier et al. (2000) found positive levels of willingness among women to use such a method in their relationship. Campo-Engelstein (2013) asserts that there is limited evidence of women's distrust of men to use new male contraceptives. Others argue that there will be important issues of desirability, trust and reliability for any

new male method developed (Edwards, 2017). Given the challenges of communication and men's desire for control of women's fertility within Southern Malawi, as well as the men advocating for greater male methods showing other inequitable behaviours, my research would pose the need to address power differentials in any method development process, a factor which does not appear to have been explored within the research on novel male methods to date.

The need to nuance approaches to contraceptive communication and decision making

Similar to Palamuleni (2013) and Shattuck et al. (2011), I found positive couple communication can be a facilitator for method use. The fact that a minority of men in my research played a supportive role in reminding women to take methods points to the emergence of alternative positive masculinity and less patriarchal male contraceptive practices. Kriel et al. (2019) similarly found men playing this supportive role in South Africa. The Malawi Male Motivator intervention highlighted the potential for encouraging and enhancing men's ability to communicate on the topic with their partners (Shattuck et al., 2011).

My study results also support Chipeta et al. (2010) and Ntata et al.'s (2013) qualitative research findings that negative contraceptive communication within relationships in Malawi appeared to undermine method use. I found that where women are expected to be subservient to their partners and are not encouraged or enabled to start or lead conversations, this impacts on their ability to open up to men around contraceptive use. My study adds a new component to how hegemonic masculinities impact these dynamics, not previously documented in Malawi; that contraceptive communication flows were emasculating for some men. In the context of gendered access to contraceptive information, I found men rely on their female partners to relay information. Similar to Withers et al.'s (2015b) findings in Kenya, some men rejected these information flows from female to male, with married men resorting to verbal abuse and seeking contraceptive information from others, often inaccurate, that directly undermined contraceptive use, in order to re-

establish control and dominance. This would suggest the need to include men in contraceptive services and information, as Maharaj (2000) argues in South Africa, acknowledging that the current social construction of contraception as female-only poses additional challenges for women given power differentials.

Contraceptive communication is also undermined by a culture of limited communication around sex. Limaye et al.'s (2012) research on HIV has highlighted the poor quality and limited sex education in Malawi, with boys not encouraged to talk about their bodies or puberty (Ntata et al., 2013). I found that in the absence of available and accurate information about sex and methods, men in relationships seek information from their friends, as Paz-Soldan (2004) also found in Malawi, some of which can be misleading and reassert masculine norms, which can discourage contraceptive use, or deter men from certain methods. These results suggest the importance of focusing not only on couple communication around contraception but the *quality* of such communication, and also that gendered power dynamics within relationships need to be taken into consideration. My findings pose questions of Becker and Costenbader's (2001) assumptions of predictors of contraceptive use based solely on whether couples have discussed contraception, without deeper analysis of the broader outcomes of those discussions. My findings would support Dadoo et al.'s (2001) caution that spousal communication on contraception itself should not be assumed to mean men's approval of contraceptive use.

Involving men in contraceptive *decision making* is seen as effective. Phiri et al.'s (2015:1) review on increasing modern contraceptive use in low- and middle-income countries asserts, "The most effective interventions were those that involve male partner involvement in the decision to initiate contraceptive use." My qualitative findings of a minority of men whose engagement in decisions was reported as positive for increasing contraceptive uptake, supports this, and concurs with Shattuck et al.'s (2011) similar findings in Malawi. I found men desiring to be more involved in decision making and asserting this would be beneficial for their relationship,

as Withers et al. (2015a) found among men in Kenya. However, my finding that men's broader desire for more involvement in decision making was ultimately to have greater control of decisions around contraception, particularly where it challenged embedded notions of masculinities, calls for interrogation of how such effectiveness is defined by Phiri et al. (2015) and others. Despite men's influence on decision-making, and the potential benefits and challenges, this authority that men hold is not acknowledged in the government's 2016-2020 Costed Implementation Plan for family planning (Government of Malawi, 2015), further reflecting the invisibility of men in contraceptive processes.

The concept of *shared* decision making among couples around contraception is often advanced within the field of male involvement, and the value of such has been specifically advocated within Southern Malawian research by Mbweza et al. (2008) and Hartmann et al. (2012). Married women and men in Malawi report a high level of joint decision making on using contraception (NSO and ICF, 2017). In the application of the GEM scale, shared decision making on method type is positioned as an equitable gender norm (Pulerwitz and Barker, 2008) and the highest weighting in scoring this item goes to men who strongly agree to shared decision making (Singh et al., 2013). Dworkin et al. (2011) argues that there may be exaggeration of concerns of male dominance in decision-making around health outcomes. My study adds to understanding by suggesting the need for greater caution to be applied to the promotion of shared decision making than appears the case within the Malawian literature. In the context of relationships in Malawi, I found 'shared' decision-making often meant men informing their wives on the method they wanted to be used, based on the method men perceive as most appropriate, or least objectionable, or because they 'lacked' confidence in their wives' ability to choose such a method (as was also found in Kenya by Withers, 2015b). Health workers found women aware of their partners' preference and making decisions based on that. In Mozambique, Capurchande et al. (2016) describe this situation as women feeling conflict between their bodily autonomy and the expectations of equitable coupledness. For men in my study, therefore, family planning was an issue for both men and women, not

a women's issue alone, which has not previously been documented, with specific reasoning that men wanted to retain control of family size matters.

My study further contributes to the knowledge base on the fact that married men's involvement in decision-making processes regarding contraceptive use can directly undermine women's use. Palamuleni (2013) found spousal disapproval as a negative determinant of use based on Malawian women's reports as a proxy, and my study complements this by providing quantitative data with men themselves on these decision-making dynamics. My finding that men who alone made final decisions in relation to women's health seeking had 77% lower odds of reporting contraceptive use, compared to where such decisions were made jointly, underscores the limitations of Malawi's current gender-specific approach to contraception. This finding was supported by my qualitative data, providing a further contribution through the strength of mixed methods. A key rationale that emerged from my qualitative data, which appears new to the literature in Malawi, is that for some married men, female contraceptive methods were seen as emasculating, undermining their hegemonic masculine role. Mirroring Chikovore et al. (2002) in Zimbabwe, shifting gender roles through women accessing methods without men's authority was problematic to men and influenced their objections to method use. I found that women, attending clinics, become the experts and gatekeepers to methods, which led in some cases to men feeling that they had lost control over an aspect of their household. Where women had already been given methods, these married men reacted with fury, even violence. Despite women's greater agency in being able to access methods I found men's prescription to this 'challenge' was for a reassertion of traditional patriarchal decision-making processes, rather than a desire to imagine more equal gender roles. Therefore, while men may approve of method use in the abstract, the implications of contraceptive use in practice on challenging hegemonic masculinities becomes men's greater concern. Given Malawi's high rates of contraceptive discontinuation among women (NSO and ICF, 2017), further understanding and addressing the manifestations of men's sense of emasculation, in a context of their power and ill-informed approach, is arguably important.

A further reflection of the 'negative' impact of man's authority was some women reporting covertly using contraceptive services, as previously identified in Malawi (Bisika, 2008; Chipeta et al., 2010; Gipson et al., 2010; Ntata et al., 2013; Anderson, 2015). This highlights that women are not powerless in this area. Equally, it reinforces the significant challenges for women to negotiate use. My study adds context to men's specific perception of this behaviour, which does not appear to have been previously documented in Southern Malawi. It is seen as 'destroying families,' emasculating, and violence may be used towards those women who are discovered doing so, as Chikovore et al. (2002) similarly found. Such a context arguably further undermines women's continuation of method use. It also brings into sharp relief the dangers of an exclusive focus on reaching women as contraceptive users: their socially accepted responsibility for contraceptive use becomes complex where women lack the power of decision making (Capurchande et al., 2016). In taking direct action to fulfil this role, and protect themselves, they bring on attendant risks of violence and dangers of divorce. Ashraf et al.'s (2014) research with women in Zambia on their household bargaining around contraception has described this context as a trade-off, given their finding that women's ability to conceal hormonal contraception led to a dramatic increase in use on the one hand, but also lowered women's reports on the conjugal value of marriage, and their health and happiness, on the other. Potential adverse outcomes and such trade-offs as a result of covert use, and the male partner finding out, illustrate the need to think innovatively in the context of male involvement about the best strategies to increase access to methods.

This creates a central conundrum to male involvement. On the one hand, men are already having an influence on decisions, in a context in which they are misinformed and see contraception as emasculating, and therefore their effective engagement could facilitate more supportive processes and reposition contraception as a matter of joint responsibility and concern. On the other hand, it can also undermine women's reproductive autonomy, with serious life and death impacts for women. This highlights that male

involvement must be pursued with caution and done in a way where men internalise the benefits whilst also challenging their power. Programming with men seeking to be gender transformative has been found to inadvertently increase male dominance (Edström et al., 2015), which is problematic in this context. This calls into question my hypothesis that male engagement in contraception is necessarily always a desirable aspiration. Hardee et al. (2017) have argued that women's agency to make decisions alone is critically important. Any involvement of the male partner should not prevent women being able to access services and choose contraception free from the influence of a male partner. Ultimately, it requires asking women the extent to which men should be involved in the process, if at all. And, given the constraints that hegemonic masculinities can pose for women to have such agency, it requires empowering them to strategize subtle ways they can challenge gender norms to uphold their reproductive autonomy, as MacPhail et al. (2009) argues in the context of barrier methods for HIV prevention in South Africa.

The countervailing impact of performative hegemonic masculinities

Fathering children is a marker of manhood in Malawi (Kishindo, 1994; Parrott, 2014), which my study finds both reinforces hegemonic masculinities and is part of the performance of masculinities. Reflecting Capurchande et al.'s (2017) research in Mozambique, having children was essential to creating and maintaining men's dominant masculine identity. Multiple children strengthened men's identity as provider, which is important to kin in Malawi (Palamuleni, 2013). My results point to a complex interplay of this marker of manhood with the simultaneous distrust of, as well as need for, contraception. Men's reported desire to have children, and their concern about being stigmatised by their community as childless, meant they were often against contraceptive use. This mirrors Withers et al.'s (2015b: 206) research in Kenya, where men using contraception were "avoiding their duty to have many children." Women in my research reported these male gender norms had a negative effect on their reproductive autonomy. My study provides specific additional contribution in Southern Malawi on how contraception has become associated with male infertility. Men perceived

female methods, especially the injection and the lengthy menstruation it was seen to cause, as associated with short or even permanent infertility, which affronted their manhood, as Parrott (2014) also found in Northern Malawi, and therefore rejected its use. I found traditional healers were diagnosing men's infertility as a problem of male sexual virility, thus conflating infertility with impotence, as Moyo (2013) found in Zimbabwe. This was reinforced by the fact that the 'dangers' of women's menstrual fluids could only be redressed through use of traditional herbs. Male infertility is often discussed solely from a biomedical perspective without focus on male gender norms, and my study highlights the benefits of exploring how masculine notions of infertility and virility fuse to undermine men's support for contraception use.

Held in tension with the above was the attendant cost of having several children, in a context where livelihoods can be unstable, and where men's provider role, and thus their dominant manhood, can be challenged by unemployment or insufficient income to support one's family. Therefore, I found countervailing narratives of Malawian men actively choosing in many cases to limit their family size to ensure that they can fulfil their role as a breadwinner, reflecting the findings of Shattuck et al. (2011). While high fertility was regarded as economically rewarding in the past (Caldwell and Caldwell, 1987), this appears far less salient today. It points to the potential entry point men's role as economic provider could offer to engage men in contraception. However, as men's primary motivation here was economic development, not women's rights, this entry point alone may not shift overall inequalities between men and women. Malawian men's gendered provider role, as Anderson (2015) notes, absolves them of direct responsibilities in SRH. My results also speak to the importance of understanding the broader impact of provider masculinity, an area not well articulated within the contraceptive research. Silberschmidt (2001) argues for greater acknowledgement within SRH of how men's inability to fulfil their breadwinner role undermines their social value and self-esteem, which causes men to reassert their masculine identity through risky sexual behaviours that impact on women. This reflects my findings, and speaks to the need for alternative role models for men which celebrate men playing a

domestic role beyond the provider, such as fatherhood, as Settersten and Cancel-Tirado (2010) argue, and that also supports men to reassess existing inequitable norms around contraceptive use.

My finding that men's desire to show strength and stoicism may lead them to disengage with preventative health-seeking, reflects similar findings in Malawi in relation to HIV (Anderson, 2015) and tuberculosis (Chikovore et al., 2014, 2015). The linkages to contraception in this respect appear less explored. I found that engaging in contraceptive services was seen as a sign of male weakness, incongruent with showing strength, whereas disengagement enabled men to perform their dominant masculinities. I also found that norms of stoicism intersected with men's perceptions of HIV, to create a further barrier to their engagement in contraceptive services. HIV was a daily reality for those within my research, underpinning all my conversations with men about their health-related behaviours, and an emerging finding in my study was that HIV was equally a threat to their masculine identity (Wyrod, 2011). Men therefore reported assuming they were HIV positive and avoiding HIV testing, as Sileo et al.'s (2018) also found, including disengaging with ANC/PNC services for this reason. While men's desire to avoid HIV services could have fatal consequences, my quantitative finding that men who tested for HIV were more likely to report using contraception with their partners, could suggest men's fatalism around HIV is allayed when they actually find out their status, with benefits for male involvement.

Expanding the lens of male sexual pleasure within contraception

While pleasure is a key reason why people have sex, there has been limited attention given to sexual pleasure within the field of family planning over the last 20 years (Higgins and Hirsch, 2007), which has been primarily problem focused (Philpott et al., 2006). As Varga (2001) notes, understanding male sexual drives and enjoyment could yield insights into reasons for preferences for, or reluctance towards, different contraceptive methods. This is also important given evidence suggesting that sex-positive approaches are more likely to lead to internalised behaviour change among men, and provide

opportunities to challenge inequitable gender norms (Barker et al., 2012). In Malawi there has been a greater exploration of male gender norms and sexual pleasure in the context of HIV (Woodsong and Allemen, 2008; Shacham et al., 2014; Anderson, 2015). Only John et al. (2015), focusing on Southern Malawi, have explicitly explored the linkages between sexual pleasure and contraceptive use to date, using FGDs. My research also provides new insight into how female methods are seen by both men and women to impact on sexual pleasure and male and female libido, particularly the Depo-Provera injection. This mirrors findings by Withers et al. (2015a) in Kenya, where injectables were perceived by men to affect women's libido and reduce desire among wives to have sex with their husbands. Particular concerns around menstruation, and vaginal wetness, associated with female methods may also reflect a preference for dry sex, as has been found among men in Zimbabwe (Civic & Wilson, 1996) and South Africa (Kriel et al., 2019). The sharing of ejaculate was central to 'real' sex, embodying masculinities, and therefore the condom which blocks the passage of these fluids was often rejected, as Tavory and Swidler's (2009) research in Malawi also found. Given men's added concerns that condoms may prevent them from ejaculating quickly, having multiple rounds of sex and sustaining their erection, these became further barriers. This was also a particular challenge for vasectomy, given misinformation and there being insufficient distinction in Chichewa between the terms 'sperm' and 'ejaculation,' which compounded the belief that men would no longer produce fluids. These were not just concerns for men, as women equally expressed a preference for unprotected sex. Despite this, my study found the health system did not address concerns about the negative impact of contraception on sexual pleasure, in discordance with men and women's views. This may also speak to a deeper issue that contraception is not operationalised as about sex as it is feminised. Ringheim (2002: 172) asserts that giving men the chance to discuss their concerns about "semen loss" related to condom use made men more open to considering the risks of not using condoms. These perspectives on pleasure and contraceptive methods, and the differing narratives of the health system around sexual pleasure, do not appear to have been previously documented by research in Malawi.

Sexual pleasure concerns were also embedded within Malawian men's performance of hegemonic masculinities. Virility was a marker of dominant masculinity, reflecting Izugbara and Undie's (2008) findings among young Malawian men. Men's multiple concurrent sexual partners were part of this construction, as identified within HIV (Anderson, 2015), and its potential undermining of contraceptive use appears to have not been previously documented in Malawi. Men also expressed concern about their partner not being content with their 'performance' if methods were used. Male sexual pleasure has primacy in Malawi among men and women in the context of contraception, reflecting research findings in South Africa (Swartz et al., 2018) and Mozambique (Macia et al., 2011), and women may surrender their sexual autonomy to men in relationships, particularly marriage. As seeking sexual pleasure was a performance of masculinity, men relied on women to ask for condoms to be used. Equally, the large proportion of men reporting concerns about potential sexual dysfunction, usually not discussed openly with one's partner, highlights how male bravado produces norms of virility and may inhibit more nuanced presentations of men's actual sexual behaviours and experiences.

While identifying the need for greater consideration of sexual pleasure concerns as they impact on methods, my study also highlights the need for this to be situated within an analysis of hegemonic male power. Men's preference for 'plain sex' could mean that women have challenges negotiating condom use. This would reflect Cleland et al.'s (2011) broader analysis on women having limited negotiation power over contraception. Men argued that greater 'openness' between partners would improve sexual satisfaction, but this was frequently a euphuism for men not being refused sex by their partner. Moreover, 'insufficient openness' was provided as a justification by both men and women for infidelity on the part of men, which further undermined contraceptive use. Despite this context, I found the 'solution' among men, women and the health system on addressing men's concerns on sexual pleasure was for women to be 'more open to their husbands', a reflection of how women also reinforce hegemonic masculine

norms (Connell and Messerschmitt, 2005), as well as the health structures. Given men's sense of ownership and entitlement over women's bodies, as Stern and Buikema (2013) also found in South Africa, sexual pleasure must not become a modus operandi for condoning sexual coercion. In the Malawi-wide IMAGES data, a high level of men reported experiencing sexual violence from their partner (Zamawe et al., 2014), and my findings suggest such 'violence' could be associated with men perceiving they are being denied sex, highlighting the dangers of a focus on openness without shifting male gender norms and power.

Despite men's own infidelity, men worried that women using contraceptive methods would have greater sexual agency and therefore have additional sexual partners, which would challenge their hegemonic masculinities, so men objected to use as a means of reasserting their dominance. This mirrors Chikovore et al.'s (2002) findings in Zimbabwe. While men associating contraception with women's promiscuity has been documented in Malawi (John et al., 2015), that this becomes a barrier to method use appears to feature only in older literature (Kalipeni and Zulu, 1993; Kishindo, 1994). Arguably the aforementioned historical perception among the family planning sector that HIV (not contraception) is about promiscuity (Robinson, 2017) may have obscured deeper exploration of this double standard.

Hegemonic masculinities and contraceptive services

There is limited research in Malawi on the interplay of masculinities and men's perceptions of contraceptive services or on the opinions of the health system itself on male involvement in contraception. Research in Malawi has found Malawian men expressing shyness about going to contraceptive services (Dral et al. (2018), considering them places where only women go (Anderson, 2015) and feeling excluded from such services (Kalipeni and Zulu, 1993). Through not engaging in services, Dwadwa-Henda et al. (2010) argues it is harder to correct men's misinformation about contraception, and also places the burden of conveying information solely on women's shoulders. My study provides new analysis on how male gender norms interplay with the contraceptive health system, as has been found in Malawi

in the context of HIV services (Dovel et al., 2020). Unlike Kriel et al.'s (2019) research in South Africa, male involvement in Malawi had particular boundaries: men disapproved of attending contraceptive clinics alone or accompanying their partner, perceiving them as feminine spaces and that it is their wives/partner's role to access methods. This mirrors Cleland et al.'s (2011) analysis across 24 sub-Saharan African countries. At the same time, men expressed an interest in receiving greater information and services, as Hardee et al.'s (2017) global review found. I also found men asserting that breadwinner masculinities was a reason they did not go to reproductive health clinics, mirroring Sileo et al.'s (2017) study in Uganda. The negative impact of the need for men to work or find work on men's health-seeking has been documented in Malawi in the context of general health services (Gipson et al., 2010), tuberculosis (Chikovore et al., 2015) and maternal health (Kululanga et al., 2011). This highlights the need for alternative health system approaches to reach men.

I also found the health system itself, from its structures, outreach, and services available, as well as the donors that supported it, did not see male involvement in contraception as a key priority, or men as contraceptive users themselves, and therefore did not seek to deliberately target men, reflecting the feminisation of contraception. This partly relates to the fact that women bear children and have a direct means of contact with the health system as a result. This primary service orientation towards women was despite men's clear desire for greater targeting and involvement. Opening hours being restricted to weekdays and daytime, and long wait times, created structural barriers to men's engagement. However, juxtaposed to this orientation, many health providers themselves presented a more positive perception of male involvement, an area which has hitherto only been documented in the context of maternal healthcare providers in Malawi (Kululanga et al., 2011). As a reflection of hegemonic masculinities, men felt that health providers, who are typically younger women, did not sufficiently respect men's status and men expressed embarrassment speaking with female providers. Equally, while many female health workers acknowledged the importance of doing

more to reach men, the management of the health systems, often male, did not prioritise male involvement.

I found men's desire to avoid HIV testing meant they avoided ANC/PNC with their partners/wives, and thus further disengaged from contraceptive services simultaneously provided. This HIV-related barrier to men's engagement in reproductive health services mirrors Sileo et al.'s (2017) findings in Uganda. Several HIV interventions have explored integrated contraceptive services, and in East and West Africa have had success in increasing men's engagement with health facilities (Bradley et al., 2009; Chabikuli et al., 2009). Given the Malawian government's focus on engaging men through ANC, including pressuring women to bring their partners, and on couple HIV testing through ANC, my findings suggest this may inadvertently further discourage men. In Malawi, HIV services for men are separate to contraception, while often combined for women in the context of ANC. Further analysis of how the integration of HIV and contraceptive services may impact on couple dynamics, particularly around power and women's agency, is necessary as part of advancing integration.

By not focusing on men's gender, the health system also had the potential to reinforce dominant masculine norms. An acknowledgement of the need to increase male involvement did not have a commensurate understanding of the necessity to respond to current power imbalances between men and women. This reflects the health system failure to see its role as incorporating gender equality considerations, beyond only being responsible for measuring health outcomes (Edström et al., 2015), and providers not being trained to examine gender power dynamics (Ringheim, 2002). A male involvement intervention in Uganda which increased men's accompaniment of their partner to services did not shift deeply held male gender norms about women's autonomy (Ghanotakis et al., 2016). Audet et al.'s (2016) research on male involvement in antenatal care in Mozambique found men's desire to control pregnant partners was at root of their motivations to be engaged in ANC. A recent intervention in Malawi targeting community health workers to provide couple counselling, which did not target men directly, led to an

increase in male presence during counselling visits (Lemani et al., 2017). While the authors presented this as a model for male involvement (ibid.), there was no discussion of any potential implications around communication and decision making among these couples. Relatedly, one key recommendation from men, women and health providers in my study was for couple counselling approaches, and my findings suggest health providers can play an important role in promoting gender equality within such counselling. Given men feel emasculated by women as contraceptive knowledge brokers, the formal health system could assuage men's concerns. Fundamentally, however, addressing structural barriers alone, while critical, will not address the underlying gender and power dynamics influencing male involvement.

Methodological implications

My findings point to the need for improved measures for men's contraceptive use and frequency of condom use. On contraceptive use, standardised questions and practice, for example not equating questions on male condom use alone as male contraceptive use, may be beneficial. My study created a dichotomous variable to measure men's frequency of condom use, but did not specify to whom this frequency related (main partner or extra-marital partner) and for what reason (disease or pregnancy prevention). Current similar methodological approaches in Southern Africa for measuring men's frequency of condom use presume that condoms are for disease prevention only, such as Chirinda and Peltzer (2014) and Reynolds et al.'s (2012). My results suggest men may answer questions differently depending on whether they are thinking about their stable partner or casual partner, and that greater specificity of condom frequency measures could be beneficial.

In Malawi, Chichewa-English translation alone may be insufficient without understanding the context. For example, the term *kulera* can mean family planning or contraception depending on the context, and there is no direct Chichewa translation for 'sexual partner.' There are also limited distinctions between 'sperm' and 'ejaculation' in Chichewa and cultural nuances where 'tough' in Chichewa can denote a bad person. Thorough qualitative research

is needed not only on the translated language but the concepts prior to research tools being used.

My study also finds limitations in the current GEM scale measures and supports the call in the Lancet for improved measures on gender norms (Weber et al., 2019). Assumptions about men's support for gender equality using GEM scores without further in-depth analysis could offer skewed findings on men being more equitable than they actually are, as reflected above. Equally, my findings pose questions on the current orientation of some of the GEM scale measures. For example, agreeing with joint decision making on contraceptive methods is rated in GEM as the most equitable response among men, and agreeing that pregnancy prevention is a women's responsibility is rated as the most inequitable response. Accepting this without problematising it does not take into account that, in Malawi, men's desire for greater decision making, or to see pregnancy prevention as also *their* responsibility, can be another way that men can control women's sexuality and their bodies. During reflections with IMAGES researchers, it was also evident that the intention of the GEM questions to measure men's attitudes on certain matters rather than measure what they believe to be factual, was not always understood; for example, measuring whether men perceive pregnancy prevention to be a women's responsibility rather than whether they think it is true that women are responsible for pregnancy prevention. These concepts, and what question men believe they are responding to, is worthy of deeper analysis, given that method use, pregnancy and childbearing impact significantly on the female body rather than the male.

Despite my intention to adopt a participatory approach to my research, I often found this challenging. The research team had learnt the traditional approach, and struggled to engage with my questions on what they thought. Perhaps reflecting the legacy of colonial power, my perception was that they were not used to giving their opinions and perceived their role as solely following instructions. Robson et al. (2009) found similar challenges in trying to put such principles into practice with young researchers in Malawi. I found

this process to be most useful and successful when asking the researchers for insights into my findings.

Finally, my analysis has also identified a number of limitations within DHS data. As noted, Malawi DHS questions to men on current contraceptive use are within the sexual activity section under method used during last sex (not the family planning section measuring use in relationships, as is the case for women). The DHS 2010 also calculates men's ever use of contraception, but this question only asks about use of male methods (condoms, sterilisation, rhythm and withdrawal) not all methods (which are used for women's ever use of contraception reports), which means national findings on unmet need can only be made from the female data. As such, there are methodological challenges measuring men's unmet need (Ngom, 1997) and national or multi-country contraceptive measurements are solely calculated using women's reports based on DHS, which leads to a lack of male perspectives (Cleland et al., 2014). In addition, deeper interrogation of assumptions in men's response to the question on whether 'contraception is a women's business', and the limitations of the variable around couples discussing contraception, may be valuable. Sexual pleasure concerns are also not measured as a potential cause of discontinuation. Given that my literature review found a significant proportion of Southern African research uses DHS for multi-country analysis, these limitations may be worthy of greater exploration.

10.3 Personal reflections

I have found this PhD a very challenging endeavour. I underestimated how difficult it would be to continue working full-time, while analysing and integrating my data, and writing up my thesis. I was naïve about the amount of work involved and the importance of dedicated time to build momentum and allow my argument to coalesce. I also collected too much data, and while this was a reflection of my enthusiasm, I felt overwhelmed by its weight and became lost for a period of time in the myriad stories and opportunities for analysis before me. Once I had chosen to focus primarily on

contraception, I struggled to let go of other parts of my data set which did not relate to this topic. I sought advice from many people throughout this journey, to whom I am extremely grateful, though ironically this proffered competing opinions and led me to initially neglect one voice that is particularly important in my research, that of my own. All that said, it has been a hugely rewarding journey in which I have learnt as much about myself as I have benefited professionally, and I have had the privilege to get to know Malawi better.

Becoming a parent of two children is also inseparable from my PhD journey. Witnessing the challenges of pregnancy, being involved in ANC and being present during childbirth, has renewed my belief both in the important supportive role male partners (in heterosexual relationships, in my case) can play, but equally in the critical importance of women having autonomy over their own reproductive decisions and the methods they choose to use. My son's serious health issues at birth also led to a two-year interruption in my studies, which caused delay and reminded me that my destiny was not entirely under my control.

Beginning my career before embarking on a PhD brought benefits and challenges. My PhD proffered greater academic rigor to my employment, access to online journals (which many NGOs cannot afford), and appreciation of the research process and the challenges involved. As I have often worked at the policy and advocacy level, I also benefited from being grounded by my research discussions with men themselves. My PhD findings also challenged my assumptions around my prior publications that promote shared decision making (e.g. Hook et al., 2018), and the work that I undertook on masculinities; this was both humbling and informative. While my advocacy has been driven by passion for a cause, a thesis is about a contribution to existing knowledge, and I often struggled with that shifting mind-set, with the former being more in my comfort zone. That said, I believe my research was also strengthened by my understanding of work being undertaken by practitioners and related opportunities to share my findings.

As the primary family earner during much of my PhD, I could empathise with the pressure my male interviewees talked about to be the main provider. When I no longer had a 'stable' job, and my wife was the main earner, I also recognised my own investment in performing the breadwinner role in our family. It has been a personal reminder that these socially constructed norms put pressures on men everywhere, not just in Malawi.

As a white educated man from the global North, I was also aware of the danger of seeing men in Malawi as the problem, an orientation (Keeton, 2007) has critiqued, and of the power differentials between myself and these men (and the research team), many of whom were sharing intimate details of their life to a stranger, as I discussed in chapter 3. Doing this thesis has forced me to face some often uncomfortable truths about my own involvement and indeed whether my wife wants this! I benefit from the privilege that it is not my behaviour which is under analysis in this thesis. These dynamics have increased my desire to further explore the engagement of men in contraception, and sexual health more broadly, within my own community in London, and to find spaces to share my own journey, recognising that such challenges are often universal.

Finally, this PhD had led to searching personal questions on the current modalities of global health research, reflecting the concept of extraversion (Connell, 2014). Malawi has been, and continues to be, extensively researched by the global North, with international research centres set up to facilitate this, including MLW to which I was connected. I questioned at times the significant funds I witnessed being spent on expensive research given the context of Malawi's poverty, and the lack of dissemination and engagement with the local communities based on the findings, and how research such as my own received funds while frontline health providers and infrastructures struggled. I also struggled with the power dynamics I saw of white foreigners like myself in charge of projects and local staff, or locals being the ones who implemented the research but often receiving limited credit for it. I had status as an expatriate researcher, and Malawians also gained status in being associated with my research, given its connection to

MLW. I saw local nurses and staff leaving struggling health centres to join research projects where they were better paid.

10.4 Strengths and limitations of the study

My study has a number of strengths, including:

1. The value of research with men themselves. Assumptions about couples' approaches to family planning and contraceptive use are often made through research with women only, which is also the case in Malawi. There is a paucity of research in Southern Malawi, as I note above, and globally, which asks men themselves about the relationships between male gender norms, gender equality and contraception (Hardee et al., 2017). I found that men, during my research, would express appreciation for the opportunity to talk, and stress how important it is for themselves and other men to explore this topic, and SRH more broadly, with some saying this was the first time they had been asked about these issues. This highlights men's blindness to their own gender, and the value of gender-related research with men.

2. Using mixed methods. I have used both quantitative and qualitative methods, including a survey, interviews, focus groups and observation, facilitating an in-depth and more holistic understanding of this topic. This enabled me to identify areas where there was concurrency of findings between methods (such as on men's overall decision-making authority in relationships), to find inconsistencies or contradictions between men's responses (such as between men's high GEM scores in IMAGES masking deeper patriarchal views I found qualitatively), to enable the qualitative research to deepen my quantitative findings (such as understanding the nuances behind men's IMAGES responses on contraceptive method use) and for the quantitative to deepen the qualitative (such as providing statistically significant associations impacting on contraceptive use). I was also able to use multiple similar methods for greater depth, such as observation to deepen understanding on what men told me in the in-depth interviews, or quantitative data collected during my interviews to complement

the IMAGES study. This supported triangulation within my data and enriched understanding through the combination of different data types.

3. Using multiple data sources and being embedded within a broader dataset. Including the voices of women (often absent from male involvement and masculinities research) provided a more holistic picture, and also highlighted how masculine norms are also reinforced by women. Data from health services and client statistics and clinical observations aided an understanding of structural determinants. Interviews with health providers and stakeholders deepened understanding about how the health system also reflected male gender norms. This enhanced the validity and credibility of the data, and sought to address the limitations of hegemonic masculinities theory discussed in chapter 1. By being embedded within a broader set of data, I was also able to identify linkages that may not have necessarily presented themselves, such as the responses from men on contraception within questions on HIV and AIDS. This added to my understanding of how these other behavioural factors impacted on contraceptive dynamics.

4. Using a hegemonic masculinities theoretical framework. I found that my understanding of responses from men and women was greatly aided by employing my theoretical framework. While I had initially presumed that this framework would be particularly useful in its application to men's responses, I found it was also helpful for understanding the responses from women, health providers and stakeholders. I believe this study also strengthens the use of the hegemonic masculinities framework through its inclusion of women and service providers and application in the context of contraception and family planning.

5. I used a number of innovative approaches during the qualitative research to aid understanding of my findings. All transcripts were first transcribed into Chichewa and then translated alongside in English by the T&T staff, allowing for repeat translations and deeper analysis of the original language at later stages. The research assistants produced a written summary of the main findings after each interview using a template, which aided quicker

understanding of findings given that full transcription/translation could take several weeks. I developed specific tools for health service observation and secondary data collection. The recruitment of more than one trained research assistant also enabled the study to benefit from investigative triangulation and less potential bias. My approach reflected the co-production of knowledge, with regular meetings held with the research team to reflect on findings, and with organisations and stakeholders, and through discussions with community members and asking men interviewed for their recommendations. I employed an iterative process, supported by the written summaries and meetings, where initial findings led to further lines of enquiry or deeper analysis on specific topics. These steps also aided validity, reliability and triangulation of my findings.

6. Feeding back my findings to the research communities. The dissemination meetings I held in each of my research communities, in conjunction with local leaders, provided both an opportunity for validation of my findings and to share what I had learnt with the communities that had given up their time to participate. These were combined with a national radio show discussion and meetings with policy-makers. I found that, while these public meetings often generated differing opinions, they were well received by all the communities, with respondents saying 'they did not feel cheated' as a result of the process.

My study has a number of limitations, including:

1. My research had a limited focus on broader social determinants of health, such as poverty, early life experiences and environmental factors, which could provide additional insight into men's behaviours in Southern Malawi. As noted, location, education, employment, ethnicity and religion were not found to be statistically significant with contraceptive use or GEM scores (with the exception of education). I continued to explore both location and men's employment as factors influencing male gender norms, and my addition of health service data and interviews with health providers helped to deepen understanding of structural determinants. This limitation did not prevent me from answering my research questions.

2. Limited matched quantitative and qualitative data. It was not possible to link the respondents from IMAGES to their qualitative responses, due to logistical challenges. I therefore collected additional quantitative data on the male IDI participants. As this was from the same study population and communities, following the same inclusion/exclusion criteria and using the same research team, this enabled meaningful integration. As the research took place in the community, and not health centres, it was also not possible to link responses to people's particular clinical behaviour. My use of multiple data sources allowed for triangulation of the trends within the data, which clearly emerge in relation to men's contraceptive behaviour.

3. Limitations of research instruments and focus. The IMAGES survey did not include a follow-up question on the contraceptive method type being used by men in their relationships. I therefore collected this data during the IDIs. While the GEM scale was pre-tested, it was not locally validated. This was addressed by exploring the items during my follow-up qualitative research. I also did not focus directly on gender-based violence, though this issue was raised by respondents and has been included in my results. As noted, Chichewa-English language differences could also make interpretations of men's responses challenging. This was addressed before and during data collection through rigorous training of my researchers, translation and back translation of the questions, and regular debriefing meetings. During analysis I rechecked several parts of the original Chichewa language to ensure my proper interpretation of what men were saying. Using multiple methods, and the depth of qualitative data collected, helped to address this limitation.

4. Social desirability bias. It is well known that what people say and how they behave in relation to sex often differs. Quantitative methods, such as IMAGES, can be a weak instrument for reporting sensitive sexual behaviours as a result. I worked to overcome this by training researchers in interview techniques and building a good rapport with the respondents. During the qualitative research, the sequencing of questions and specific interviewer techniques, such as the use of probes, and collecting separate behavioural

data, aided this process. I also sought to triangulate the data to limit this bias, including using the qualitative data to interrogate IMAGES findings, undertaking community and clinical observation, and asking women and stakeholders for their views on men's responses.

5. The time period in completing my research and integrating mixed methods data. For both personal and professional reasons, and as a result of being a part-time PhD student, I completed my analysis, data integration and write-up over a period of several years. Mixed methods data integration is a time consuming and iterative process. My literature review gaps highlight that my data nevertheless remains very relevant to the Malawi context today. I believe my data integration and writing also benefited from having gaps which allowed for greater reflection on my findings.

5. Masculinities are context dependent (Cornwall et al., 2011) and Malawi's post-colonial history provides unique expressions of masculinities in the context of contraceptive use. This suggests these findings are less generalisable to other settings. Equally, my literature review highlighted similarities across Southern Africa, suggesting that many of my findings could apply to those contexts.

10.5 Summary of contribution to knowledge

This thesis provides both broad and specific contributions to knowledge around theory, methodology, semantics, gender norms, contraceptive methods, and structural determinants. On theory, it makes a broader contribution through being the first study in Southern Africa, including in Malawi, that appears to employ Connell's hegemonic masculinities theoretical approach to explore male involvement in contraception and family planning. It also adds an additional specific theoretical contribution in Malawi through the first known analysis applying this theory to women and the health system in the context of male involvement. With respect to methodology, it makes a broad contribution through highlighting the need for improved measures for men's contraceptive use, including within DHS, and more

nuanced measures for shared decision-making and equitable male norms (including limitations of the GEM scale), and ways to engage communities in research outcomes. It makes a specific methodological contribution through building on current mixed methods studies in Malawi on single topics related to male involvement - conjugal condom use (Chimbiri, 2007) and couple counselling (Shattuck et al., 2011) - to provide a comprehensive mixed methods exploration of how the social construction of being a man informs men's attitudes, norms and behaviours towards family planning and contraception. It also specifically contributes through its use of multiple forms of qualitative methods in Malawi, similar to Bornstein et al. (2020a). Additionally, it provides the first known analysis of the voices of women in communities on male involvement in contraception in Southern Malawi, and highlights the importance of Chichewa semantics, particularly men's understanding of the term 'family planning'.

With respect to gender norms, the study makes a broader contribution through adding to the comparatively limited global research within the field of masculinities, gender equality and SRH that specifically focuses on contraception (Ruane-McAteer et al., 2019). It also adds new quantitative data from men on the impact of their decision-making authority on contraceptive use, complementing existing female-only data in Southern Africa (Cau, 2015; Letamo and Navaneetham, 2015; Mboane and Bhatta, 2015; Prata et al., 2017) and Malawi (Palamuleni, 2013). The study makes a specific contribution by using the full GEM scale in Malawi to measure men's support for gender equitable norms and through finding stronger GEM associations with method use than Shattuck et al. (2011). It further contributes specifically through new findings on Malawian men feeling emasculated by contraceptive communication flows and decision-making dynamics, due to women being the knowledge brokers and principal accessors of methods. It adds further specific contributions through providing greater exploration of sexual pleasure and male and female methods within Malawi (beyond John et al. 2015). The thesis also complements existing empirical research exploring the construction of manhood in Southern Malawi (Kaler, 2004b; Gipson et al., 2010; Ntata et al., 2013; Chikovore et

al., 2014, 2015; Anderson, 2015) contributing findings on the interplay between male involvement in contraception and norms of male stoicism, provider masculinities, fertility and infertility, multiple concurrent partners and ownership of women's sexuality.

On male methods, the thesis makes a broader contribution by highlighting the need for deeper interrogation of assumptions around men's contraceptive knowledge in Southern Africa. It also complements broader calls for condoms to be conceptualized beyond HIV/STIs (Hardee et al., 2017). It makes a specific contribution by showing how contraception is both constructed and operationalised as feminine in Malawi. It adds to extant knowledge in Southern Malawi on how married and unmarried men use and perceive male condoms, that unmarried men transition away from using condoms once married, and that men report inconsistency of condom use. The thesis also illuminates the significant normative and cultural challenges around increasing vasectomy uptake in Southern Malawi. For both male and female methods, my findings deepen understanding on the gender normative barriers to their use by men.

This study makes a specific contribution in Malawi by exploring the perspectives of health providers and stakeholders towards male involvement and male gender norms related to contraception. It also adds knowledge on how men in Southern Malawi perceive the contraceptive health system, including in the context of HIV, particularly the attitudes of providers and structural barriers, and how this impacts on their involvement.

10.6 Implications for research, methods, policy and programming

I offer the following implications for family planning and contraceptive research, policy and programming based on my results:

Research

- **Contraceptive linguistics:** Using IDIs, and testing variations of quantitative questions, undertake additional analysis of different ways of

asking men about family planning and contraception, and their responses to these. This would deepen knowledge around the distinctions men make between family planning and contraception, their related understanding and beliefs around these terms, and aid knowledge around how the framing and language may impact use. Given that the term family planning is often conflated globally as meaning only methods, this could potentially have broader benefits.

- **Male condoms:** Undertake ethnographic research with men and women on male condom use, coupled with IDIs of women, health providers, practitioners and policy-makers, to explore opportunities for advancing condoms as a viable contraceptive method and the necessary changes needed within health service orientation and policies. This would also explore how perceptions of condom use change when relationships become more stable.
- **Sexual pleasure:** Using IDIs, undertake further analysis with men and women, health providers and practitioners exploring how perceptions of sexual satisfaction impact on different contraceptive methods, particularly the injection. This could assess how these perceptions around each method play out in different relationships (married, unmarried/in relationship, and in casual sexual relationships), within the health system, the connections to male performance (and sexual dysfunction) and ways that advancing sexual pleasure can be positioned without condoning sexual coercion.
- **HIV and contraception:** Using IDIs with health providers and programme managers, explore the motivations of the health system for HIV and contraceptive linkages, and examine the impact of the push for couple HIV testing within ANC/PNC on male involvement, and on women's contraceptive use, and whether such linkages have unintended impacts on power dynamics and women's reproductive autonomy.
- **Men's broader health seeking:** Using mixed methods, explore whether men's broader health-seeking when ill, including in relation to tuberculosis and non-communicable diseases, impacts on men's approach to male

involvement, and whether other health issues provide entry points for increasing men's support for contraceptive use and gender equality.

- **Women's views on joint decision making:** Undertake mixed methods research to explore whether women in Southern Malawi wish to have their partners involved in joint decision making and burden sharing around contraception, and what is and is not desirable for women, and the impact of increased programming on male involvement on women's agency.
- **Policy-maker and programme blockages:** Undertake research with NGO programme managers, policy-makers and donors on the blockages to advancing men's greater involvement in contraception, and on their views towards embedded power analysis within these approaches.

Measurement

- **Measures on men's contraceptive knowledge:** Qualitatively field test, and then explore, a range of quantitative measures to identify more nuanced ways to measure men's knowledge and understanding of different contraceptive methods.
- **Measures on equitable male norms and contraception:** Qualitatively field test and then explore additional quantitative measures for equitable male gender norms and how they correlate with contraceptive behaviours, recognising that men may increasingly know the 'right things to say.'
- **Measures on men's contraceptive method use:** Support better measures on male contraceptive use through the development of standards and highlighting current pitfalls in measurement approaches with men.

Policy

- **Shift focus on gender equality to highlight benefits to men:** Adopt a relational narrative with national policies that recognises how men and women both gain from gender equality, how women's empowerment requires also working with men, the need to promote more equitable

forms of masculinity, and that gender equality is not a zero-sum game in which men lose out by women's advancement.

- **Gaps in contraceptive policies on gender norms and patriarchy:** Include a sufficient focus on male gender norms, and on men's power, within national family planning strategies in Malawi. This should include: a recognition of the impact of male gender norms; reorientation of contraception as a concern also for men, including men's role as users; recognition of how gender norms are reinforced by women and the health system; and acknowledgement of the opportunities and dangers of couple approaches and greater male involvement. Encourage a greater focus on these areas within international policies and donor priorities.
- **Education:** Strengthen the provision of comprehensive sexuality education in schools aimed specifically at boys, including educating men on women's reproductive health and sexual autonomy, as well as on gender equality between men and women.
- **Structural and service barriers:** Address the structural barriers to men engaging in the health system, including greater provision of vasectomy services, exploring ways for the public health system to be more male friendly, and addressing men's specific concerns (such as in relation to infertility and sexual dysfunction) as an opportunity to engage them more broadly in SRH and supportive approaches to women's health.

Programming

- **Target men as well as women with information and services:** Efforts by NGOs and the health system to increase contraceptive use should also reach out to men with information and services, including on male methods, highlighting that pregnancy prevention is a matter for men and women, and reflecting men's desire for a more targeted approach. Explore male-only spaces, while recognising their potential to reinforce masculinities. Reach men outside the health system, including through workplaces, churches and home visits, while simultaneously challenging gender norms in doing so.

- **Gender transformative approach with men:** As part of all work with men in relationships around male involvement within Malawi, recognise power differentials, and question stereotypes around male gender norms and patriarchal power. These approaches should recognise men's existing involvement in communication and decision making, and seek to improve the frequency and quality of these processes, upholding women's autonomy.
- **Promote the male condom as a contraceptive method:** Shift from the historical focus of the condom being solely for HIV prevention, to promote its use through campaigns, health services, and outreach as a viable method. Improve the quality of free condoms, and work with and train health providers to reduce stigma around access. Engage with men and young couples to reposition condoms as a suitable method once married, and with married couples in a sensitive manner to promote acceptability of the condom. Encourage men and couples to consistently use condoms.
- **Address sexual pleasure concerns relating to contraception.** Include a focus on sexual pleasure within the promotion of male and female methods, showing a willingness to level with men and women's concerns, and ultimately create an atmosphere where use of methods, including the male condoms, is not undermined by sexual pleasure concerns. Support couples to have honest conversations about their sexual desires and expectations, while equally providing women with a range of options for contraception, and addressing gender power dynamics.
- **Critically review couple approaches:** Take a critical look at the provision of contraceptive counselling and information to couples, exploring the quality of counselling, opportunities for addressing power dynamics and retaining the ability for women to access methods confidentially, whilst adopting a do-no-harm approach to ensure efforts do not further undermine women's autonomy.
- **Recognise men's role as economic provider and concern for family size as an entry point:** Tap into men's role as breadwinner and provider, highlighting the economic benefits of contraceptive use as an entry point

to engage men in contraceptive use and shift norms on fertility, while acknowledging the existing inequitable power dynamics and promoting gender equality.

- **Vasectomy:** Address men's and women's misunderstandings and concerns around vasectomy, while simultaneously increasing the availability of this method within clinics and health services.

10.7 Final conclusion

It is over 25 years since the ICPD Programme of Action agreed its bold agenda to strengthen male involvement. The global ICPD25 Summit held in 2019 to reflect on progress in implementing this Programme made no mention of male involvement or men in its statement (UNFPA, 2020), despite the UN Secretary General's earlier review of ICPD progress calling on governments to promote the participation of men and boys (UN, 2014). Men's share of the contraceptive burden remains similar now to what it was in 1994 (Ross and Hardee, 2017). The Sustainable Development Goals, while centrally focusing on women's empowerment, do not include any targets around addressing restrictive male gender norms, or challenging patriarchy and male hegemony in relation to contraception and family planning (UNGA, 2015). In Malawi, significant challenges remain for increasing contraceptive uptake (NSO and ICF, 2017) and addressing gender inequalities (UNDP, 2020). The voices from Southern Malawi in this thesis highlight that expanding the lens on contraception to include a focus on men's gender, within a context that vigorously upholds women's rights and bodily autonomy, will arguably bring benefits for everyone.

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Appendices

A. Search terms used for literature review databases searches

Databases	Malawi search terms	Other Southern African countries
Pubmed	(Masculinity OR men OR gender norms OR male involvement) AND (family planning OR contraception) AND (Malawi)	<p>(Masculinity OR men OR gender norms OR male involvement) AND (family planning OR contraception) AND (Angola)</p> <p>(Masculinity OR men OR gender norms OR male involvement) AND (family planning OR contraception) AND (Botswana)</p> <p>(Masculinity OR men OR gender norms OR male involvement) AND (family planning OR contraception) AND (Eswatini)</p> <p>(Masculinity OR men OR gender norms OR male involvement) AND (family planning OR contraception) AND (Swaziland)</p> <p>(Masculinity OR men OR gender norms OR male involvement) AND (family planning OR contraception) AND (Lesotho)</p> <p>(Masculinity OR men OR gender norms OR male involvement) AND (family planning OR contraception) AND (Mozambique)</p> <p>(Masculinity OR men OR gender norms OR male involvement) AND (family planning OR contraception) AND (Namibia)</p> <p>(Masculinity OR men OR gender norms OR male involvement) AND (family planning OR contraception) AND (South Africa)</p> <p>(Masculinity OR men OR gender norms OR male involvement) AND (family planning OR contraception) AND (Zambia)</p> <p>(Masculinity OR men OR gender norms OR male involvement) AND (family planning OR contraception) AND</p>

		(Zimbabwe)
Scopus	As above	As above
Web of Science	As above	As above
Science Direct	<p>((Masculinity OR men OR "gender norms" OR "male involvement") AND ("family planning" OR contraception) AND (Malawi))</p> <p>Using Malawi as key word</p>	<p>((Masculinity OR men OR "gender norms" OR "male involvement") AND ("family planning" OR contraception) AND (Angola))</p> <p>((Masculinity OR men OR "gender norms" OR "male involvement") AND ("family planning" OR contraception) AND (Botswana))</p> <p>((Masculinity OR men OR "gender norms" OR "male involvement") AND ("family planning" OR contraception) AND (Eswatini))</p> <p>((Masculinity OR men OR "gender norms" OR "male involvement") AND ("family planning" OR contraception) AND (Swaziland))</p> <p>((Masculinity OR men OR "gender norms" OR "male involvement") AND ("family planning" OR contraception) AND (Lesotho))</p> <p>((Masculinity OR men OR "gender norms" OR "male involvement") AND ("family planning" OR contraception) AND (Mozambique))</p> <p>((Masculinity OR men OR "gender norms" OR "male involvement") AND ("family planning" OR contraception) AND (Namibia))</p> <p>((Masculinity OR men OR "gender norms" OR "male involvement") AND ("family planning" OR contraception) AND (South Africa))</p> <p>((Masculinity OR men OR "gender norms" OR "male involvement") AND ("family planning" OR contraception) AND (Zambia))</p> <p>((Masculinity OR men OR "gender norms" OR "male involvement") AND ("family planning" OR contraception) AND (Zimbabwe))</p>

		<p>((Masculinity OR men OR "gender norms" OR "male involvement") AND ("family planning" OR contraception) AND (Malawi))</p> <p>Using each country as key word</p>
JSTOR	Masculinity OR men OR gender norms OR "male involvement" AND family planning OR contraception AND Malawi	<p>Masculinity OR men OR gender norms OR "male involvement" AND family planning OR contraception AND Angola</p> <p>Masculinity OR men OR gender norms OR "male involvement" AND family planning OR contraception AND Bostwana</p> <p>Masculinity OR men OR gender norms OR "male involvement" AND family planning OR contraception AND Eswatini</p> <p>Masculinity OR men OR gender norms OR "male involvement" AND family planning OR contraception AND Swaziland</p> <p>Masculinity OR men OR gender norms OR "male involvement" AND family planning OR contraception AND Lesotho</p> <p>Masculinity OR men OR gender norms OR "male involvement" AND family planning OR contraception AND Mozambique</p> <p>Masculinity OR men OR gender norms OR "male involvement" AND family planning OR contraception AND Namibia</p> <p>Masculinity OR men OR gender norms OR "male involvement" AND family planning OR contraception AND South Africa</p> <p>Masculinity OR men OR gender norms OR "male involvement" AND family planning OR contraception AND Zambia</p> <p>Masculinity OR men OR gender norms OR "male involvement" AND family planning OR contraception AND Zimbabwe</p>

B. List of Malawian stakeholders engaged for feedback on my research plans

- Local PhD students at Malawi-Liverpool-Wellcome Trust (MLW), Blantyre
- Centre for Social Research, Chancellor College, University of Malawi, Zomba
- Department for International Development (DFID) Malawi, Lilongwe
- University of California, Los Angeles (UCLA) Malawi, Lilongwe
- Malawi-Scotland partnership, Lilongwe
- Medical Research Council (MRC) South Africa (via skype)
- Médecins Sans Frontières (MSF), Chiradzulu
- District Health Offices, Blantyre and Chiradzulu
- Department of Health, Lilongwe
- Pakachere Institute for Health and Development, Blantyre
- College of Medicine, Blantyre
- UNFPA Malawi, Lilongwe
- UNDP Malawi, Lilongwe
- FHI360 (via skype)
- Active Youth Initiative for Social Enhancement (AYISE), Lilongwe

C. Quantitative research IMAGES survey instrument

INTERNATIONAL MEN AND GENDER EQUALITY SURVEY MEN QUESTIONNAIRE

PACHI MALAWI

The purpose of this questionnaire is to ask men and women about their relationships, their families, their working life, their health, and their relationships with their children, if they have children. All the information in this questionnaire will remain confidential. No information such as your name or address or any detail that would identify you will be used in any way. If at any time you want to stop the interview, please let me know. If there is any question you do not want to answer, feel free to tell me. The interview will last about xx minutes. Do you agree to participate in the questionnaire?

SECTION ONE: Sociodemographic characteristics and employment

First, we want to ask you some questions about your age, your current employment status and conditions at work, and who you live with.

QUESTIONS AND FILTERS	CODING CATEGORIES
1.1. How old are you?	— — years ____ estimated years
1.2. What is the highest standard or grade you have completed at school?	No schooling 0 Primary up to STD7 1 Primary school complete 2 Incomplete secondary school.....3 Complete secondary school..... 4 Incomplete B degree/Diploma/Certificate5 Complete B degree/Diploma/certificate..... ..6 <i>Higher Degree more than 4 years..... ..7</i>
1.3. Which ethnic tribe do you consider yourself?	Chewa1 Tumbuka2 yao 3 Ngoni.....4 Lambya.....5 Lomwe.....6 Tonga.....7 Sena.....8 Ngonde.....9 Other(specify).....97
1.4. Do you belong to any religion?	Yes 1 No.....2 (skip to 1.6)

1.5. What is your religion?	Catholic.....1 Protestant..... 2 Pentecostal..... 3 Traditional Religions 4 Seventh day Adventist.....5 Islam.....6 Other (specific).....97 No answer.....99
1.6. How many persons do live with you?	— — (Total number) Only me.....99 (skip to 1.8)
1.7. Who lives with you? Multiple responses	Partner/spouse 1 With my children.....2 With my wife and children.....3 Children of your partners with another man.....4 My parents.....5 Parents of my partner6 Other relatives.....7 Other friend8
1.8. Who provides the main source of income in your home?	Self.....1 Partner (Wife).....2 Parents.....3 Parents of my partner (Wife).....4 Relatives.....5 Pension.....6 Government support (welfare).....7 Other (specific).....97
1.9. After taxes, how much do you earn per month? [Categories to be defined by country]	Less thanMK10,000.00.....1 MK10,000.00-15,000.00.....2 Mk16,000.00-25,000.00.....3 MK26,000.00-50,000.00.....4 MK51,000.00-125,000.00.....5 MK126,000.00-200,000.00.....6 MK201,000.00-250,000.00..... 7 MK251,000.00-500,000.00.....8 More than MK500,000.00.....9
1.10. Do you or your family receive any form of financial support from the government on a monthly basFstis?	Yes1 No.....2 (skip to 1.12)
1.11. How much (per month)?	Less thanMK10,000.00.....1 MK10,000.00-15,000.00.....2 Mk16,000.00-25,000.00.....3 MK26,000.00-50,000.00.....4 MK51,000.00-125,000.00.....5 MK126,000.00-200,000.00.....6 MK201,000.00-250,000.00.....7 MK251,000.00-500,000.00.....8 More than MK500,000.00.....9 I don't know.....98

1.12. What is your employment status?	Never worked.....1 (skip to 1.21) Unemployed.....2 (skip to 1.21) Formally employed..... 3 Informally employed..... 4 Retired.....5 (skip to 2.1)
1.13. How many hours per day do you normally work, including overtime and paid work outside the home?	— — hours per day
1.14. If you normally work more hours than is a normal working week outside the home (approx. 40 hours), what is the main reason?	I do it in order to maintain my and/or my family's standard of living1 It is necessary for my career2 My workplace demands that I do3 Work plays a major role in my life4 Other (specific).....97
1.15. Is your current boss male or female?	Male.....1 Female.....2 NA/Self-employed/don't have a boss3
1.16. Have you ever had a female boss?	Yes1 No.....2
1.17. Would you mind if you had a female boss?	Yes1 No.....2

Now, I'd like to read a series of statements about your work situation. Please tell me if these phrases apply to you:	Yes	Partly	No	Don't Know
1.18. My work or employment situation is mostly stable	1	2	0	98
1.19. I am frequently stressed or depressed because of not having enough work.	1	2	0	98
1.20. I am frequently stressed or depressed because of not having enough income.	1	2	0	98

FILTER: ONLY UNEMPLOYED. IF NOT, SKIP TO 2.1				
Now, I'd like to read a series of statements about unemployment. Please tell me if these phrases apply to you:	Yes	Partly	No	Don't Know
1.21. I sometimes feel ashamed to face my family because I am out of work.	1	2	0	98
1.22. I spend most of my time out of work or looking for work	1	2	0	98
1.23. I have considered leaving my family because I was out of work.	1	2	0	98
1.24. I sometimes drink or stay away from home when I can't find work	1	2	0	98

SECTION TWO: Childhood Experiences

These next questions are about your childhood and your family when you were growing up. These questions will ask you about your life when you were growing up and the relationship you had with your parents or the people who cared for you then.

2.1 Who took care of you when you were growing up?	Mostly my mother or stepmother or female relative.....1 Mostly my father or stepfather or male relative.....2 Only mother.....3 Only father.....4 Nearly equal (received similar amount of care from mother and father).....5 Other (specific).....97
2.2. What level of schooling did your mother complete?	No schooling0 Primary school up to STD 7.....1 Primary school complete (STD 8)2 Secondary school incomplete.....3 Secondary school completed.....4 Didn't finish B.degree/Diploma/Certificate 5 Finished Bdegree/Diploma/Certificate.....6 Tertiary education more than 4 years 7 Don't know98
2.3. What level of schooling did your father complete? (By father, we mean the man you called your father when you were growing up, if you had one.)	No schooling0 Primary school up to STD 7.....1 Primary school complete (STD 8)2 Secondary school incomplete.....3 Secondary school completed.....4 Didn't finish B.degree/Diploma/Certificate 5 Finished Bdegree/Diploma/Certificate.....6 Tertiary education more than 4 years 7 Don't know98
2.4. Between the ages of 0-18 how many years did you live with your biological father?	How many years? — — years.....(skip to 2.6) I did not know him 97 He died before I was born..98
2.5. If you did not live with your biological father, were there other important male figures in your life when you were growing up?	None1(skip to 2.13) My step father 2 My uncle3 My grandfather4 My brother5 Family friend6 Teacher, coach or religious leader 7 Other (specific).....97

I will now read some statements to you and I would like you to indicate what you think of them:					
	Frequently	Sometimes	Hardly ever	Never	No answer
2.6. My father or another man who lived with my mother treated my mother with respect.	1	2	3	4	99
2.7. My mother treated my father or another man who lived with her with respect	1	2	3	4	99

When you were a child or teenager, did your father or another man in the home:					
	Frequently	Sometimes	Hardly ever	Never	No answer
2.8. Prepare food	1	2	3	4	99

2.9. Clean the house	1	2	3	4	99
2.10. Wash clothes	1	2	3	4	99
2.11. Clean the bathroom/toilet	1	2	3	4	99
2.12. Take care of you or your siblings	1	2	3	4	99

2.13. Who had the final word in your household about decisions involving you and your brothers and sisters (their schooling, their activities)?	Mother.....	1
	Father.....	2
	Both equally.....	3
	Others (specific)_____	
	97	
Not Apply.....		99

Who had the final word about decisions involving how your family spends money on:

2.14. Food and clothing	Mother.....	1
	Father.....	2
	Both equally.....	3
	Others (specific)_____	4
	Not Apply.....	5
2.15. Large investments such as buying land , bicycle, a radio, a car, or a house, or a household appliance	Mother.....	1
	Father.....	2
	Both equally.....	3
	Others (specific)_____	
	97	
Not Apply.....		99

Now we have some questions about YOUR CHILDHOOD AND TEENAGE YEARS, specifically FROM THE TIME YOU WERE BORN UNTIL YOU WERE 18 YEARS OLD.

When you were a child or teenager, were you taught how to or being responsible for:	Yes 1	No 0	NA 99
2.16. Prepare food	1	0	99
2.17. Clean the house	1	0	99
2.18. Clean the bathroom/toilet	1	0	99
2.19. Wash clothes	1	0	99
2.20. Care for younger siblings	1	0	99

Now some statements will be read to you, and we would like to know how often each of the things described in the statements happened to you. It may be that they Never happened, or that they Happened Sometimes, Happened Often or Happened Very Often. Please remember that everything your say is strictly confidential and will help us a lot in understanding the lives of men.

Before I reached 18.....	Never	Sometimes	Often	Very Often	Does not apply
2.21. I saw or heard my mother being beaten by her husband or boyfriend	1	2	3	4	99
2.22. Someone touched my buttocks or private parts or made me touch their private parts when I did not want to	1	2	3	4	99
2.23. I was insulted or humiliated by someone in my family in front of other people	1	2	3	4	99
2.24. I was spanked or slapped by my parents or adults in the home.	1	2	3	4	99

2.25. One or both of my parents were too drunk or high on drugs to take care of me	1	2	3	4	99
2.26. I had sex with someone because I was threatened or frightened or forced	1	2	3	4	99
2.27. I was beaten or physically punished at school by a teacher	1	2	3	4	99
2.28. I was threatened with physical punishment in my home.	1	2	3	4	99

Your Experiences at School: Now we are going to ask a series of questions about your experiences with school.	
2.29. Was your primary school a boys school?	Yes..... 1 No..... 2 I've never studied..... 3 No answer99

We know some of those were difficult questions to answer. Thank you for doing so, your answers are really important. The next sets of questions are about you and your friends and school and neighbourhood when you were growing up and before you turned 18.			
	Yes	Partly	No
2.30. Was there bullying or teasing and harassment in school or neighbourhood in which you grew up?	1	2	3
2.31. Were you yourself teased and harassed?	1	2	3
2.32. Did you tease and harass others?	1	2	3

These next questions ask you about your experiences at school . Please indicate by responding to the corresponding number if this Never happened to you, or it happened Sometimes, or Often or Very Often.				
	Never	Sometimes	Often	Very Often
2.33. Girls were mostly treated with respect at my school	1	2	3	4
2.34. At school I was punished because I bullied other kids using physical violence.	1	2	3	4
2.35. My friends and I would touch girls or say sexual things to them to tease them	1	2	3	4
2.36. Me and my school friends were a group and we would arrange to have sex with girls after school.	1	2	3	4
2.37. Me and my school friends were a group and we would fight with rival groups at school.	1	2	3	4
2.38. Me and my school friends were a group and we would rotate a girl amongst ourselves all having sex with her.	1	2	3	4
2.39. I and my school friends were a group and we all belonged to sport clubs, or sing in a choir.	1	2	3	4
2.40. My friends and I used drugs and alcohol at school	1	2	3	4
2.41. My school friends helped me overcome problems in my life or were supportive	1	2	3	4
SECTION THREE: Attitudes about relations between men and women				

You are doing very well, thank you for your enthusiasm on this questionnaire. We are progressing well. This section will ask you about your views regarding various issues in society . We are interested in your views regarding these statements. Please feel free any way you like -- there are no right or wrong answers.						
	Statements	Strongly Agree	Agree	Disagree	Strongly Disagree	NA

3.1.	When women work they are taking jobs away from men	1	2	3	4	99
3.2.	When women get rights they are taking rights away from men	1	2	3	4	99
3.3.	Rights for women mean that men lose out	1	2	3	4	99
3.4.	When a woman is raped, she usually did something careless to put herself in that situation	1	2	3	4	99
3.5.	In some rape cases women actually want it to happen	1	2	3	4	99
3.6.	If a woman doesn't physically fight back, you can't really say it was rape	1	2	3	4	99
3.7.	In any rape case it is necessary to consider whether the victim is promiscuous or has a bad reputation	1	2	3	4	99

Gender Equitable Men Scale				
The next set of questions will ask you about your views on relations between men and women . Please indicate if you totally agree, partially agree or disagree with the following statements.				
	Attitudes	Totally Agree	Partially agree	Disagree
3.8.	A woman's most important role is to take care of her home and cook for her family. 5	1	2	3
3.9.	Men need sex more than women do.	1	2	3
3.10.	Men are not open to talk about sex with their partners, they just do it.	1	2	3
3.11.	There are times when a woman deserves to be beaten.	1	2	3
3.12.	Changing diapers, giving kids a bath, and feeding the kids are the mother's responsibility.	1	2	3
3.13.	It is a woman's responsibility to avoid getting pregnant.	1	2	3
3.14.	A man should have the final word about decisions in his home.	1	2	3
3.15.	Men are always ready to have sex.	1	2	3
3.16.	A woman should tolerate violence in order to keep her family together.	1	2	3
3.17.	I would be outraged if my wife asked me to use a condom.	1	2	3
3.18.	A man and a woman should decide together what type of contraceptive to use.	1	2	3
3.19.	I would never have a gay friend.	1	2	3
3.20.	If someone insults me, I will defend my reputation, with force if I have to.	1	2	3
3.21.	To be a man, you need to be tough	1	2	3
3.22.	Men should be embarrassed if they are unable to get an erection during sex.	1	2	3

	To what extent do you agree or disagree with the following statements?	Completely agree	Partly agree	Partly disagree	Completely disagree	Don't know
3.23.	Gender equality, meaning that men and women are equal, has come far enough already	1	2	3	4	98
3.24.	Gender equality has already been achieved for the most part	1	2	3	4	98
3.25.	Work to achieve gender equality today benefits mostly well-to-do people	1	2	3	4	98

In order to correct gender inequalities in education and the workplace, it has been suggested in some countries that a fixed proportion or quota of university places and jobs as well as representation in government should be reserved for women in areas where women are in the minority.	
3.26. Are you for or against such a quota system which guarantees a fixed proportion of places for women in government?	For.....1 Against.....2 Don't know.....98
3.27. Are you for or against such a quota system which guarantees a fixed proportion of places for women to study in universities?	For.....1 Against.....2 Don't know.....98
3.28. Are you for or against such a quota system which guarantees a fixed proportion of places for women in executive positions?	For.....1 Against.....2 Don't know.....98
3.29. Are you for or against such laws that promote equal salaries for men and women in the same position?	For.....1 Against.....2 Don't know.....98

SECTION FOUR: Sexual Diversity

Now I am going to read a series of statements and I would like to know your opinion				
	Attitudes	Totally Agree	Partially Agree	Disagree
4.1.	Being around homosexual men makes me uncomfortable	1	2	3
4.2.	Homosexuality is natural and normal.	1	2	3
4.3.	Homosexual men should not be allowed to work with children.	1	2	3
4.4.	Homosexual men should not be allowed to adopt children.	1	2	3
4.5.	Homosexual couples should be allowed to legally marry just like heterosexual couples.	1	2	3
4.6.	I would be ashamed if I had a homosexual son.	1	2	3

I would like to know your opinions related to some recent incidents on this issue				
	Attitudes	Agree	Disagree	Don't know
4.7.	Verbal and physical abuse towards homosexual men is justified	1	2	98
4.8.	Verbal and physical abuse towards lesbians is justified	1	2	98
4.10.	Homosexual men or lesbians in Malawi should not have the same rights as everyone else	1	2	98
4.11.	Homosexual men or lesbians in Malawi should not have access to HIV and other health services	1	2	98

I would like to know your opinion about in which of the situations below it would be justified to use violence against a homosexual man, <u>WHO IS NOT A PERSONAL FRIEND.</u>					
Cód.	Situations	Justified	Not Justified	Don't know	No answer
4.12.	When he keeps hitting on me	1	2	98	99
4.13.	When he keeps staring at me	1	2	98	99
4.14.	When he is romantically kissing another man in public	1	2	98	99
4.15.	When he acts in an effeminate way	1	2	98	99

SECTION FIVE: Relations at home questions
This section will ask you about your life now and relationship you have with various people in your home and in your community.

Family Decisions Questions	
The next set of questions asks you about your current family.	
5.1. Do you have a stable partner? <u>By partner we mean boyfriend, girlfriend, or spouse.</u>	Yes..... 1 No... 2 (skip to 5.39) No answer 99
5.2. How old is she/he?	— — year (s)
5.3. Does your partner live with you?	Yes..... 1 No..... 2 (skip to 5.22) No answer 99
5.4. How long have you lived with this partner?	— — year (s) — — month (s) Other (specify) _____ 97
5.5. Do you and your partner have the same level of education or do you have more schooling or does she (or he) have more schooling?	Same.....1 I am more educated.....2 She is more educated.....3
5.6. What is the employment status of your partner?	Never worked.....1 Unemployed looking for work.....2 Unemployed not looking for work.....3 Formally employed.....4 Informally employed.....5 Retired.....6 Student.....7 Studying and working.....8 On maternity or other leave9 No answer.....99
5.7. Do you and she (or he) both earn the same amount of money or does she (or he) have more money or you have more money?	Same.....1 I earn more2 She/He earns more.....3 No answer99

Who in your family or relationship usually has the final say in how you spend money on?						
	Yourself	Wife or Partner	Yourself / wife/ partner jointly	Someone else	You and someone else jointly	NA
5.8. Food and clothing	1	2	3	4	5	99
5.9. Large investments such as buying land, a bicycle, a radio, a car, or a house, or a household appliance	1	2	3	4	5	99
5.10. Regarding spending time with family friends or relatives	1	2	3	4	5	99

5.11. Do you and your partner receive any outside help for tasks at home, including cleaning the house, preparing food and taking care of children?	Help from our child/children..... 1 Paid help (maid, nanny, etc.)..... 2 Help from others (family, relatives)..... 3 No help.....4 No answer 99
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If you disregard the help you receive from others, how do you and your partner divide the following tasks:						
	I do everything	Usually me	Shared equally or done	Usually partner	Partner does everything	Does not apply

			together			
5.12. Washing clothes	1	2	3	4	5	99
5.13. Repairing house	1	2	3	4	5	99
5.14. Buying food	1	2	3	4	5	99
5.15. Cleaning the house	1	2	3	4	5	99
5.16. Cleaning the bathroom/toilet	1	2	3	4	5	99
5.17. Preparing food	1	2	3	4	5	99
5.18. Paying bills	1	2	3	4	5	99

5.19. What do you think of this division of tasks?	She does a lot more.....1 She does little.....2 We share equally3 I do little.....4 I do a lot.....5
5.20. Are you satisfied with this division?	Very satisfied.....1 Fairly satisfied.....2 Unsatisfied.....3 No answer 99

5.21. Do you think your partner is satisfied?	Very satisfied.....1 Fairly satisfied.....2 Unsatisfied.....3 No answer 99
5.22. Have you personally or both of you sought help, e.g., family counseling, religious, family member, in order to solve problems related to your relationship? If so, who took the initiative to get help?	I did.....1 My partner did.....2 Both of us did.....3 Have not used such help.....4
5.23. How would you characterize your relationship with your partner on the whole? Would you say it is/was ...	Very good.....1 Fairly good.....2 Not good.....3 Fairly bad.....4 Bad.....5

What things do you do together with your partner that you most enjoy? Please rank these activities from 1 to 5 with 5 being greatly enjoy and 1 being not enjoy.						
	Do not enjoy	Fairly not enjoy	Enjoy	Fairly enjoy	greatly enjoy	NA
5.24. Caring for or spending time with children	1	2	3	4	5	99
5.25. Traveling	1	2	3	4	5	99
5.26. Going to cultural events (theatre, movies, music, dancing)	1	2	3	4	5	99
5.27. Participating in sports/recreation	1	2	3	4	5	99
5.28. Talking	1	2	3	4	5	99
5.29. Having meals together	1	2	3	4	5	99
5.30. Working together	1	2	3	4	5	99

5.31. Having sexual relations	1	2	3	4	5	99
5.32. Watching TV together	1	2	3	4	5	99
5.33. Cooking together	1	2	3	4	5	99

5.34. What is your current marital or civil status?	Female partner or girlfriend (but we don't live together)1 Male partner (but we don't live together).....2 Legally married or in civil union with a woman with whom I live.....3 Cohabitate with a female partner (but not legally married) 4 Civil union with a male partner with whom I live.....5 Cohabitate with a male partner but not in a legal union 6 More than one male partner (polygamous relationship)..7 I have no regular or stable partner8 Other (specific).....97
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Now I'm going to ask you about your relationship with your main or stable partner. I am going to read some statements and would like to answer if these apply to you and when they happened.	
5.35. When was the last time you talked to your partner about problems you are facing in your life?	Within this week.....1 One to two weeks.....2 2-4 weeks ago.....3 More than 4 weeks ago but less than 6 months.....4 Longer ago or never.....5 No answer.....99
5.36. When was the last time that your partner came to explain her (or his) problems to you?	Within this week.....1 One to two weeks.....2 2-4 weeks ago.....3 More than 4 weeks ago but less than 6 months.....4 Longer ago or never.....5 No answer.....99

Sexual behaviors

The next questions are about your sexual relationships. Please remember that everything you say will be kept secret and your name will not appear anywhere on the questionnaire.

Thank you very much for being so open in answering those questions. We know it can be hard thinking about these things and answering questions like this, but it is very important for us to learn more about men and that is why we are asking them. We are now close to the end of the questionnaire.

5.37. Would you describe your sexual relationship with your main partner as	Very satisfying.....1 Satisfying.....2 More or less satisfying.....3 Somewhat unsatisfying.....4 Very unsatisfying.....5
---	--

5.38. Would you describe the frequency of sexual relations with your main partner as	Very satisfying.....1 Satisfying.....2 More or less satisfying.....3 Somewhat unsatisfying.....4 Very unsatisfying.....5
5.39. How often have you used condoms when having sex in the past year?	I don't use them.....1 Always use a condom.....2 Mostly use a condom.....3 Occasionally use a condom.....4
5.41. Including stable partners and occasional partners, how many partners have you had sex with in the last year?	— — — NUMBER
5.42. Of these, how many were partners with whom you had sex just on one occasion?	— — — NUMBER
5.43. Excluding your present relationship, how many women have you married/cohabited with?	— — NUMBER
5.44. Excluding your present relationship, how many men have you married/cohabited with?	— — NUMBER
5.45. The last time you had sex, who was it with?	Wife / Husband / main partner.....1 Other partner.....2 Someone I went with once.....3 Friend.....4 Ex-partner.....5 Sex worker or someone I paid to have sex with me.....6 I never had sex.....7 Other (specific).....

97

SECTION SIX: Policies

This section will ask you about your knowledge about some policies.

6.1. Is there a law in your country that guarantees fathers time off when their child is born, also known as paternity leave?	Yes 1 No 2 (skip to 6.3) Don't know98(skip to 6.3)
6.2. If yes, how long is the leave?	Less than a week 1 One-two weeks2 3-4 weeks3 1-2 months4 3-4 months5 4-5 months 6 More than 5 months7 Interviewer: after response, skip to 6.4
6.3. Do you think paternity leave should be guaranteed by law?	Yes1 No2 Don't know.....98
6.4. Is there a law in your country that guarantees mothers time off when their child is born, also known as maternity leave?	Yes 1 No 2 (skip to 6.6) Don't know98 (skip to 6.6)
6.5. If yes, how long is the leave? Interviewer: after response, skip to 6.7	Less than a week 1 One-two weeks2 3-4 weeks3 1-2 months4 3-4 months5 4-5 months 6 More than 5 months7

6.6. Do you think maternity leave should be guaranteed by law?	Yes1 No2 Don't know98
6.7. Do you feel that divorce or separation laws in your country favor the man or the woman?	Man1 Woman2 Neither, both are treated equally3 Don't know98
6.8. Do you feel that men and women have equal chances to get custody of the child (ren) in a divorce proceeding?	Man1 Woman2 Neither, both are treated equally3 Don't know98
6.9. Is shared custody common in your community?	Yes1 No2 Don't know98
6.10. Do you feel child support laws (meaning laws that oblige fathers to provide income for their biological children even if they are not living with those children) in your country are?	Fair to both men and women1 Unfair to men2 Unfair to women3 Don't know98
6.11. Are there laws in your country regarding the establishment of paternity? (Establishment of paternity means when a man registers the child or legal registers the child as being his.)	Yes1 No2 (skip to 6.14) Don't know98 (skip to 6.14)
6.12. What does the law or laws entail?	Required DNA test1 Official registration as father of child 2 Child support requirement3 Don't know98
6.13. What do you think about these law(s) regarding paternity establishment?	They are fair to both men and women1 Unfair to women2 Unfair to men3 No opinion4
6.14. Are there any laws in your country about violence against women?	Yes.....1 No.....2 (skip to 6.20) I don't know.....98 (skip to 6.20) No answer.....99 (skip to 6.20)

About these laws, do you think that?	Agree	Partly agree	Disagree
6.15. They make it too easy for a woman to bring a violence charge against a man.	1	2	3
6.16. They are too harsh.	1	2	3
6.17. They are not harsh enough.	1	2	3
6.18. They do not provide enough protection for the victim of violence.	1	2	3
6.19. They expose the woman to even more stigmatization and pain.	1	2	3

6.20. Do you think there should be laws/policies in your country that recognize same-sex relationships?	Yes 1 No 2 Do not Know98
6.22. Do you think there should be laws/policies in your country that guarantee civil union or marriage between same-sex or gay or lesbian couples?	Yes 1 No2 Do not Know 98

Campaigns and activities in your community	
6.24. Have you ever heard of any campaigns or activities in your community or workplace that talk about preventing violence against women?	Yes.....1 No.....2 No answer.....99
6.25. Have you ever seen an advertisement or public service announcement on television questioning men's use of violence against women?	Yes.....1 No.....2 No answer.....99
6.26. Have you ever participated in an activity (group session, rally, etc.) in your community or workplace to question other men's use of violence against women?	Yes.....1 No.....0 No answer.....99
6.27. Have you ever heard of any campaigns or activities in your community or workplace that promote men's involvement as fathers?	Yes.....1 No.....2 No answer.....99
6.28. Have you ever participated in an activity (group session, rally, etc.) in your community or workplace to talk about fatherhood or your role in your children's lives?	Yes.....1 No.....2 No answer.....99
6.29. Have you ever heard of any campaigns or activities in your community or workplace that question homophobia or discrimination against homosexuals?	Yes.....1 No.....2 No answer.....99

SECTION SEVEN: Parenting and men's relationships with their children

<p>These questions are about yourself and the children you may have fathered or adopted, or children who may live with you even if they are not legally or biologically yours. We want to know how your relationship with them is. Please feel free and remember that the information you share with us will be kept secret from anyone not concerned here and will only be used for research purposes.</p>	
7.1. Do you have any BIOLOGICAL child/children?	Yes.....1 No.....2 (skip to 7.4)
7.2. How many biological children?	— — Biological Children
7.3. Do any of your biological child/children live IN YOUR HOUSEHOLD?	Yes, all.....1 Yes, not all.....2 None.....3 (skip to 7.36)
7.4. How many children altogether (biological and other) live with you IN YOUR HOUSEHOLD?	— — Children If no children live in household, skip to 8.1
7.5. Who in your family usually has the final say regarding the health of women at home?	Yourself 1 Wife/Partner 2 Yourself/wife/partner jointly 3 Someone else 4 You and someone else jointly5 Other.....97
7.6. Who in your family usually has the final say regarding the health of children at home?	Yourself 1 Wife/Partner 2 Yourself/wife/partner jointly 3 Someone else 4 You and someone else jointly5 Other.....97
7.7. Where were you during the birth of your last child?	Yes, I was in the delivery room.....1 Yes, I was in the waiting room.....2 Yes, I was some other place in the hospital or clinic.....3 No, I was in home.....4 No, It didn't occur to me to be present 5

	No, the mother did not want me present6 No, her family did not want me present.....7 No, I had to work8 No, I was traveling or living outside the city 9 No, my home it was so far.....10 No, I wanted to go but was not permitted entry to the delivery room11 No, I knew I could go but did not want to12 No, I was scared13 No, It's not common in my community for men to do that.....14 Others (specific)_____ 97
7.8. Was it you or your partner who wanted to have a child the last time you had a child or adopted one?	Mostly me.....1 Mostly my partner.....2 Both equally.....3 Not planned.....4
7.9. Did you take leave the last time you had a child, and if so how many days?	I took ____ days of paid leave 1 (skip to 7.11) I took ___ days of unpaid leave 2 (skip to 7.11) I took no leave3 I was not employed at the time4 (skip to 7.13) Other (specific)_____ 97
7.10. If you did not take leave, why not? <u>Interviewer, after response, skip to 7.14</u>	Work not permit.....1 Did not want to.....2 Could not afford.....3 Other (specific)_____ 97
7.11. If you took leave, when you were at home with the child, who were you with mainly?	Alone1 Together with your partner 2 Together with a nanny or other care giver..... 3 Others (specific)_____ 97
7.12. Would you say that this period at home with the child led to better contact or relationship with the child later on?	Yes1 No2 Don't know98
7.13. How many days/weeks leave (paid and unpaid) did your partner take last time you had or adopted a child?	She took ____ days of paid leave1 She took ___ days of unpaid leave2 She took no leave3 I was not employed at the time4 Other (specific)_____ 97
7.14a. Did you accompany the mother(s) of your child (ren) to a prenatal visit during the last or the present pregnancy?	I do not know if she had/has prenatal visits..... 1 She did/does not have prenatal care 2 Yes, I went/go with her to every visit 3 Yes, to some visits 4 No, not to any visit 5 (skip to 7.16)
7.14b. If yes to above, where were you in general on these visits?	Outside in parking lot..... 1 In waiting room..... 2 In the consultation room.....3 Just dropped her off 4 Other (specific)_____ 97
7.15. Did you assist your partner to attend any support groups or counseling during her pregnancy, if applicable?	Yes, she attended support groups, and I assisted in her doing so.....1 Yes, she attended support groups, but I was not in favour of this.....2 No, she did not attend support groups as I was not in favour of this 3

	She did not attend support groups for other reasons..... 4 There were no such support groups..... 5
7.16. What information and/or support would have helped you to be (even) more involved during your partner's last or the present pregnancy?	Specific pregnancy support groups or counseling for men..... 1 Information on pregnancy for men 2 More male friendly pregnancy services..... 3 Other (specific) 97 Don't no.....98

Do the following circumstances apply to your everyday life in your home?				
	Yes	No	Don't Know	NA
7.17. I spend too little time with my children on account of my job	1	0	98	99
7.18. I would work less if it meant that I could spend more time with my children	1	0	98	99
7.19. Overall , I have the main responsibility for providing for the family	1	0	98	99
7.20. I am afraid that I would lose contact with the children if the relationship ended/broke up	1	0	98	99
7.21. My role in caring for my children is mostly as a helper.	1	0	98	99

The next questions will ask you about the amount of time you spend with your children doing different things with or for them.

Disregarding the help you and/or your partner may get from others, how do/did you and your partner distribute the following tasks related to the care of children?						
	Always me	Usually me	Equally or done together	Usually partner	Always partner	NA
7.22. Daily care of child	1	2	3	4	5	99
7.23. Staying at home with a child when he/she is sick	1	2	3	4	5	99
7.24. Collecting child from school/day care centre	1	2	3	4	5	99
7.25a. Driving or taking the child to leisure-time activities	1	2	3	4	5	99
7.25b. disciplining children	1	2	3	4	5	99

FILTER: HAVE CHILDREN BETWEEN 0 TO 4 YEARS OLD. IF NOT, SKIP TO 7.30

If you have children between 0-4 living with you, how often do you do any of the following together or for your children?	Rarely or Never	Now & again	Several Times a Week	Every Day
7.26. How often do you play with your children at home?	1	2	3	4
7.27. How often do you cook or fix food for your children?	1	2	3	4
7.28. How often do you change diapers or any clothes of your children?	1	2	3	4
7.29. How often do you give a bath to your children?	1	2	3	4

FILTER: HAVE CHILDREN BETWEEN 5 TO 13 YEARS OLD. IF NOT, SKIP TO 7.36

If you have children between the ages of 5-13 living	Rarely or	Now &	Several	Every Day
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with you, how often do you do any of the following together or for your children?	Never	again	Times a Week	
7.30. How often do you play with your children at home?	1	2	3	4
7.31. How often do you talk about personal matters with your children?	1	2	3	4
7.32. How often do you do physical exercise or play games outside home with your children?	1	2	3	4
7.33. How often do you help them with their homework?	1	2	3	4
7.34. How often do you cook or fix food for your children?	1	2	3	4
7.35. How often do you wash clothes for your children?	1	2	3	4

FILTER: HAVE BIOLOGICAL CHILDREN under the age of 18 NOT LIVING WITH YOU. IF NOT, SKIP TO 8.1

7.36. How many days per week do you see <u>the biological child who is not living with you</u> ?	Less than one day.....1 1 to 3 days.....2 4 to 5 days.....3 6 to 7 days.....4
7.37. Do you provide financial support for your biological children who do not live with you?	No.....0 Occasionally.....1 Frequently.....2 Pay most expenses.....3

SECTION EIGHT: RELATIONSHIPS AND VIOLENCE

The interview is going very well so far and we're very nearly finished. The next questions ask about things which happened in your relationships, with any female partner you have ever had or your wife if you have been married.

FILTER: HAS EVER HAD FEMALE PARTNER. IF NOT, SKIP TO 9.1

INTERVIEWER: If the respondent says ONCE or MORE THAN 1 TIME to questions 8.1 – 8.5, PLEASE ALSO ask him if the behavior happened in the last year (last column).

Cod.	How many times...	Never	Once	More than 1 time	MARK HERE IF THIS HAPPENED IN THE LAST YEAR
8.1.	Have you ever had slapped a partner or thrown something at her that could hurt her?	1	0	2	3 (YES) 4 (NO)
8.2.	Have you ever had pushed or shoved a partner?	1	0	2	3 (YES) 4 (NO)
8.3.	Have you ever had hit a partner with a fist or with something else that could hurt her?	1	0	2	3 (YES) 4 (NO)
8.4.	Have you ever had kicked, dragged, beaten, choked or burned a partner?	1	0	2	3 (YES) 4 (NO)
8.5.	Have you ever had threatened to use or actually used a gun, knife or other weapon against a partner?	1	0	2	3 (YES) 4 (NO)

8.6. Do you have a male friend who uses physical violence against his female partner or wife?	Yes.....1 No.....2 No answer.....99
8.7. Would you be capable of questioning/challenging his behavior?	Yes, I would.....1 Yes, I have already in fact.....2 No.....3 No answer.....99

8.8. What would you do if you saw a male friend use violence against a woman?	Intervene during the episode.....1 Speak to him after the episode.....2 Avoid/shun the stranger guy.....3 Call the police.....4 Do nothing, it is their problem.....5 Mobilize the neighbors.....6
8.9. What would you do if you saw violence being carried out by a stranger (man) against a woman?	Intervene during the episode.....1 Speak to your friend after the episode.....2 Avoid/shun your friend.....3 Call the police.....4 Do nothing, it is their problem.....5 Mobilize the neighbors.....6
8.10. Have you ever talked to your son or a boy you care for in the home or outside the home about violence against women?	Yes.....1 No.....2 NA3 No answer.....99

SECTION NINE: Health and Quality of Life

We are very close to the end and you are doing very well. Please remember that we appreciate and value your information. Having said that, I want to remind you that whatever you share with us today will be kept confidential and will only be used for the purpose of research.

The next sets of questions are about different aspects of your health.

9.1. When was the last time you sought out health services at a clinic or hospital for yourself, including a traditional healer?	In the last three months0 Within the last year1 Within the last two years2 Within the last 5 years.....3 More than 5 years ago4 Never5 (skip to 9.3)
9.2. The last time you sought healthcare services, what was the principal reason that led you to seek medical attention?	Medical Check-up1 Exam, diagnosis or treatment for an STD2 To accompany my primary partner to an appointment (including pre-natal)3 To get the result of an HIV/Aids test4 To get HIV/Aids treatment.....5 Health Certificate6 Sexual Dysfunction.....7 Acne or other skin problems8 Dental treatment9 To get information about sex, family planning or STDs10 Related to coronary illness or other chronic illness 11 Other (specific) _____ 97 No answer.....99
9.3. Have you ever had a prostate exam if over 40 years old?	Yes1 No.....2 40 years old or under.....3
9.4. Have you ever been tested for HIV?	Last 12 months.....1 2-5 years ago.....2 More than 5 years ago.....3 Never tested.....4 (skip to 9.6)
9.5. Did you wait for or go back for the result?	Yes.....1 No.....0

9.6 Have you ever been told by a health worker that you have a sexually transmitted infection?	Yes.....1 No.....0
9.7. How many times have you had symptoms due to a sexually transmitted infection (such as an ulcer on your penis/genitals or discharge from your penis)?	Never.....0 Once.....1 Twice.....2 Three or more times.....3
9.8. If you ever had sexual health symptoms or concerns, and you did not seek the help of a health service at a clinic or hospital, why was this?	I felt embarrassed.....1 I did not believe it was important.....2 I did not trust it would be confidential.....3 The available services were not for men.....4 Services did not exist/too far away.....5 I did not know where to seek help6 Other (specific).....97 Not applicable.....99
9.9. If you are in a relationship, do you or your wife/partner currently use family planning methods (e.g. pill, injectable, male or female condom)?	Yes1 No.....2 Not applicable99

We would like you to answer other questions about abortion	
9.10. Has a partner of yours ever had an abortion?	Yes.....1 No.....0(skip to 9.14) I don't know.....98(skip to 9.14)
9.11. Have you ever participated in a decision to abort a partner's pregnancy?	Yes.....1 No.....2 (skip to 9.14) I don't know.....98 (skip to 9.14) No answer.....99 (skip to 9.14)
9.12. Did you provide financial support for the abortion? (If more than once, ask about the last time this happened.)	Yes.....1 No.....2 No answer.....99
9.13. Did you accompany the partner for the abortion? (If more than once, ask about the last time this happened.)	Yes.....1 No.....2 No answer.....99

We would like you to answer other questions about health and well-being					
	Completely agree	Partly agree	Partly agree and disagree	Partly disagree	Completely disagree
9.14. I am happy with my body	1	2	3	4	5
9.15. I feel that my life is of no use to anyone	1	2	3	4	5
9.16. I have a lot to be proud of on the whole	1	2	3	4	5
9.17. I have a good sex life	1	2	3	4	5
9.18. I feel inferior sometimes when I am together with friends	1	2	3	4	5

9.19. When you feel sad, disappointed or frustrated, do you seek help from others? If yes, whom?	No.....1
	Partner/girlfriend.....2
	Relatives.....3
	Professional counseling.....4
	Family Meetings.....5
	Teacher/Social Worker.....6
	Doctor.....7
	Priest/Religious Leader.....8
	Female friends.....9
	Male friends.....10
	Traditional Healer.....11
Other.....97	
No answer.....99	

In the last month, how often did you experience the following?				
	Never	Seldom	Sometimes	Often
9.20. Stress	1	2	3	4
9.22. Depression	1	2	3	4
9.23. Suicidal thoughts	1	2	3	4
9.24. Weight gain or loss	1	2	3	4
9.25. Indigestion/stomach problems	1	2	3	4
9.26. Headache	1	2	3	4
9.27. Loss of sexual desire	1	2	3	4
9.28. A health problem related to work or an injury at work.	1	2	3	4

9.29. Have you suffered any permanent disability or health problem as a result of an accident, injury or violence?	Yes, as a result of injury.....1
	Yes, as a result of violence.....2
	Yes, as a result of traffic other accident.....3
	Yes, as a result of illness.....4
	No.....5
	No answer.....99
9.30. Do you believe that there should be specific health facilities for men or specific times/days for male health services?	Yes.....1
	No.....2
	Don't know.....98
	No answer.....99
9.31. Do you feel that the health services available to you are friendly towards men?	Yes.....1
	No.....2
	Don't know.....98
	No answer.....99

We have now got some questions that ask about **things you may have done in your life**. In answering the questions we want you to think back across your whole life, including when you were a child or teenager. You might find these more difficult to answer but we really hope you will feel free to answer them openly. The research is very important in trying to understand the lives of men. When you answer the questions please remember that everything you say is being kept secret, and we are not even collecting information on your name. When we write a report from the research what you tell us will be put together with information from 1500 other men so no one will ever know what you say.

SECTION TEN: FINAL QUESTIONS

These next questions ask about things you may have done over the course of your whole life from your childhood up to the present day. The questions ask you how often you have done a range of different things:

	Never	Once	2-3 times	More often
10.1. Have you ever robbed someone?	0	1	2	3
10.2. Have you ever been involved in a fight with a knife, spear, stone, bow and arrow, axe, caterput, gun or other weapon?	0	1	2	3
10.3. Have you ever participated in a gang?	0	1	2	3

10.4. Do you own a firearm?	Yes, a licensed one.....1 Yes, an unlicensed one.....2 Yes, both a licensed and unlicenses one.....3 No.....4
10.5a. Have you ever been arrested?	Yes.....1 No.....2 (skip to 10.8)
10.5b. Why were you arrested	Robbery.....1 Rape.....2 Theft.....3 Others-Specify.....97
10.6. How many times have you been arrested?	— — Number
10.7. Have you ever been sent to prison?	Yes.....1 No.....2
10.8. How often do you have a drink containing alcohol?	Monthly or less.....1 2-4 times a month.....2 2-3 times a week.....3 4 + times a week.....4 Don't take alchohol.....5 (skip to 10.10)
10.9. How often do you have 5 or more drinks on one occasion?	Never.....0 Less than monthly1 Monthly.....2 Weekly3 Daily or almost daily4
10.10. How many times have you used marijuana (or other local drugs) in the last 12 months? Would you say it was once, twice or three or more times?	Never0 Once1 Twice2 Three or more times.....3

Have you experienced any of the following forms of violence outside the home in the last 3 months?

Cod.	Types of Violence	Yes	No	Don't remember
10.11.	Been punched or hit	1	0	98
10.12.	Been threatened with a knife spear, stone, bow and arrow, axe or other weapon (excluding firearms)	1	0	98
10.13.	Been threatened with a gun	1	0	98
10.14.	Other (specific)	1	0	98

RELATIONSHIP WITH OTHER MEN QUESTION:

These questions ask you about your sexual experiences with other man.

10.15. Have you ever had sex or done something sexual with another man because you wanted to? By sex we mean: Anal sex: where a man sticks his penis in a man's anus Oral sex is when a man sticks his penis in a man's mouth. Mutual masturbation OR TOUCHING EACH OTHER'S PENISES	Yes.....1 No.....2 (skip to 10.17) No answer.....99 (skip to 10.17)
10.16. How old were you when you first had sexual intercourse with a man?	— — years
10.17. What sex attracts you sexually? I am sexually attracted to	Men.....1 Women.....2 (skip to 10.19) Both.....3 No answer.....99
10.18. If you are primarily attracted to men, and you don't live with a male partner, would you prefer to live with your current or another male partner if it were acceptable?	Yes.....1 No.....2 I live with or have lived with a male partner.....3 No answer.....99

SEXUAL EXPERIENCES QUESTION:
 These questions ask you about your sexual experiences with any girl/woman irrespective of your relationship with her/them.

10.19. How many times have you had sex with a woman or girl when she didn't consent to sex or after you forced her?	Never.....1 Once in the last 12 months.....2 More than 1 time in the last 12 months.....3 One time, over 12 months ago.....4 More than one time, over 12 months ago.....5 No answer.....99
10.20. How many times have you had sex with a woman or girl when she was too drunk to say whether she wanted it or not?	Never.....1 Once in the last 12 months.....2 More than 1 time in the last 12 months.....3 One time, over 12 months ago.....4 More than one time, over 12 months ago.....5 No answer/NA.....99
10.21. Did you ever force a girlfriend or your wife into having sex with you?	Never.....1 Once in the last 12 months.....2 More than 1 time in the last 12 months.....3 One time, over 12 months ago.....4 More than one time, over 12 months ago.....5 No answer/NA.....99
10.22. Was ever there a time when you forced an ex-girlfriend or ex-wife into having sex?	Never.....1 Once in the last 12 months.....2 More than 1 time in the last 12 months.....3 One time, over 12 months ago.....4 More than one time, over 12 months ago.....5 No answer/NA.....99
10.23. Did you ever force a woman who was NOT your wife or girlfriend at the time to have sex with you?	Never.....1 Once in the last 12 months.....2 More than 1 time in the last 12 months.....3 One time, over 12 months ago.....4 More than one time, over 12 months ago.....5 No answer/NA.....99

10.24. How many times have you and other men had sex with a woman at the same time when she didn't consent to sex or you forced her?	Never.....1 Once in the last 12 months.....2 More than 1 time in the last 12 months.....3 One time, over 12 months ago.....4 More than one time, over 12 months ago.....5 No answer/NA.....99
10.25. How many times have you and other men had sex with a woman at the same time when she was too drunk to stop you?	Never.....1 Once in the last 12 months.....2 More than 1 time in the last 12 months.....3 One time, over 12 months ago.....4 More than one time, over 12 months ago.....5 No answer.....99
10.26. Have you ever done anything sexual with a boy or man when he didn't consent or you forced him?	Never.....1 Once in the last 12 months.....2 More than 1 time in the last 12 months.....3 One time, over 12 months ago.....4 More than one time, over 12 months ago.....5 No answer/NA.....99
10.27. Have you ever done anything sexual with a boy or man when you put your penis in his mouth or anus when he didn't consent or you forced him?	Never.....1 Once in the last 12 months.....2 More than 1 time in the last 12 months.....3 One time, over 12 months ago.....4 More than one time, over 12 months ago.....5 No answer/NA.....99
10.28. How many different women/girls have you forced into sex?	Never.....1 1.....2 2 – 3.....3 4 – 5.....4 6 – 10.....5 11+.....6 No answer/NA.....99

TRANSACTIONAL SEX QUESTIONS.			
Can give more than one response:			
10.29. What do you think about an adult woman working as a sex worker or prostitute?	Yes	No	No answer
I think it is wrong morally	1	2	99
I think it violates her rights	1	2	99
I think it is her own choice	1	2	99
I think it is wrong but there is nothing that can be done about it	1	2	99
I see nothing wrong with it	1	2	99
It's a job like any other	1	2	99

10.30. What do you think about a young woman under age 18 working as a sex worker or prostitute?	Yes	No	No answer
I think it is wrong morally	1	2	99
I think it violates her rights	1	2	99
I think it is her own choice	1	2	99
I think it is wrong but there is nothing that can be done about it	1	2	99
I see nothing wrong with it	1	2	99
It's a job like any other	1	2	99

10.31. What do you think about an adult man working as a sex worker or prostitute?	Yes	No	No answer
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I think it is wrong morally	1	2	99
I think it violates his rights	1	2	99
I think it is his own choice	1	2	99
I think it is wrong but there is nothing that can be done about it	1	2	99
I see nothing wrong with it	1	2	99
It's a job like any other	1	2	99
10.32. What do you think about a young man under age 18 working as a sex worker or prostitute or who have sex with old women for money.	Yes	No	No answer
I think it is wrong morally	1	2	99
I think it violates his rights	1	2	99
I think it is his own choice	1	2	99
I think it is wrong but there is nothing that can be done about it	1	2	399
I see nothing wrong with it	1	2	99
It's a job like any other	1	2	99

10.33. What do you think about men who purchase sex?	Yes	No	No answer
I think it is a natural thing for men to do	1	2	99
I think it is morally wrong.	1	2	99
I think it is OK as long as he is not married or in a relationship with someone.	1	2	99
I think it is something that most men do at least once in their lifetime.	1	2	99
I think it is something that only sick men do.	1	2	99
I think that sex is a service that can be bought like any other service.	1	2	99

10.34. Do you think it should be against the law to purchase sex from a sex worker or prostitute?	Yes.....1 No,.....2 No, unless the girl or woman is under 18.....3 No answer.....99
10.35. Do you think it should be against the law to work as a sex worker or prostitute?	Yes.....1 No,.....2 No, unless the girl or woman is under 18.....3 No answer.....99

Please think about the main partners or steady girlfriends you have had. Do you think any of them become involved with you because they expected you to do, or because you did do any of the following:			
	Yes	No	No answer
10.36. Provided her with food, clothes, cell phone or transportation	1	0	99
10.37. Paid her school fees or residence fees	1	0	99
10.38. Provided her with somewhere to stay	1	0	99
10.39. Gave her cosmetics or money for beauty products	1	0	99
10.40. Gave items for her children or family	1	0	99
10.41. Gave her cash or money to pay her bills	1	0	99
10.42. Provided her anything else that she could not afford by herself	1	0	99
10.43. Did handyman work for her or fixed her car	1	0	99

Please think now about any women or girl you had sex with more than once but who you didn't consider to be your main girlfriend or partner at the time. Do you think any of them may have ever become involved with you because they expected you to do, or because you did do any of the following:			
	Yes	No	No answer
10.44. Provided her with food, clothes, cell phone or transportation	1	0	99
10.45. Paid her school fees or residence fees	1	0	99
10.46. Provided her with somewhere to stay	1	0	99
10.47. Gave her cosmetics or money for beauty products	1	0	99
10.48. Gave items for her children or family	1	0	99
10.49. Gave her cash or money to pay her bills	1	0	99
10.50. Provided her anything else that she could not afford by herself	1	0	99
10.51. Did handyman work for her or fixed her car	1	0	99

Finally, please think about women or girl you may have had sex with just once. Have you ever had sex with a woman just as a once off because you gave her or she expected that you would give her:			
	Yes	No	No answer
10.52. Food, clothes, or cosmetics	1	0	99
10.53. A lift, a ticket, or money for transport	1	0	99
10.54. A place to sleep for the night	1	0	99
10.55. Cash or money to cover expenses	1	0	99
10.56. Anything else that she could not afford by herself	1	0	99
10.57. Did handyman work for her or fixed her car	1	0	99

10.58. Have you ever had sex with a prostitute or sex worker? [Use appropriate local terms]	Yes, with a female sex worker or prostitute.....1 Yes, with a male sex worker or prostitute.....2 Yes, with a transvestite (travesty in Brazil, hijra in India).....3 No.....0(End) No answer.....99
10.59. Have you ever had sex with a prostitute or sex worker you know or suspected was under 18 years of age?	Yes.....1 No.....0 No answer.....99
10.60. Have you ever had sex with a prostitute or sex worker you think was forced or sold into prostitution?	Yes.....1 No.....0 No answer.....99
10.61. If you knew that a prostitute or sex worker was forced or sold into prostitution, what would you do?	Call police.....1 Escort her to police.....2 Avoid having sex.....3 No answer.....99

We have come to the end of the survey. We appreciate the time you have spent answering these questions. Your response and those of approximately 1500 other men will give us an understanding of men's roles in society today, information that could be useful for driving changes in policies. It is important to emphasize that the laws in our country make it a crime to use physical violence against women, or to have sex with someone under age 18, and to force a woman to have sex with you.

THANK YOU FOR YOUR TIME.

D. Topic Guide for in-depth interviews with men

Men's Sexual Health/HIV Attitudes, Behaviours and Health-seeking in Malawi

Introductory comments:

- Introduce study and purpose
- Interview purpose: talk about issues related to men's health regarding sex and sexuality
- Consent form: confidentiality, voluntary, reimbursement, use of results
- Explanation of recording
- There are no right or wrong answers to these questions – no-judgemental approach
- Some of these topics are sensitive. We understand that, and appreciate you being willing to help us understand these topics a little better.
- Any questions?

I'd like to start with some general questions about your attitudes towards your health, and sex and sexual practices.

Section 1: Men's general perceptions on their health

1. Do you look after your health when you're sick? Why is this? Are there any particular events/reasons/factors that make you more likely to look after your health?
2. Do you ever talk about your health with others? If so, who do you speak to first if you have a health issue or concern? Why is that?
3. We found many men don't look after their own health. Why do you think this is? (**Probe:** Is looking after your health or seeking help seen as not being a man?)

Section 2: Men's sexual identity

4. Is performing well during sex important to you? Why is this? Have you ever taken anything to improve your sexual performance? If so, why? (**Probe:** have you taken Mthubulo, Viagra or anything else similar and why?)
5. How do other people affect how you think about and act in relation to sex? Can you please explain (**Probe:** What effect do women's attitudes have on how you think about and act in relation to sex? [Probe beyond the way that women dress]. How do other men affect your sexual behaviour?)
6. What for you constitutes a satisfying sexual relationship? (**Probe:** is it focused mainly on your own sexual pleasure, or also on your partner's enjoyment). Is it important to you that you have a satisfying sexual relationship? Why?

Section 3: Men's perceptions on risk-taking

7. Do you have, or have you ever had, multiple concurrent sexual partners (more than one partner you have sex with that overlap in time)? If yes, why was that?
 - a. **Probe:** If not, why do you think many men have multiple concurrent sexual partners (more than one partner you have sex with that overlap in time)?

8. Are there pressures on men from women to have multiple concurrent sexual partners?
9. What do you think about risky sexual behaviour (such as having multiple concurrent sexual partners)? Why? Why do men behave this way?
10. Have you changed your behaviours as a result of hearing/learning about the effects of risky sexual behaviours (such as multiple concurrent partners, not using condoms, etc)? If yes, please provide examples? (**Probe:** why did you change your behaviour in this way?) What about other men you know?
11. Some men are aware of the health risks of multiple concurrent sexual partners and unprotected sex, but do not change their behaviours (e.g. they don't use condoms, don't have fewer concurrent partners, etc). Why do you think this is that some men don't change their behaviours? (**Probe:** Do some men feel that changing their behaviour will have no effect on their health?)

Section 4: Men's use of condoms, contraception and family planning

I'd now like to ask you about your approach towards condoms, contraception & family planning

12. Do you prefer to use condoms or not during sex? Why is this? Do you behave differently inside the home and outside in terms of condom use?
13. Why do you think most men we spoke to do not use condoms when having sex? (**Probe:** Why is skin-to-skin sex much preferable?)
14. What do women say about men using condoms? [*women's opinion/attitude*] (**Probe:** Does what women say influence whether you use condoms?)
15. Are you involved in discussions and decisions at home or in your family about contraception/family planning? Why is this? If not, why? What areas are you involved in? (**Probe:** e.g. no areas, discussing no of children, discussing the family planning method, etc)?
16. Do you think family planning is only a women's issue? Why? Why not? Why do many men disapprove/not approve of the use of family planning methods by their partner/wife? Which family planning methods specifically for men are you aware of?
17. One male method is a vasectomy, where a man has a simple operation so that he no longer ejaculates sperm during sex. Why do few men want to have a vasectomy? (**Probe:** related to ideas on manhood/pleasure?). What do you think about this (vasectomy) as a form of contraception?

Section 5: HIV and AIDS

We are now going to move on to talk about HIV and AIDS.

18. If you have tested for HIV, why is this? If not, why not?

19. Large numbers of men we spoke to (more than 50%) said they had tested for HIV in last 12 months. Do you think this is the case? Why? Why not? (**Probe:** What makes some men more likely to get an HIV test?)
20. Why do you think many men often assume the HIV status of their wives/partners?
Probe: If you have not tested, are you assuming the status of your wife/partner status (if they have partner and partner has been tested)? Why/why not?
21. a). If HIV positive: Have you faced challenges in terms of telling other people (disclosing) your HIV positive status? Who did you talk to about this?
b). If not HIV positive (or not tested for HIV): Have any other men you know faced challenges in terms of telling other people (disclosing) about their HIV positive status? Why?
22. Why do you think men often come to health facilities very late for treatment for HIV, once they are already very sick? (**Probe:** Have you or other men you know faced challenges in terms of accessing treatment for HIV and continuing to take it (adhere to the treatment)?)
23. Would do you think about medical male circumcision? Why have you been circumcised or not? Do you think you can continue unprotected sex after circumcision?

Section 6: STIs/other sexual health concerns

I'd now like to ask some questions about other sexual health issues beyond HIV. [When I say sexual health here, I mean sexual dysfunction, syphilis, gonorrhoea, urethral discharge, ulcers, etc.]

24. Beyond HIV, have you experienced other sexual health concerns/issues? (**Probe:** Have you had STIs such syphilis, gonorrhoea, urethral discharge, ulcers?) Please explain. What about other men you know?
25. Have you experienced sexual dysfunction (erectile dysfunction, premature ejaculation, etc)? Please explain. What about other men you know?
26. Did you seek support for these other sexual health concerns/issues? Why or why not? What kind of support did you seek? Why are men more likely to seek treatment/support for STIs faster than seeking support for HIV?
a. **Probe:** If no other sexual health issues, what about other men you know? Did they seek support? Why or why not? What kind of support did they seek? Why are men more likely to seek treatment/support for STIs faster than seeking support for HIV?
27. If you have had an STI before, did you talk to your friends and sexual partners about this issue? Why is this? **Probe:** Or do you know if other men talk to their friends and sexual partners about STIs?

Section 7: Men's experiences of sexual health services for men

I'd now like to ask about your experiences of services available to men for their health relating to their sexual health/sex and sexuality.

28. Are you aware of specific services available in your community/area to help you with health issues relating to sex and sexuality? (**Probe:** are you aware of _____?)
29. Where would you go first if you have an issue relating to your sex and sexuality? Why? **Probe:** Or, in your experience, where do men go first if they have an issue? Why?
30. Have you used a public health facility for services around sex and sexuality? Why was that? What services did you go for? What was your experience? **Probe:** If not used public facility: why do you think some men use public facilities when they have an issue relating to their sex and sexuality? How was their experience?
31. Have you used private health services for services around sex and sexuality? Why is that? What services did you go for? What was your experience? **Probe:** If not used private services: some men prefer private health services to public service. Why do you think that is? How was their experience?
32. Have you used the services of a traditional healer? If yes, why was that? What services did you go for? How did you experience their services? Are there different services men get from traditional healers, rather than public or private system? **Probe:** If not use traditional healer: why do other men often use the services of traditional healers? How do they perceive and experience these services?
33. In general, do you go to different services/facilities for different things? At the same time? (**Probe:** Are there other institutions/services you go to for services related to sex and sexuality? e.g. religion)

Section 8: Barriers to using public sexual health services

You are doing very well. Two more sections to go. Thank you for your responses. Next I'd like to ask you about any barriers men might face to using public services for their health around sex and sexuality issues

34. We know that many men do not use public sexual health facilities, even if they are aware of them and need help. Why do you think this is? (**Probe:** Are they seen as spaces for only women and children?)
35. Have you ever faced any particular barriers, challenges or concerns when using a public health service? (**Probe:** such as quality of services, non-availability of drugs, lack of accessibility, queues, friends/family members getting preferential treatment, and/or confidentiality?). In general, are there specific barriers, concerns or challenges that keep men from accessing and using services they need?

36. Are current public health services friendly to men? (By friendly we mean courteous, accessible, welcoming, etc). Are these services better for men or for women? Why?
37. If you work during the day, does this affect your ability to access services? How is this? Are other men also affected by working during the day?
38. Many men we spoke to talked about being frequently stressed due to not having enough income. Does this affect your ability to use health services that you need/your approach towards your health?

Section 9: Improving men's sexual health seeking behaviour and service use

Lastly, I'd like to explore possible solutions to improving men's ability to look after their health relating to sex and sexuality

39. Are there services that should be made more available/developed for you and other men to help you/them better look after their health relating to sex and sexuality? (**Probe** for ideas)
40. If you were given a chance, would you change anything in existing services for men? (**Probe:** should services be re-orientated/adjusted?) If yes, how?
41. Most men in our survey said they do not want specific health facilities for men. Can you help us understand why this is? Do you think there should be specific facilities for men?
42. In addition to this, are there other ways we can encourage/motivate men to seek care and better look after their health? (**Probe:** Could male support groups/networks play a role?)
43. How could we encourage men to be more interested/involved in family planning?
44. Do you have anything else to say? Do you think this is an important research topic?

Thank you very much for your time. Your feedback will be very important to inform programming towards men's health.

E. Demographics Form completed prior to in-depth interviews with men



ID number
_____/____/____

Men's Sexual Health/HIV Attitudes, Behaviours and Health-seeking in Malawi

Male Interview Demographics Form

Interview Date/Tsiku lofunsidwa ___/___/2014		Name/Dzina
A: General information		
1) Age/Zaka _____	2) Number of children/Muli ndi ana angati? _____	3) Marital/partner status/Muli pa banja? _____ 1 = single;/Sindili pa banja 2 = married/partner/Ndili pa banja
4) Level of education/Maphunzilo _____ 1 = No formal education/ incomplete primary/sadaphunzile 2 = Complete Primary/adamaliza pulayimale 3 = Secondary/ incomplete tertiary/Sekondale/sadamalize ku College 4= Tertiary or higher/Apamwamba/kuposela	5) Religion/Chipembezo _____ 1 = Muslim 2= Catholic 3 = Presbyterian/Protestant/CCAP 4 = Adventist 5=Pentecostal 6=Other/Zina..... 7=None/Palibe	
6) Occupation/Ntchito /Chochita _____ 1 = Farmer, Fishing/Mulimi, Msozi 2 = Health worker, policeman/Wa Za Umoyo/Wa Polisi 3 = Driver, Manual worker /Woyendetsa galimoto/Wa ntchito zamanja 4 = Sales, service worker, clerical /Wogulitsa, Wothandizila. 5= Self employed, vendor/Woziyimila payekha, Wogulitsa malonda 6 = Professional, managerial, academic/Wa mu ofesi, wa udindo, za ukachenjede 7 = No employment (student, unemployed);/Osagwira ntchito (phunzi) 8 = Other/Zina..... 9= Retired/Opuma	7) Ethnicity/Mtundu _____ 1 = Chewa 2 = Tumbuka 3=Yao 4=Ngoni 5 = Lomwe 6 = Sena 7= Other/Zina.....	
B: Sexual behaviours		
8) Do you and your wife/partner use contraction?/Inu ndi mkazi/okondedwa wanu mumagwiritsa njira zolera? _____ If no (no partner), skip to 10		9) If yes, which method are you using?Ngati mukulera,mukugwiritsa tchito njira yanji?_____ 1 = Injection/yobayitsa

<p>1 = yes;/Eya; 2 = no; /Ayi; 3=N/A/Sizikugwilizana/<i>Palibe/ bwenzi palibe</i></p>	<p>2= Condom/<i>kondomu</i> 3=Pills/<i>mapilisi</i> 4=Intrauterine device (IUD) /Loop 5= vasectomy/<i>Yotseka ya abambo</i> 6= Implant/<i>yoyikitsa lupu</i> 7 = Other/<i>Zina.....</i></p>
<p>10) Have you had a vasectomy?/<i>Mudatseketsa njira ya abambo?</i>_____</p> <p>1 = yes;/Eya 2 = no/Ayi</p>	<p>11) Number of sexual partners in last 12 months?/<i>Mwakhala ndi abwenzi ogonana nawo angati miyezi 12 yapitayi?</i> _____</p>
<p>12) How often have you used condoms when having sex in the last 12 months? <i>Mwagwiritsa ntchito ma kondomu mochuluka bwanji mu miyezi 12 yapitayi?</i>_____</p> <p>1=I don't use/<i>Sindigwilitsa;</i> 2=Always use;/<i>Nthawi zonse</i> 3=Mostly use;/<i>Nthawi zambiri</i> 4=Occasionally use;/<i>Nthawi zina</i> 5=N/A/Sizikugwilizana</p>	<p>13) Are you circumcised?/<i>Kodi munapangisa mdulidwe wa a bambo?</i>_____</p> <p>1 = yes/Eya; 2 = no/Ayi</p>
<p>C: HIV testing</p>	
<p>14)Have you ever tested for HIV?/<i>Munayezetsapo HIV?</i> _____</p> <p>If no, skip to D</p> <p>1 = yes/Eya; 2 = no/Ayi</p>	<p>15) If yes to HIV test, when was last test/<i>Ngati munayezetsapo, munayezetsa komaliza liti?:</i> _____</p> <p>1 = Last 30 days/<i>Mwezi umenewu</i> 2=Last 6 months/<i>Miyezi isanu ndi imodzi yapitayo</i> 3=Last 12 months/<i>Miyezi 12 yapitayo</i> 4=In the last 2 years/<i>Zaka ziwiri zapitazo</i> 5=<i>In the last 3-5 years/Zaka 3-5 zapitazo</i></p>
<p>16) If yes to HIV test, where did you test? <i>Ngati munayezetsapo HIV, munayezetsela kuti?</i>_____</p> <p>1=Private health facility/<i>Chipatala cha private</i> 2=Public facility, primary/community/ <i>Chipatala cha boma chaching'ono</i> 3=Public facility, district/tertiary/referral/<i>Chipatala chachikulu cha ku boma</i> 4= Other/<i>Zina</i></p>	<p>17) Was this service in your local area?/<i>Kodi Chipatala chimenechi chinali ku dela lanu?</i> _____</p> <p>1 = local/in my area/<i>Ku dela langa;</i> 2 = no, traveled to another area/town/village/<i>Ayi ndinatuluka kupita ku dela lina.</i></p> <p>If 2, traveled to another area/town, why was this?/<i>Ngati yankho lanu lili 2, munapita ku dela lina chifukwa chiyani?</i> _____</p>
<p>18) If yes, what is your HIV status?/<i>Ngati inu munayezetsapo HIV, munapezeka kuti muli nako kachiro mbo ka HIV kapena mulibe?</i> _____</p> <p>1 = positive/<i>Ndili nayo</i> 2 = negative/<i>Ndilibe</i> 3=Unknown/<i>Sindikuziwa</i> 4=No answer/<i>Sanayankhe</i></p>	<p>19) What is your partner's HIV status?/<i>Kodi okonedwa anu ali ndi HIV kapena Alibe?</i> _____</p> <p>1 = positive/<i>Ali nayo</i> 2 = negative/<i>Alibe</i> 3=Unknown/<i>Sizikuziwa</i> 4=N/A/Sizikugwilizana 5=No answer/<i>Sanayankhe</i></p>

<p>20) If positive, are you using HIV treatment (ARV)?/Ngati muli ndi HIV, kodi mukumwa ma ARV? _____ If negative, skip to D</p> <p>1 = yes;/Eya 2 = no/Ayi</p>	<p>21) If yes, where are you accessing HIV treatment?/Ngati muli mukumwa ma ARV,kodi mumalandilira kuti? _____</p> <p>1=Private health facility/Zipatala za Private 2=Public facility, primary/Zipatala za zing'ono za boma 3=Public facility, tertiary/Zipatala zazikulu za ku boma 4= Other/Zina</p>
<p>D: STI Experiences</p>	
<p>22) Ever had STI symptoms?/Kodi munakhalapo ndi zizindikilo za matenda opatsilana pogonana? _____ If no, skip to E</p> <p>1 = yes;/Eya 2 = no/Ayi</p>	<p>23) If yes to STI, what symptoms did you have?/Ngati munakhalapo ndi zizindikilo zimenezi,kodi zinali zotani? _____</p> <p>1=urethral discharge (UD)/ mafinya ndi zina zochoka mu chikhozodzo 2=genital ulcer/zilonda zaku ku maliseche 3=UTI/Kumva kupweteka pokodza 4=Other/Zina.....</p>
<p>24) Did you seek treatment for your STI?/Munalandila chithandizo cha matenda opasilana pogonana? _____ If no, skip to E</p> <p>1 = yes;/Eya 2 = no/Ayi</p>	<p>25) If yes to treatment, where did you go?/Ngati munalandila chithandizo,munachipeza kuti? _____</p> <p>1=Traditional healers/Asing'anga /adzitsamba 2=Private health facility/Chipatala cha private 3=Public facility, primary/Chipatala chaching'ono cha boma 4= Other/Zina.....</p>
<p>E: Other sexual health/sexuality issues</p>	
<p>26) Have you used services for any other sex and sexuality concern (beyond HIV & STIs)? List those below /Kodi munagwilitsapo ntchito chithandizo china chilichonse chokhudzana moyo wogonana (pambali pa HIV ndi matenda opatsilana pogonana)? _____</p> <p>If no, skip to F</p> <p>1= Sexual dysfunctions (erectile dysfunction, premature ejaculation, male infertility, pain during sex)/Kusagwila bwino ntchito kwa ziwalo zokhuza kugonana(kulephela kudzuka kwa chida cha abambo, kutulutsa umuna mwachangu pogonana, kusabeleka kwa abambo, kumva kuwawa pogonana) 2=Male cancer/kansa ya abambo 3=Family Planning/kulela 4= Other/Zina..... 5. N/A/Sizikugwilizana</p>	<p>27) If yes, What type of service did you use?/Ngati munagwilitsapo,Munagwilitsa ntchito chipatala chotani? _____</p> <p>1=Traditional healers/Asing'anga achikuda/adzitsamba 2=Private health facility/chipatala cha private 3=Public facility, primary/Chipatala chaching'ono cha boma 4=Public facility, tertiary/Chipatala chachikulu cha boma 5= Other/Zina.....</p>
<p>F: Use of services and traditional medicine</p>	
<p>28) If you used service/facility for HIV/STI or other sexuality concerns, why did you choose</p>	<p>29) Have you used traditional medicine for sex and sexuality issues?/Munagwilitsapo tchito</p>

<p>that type of service/facility?/Ngati munagwilitsapo zipatala zimenezi(service facility) zokhudza HIV/Matenda opatsilana pogonana, Munasankhilarji kulandilira chithandizo cha ku chipatala chimenechi? _____</p> <p>1=Available services/Zithandizo zopezekako 2=Better quality of care/Kuli chisamaliro chabwino 3=More confidential/amasungilana chinsisi kwambiri 4=Distance to services/Ndipafupi 5= Less waiting time;/Nthawi yodikilira chithandizo imakhala yochepe 6=Cheaper/Kunali kotsika mtengo 7= Other/Zina.....</p>	<p>mankhwala a chikuda okhudzana ndi kugonana ndi moyo wogonana? _____</p> <p>1 = yes;/Eya 2 = no/Ayi</p> <p>30) Have you ever used Mthubulo, gondolosi, tseketeke, nkondo kubedi or similar traditional medicine to improve your sexual performance?/Kodi inu munagwilitsapo ntchito mankhwala a Mthubulo,gondolosi,tseketeke,nkhondo kubedi kapena ena ofanana nawo kuti muwonjezele mphamvu mukachitidwe kanu ka kugonana? _____</p> <p>1= yes/Eya; 2 = no/Ayi</p>
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F. Summary Form for researcher to complete after in-depth interviews with men



ID number
C2-CH1/010

Men's Sexual Health/HIV Attitudes, Behaviours and Health-seeking in Malawi Male Interview Summary Form

Interview Date	10/10/2014	Interviewer Name	Joseph Mphahlele
Section 1: Men's general perceptions on their health			
<ul style="list-style-type: none"> - The respondent said that he looks after his health due to family responsibilities. If he falls sick it implies his family (children and wife) will suffer. - He rush to hosp. to know his health status. - The respondent discusses with his wife first whenever he has a problem because she is accept every situation. - The respondent said that most men go to hospital when sick due to shy, fear (due to their risky sexual behaviour) of being tested HIV. 			
Section 2: Men's sexual identity			
<ul style="list-style-type: none"> - The respondent said that good performance during sex is important because it helps both partners to have pleasure. - He once used goudolosi and thumbololo when he was a boy to enhance his sexual performance (sperm production and pleasure). - The respondent said that if he ejaculates, he gets satisfied sexually. And according to him, sexual satisfaction is important because it strengthens faithfulness in the family. - The respondent said no one has any influence on how he get sexually 			
Section 3: Men's perceptions on risk taking			
<ul style="list-style-type: none"> - The respondent had two sexual partners. This is when he was a boy and he was due to lack of satisfaction with one partner because of dressing, beauty and sexual expertise was an influence. - According to the respondent through risk sexual behaviour one can contract STIs and HIV. The respondent said that risky sexual behaviour comes due to lack of partner openness among married couples. - Development in culture, (cultural) has also facilitated an increase in risky sexual behaviour i.e. feeding centers. 			
Section 4: Men's use of condoms, contraception and family planning			
<ul style="list-style-type: none"> - He uses a condom rather not to infect his wife with HIV, but in the past the wife was using injection but stopped due some problems (side effects), hence they use a condom both as family planning methods and preventive measure. - Most women say that condoms are not good, hence they prefer plain sex. Some women claim that they develop side effects when using condoms. - Anything else specific on contraception and family planning? - According to the respondent vasectomy is not good for men but condoms. 			
Section 5: HIV and AIDS			
<ul style="list-style-type: none"> - The respondent is HIV positive, but his wife is ^{HIV} negative. - He said that most men lied with their during the serological study that they want for HIV testing, only few men might have gone. - He said that he faced discrimination/stigmatisation after disclosing his HIV status. - The respondent said most men go to hosp. when they are too sick because of fear to be tested for HIV, lack of hospital ^{service} providers for ART services are not punctual. 			

<p>Section 6: STIs/other sexual health concerns</p> <ul style="list-style-type: none"> - The respondent had an STIs and he went to hospital for medical help. - The respondent also experiences erectile dysfunctions, but has never gone to seek for medical attention. - The time that he had STIs, he disclosed to his wife. - According to the respondent men rush to hosp. when they have STIs, because of the pain they experience.
<p>Section 7: Men's experiences of sexual health services for men</p> <ul style="list-style-type: none"> - The respondent said that there ^{sexual} health services / facilities in the community, i.e. VCT services, ART. - The respondent said that whenever he has a sexual health issue he rush to hospital for medical attention. - He said most men go to private hospital for privacy. - The respondent once went to a tradi. healer because he had ^{incomp} he said most men do not go to public hosp. due to lack of hosp. services.
<p>Section 8: Barriers to using sexual health services</p> <ul style="list-style-type: none"> - Lack of hospitality - Inadequate drugs i.e. ART (Bactrim) - Lack of privacy - Bias in service delivery especially ART & Bactrim. Some are told the drug is not available they should go and buy while others are given. - He said public hosp. are friendly to both men and women.
<p>Section 9: Improving men's sexual health seeking behaviour and service use</p> <ul style="list-style-type: none"> - VCT counsellors should be friendly - People should be civic educated on disadvantages of discrimination and stigmatisation - There should not be special health facilities for men only - Given a chance the respondent said that he can improve on HIV service delivery and availability of condoms.
<p>Interview dynamics/general perceptions/other comments</p> <ul style="list-style-type: none"> - The interview went on well - According to the respondent, the study is good and he want to have a feedback from the findings

Could this person's story be used for a specific life history? Tick if yes

Did this person mark whether they can speak English? Tick if yes

Section 7
The respondent ~~say~~ buy medicines/drugs during weekends more especially when the hosp. is closed.

G. Topic Guide for Focus Group Discussions with men

Men's Sexual Health/HIV Attitudes, Behaviours and Health-seeking in Malawi

Introductory comments:

- Introduce study and purpose
- Interview purpose: talk about issues related to men's health regarding sex and sexuality
- Consent form: confidentiality, voluntary, reimbursement, use of results
- Explanation of recording
- There are no right or wrong answers to these questions – no-judgemental approach
- Some of these topics are sensitive. We understand that, and appreciate you being willing to help us understand these topics a little better.
- Any questions?

I'd like us to start with discussing some general issues regarding men's attitudes towards their health, and sex and sexual practices.

Section 1: Men's general perceptions on their health

1. What motivates/triggers some men to look after their own health and act to improve their health if they are sick/ill? Do men's wives/partners play a key role in this? What about other people?
2. Why do many men not look after their health when they are sick. Why are men shy to seek health care and support? (**Probe:** Is looking after your health or seeking help seen as being weak/not being a man?)

Section 2: Men's sexual identity, sexual pleasure and performance

3. What does sexual satisfaction mean to men? Why is sexual satisfaction so important to men? How do men ensure satisfaction in their sexual relationships?
4. Is sexual satisfaction also important for men's partners? Are men concerned that women will leave them, or sleep with other men, if they are not performing well during sex/women are not sexually satisfied?
5. Many men told us they take something to improve their sexual performance (e.g. Mthubulo). Why? What type of men and relationships?
6. How does society (other men and women) and culture influence men's attitudes towards sex? **Probe:** on women
7. What else influences men's attitudes towards sex/sexuality? (**Probe:** How does religion [e.g. church groups] influence men's attitudes towards sex?)

Section 3: Men's perceptions on risk-taking

8. Why is it common that many men have multiple concurrent sexual partners [more than one partner you have sex with that overlap in time]? Are men pressured by their peer group?

9. Do women also have multiple concurrent sexual partners? What encourages women to have multiple concurrent sexual partners?
10. Why are men risk takers when it comes to sexual behaviour (such as having multiple concurrent sexual partners)?
11. What makes some men change their sexual behaviours (take less risks)? For example, do men change their behaviours once they find out about their HIV status?

Section 4: Men's use of condoms, contraception and family planning

I'd now like us to discuss about men's approach towards condoms, contraception and family planning

12. Why do men prefer unprotected sex (plain, no condoms)?
13. Do men behave differently inside the home and outside in terms of condom use (for example, use condoms when having sex outside the home with a sex worker?) Why is this?
14. What do women say about men using condoms? [women's opinion/attitude] (**Probe:** Would women rather have unprotected sex?)
15. Are men involved in discussions and decisions at home about contraception/family planning? What areas are they involved in? (**Probe:** e.g. no areas, discussing no of children, discussing the family planning method, etc)?
16. Why is family planning use so low (in general) in Malawi? Why is family planning often seen as only a women's responsibility (men do not get involved)? Why do many men disapprove/not approve of the use of family planning methods by their partner/wife?
17. Why do few men want to have a vasectomy?

Section 5: HIV and AIDS

We are now going to move on to talk about HIV and AIDS

18. Do men feel vulnerable or scared in relation to HIV and AIDS? What do they fear? Why?
19. Why do many men not test for HIV? Why are many men afraid of knowing their HIV status? (**Probe:** Why do many men just assume the status of their wives?)
20. When men do decide to test for HIV, what influences/makes them to do this? Why?
21. What challenges do men face in disclosing (telling other people about) their HIV positive status? (**Probe:** Do they face discrimination if they disclose their status?) Who would a man talk to about this?
22. Is disclosure (of HIV positive status) different for men than women?

23. Why do men often come to health facilities very late for treatment for HIV, once they are already very sick (sometimes when it is already too late)? Are they afraid? Why?
24. What do you think about medical male circumcision? Why do some men get medically circumcised? Do men think they can continue unprotected sex after circumcision?

Section 6: STIs/other sexual health concerns

I'd now like to ask some questions about other sexual health issues for men beyond HIV. [When I say sexual health here, I mean sexual dysfunctions, syphilis, gonorrhea, urethral discharge, ulcers, etc.]

25. Beyond HIV, what are the main sexual health concerns for men? (**Probe:** STIs such as syphilis, gonorrhea, urethral discharge, ulcers?) Please explain.
26. Have men experienced sexual dysfunction (erectile dysfunction, premature ejaculation, etc)? Please explain.
27. Do men seek support for these other sexual health/STI concerns/issues? Will they go for treatment? Why or why not? Where do they go for treatment? Why are men more likely to seek treatment/support for STIs faster than seeking support for HIV?
28. To whom do men disclose if they have an STI? In what circumstances do they disclose?

Section 7: Men's experiences of sexual health services for men

I'd now like us to talk about men's experiences of services available to them for their health relating to their sexual health/sex and sexuality.

29. Are men aware of the services/facilities available for them (to help them with health issues relating to sex and sexuality)?
30. For what reasons do men use public health facilities for services around sex and sexuality? Why? How do they experience them?
31. For what reasons do men use private health facilities for services around sex and sexuality? Why? How do they experience them?
32. Why do some men prefer private health facilities to public (to help them with health issues relating to sex and sexuality)?
33. For what reasons do men use the services of a traditional healer? How do they experience them?
34. Are there different services that men go to traditional healers for (as opposed to public or private facilities)? Would men use the services of a traditional healer at the same time as going to a public or private facility?
35. Is self medication (off the counter medication) common among men? Why is that?

Section 8: Barriers to using public sexual health services/facilities

Everyone is doing very well. Two more sections to go. Thank you for your responses. Next I'd like to ask about any barriers men might face to using public services/facilities for their health around sex and sexuality issues

36. What barriers/challenges, if any, do men face that might keep them from accessing and using the public health facilities they need? (**Probe:** such as quality of services, non-availability of drugs, lack of accessibility, queues, friends/family members getting preferential treatment, and/or confidentiality?)
37. Are current public health services friendly to men? (By friendly we mean courteous, accessible, welcoming, etc). Are these services better for men or for women? Why?
38. Would men rather be seen by a male service provider? Why?
39. Many men travel some distance to use health facilities in other villages, why is that?
40. Does the fact that men work during the day affect their ability to access health services/facilities?
41. Many men we spoke to talked about being frequently stressed due to not having enough income. Do you think this affects men's ability to use health services that they need and their approach towards their health?

Section 9: Improving men's sexual health seeking behaviour and service use

Lastly, I'd like us to explore possible solutions to improving men's ability to look after their health relating to sex and sexuality

42. If you could change anything within existing services/facilities, what would it be? Are there services that should be made more available/developed for men? (**Probe:** would men go to a male only clinic? Why?)
43. Is there a role that women can play to further support men to better look after their health? What about others?
44. In addition to this, are there other ways we can encourage/motivate men to seek care and better look after their health? (**Probe:** Could male support groups/networks play a role?)
45. How could we encourage men to be more interested/involved in family planning?
46. Do you have anything else to say? Do you think this is an important research topic?

Thank you very much for your time. Your feedback will be very important to inform programming towards men's health.

H. Topic Guide for Focus Group Discussions with women

Men's Sexual Health/HIV Attitudes, Behaviours and Health-seeking in Malawi

Introductory comments:

- Introduce study and purpose
- Interview purpose: talk about issues related to women's views on men's health regarding sex and sexuality and their own health issues
- Consent form: confidentiality, voluntary, reimbursement, use of results
- Explanation of recording
- There are no right or wrong answers to these questions – no-judgemental approach
- Some of these topics are sensitive. We understand that, and appreciate you being willing to help us understand these topics a little better.
- Any questions?

I'd like us to start with discussing some general issues regarding women's opinions on men's attitudes towards their health, and sex and sexual practices.

Section 1: Men's general perceptions on their health

1. What do you think motivates/triggers some men to look after their own health and act to improve their health if they are sick/ill? Do men's wives/partners play a key role in this? What about other people?
2. Why do you think many men do not look after their health when they are sick. Why are men shy to seek health care and support?

Section 2: Men's sexual identity, sexual pleasure and performance

3. What does sexual satisfaction mean to women? Is sexual satisfaction important for women?
4. Men told us that sexual satisfaction is important to them, why is sexual satisfaction so important to men?
5. Many men told us they take something to improve their sexual performance (e.g. Mthubulo). Do you think this is true? Why? Are men concerned that women will leave them, or sleep with other men, if they are not performing well during sex/women are not sexually satisfied?
6. How do women influence men's attitudes towards sex? How does society (other men and women) and culture influence men's attitudes towards sex?
7. What else influences men's attitudes towards sex/sexuality? (**Probe:** How does religion [e.g. church groups] influence men's attitudes towards sex?)

Section 3: Men's perceptions on risk-taking

8. Why is it common that many men have multiple concurrent sexual partners [more than one partner you have sex with that overlap in time]? Do women accept men having

multiple concurrent sexual partners? Why do many wives accept or stay with men (stay in the relationships) even if they know these men have other partners outside marriage?

9. Do women also have multiple concurrent sexual partners? What encourages women to have multiple concurrent sexual partners?
10. Why do you think some men are risk takers when it comes to sexual behaviour (such as having multiple concurrent sexual partners)?
11. What makes some men change their sexual behaviours (take less risks)? For example, do some men change their behaviours once they find out about their HIV status?

Section 4: Men's use of condoms, contraception and family planning

I'd now like us to discuss about women's opinion's on men's and women's approach towards condoms, contraception and family planning

12. Why do men have unprotected sex (plain, no condoms)?
13. Do you think men behave differently inside the home and outside in terms of condom use (for example, use condoms when having sex outside the home with a sex worker?) Why is this?
14. What is women's opinion/attitude about using condoms? (**Probe:** Would women rather have unprotected sex?) Why are male condoms preferred by women over female condoms?
15. Are men involved in discussions and decisions at home about contraception/family planning? If men are involved, in what areas are they involved in? (**Probe:** e.g. no areas, discussing no of children, discussing the family planning method, etc)?
16. Why is family planning often seen as only a women's responsibility (men do not get involved)? (For example, many men do not go to the clinic with their wives to discuss family planning issues, even if they are requested to go). Is it important to women that men are involved in family planning/contraception? Do you think use of family planning affects sexual performance?
17. Why do you think many men disapprove/do not approve of the use of family planning methods by their partner/wife? Does men's disapproval affect women's ability to use family planning methods? (For example, does it affect your ability to seek family planning services?) How could we encourage men to be more interested/involved in family planning?
18. What do women think about men having a vasectomy? [Where a man has a simple operation so that he no longer ejaculates sperm during sex]

Section 5: HIV and AIDS

We are now going to move on to talk about HIV and AIDS

19. What do women think about men testing for HIV (it is a good thing if they test)? Do women encourage men to go for HIV testing?
20. Why do you think many men do not test for HIV? Why are many men afraid of knowing their HIV status? (**Probe:** Why do many men just assume the status of their wives?)
21. When men do decide to test for HIV, what do you think influences/makes them to do this?
22. What challenges do men face in disclosing (telling other people about) their HIV positive status? (**Probe:** Do they face discrimination if they disclose their status?) Who would a man talk to about this?
23. Is disclosure (of HIV positive status) different for men than women? Are women more comfortable disclosing their HIV status? Why/why not?
24. If a women's husband is tested HIV positive, is he still accepted by the wife (in other words, the marriage stays together)? Do men accept women who are HIV positive?
25. Why do men often come to health facilities very late for treatment for HIV, once they are already very sick (sometimes when it is already too late)? Are they afraid? Why?
26. What do women think about medical male circumcision? Why do some men get medically circumcised? Do men think they can continue unprotected sex after circumcision?
27. Do you think it is important to involve men in the prevention of mother to child transmission of HIV (PMTCT)? Why is that? If men are not involved, does this have an effect on HIV positive women's ability to take treatment (ARVs/ naverapine) to prevent passing on the HIV infection to unborn child?

Section 6: STIs/other sexual health concerns

I'd now like to ask some questions about other sexual health issues for men beyond HIV. [When I say sexual health here, I mean sexual dysfunctions, syphilis, gonorrhea, urethral discharge, ulcers, etc.]

28. Beyond HIV, are you aware of other sexual health concerns (STIs) that men in this community have? (**Probe:** STIs such syphilis, gonorrhea, urethral discharge, ulcers?) Please explain.
29. Have men you know experienced sexual dysfunction (erectile dysfunction, premature ejaculation, etc)? Please explain.
30. Do men seek support for these other sexual health/STI concerns/issues? Will they go for treatment? Why or why not? Where do they go for treatment?
31. Do men disclose to their wives that they have an STI? If not, to whom do you think they disclose that they have an STI?

Section 7: Men's experiences of sexual health services for men

I'd now like us to talk about women's opinions on men's experiences of services available to them for their health relating to their sexual health/sex and sexuality.

32. Are men aware of the services/facilities available for them (to help them with health issues relating to sex and sexuality)?
33. For what reasons do you think men use public health facilities for services around sex and sexuality? Why?
34. For what reasons do you think men use private health facilities for services around sex and sexuality? Why?
35. For what reasons do you think men use the services of a traditional healer? Why?
36. Do you think self medication (off the counter medication) is common among men? Why is that?

Section 8: Barriers to using public sexual health services/facilities

Everyone is doing very well. Two more sections to go. Thank you for your responses. Next I'd like to ask about any barriers men might face to using public services/facilities for their health around sex and sexuality issues

37. What barriers/challenges, if any, do you think men face that might keep them from accessing and using the public health facilities they need? (**Probe:** such as quality of services, non-availability of drugs, lack of accessibility, queues, friends/family members getting preferential treatment, and/or confidentiality?)
38. Are current public health services friendly to men? (By friendly we mean courteous, accessible, welcoming, etc). Are these services better for men or for women? Why?
39. Many men travel some distance to use health facilities in other villages, why is that?
40. Does the fact that men work during the day affect their ability to access health services/facilities?
41. Many men we spoke to talked about being frequently stressed due to not having enough income. Do you think this affects men's ability to use health services that they need and their approach towards their health?

Section 9: Improving men's sexual health seeking behaviour and service use

Lastly, I'd like us to explore possible solutions to improving men's ability to look after their health relating to sex and sexuality

42. If you could change anything within existing services/facilities for men, what would it be? Are there services that should be made more available/developed for men?
43. Is there a role that women can play to further support men to better look after their health? What about others?

44. In addition to this, are there other ways we can encourage/motivate men to seek care and better look after their health?

45. Do you have anything else to say? Do you think this is an important research topic?

Thank you very much for your time. Your feedback will be very important to inform programming towards men's health.

I. Topic Guide for Health Providers and Key Stakeholder Interviews

Men's Sexual Health/HIV Attitudes, Behaviours and Health-seeking in Malawi

This questionnaire was adapted, as necessary, for public versus private health providers, and for stakeholders. Only those questions directly relevant to the interviewee were asked.

Introductory comments:

- Introduce study and purpose
- Interview purpose: talk about issues related to men's health regarding sex and sexuality
- Consent form: confidentiality, voluntary, reimbursement, use of results
- Explanation of recording
- There are no right or wrong answers to these questions – interested in thoughts/opinions
- Some of these topics are sensitive.
- Any questions?
- **Collect Demographic information**

I'm keen to get your thoughts as a health service provider/manager/stakeholder, as your perspective is very important. I'd like to start with some general questions about your views on men's attitudes and behaviours towards their sexual health, and sex and sexual practices.

Section 1: Men's approach and behaviours towards their sexual health, sexual identity and risk taking

1. In our prior study we found that many men don't look after their own sexual health. Why do you think this is? (**Probe:** Is looking after your health or seeking help seen as being weak/not being a man?).
2. Are there any particular events/reasons/factors that make some men more likely to look after their sexual health? (**Probe:** Do they speak with their friends or partners, and does this affect their health-seeking behaviour?)
3. How do other people affect how men think about and act in relation to sex? Can you please explain (**Probe:** What effect do women's attitudes have on how men think about and act in relation to sex? Other factors/institutions, such as religion?)
4. In our previous study most men we spoke to did not use condoms when having sex. Why do you think this is? (**Probe:** Why is skin-to-skin sex much preferable?) Do you think this is a true reflection of what is going on?
5. We also found that some men are aware of the health risks of multiple concurrent sexual partners and unprotected sex (risky sexual behaviours), but do not change their behaviours (e.g. they don't use condoms, don't have fewer concurrent partners, etc). Why do you think this is that some men don't change their behaviours? (**Probe:** Do some men feel that changing their behaviour will have no effect on their health?) Some men do change their behaviours. Why do you think this is?

Section 2: Men's experiences of sexual health services

I'd now like to ask about services available to men for their health relating to their sexual health/sex and sexuality and men's experiences of them

6. I understand that you provide _____ sexual health services. Is that correct? Can you tell me more about how men use those services?
7. In general, do many men use your health facility/services for sexual health issues? Why? Why not? (**Probe:** Are they aware of the services? Do they see them as accessible?)
8. How do men experience your facility/services around sexual health/sex and sexuality? Why is that? (**Probe:** Are they male friendly?)
9. What is the pathway of care for men in your services?
10. Why do you think men use your services, rather than private or other services? Do you think they come to you first? (**Probe:** where do men go first if they have an issue relating to their sexual health/sex and sexuality?)
11. Some men do instead use private health services for services around sexual health/sex, such as _____. Why do you think that is? How do you think men experience private health services?
12. Why do think other men use the services of traditional healers? How do they perceive and experience these services? Are there different services men get from traditional healers, rather than public or private system? (**Probe:** for example, Mthubulo or Viagra or anything else similar?)
13. In general, do you think men go to different services for different things? (**Probe:** Are there other institutions/services men go to for services related to sex and sexuality?)

Section 3: Specific focus on HIV and AIDS, STIs/other sexual health concerns

I'd like to ask some more specific questions about your HIV and AIDS, and other sexual health services, and men's behaviours towards these issues.

14. Do many men test for HIV in your health centre? Do you find it a challenge to get men to test for HIV? Why? (**Probe:** What makes some men more likely to get an HIV test?)
15. Large numbers of men we spoke to in our study (more than 50%) said they had tested for HIV in last 12 months. Do you think this is the case? Why? Why not?
16. Do you think men who come to your services face any challenges in terms of telling other people about (disclosing) their HIV positive status? Why?
17. We know from research that men often come to health facilities late for treatment for HIV, once they are already very sick. Is this the case with your services? Why is this? How could we encourage men to present earlier and to adhere to HIV treatment? (**Probe:** managing HIV chronic care for men)
18. Do you offer medical male circumcision? What do men think about this?

19. Other than HIV, what are the main sexual health concerns/issues that men present with here? (**Probe:** e.g. syphilis, gonorrhoea, urethral discharge, ulcers?) Why do you think this is?

Section 4: Specific focus on contraception and family planning

Now a couple of more specific questions about your family planning and contraception services, and men's behaviour towards these issues.

20. Do men use your family planning services? Why is that? Are they aware of these services? What do you think about male involvement in family planning? (**Probe:** Is family planning only a women's issue?)
21. In your experience, are men involved in discussions and decisions at home or in their family about contraception/family planning? Why is this? If not, why?
22. Do you offer vasectomy? Why is this? Why do few men want to have a vasectomy? Vasectomy is where a man has a simple operation so that he no longer ejaculates sperm during sex. What do you think about this as a form of contraception?
23. Do you provide condoms and encourage men to use them? Why? Why not?

Section 5: Barriers to using public sexual health services

Thanks for all this very helpful information to date. Only two more sections to go. I'd now like to ask you more about any barriers men might face to using public services.

24. We know that many men do not use public sexual health facilities, even if they are aware of them and need help. Why do you think this is? (**Probe:** Are they seen as spaces for only women and children?)
25. Do you think men face any particular barriers, challenges or concerns when using your health service? (**Probe:** such as quality of services, queues, confidentiality, messaging doesn't target them?). Is there anything else that keeps men from accessing and using services they need?
26. Most men we asked in our survey said current health services available are friendly to men. Why do you think they said that? Can you help us understand this, given that we found many men don't use these services
27. Do you think the fact that men work during the day affects their ability to access your services? How is this?

Section 6: Improving men's sexual health seeking behaviour and service use

Lastly, I'd like to explore possible solutions to improving men's ability to look after their health relating to sex and sexuality

28. Are there services that should be made more available/developed for men to help them better look after their sexual health? (**Probe** for ideas) Do you think current service provision is sufficient?

29. Would you change anything in your existing services for men? (**Probe:** should services be re-orientated/adjusted?) If yes, how? How can we better retain men within the health system?
30. Most men in our survey said they didn't want specific health facilities for men. Can you help us understand why this is? Do you think there should be specific facilities for men?
31. Are there specific legal or policy changes we should seek to improve men's health seeking behaviour and service use?
32. In addition to this, are there other ways we can encourage/motivate men to seek care and look after their health? (**Probe:** Could male support groups/networks play a role?)
33. Do you think the topic of men's sexual health is an area requiring more exploration/research? Are there any other key issues on this topic for you that we haven't discussed, or any other comments you have on the topic?

Thank you very much for your time. Your feedback will be very important to inform programming towards men's health. **Ensure to leave a copy of the information sheet,**

- Are there other people/staff you recommend I speak to?
- Are there specific outputs from my research that could support your work? (poster idea)
- Ok to conduct observation (if applicable)?
- Any additional suggestions for my research?

J. Example of bespoke questions for Key Stakeholder Interviews

~~Reproductive Health Unit~~ Reproductive Health Unit

- Men and women said they preferred plain sex. Do you agree? How can we address this? (K11033)
- FI seen by some men as only a women's issue. Why do you think this is the case?
- Men's objections to FP. ^(pleasure, side effects, heavy side effects, etc) Are there ways we can address these?
- Men's lack of knowledge on FP methods. Is that true?
- ~~Discomfort~~. What do you think about that method?
- Family planning services in district. Do you think these are more orientated to women?
- STIs. Who does that fit within your?
- Men seeking STI care. Is this an opportunity to link men to other services?
- Male sexual dysfunction + impotence. Is this something you can address?
- Many men for their key'd had MI. Do you agree? Why is this?
- Sexual pleasure and openness concept or important for men and women. Is this something that is discussed by you?
- What could we do to encourage men to be more involved in FP?
- Contraception does not focus much on men's role in FP. Why is this?
- Men use traditional leaders for impotence. Are there links between traditional leaders and sexual health services?
- Do you agree that we face specific barriers to access ^{public} health facilities (lay line, length of queue, no internet, sign for women, environment very crowded by female staff members)?
- Service
- Why do you think that is the case?
- Disruption

K. Template for health facility observation

Participant Observation checklist: Health Services

ID number
_____ / _____

Location _____
Date _____
Time period/s _____

Clinic type/service	
Clinic opening hours	
Number of men in the clinic (compared to women and children)	
Who are men? Are they alone? Are couples attending together?	
Appearance of men (estimated age, expressions, do they appear comfortable?)	
Verbal behaviour and interactions by men with health care staff (engagement with staff, how long, tone of voice)	
Interactions with other people (between couples, between men and women, how long, tone)	
Physical behaviours (what men do, personal space, physical interactions)	
Clinic space (open/closed, privacy, queues, same waiting area for men and women?)	
Pathway of care and flow (is there clear pathway for men? How much of a flow in place?)	
Average time in clinic (when men come and leave)	
Quality of care indications (confidentiality, positive treatment by staff)	
Signs/posters/materials (and specifically targeting men?)	
Any male targeted services? (such as male only clinic or room)	
HIV VCT services (men using services? Targeted to men?)	
ART services (men using services? Targeted to men?)	
STI services (signs of men using services? Targeted to men?)	
Family planning services (are men using family planning services? Targeted to men?)	
Antenatal care (ANC) services (Do male partners come with wives/partners? Are	

men involved in ANC services?)	
Other sexual health services for men - sexual dysfunction, etc (signs of men using services? Targeted to men?)	
Condoms available? Are they visible?	
Other services being offered	
Educational and health talks Topic? Men attending? Relevant for men?	
Anything else related to service? Any other notes.	

L. Matrix for secondary male client data collection from health facilities

Public & Private Health Service Follow-up Checklist: men's Use of Sexual Health/HIV Services/Male Clients. THIS IS ABOUT MEN ONLY

Ref	Clinic and area	Date:	Name, position and tel no:	
HIV testing and men coming late				
HIV testing male/female client numbers (numbers or percentage and period)		Male:	Female:	Period of time for figures:
Average age of your male HIV testing clients				
Of those testing HIV positive, how many (or percentage) men and women?		Male:	Female:	Period:
Are your male clients for HIV testing mostly local (this town or area) or from another town (not this area)?		Percentage local (this town/area):		Percentage from elsewhere:
What percentage of men would come directly to test through HCT/HIV testing (excluding MMC) and what percentage would be referred from Out Patient Department (OPD) (likely that they are already sick)?		Percentage male HIV testing clients coming directly through HCT/HIV testing (excluding MMC):		Percentage male HIV testing clients referred from OPD:
Of total men testing positive, how many (percentage) do not go on for treatment/other services/are lost to follow-up?				
HIV treatment				
Do you provide ART? If yes, what are your ART/HIV treatment client numbers male/female		Male:	Female:	Period:
Average age of your male ART clients				
If no to ART provision, do you refer? Where?		Refer, yes/no:	Location of referrals for ART:	
What percentage of your <u>male</u> ART clients would be local (this town or area) or from another town (not from this area)?		Percentage local (this town/area):		Percentage from elsewhere:
Do you sometimes have ARV drug shortages? How common?		ARV drug shortages: yes/no?		If yes, how common?

Men coming late and other HIV services			
Out of all men who come for your HIV services (esp. testing), what percentage come late for HIV services (when already sick and have advanced stage HIV)? How common is this?	Percentage men coming late for HIV services?	How common?	
For those men who do come late with HIV, how many (what percentage) die as a result?	No men dying coming late:	Period:	
How many (percentage) men, if any, accompany their partners within your PMTCT services?	Percentage PMTCT women with accompanying partners:	Period:	
How many men come for MMC? What ages?	No MMC clients:	Period:	Typical age:
Is HIV testing a requirement of your MMC services?			
Do you have HIV support groups? If yes, what percentage of men are a part of these?	HIV support groups: yes/no	Percentage membership male:	
Sexually Transmitted Infections			
Do you offer STI testing and treatment? STI client numbers (percentage) male/female?	Male:	Female:	Period:
If no to STI services, do you refer? Where?	Refer, yes/no:	Location of referrals for STI services:	
Are your male clients for STIs mostly local (this town or area) or from another area/town (not from this area)?	Percentage local (this town/area):	Percentage from elsewhere:	
Average age of your male STI clients			
Are men required to bring wife/partner before accessing STI treatment? If they do not, do you still provide treatment?	Requirement to bring partner STI services:	What happens if men come alone:	
Must a man coming for STI treatment be tested for HIV?			
Most common STIs among men in your clinic?			
Family Planning			
How many men (percentage) accompany wives to your family planning (FP) services?	Percentage men accompanying wives:	Period:	
How many men use your FP services separately (alone)?	Percentage men using FP services alone:	Period:	

Vasectomy. Do you offer it in your clinic? If so, how many men use this service?	Number/percentage men having vasectomy:	Period:			
Any other specific family planning services for men?					
How many men attend ANC services with wives?	Percentage men accompanying wives:	Period:			
Do you provide condoms? If yes, male and/or female? How do men access them? Do men need to ask for them, or are they available at points in the clinic (in a box, toilets, etc)?	Condoms, yes/no?	Male and/or female?	How to access?		
Other male sexual health services					
Do you provide male infertility services?	Yes/no:	Details:			
Do you provide services for sexual dysfunction for men?	Yes/no:	Details:			
Do you have any specific group meetings/activities for men?	Yes/no:	Details:			
Charges and referrals					
Any other sexual health services for men that you provide?					
Charges/Cost of services? HIV testing? HIV treatment? STI testing? STI treatment? Family Planning?	Cost HIV testing	HIV treatment	Cost STI testing:	STI treatment:	Cost FP:
Private services only: are your HIV or STI services subsidised by government?	Yes/no:	Details:			
Do you refer for any male sexual health services to public? Private? Traditional healers? For what do you refer?	Refer public, yes/no: Details:	Refer private, yes/no: Details:	Refer traditional, yes/no: Details:		
General details on service					
Opening and closing hours					
Do you offer services to men in the evening or the weekend? If yes, do many men use them?	Evening services hours: Details on men's use:		Weekend services hours: Details on men's use:		
Which health passport do men use in your clinic?					

Any notes	
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M. Handout at community meeting to disseminate initial research findings



Community meeting on results of men's Sexual Health/HIV research in Ndirande South

Kafufuku wa chiyani?: Tikambirana zotsatira za kafukufuku amene tinachita mbuyomu okhudzana ndi umoyo wa abambo pa nkhani ya kugonana, ndi HIV. Tinacheza ndi anthu ambiri mu madera, abambo, amayi ndi ogwira ntchito mu zipatala, timakhala nawonso ku malo olandilira zithandizo za umoyo.

Msonkhano uno: Tikambirana zomwe tinapeza mukafukufuku ameneyu kenako tiunikilana kuti titani pa zimenezi. kukambirana zotsatira zakafukufuku ndi anthu amene anatenga nawo gawo pakufukufukuyi ndi mbali imozi yofunika kwambiri pakafukufuku aliyense kuti akhale ndi phindu. tikuzani zomwe tinapeza kenako tikambirana tonse inu ndi ife. osadandaula zakumwa zozidziritsa kukhosi zilipo ndithu.

1: Men's health, sexual identity and gender norms

- Poomba mkota amuna sakhala ndi chidwi kuyang, anira thanzi kapena umoyo wao. zifukwa zina zolepheletsa iwo kutero ndi monga: kusowa kwa mauthenga oyenera komanso kusamvetsetsa, mantha, manyazi, kunyozera, udindo omwe ali nawo mbanja, kutanganidwa komanso ali ndi tizifukwa ndi zithandizo zakuchipatala. akazi amatsatira bwino nkhani za umoyo.
- Amuna akuyenera kukhala olimba komanso athanzi nthawi zonse ndinso osadwaladwala. kupita pita kuchipatala kumaonetsa kufooka kapena kuti kusakhala mwamuna weni weni
- Abambo amakhala ndi nkhwawa yosamalira banja lawo. Kuyang'anila thanzi lawo sichofunikila kwa iwo.
- Kusapeza nthawi yopumula pa ntchito kapenanso kusakasaka ntchito kumapangitsa kuti asamaziyang'anile thanzi lawo.
- Akazi awo, abale, ndi anzawo ali ndi udindo waukulu kwambiri pa kapitidwe ka kuchipatala ka amuna. Abambo okwatira amatha kuwulira akazi awo. Osakwatila amatha kuwulira anzawo.
- Anzawo amalikitsa amuna kuyanganira umoyo wao, amapeleka malangizo kunkhani zogonana, kukambirana zamatenda opatsilana pogonana komanso atha kuwalimbikitsa kukhala ndi zibwenzi za nseli. amuna amauza nzawo wapamtima yekha ngati atapezeka ndi kachilombo ka HIV
- Kusamasukilana pankhani zogonana kuli ndi kuthekera kopangitsa amuna kupanga zibwenzi za nseli
- Kuchita bwino ndi kukhutitsidwa pogonana ndikofunika kwa amayi ndi abambo. zingapewetse kukhala ndi zibwenzi za nseli, ndi kuteteza ku kachilombo ka HIV. Mamuna akathila umuna amakhala kuti wakhutira. Amuna ambiri amagwilitsa ntchito mthubulo ndi tseketeke kuti azikhala ndi mphamvu zambiri pogonana. Amuna ambiri amangoyang'ana za kukhutitsidwa kwa iwo okha pogonana. Akazi ena amatenga gawo lalikulu pa nkhani zogonana pa amuna awo.
- Amuna ambiri adakhalapo kapena ali ndi zibwenzi za nseli. Chifukwa cha kuonela anzawo, pofuna kungoyesa chabe, ndalama, mowa, kungofuna kungosangalala, kapena kukopeka ndi mabvalidwe a akazi ena. Akazi zimenezi amazibvomeleza. Kudziwa

amadziwa kuti izi zimayika miyoyo yawo pa chiwopsyezo, koma amuma ambiri amasankha kusasintha chikhalidwe chawo pa nkhani imeneyi komabe ena akusantha , ziwainso kuti akazi nawonso amakhala ndi zibwenzi za nseli. Akazi amenewa amachita izi kamba kofuna ndalama, komanso ngati chida chopezela katundu (ngati mphatso/ ma units amu phone). *(kusakhutitsidwa ndi amuna awo pogonana)*

Section 2: Condoms and family planning

- Anthu ambiri amakonda kugonana kwa plain. Zifukwa zolepheletsa kugwilitsa ntchito makondomu kwa iwowo zimakhala ngati; kondomu imalepheletsa kumva kukoma kwambiri, chizolowezi, zobetchela zomwe zimadza ngati khansa ya khomo la chibelekelo, ngakhale HIV imene, kusapezeka kwa kondomu, kuchuluka kwa mafuta a mukondomu. Maganizo a akazi pankhani yokhudza kondomu amakhudza abambo. Nthawi zambiri akazi safunsa kugwilitsa ntchito kondomu, ena amachita manyazi kupeza kapena kufunsa makondomu.
- Kugwilitsa ntchito kondomu mu banja zimaonetsa ngati simukukhulupilirana.
- Amuna amachita mosiyana pogwilitsa ntchito kondomu kunja kwa banja, kaya ndi zibwenzi koma osati mu banja mwawo, koma ngati analipila ndiye amafuna plain cholinga choti ndalama zawo azinjoye.
- Kulera ndi nkhani ya banja lonse osati amayi okha. Onse amatha kukambirana za njira yoti agwilitse ntchito kapena akhale ndi ana angati koma kukatenga njira zimenezo, amawasiyila amayi.
- Zolepheletsa abambo pa nkhani ya njira za kulera, kuchepa kwa chilakolako pogonana, mabvuto amene amadza pogwilitsa ntchito njirazi, chipembezo, kukhala ndi ana ochepa, komanso kupezeka ndi zibwenzi za nseli kwa okondedwa awo. Akazi ambirri anabvomelezanso nkhani zimenezi.
- Kukhala ndi ana mu banja ndi kofunikila kwambiri kwa aliyense.
- Ndalama zosamalira ana kuti akule ndi chifukwa chachikulu chimene amuna amuna amabvomelera njira za kulera.
- Amuna ambiri sadziwa njira za kulera zomwe angagwilitse ntchito. Amuna ndi akazi onse amakana njira ya kutseketsa, nkhwawa pa njira yotseketsa; ndi yamuyaya, sipezeka, mantha ndi operation, kuchepa kwa chilakolako pogonana (chikhulupiliro kuti sumakodzela umuna ukapanga njira imeneyi).
- Amuna amafuna atamva zambiri pa nkhani zakulera. Mauthenga amene alipo kwa amuna okhudza njira za kulera ndi ochepa. Komanso njira za kulera zimaoneka ngati ndi za amayi okhaokha.

Section 3: HIV and AIDS

- Amuna amamvetsetsa za HIV ndi kuopsya kwake, ngakhalebe anthu ena ali ndi nkhani za bodza pa nkhani imeneyi.
- Amuna ambiri akuti anayezetsa HIV kuti adziwe mmene nthupi mwawo muliri kapena chifukwa choti okondedwa wawo anawakakamiza kutero, komabe, achipatala akuti amuna sayezetsa ambiri, Kodi amuna amenewa akutinamiza?
- Zobetchela kwa amuna kuti akayezetse; kukhulupilira kuti ali ndi matenda kale, kukhulupilira kuti kupezeka ndi HIV ndiye kuti wafa basi ndi mantha kuopa kutsalidwa komanso kunyozedwa.
- Chifukwa cha izi amuna ambiri amangotengela zotsatira za akazi awo kuti nawonso ali choncho.
- Kupezeka opanda kachilombo kumapangitsa amuna kukhala ndi makhalidwe abwino.
- Akapezeka kuti alinako, ena amasantha kukhala ndi khalidwe labwino koma ena, amapatsila dala akazi cholinga kuti afanane basi.
- Kuopa kwa kachilombo kuli ndi gawo lalikulu pankhani yotenga mbali pa umoyo wawo pambali pa HIV.
- Mmodzi mwa khumi aliwonse anatiuza kuti ali ndi kachilombo ka HIV.

- Zokanikitsa amuna kuti awuze akazi awo, abale, anzawo, mabwana awo, kupatula anzawo apamtima kuti ali ndi HIV ndi mantha kuti akazi samakhalanawonso chidwi, komanso kupakidwa kuti amagonana ndi ambiri.
- Akazi amabvomeleza amuna akawauza mmene nthupi mwawo muliri koma amuna amazuzula akazi kuti ndi amene abweletsa matenda mnyumbamo.
- Kutsalidwa ukapezeka ndi HIV kulipodi komanso ena amangoganizila chabe. Kulinso kudzitsala wekha pakati pa amuna amene ali ndi HIV. Magulu othandiza amuna amene ali ndi HIV alipo ochepa.
- Amuna ena amaopa kumwa ma ARV chifukwa cha zotsatila zimene zimabwela (zimaononga maonekedwe) umadwala ukamamwa mamkhwala tsiku ndi tsiku. Amuna ambiri amapita kutali kukalandila ma ARV kuopa kuti angaonedwe pa mzere. Amuna ochepa kwambiri ndi amene akulandira ma ARV kusiyana ndi akazi.
- Amuna ambiri amapita kuchipatala mochedwa akafika podwalitsitsa. Awawa amakhala kuti alibenso njira ina koma kuyezetsa basi ndiye amuna ambiri amafa chifukwa chochedwa kulandira thandizo.
- Mdulidwe ndiwodziwika kwambiri (wakuchipatala), imaonedwa kuti ndi njira ya ukhondo, imaonjezela mkomelo pogonana, imachepetsa chiopsyeyo chotenga HIV, theka la amuna omwe tinacheza nawo anadulidwa (ochulukilapo ku Chiradzulu kusiyana ndi Blantyre). Akazi ena anati amakonda amuna odulidwa. Amuna ena anati mdulidwe wa ku chipatala ukukulitsa kupatsilana HIV, popeza amuna odulidwa amachita mchitidwe ogonana plain.

Section 4: Sexual health

- Matenda opatsilana pogonana ndi odziwika kwa amuna ku mmwera kwa dziko la Malawi. Mamuna mmodzi pa amuna atatu adanena kuti adakhalapo ndi zizindikilo za matenda opatsilana pogonana, odziwika kwambiri ndi monga, Chindoko, Chizonono, Bubo, Likango, Mauka.
- Matenda opatsilana pogonana amaoneka kuti amachilitsika kusiyana ndi HIV. Amuna amathamangila ku chipatala ndi matenda opatsilana pogonana, chifukwa cha ululu wake, zotsatila za matendawa ku moyo wawo wa kugonana komanso kuopa kuti anthu ena adziwa kuti ali ndi matenda opatsilana pogonana.
- Kuchita manyazi pamene muli ndi matenda opatsilana pogonana kusiyana ndi pamene uli ndi HIV. Amuna amatha kuwauza anzawo za izi, kusiyana ndi kuwauza akazi/abwenzi awo, ndipo amapeza chithandizo pa iwo okha pokhapokha akakhala kuti akakamizika zibvute zitani akuyenela kupita onse limodzi. Amuna amatha kungowapatsa akazi/abwenzi awo bukhu lakuchipatala kuti aziwonele okha popanda kuwafotokozela bwinobwino.
- Amuna amamafunsa chithandizo cha matenda opatsilana pogonana poyezetsa ndi kulandila mamkhwala ku zipatala za boma, za private kapena kwa aasing'anga. Zipatala za boma zimaonedwa kuti amuna amanyozedwa ndipo amawuzidwa kuti akabwele ndi akazi/abwenzi awo pokalandila chithandizo. Mmalo mwake amuna amapita ku chipatala cha private ngati angakwanitse kulipira. Ku madela a mmidzi, amuna amapita kwa asing'anga koyambilira pa matenda opatsilana pogonana. Amuna amathanso kuzigulira okha mamkhwala koyambilira pa matenda opatsilana pogonana.
- Amuna ena amada nkhwala ndi kuthila umuna mwachangu pamene akugonana ndi kusachita bwino pogonana. Amuna amasowa kuzindikila pa nkhwala zimenezi ndipo zithandizo palibe. Amuna amagula mamkhwala kapena kupita kwa asing'anga pofuna chithandizo (makamaka ku mmidzi). Amuna sakonda kukamba ndi anzawo za nkhwala zimenezi,. Akazi saganiza kuti awa ndi mabvuto amene amuna amakumana nawo.
- Amuna oposela theka amagwilitsa ntchito mamkhwala azitsamba (theka ndi theka la theka ku midzi). Ambiri amagwilitsa Nchape, Tseketeke, Gondolosi ndi Mthubulo. Dzifukwa zimene zmgwilitsa ntchito mamkhwala a zitsamba ndi; kuonjezela mphavu pogonana, kuonela anzawo ndi kufuna kukhaulitsa akazi/abwenzi awo. Amuna ena amati mamkhwala azitsamba amagwila ntchito, ndipo amuna ena amati samagwila

ntchito. Akazi amati kugwilitsa ntchito mamkhwala azitsamba pakati pa amuna sikunafalikile kwambiri.

Section 5: Health system use, experiences and barriers

- Amuna akudziwa za zipatala zomwe zilipo koma nthawi zina samadziwa za zithandizo zimene zimapelekedwa. Amuna ambiri kusiyana ndi akazi samagwilitsa ntchito zithandizo zokhudza moyo ogonana ndi zokhudza HIV. Amuna amagwilitsa ntchito zipatala ndi malo a boma, za private, asing'anga ndi kuzigulira okha mamkhwala pa nkhani ndi zokhudza moyo ogonana. Amuna amati zithandizo zimenezi ndi za aliyense – amuna, akazi, ndi ana ngakhale kuti zipatala ndi malo ambiri ndizikomela amayi.
- Amuna ambiri amagwilitsa ntchito zipatala za boma pa nkhani yokhudza kugonana ndi moyo ogonana. dzifukwa ndi monga; malo akakhala pafupi, amakhla ndi akadaulo/odziwa ntchito yawo ndipo ndi zaulele. Amuna adafotokoza kuti amalandila chithandizo chabwino ku malo amenewa. Ogwila ntchito za umoyo ena ndi ozipeleka kuthandiza amuna.
- Zobetchela kwa amuna ku zipatala za boma ndi monga; kudikilira chithandizo kwa nthawi yayitali, mizere yayitali, kuchuluka kwa anthu, kuchedwa kutsegula zipatala, kusathandizidwa moyenera kuchokela kwa ogwira ntchito, kuchiititsidwa manyazi powuzidwa kuti abvule zobvala ndi ogwila ntchito wachichepele wa mkazi, kusowa kwa mamkhwala, kusowa kwa zithandizo, kusowa chinsisi, ndi kuonedwa ndi anthu ena. Ku malowa amaika chidwi kwambiri kwa akazi ndi ana. Popeza amuna amakhala otanganidwa, amagwa ulesi/mp Hwyayi kupita ku zipatala za boma.
- Zithandizo za mu zipatala za boma zikhonza kukhala zabwino kusiyana ndi mmene amuna akunenela. Zikhoza kusiyana ndi mmene amaganizila ndi memene ziliri. Ogwira ntchito mu zipatala ndi malo a za umoyo anafotokoza za mpanipani ndi kutanagnidwa komwe amakhala nako ndi anthu ofuna zithandizo ochuluka omwe amayenela kuthandiza tsiku ndi tsiku.
- Amuna ambiri akadakonda kupita ku zipatala za private kusiyana ndi za boma., akadakhala kuti ali ndi ndalama. Ku zipatala za private kumakhala changu, chisamaliro chabwino, mamkhwala amapezeka, chinsisi chokwanira ndi kulandilidwa kwa bwino. Ndi kwabwino kwa amuna chifukwa amafuna kutandizidwa mwachangu. Amuna amagwilitsa ntchito zipatala za private ku nkhanui yokhudza matenda optsilana pogonana kusiyana ndi HIV. Amuna ena sanasangalatsidwe ndi zomwe anakumana nazo ku zipatala za private. Mitengo imasiyana mu zipatala za private pa zithandizo zofanana.
- Amuna ambiri amagwiitsa ntchito asing'anga (makamaka mmidzi). Asing'anga amapeleka chithandizo kwa munthu okha osadzela mwa munthu wina, amasunga chinsinsi. Zithandizo zina zimapezeka kwa asing'anga okha monga; kusabeleka, ufiti. Amuna ena anasangalatsidwa ndi zithandizozi, ena sanasangalatsidwe. Asing'anga amagwila ntchito yofunikila ku nkhani za umoyo ogonana wa amuna ngahale kuti pali kulumikizana kochepe pakati pa asing'anga ndi zamakono.
- Amuna ambiri amazigulira okha mamkhwala mmalo mopita ku zipatala, monga; Bufen, Bactrim ndi Panado. Khalidwe limeneri ndi lochuluka poganizila kutanganidwa kwa amuna ndi zobetchela zomwe ziri mu zipatala. Kwa amuna ena, kuzigulira mamkhwala mwa iwo okha kumangothandiza kwa nthawi kochepe bvuto lomwe ali nalo, ndipo mabvuto/matenda ena monga opatsilana pogonana amatha kumakulirakulira pamene nthawi ikupita.

Section 6: Recommendations

- Anthu ambiri amene anatengapo mbali mu kafukufuku ameneyu anati ndiwofunika. Amuna ena anati kanali koyamba kukambilana zimenezi ndi ena.
- Akazi ndi amene amalandira ma pulogalamu ndi mauthenga ku Malawi ndipo zambirir zikuyenela kuchitika pofikilanso amuna.
- Maganizo ena anali oti; Paunikilidwe ndi kuthetsa zobetchela zomwe zili mu zipatala ndi malo a zaumoyo zokhudza amuna, moga; kukonza ogwila ntchito, nthawi yotsegulira

malowa, chinsisi ndi kupezeka kwa mamkhwala, pakhale malo/zipinda/zithandizo zokhudza abambo ku malo amene alipo pakali pano, alembe owila ntchito ochulukilapo mu zipatala, Amuna afikilidwe ndi zithandizo za kuchipatala, zokopa kuti amuna azipita ku zipatala poganzizila kuti amuna amakhala ndi udindo wa pakhomo, misonkhano yowakopela amuna, kuphunzitsa kufikila malo a ntchito awo, ku mipingo, ku masewelo, magulu a amuna, ndi mapulogalamu okhuza amuna.

Questions for discussion:

1. Tikufuna timve maganizo anu pa zimenezi. Kodi zotsatirazi zikusonyeza zimene mumakumana nazo mu umoyo wanu wa tsiku ndi tsiku? Kodi zotsatirazi ndi zimene mukulingalira m'maganizo anu?

Do these research results reflect your experiences? Are they a correct interpretation of what is going on in your opinion?

2. Kodi pakufunika kuti pachitike chani mu dela lino kuti zimene zapezeka mu kafukufuku amaneyi zimveke. Kodi mukufuna pachitike zotani kutsogoloku?

What could be done in the community to address these issues raised by the research results? What would you like to see happen next?

Kafukufukuyu wachitika mogwirizana ndi University College London, University of Cape Town ku South Africa, ndi ku Malawi Liverpool Wellcome Trust ku Blantyre. Ethical approval: Malawi NHSRC protocol #1267

ZIKOMO KWAMBIRI CHIFUKWA CHA NTHAWI YANU!

Ngati pali zina zofua kudziwa, funsani Tim Shand pa kapena Zikomo from the research team...

N. Mapping template for scoping local health services in research area

Health Facility Mapping Tool

Aim: identifying available sexual health/contraception and HIV services to men across all sectors.

Typical services for men might include: HIV testing, HIV treatment (ART), STI testing, STI treatment (syphilis, gonorrhoea), MMC, PMTCT, erectile dysfunction, condoms/contraception, family planning, counselling (including couple counselling).

Specifically interested in what is available for men themselves. **Please be as specific as possible about what they provide and do not provide**

1. Public services (primary, tertiary, specific clinics)

- Identify any public services/clinics, and visit these to establish what services are available for men

Name	Location	Type	Sexual health/HIV services available for men
Any observations			

If you speak to anyone, please take their name and contact number:

Name	Location	Type	Sexual health/HIV services available for men
Any observations			

If you speak to anyone, please take their name and contact number:

Name	Location	Type	Sexual health/HIV services available for men

Any observations			

If you speak to anyone, please take their name and contact number:

2. Private clinics/health facilities

- Identify any private services/clinics, and visit these to establish what services are available for men

Name	Location	Type	Sexual health/HIV services available for men

Any observations			
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If you speak to anyone, please take their name and contact number:

Name	Location	Type	Sexual health/HIV services available for men

Any observations			
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If you speak to anyone, please take their name and contact number:

3. Traditional healers/traditional medicine

- Identify, and visit these to establish what services are available for men, if possible

Name	Location	Type	Sexual health/HIV services available for men

Any observations			
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If you speak to anyone, please take their name and contact number:

O. Information Sheet and Consent Form – IMAGES survey

ZOKHUDZANA NDI KAFUKUFUKU WA IMAGES

IMAGES ndi kafukufuku wa m'makomo amene tikupanga pofuna kupeza zambiri zokhudzana ndi uchembere wabwino komanso kusiyana kwa ntchito pakati pa amuna ndi akazi. Kafukufukuyu akhudza kagulu ka anthu amene ndi okwatira kapena osakwatira azaka za pakati pa 23 ndi 45. Anthu amenewa azafunsidwa zambiri zokhudzana ndi moyo wawo wa m'mbuyo, kasiyanidwe ka amayi ndi abambo pa ntchito zomwe amagwira komanso pa zokhudzana ndi uchembere wa bwino, maubwenzi apakati pa mkazi ndi mamuna, akazi kapena amuna okhaokha ndinso kadziwidwe kawo pa matenda a HIV/AIDS ndi ena opatsirana pogonana osayiwalanso za m'mene amasalira moyo wawo. Zimenezi zizathandiza akuluakulu okonza ndondomeko ndi mapologalamu a boma mu madera owona zaumoyo, kusiyana kwa ntchito pakati pa amuna ndi akazi komanso umoyo wabwino wa maanja. Zotsatira zakafukufukuyu zizangwiritsidwa ntchito pofuna kudziwa ndi kumvetsetsa malingaliro a amayi ndi abambo kwa wina ndi nzake komanso kulimbikitsa kumvetsetsana ndi kulemekezana pakati pawo. Tikuchita kafukufukuyu kuti tidziwe ndi kumvetsetsa za malingaliro a amuna kwa akazi makamaka kumbali ya m'chitidwe wogonana ndi uchembere wa bwino komanso za m'mene amatengera mbali pakasamalidwe ka banja.

Kafukufuku

Kafukufukuyu achitikira mu maboma asanu azigawo zonse zitatu za Malawi. Mabomawo nawa: Lilongwe, Blantyre, Kasungu, Mzimba ndi Chiradzuru. Kafukufukuyu akubwera pambuyo pa kafukufuku wina yemwenso tinachita mumadera omwewa miyezi yapitayo. Kagulu ka anthu okwana 1500 kanatenga nawo mbali mukafukufuku oyambayo koma panopa tikungofuna kucheza ndi anthu ochepa chabe kuchokera kumadera onse tatchulawa. Pali mfundo zingapo zomwe anthu anatiuza mukafukufuku oyambayo zomwe tikufuna titadzimvetsetsa kwambiri. Ichi ndichifukwa chake tabweranso kuno kuti tichenzenso ndi anthu. Mafunso adzafunsidwa kwa munthu modzi pa banja lirironse limene lidzasankhidwe moonetsetsa kuti bambo kapena mayi modzi pa nyumba iliyonse ndiyemwe wafunsidwa mafunso. Zoyankhula zanu zizalembedwa komanso kujambulidwa ndipo zidzatithandiza kukonza mfundo zofunikira potukula umoyo wa abambo komanso amayi kuno ku Malawi.

Chinsinsi

Zimene mudiuze pano ndi zofunika kwambiri makamaka pofuna kumvetsetsa ubale wa pakati pa abambo ndi amayi. Kucheza kwathu kukhala kwa chinsinsi. Pakutero simukuyenera kudandaula chifukwa chakuti zimene mudiuze pano zizagwiritsidwa ntchito pa zolinga za kafukufukuyu basi ndipo sizidzaperekedwa kapena kuululidwa kwa wina aliyense ngakhale kwa okonedwa anu. Zonse zimene mudiuze zizagwiritsidwa ntchito molingana ndi ndondomeko za kafukufuku wa bungwe la PACHI ndipo zizakhala za chinsinsi. Dzina lanu silidzaoneka pena paliponse. Angakhale kuti kucheza kwathu kudzajambulidwa pa tape, ife tikukutsimikizirani kuti zimenezi sizidzagwiritsidwa ntchito ina iliyonse kupatula ya kafukufukuyu. Zidzizaulutsidwa pa wayilesi ndipo tidzadzimvera ndife tokha akafukufuku.

Kuwopsya kwake

Inu ngati otenga mbali mukafukufukuyu, zovuta ndizochepa. Mkatikati mwa kafukufuku mukhoza kundiuza ine kapena nzanga wina aliynse amene ndikugwira naye ntchito zina zimene mukuziona kuti simukuyenera kuziulula. Ndipo mafunso ena akhoza kukhala okukhumudwitsani kapena kukuchititsani manyazi. Muli ndi ufulu kukana kuyankha mafunso otero.

Ubwino wake

Ngakhale simungaone ubwino wa kafukufukuyu panthawi yomwe akuchitika, koma zizatithandiza kudziwa mavuto amene abambo ndi amayi amakumana nawo pofuna kukhazikitsa ndondomeko zoyenera. Inuyo, anzanu kapena abambo ndi amayi a kuno ku Malawi adzapindula naye kafukufukuyu m'tsongolo muno. Komanso kafukufukuyu angathenso kutithandiza kuwonjezera ulemu ndi kuchepetsa nkhanza pakati pa abambo ndi amayi.

Ufulu okana kuyankha mafunso kapena kutenga nawo mbali

Ziri kwa inu kutenga nawo mbali pa kafukufukuyu kapena ayi. Ngati mwavomera kutenga nawo mbali pa ntchitoyi mulinso ndi ufulu kukana kuyankha mafunso ena kapena kusiiratu kutenga mbali pamene ntchitoyi ili mkati. Nganizo lanu lokana kuyankha mafunso ena kapena kusiya kutenga mbali silidzabweretsa vuto lirilonse pa inu kapena banja lanu. Ndinu omasuka kufunsa mafunso musanavomereze poika chizindikira cha dzina lanu pa tsambali, ndipo ngati mukufuna mukhoza kutenga tsamba limodzi kukhala lanu.

Chilolezo chotenga nawo mbali mukafukufuku wa IMAGES

Ndawerenga kapena andifotokozera muchiyankhulo chimene ndimamva za tsamba limeneli la chilolezo, ndipo mafunso onse amene ndinafunsa ndayankhidwa ndipo ndakhutira. Pakutero, ndikuvomereza kutenga nawo mbali mukafukufuku ameneyu. Ndauzidwanso/ndawerenga kuti kucheza kwanthu kudzajambulidwa pa tape ndipo ine ndavomereza.

Signature/chidindo cha ofunsidwa Tsiku:

Signature ya ofunsa Tsiku:

Code:

Mukafuna kudziwa zambiri funsani: Parent and Child Health Initiative (PACHI), Lilongwe, Malawi

P. Consent Form & Information Sheet for qualitative research

MEN'S SEXUAL HEALTH/HIV ATTITUDES, BEHAVIOURS AND HEALTH-SEEKING IN MALAWI

Zikomo mwabwera pano

Ndikuthokozeni chifukwa cha chidwi chanu kuti mutenge nawo mbali mu kafukufuku ameneyu. Musanavomereze kuti mutenge nawo mbali, amene akupanga kafukufukuyu ayenera kukufotokozerani bwino lomwe za kafukufuku ameneyu kuti mumvetsetse zones zokhudza kutenga nawo mbali. Ngati muli ndi funso lina liri lonse, chonde mufunsi amene akupanga kafukufukuyu musanapange chiganizo kuti mutenge nawo mbali. Mupatsidwa Ndongomeko yonse ya kafukufukuyu yomwe mutha kuona nthawi ina ili yonse.

Cholinga cha kafukufukuyu

Kafukufukuyu akufufuza za chikhalidwe cha amuna mu Malawi, maganizidwe and makhalidwe awo okukhudza umoyo wogonana, ndi HIV, komanso machitidwe okhudza kusamalira umoyo wawo, ndinso zimene amakumana nazo pokalandira chithandizo kuchipatala kapena mu njira zina, mmadera a m'mizinda ndi m'midzi ya m'Malawi muno. Kafukufukuyi athandiza kumvetsetse mozama za makhalidwe ndi umoyo wa amuna, ndi kukonza chithandizo cha kuzipatala ndi ndondomeko za boma zokhudza kupititsa mtsogolo umoyo wa amuna wokhudza kugonana, ndi HIV, ndinso m'mene amuna angapititsire patsogolo umoyo wokhudza kugonana ndi HIV wa akazi, ndi mabanja awo. Kafukufukuyu akuchitikira kuno ku Chiradzulu/Blantyre kuyambira mwezi wa July 2014 mpaka June 2015.

Ndongomeko ya kafukufukuyu

Kafukufukuyu akupanga ndi wophunzira za ukachenjere University College London (UCL), University of Cape Town, Malawi Liverpool Wellcome Trust, ndi bungwe la Parent and Child Health Initiative (PACHI). Ndipo kafukufukuyu ndi wovomerezedwa ndi Malawi National Health Sciences Research Committee (NHSRC) – protocol reference #1267 ndi a University College London Research Ethics Committee Project ID 4259/001 ndi a Cape Town Human Resource Ethics Committee ndi University College London (UCL) Research Ethics Committee.

Ufulu wotenga nawo mbali

Tabwera pano kuti tikupempheni kuti mutenge nawo mbali poyankha mafunso panokha kapena pagulu. Tikhala tikufunsa mafunso okhudza maganizidwe and makhalidwe a umoyo wogonana, HIV, ndinso chithandizo choperekedwa ku chipatala m'Malawi. Ziri kwa inu kutenga nawo mbali pa kafukufukuyu kapena ayi. Ngati mwavomera kutenga nawo mbali, mulinso ndi ufulu kukana kuyankha mafunso ena kapena kusiiratu kutenga mbali pamene kafukufukuyi ili mkati. Nganizo lanu lokana kuyankha mafunso ena kapena kusiya kutenga mbali silidzabweretsa vuto lililonse pa inu kapena banja lanu. Kutimalize kucheza nanu zititengera mphindi zosachepela 60. Anthu onse otenga nawo mbali akhalapo 80 – 100, ndipo okhawa amene ali ndi zaka 18 kapena kupita mtsogolo angatenge nawo mbali.

Ndalama

Muzapatsidwa MWK1000 ndipo cholinga chake ndi ku kuthokozani chifukwa chotenga nawo mbali mukafukufukuyu. Ndipo muzabwezedwanso ndalama ya matola ngati munakwela njinga kapena minibus pobwera.

Chinsinsi

Zomwe mundiuze pano ndi za chinsinsi. Pakutero simukuyenera kudandaula chifukwa chakuti zimene mundiuze pano zizagwiritsidwa ntchito pa zolinga za kafukufukuyu basi,

ndipo sizidzaperekedwa kapena kuululidwa kwa wina aliyense. Zonse titenge pano kudzera polemba kapena kujambula mawu, zikasungidwa mwachinsinsi ndipo zizaonedwa ndi anthuomwealiokhudzidwa ndi kafukufukuyundiponso ma membalaoyang'anirazakafukufuku pa sulukuluyaukachejenjede a ku University of Cape Town. Zonse zimene mudiuze zizagwiritsidwa ntchito molingana ndi ndondomeko za kafukufuku za malamulo a UK Data Protection Act 1998. Zimene mutiuze zitha kudzalembedwa kapena kutulutsidwa ma buku ndipo dzina lanu silizatchulidwa pena paliponse. Ndiponso sipazakhala gawo lina lililonse lomwe lizasonyeze dzina lanu.

Kuopsa kwake kotenga nawo mbali mu kafukufukuyu

Inu ngati otenga mbali mukafukufukuyu, zovuta ndizochepa. Mkatikati mwa kafukufuku mukhoza kundiuza ine kapena nzanga wina aliyense amene ndikugwira naye ntchito zina zimene mukuziona kuti simukuyenera kuziulula. Ndipo mafunso ena akhoza kukhala okukhumudwitsani kapena kukuchititsani manyazi. Muli ndi ufulu kukana kuyankha mafunso otero. Mutakhala ndi mafunsoena ndi enaokhunzana ndi kafukufukuyutiliokhozekakukuthandizani pokulumikizitsani ndi mabungweoyenera.

Ubwino wake otenga nawo mbali mu kafukufukuyu

Ngakhale simungaone ubwino wa kafukufukuyu panthawi yomwe akuchitika, koma zizatithandiza kumvetsa mozama za umoyo wa amuna wokhudza kugonana ndinso HIV, ndikukhazikitsa ndondomeko zopititsa patsogolo umoyo wa abambo. Inuyo, anzanu kapena abambo ndi amayi a kunoku Malawi adzapindula naye kafukufukuyu m'tsongolo muno.

Zomwe zidzachitike kafukufukuyu akadzamalizidwa

Padzalembedwa lipoti lofotokoza zomwe tapeza ndipo tidzagawana zimenezi ndi anthu, ma bungwe ndinso ma unduna aboma. Izi zidzathandiza ma bungwe ndi ma undunawa kuti apange mfundo zabwino komanso kuthandiza kupititsa patsogolo ntchito za ma bungwe ndi ma unduna aboma zokhudza umoyo. Zonse zotsatira kafukufukuyu zidzakhala ndi kugwiritsidwa ntchito m'dziko la Malawi.

Mukafuna kudziwa zambiri pezani awa, kapena pitani uku:

Ngati muli ndi chidandaulo chokhudza mmene kafukufukuyu akuyendera, kapena mulinaye vuto, mukhoza kuyimba foni, kulemba kalata, kapena kupita kwa anthu kapena ma ofesi amene alembedwa komalizira kwa chikalatachi.

- Wamkuluoyang'anirakafukufukuyu Tim Shand
- The National Health Sciences Research Committee (NHSRC) Secretariat
- The Chairperson of the University of Cape Town Faculty of Health Sciences Human Research Ethics Committee (HREC) in South Africa. You may also call the HREC Administrator in South Africa on the same telephone number.

ID number

Appendix: Consent form to participate in the Study: Men’s Sexual Health/HIV Attitudes, Behaviours and Health-seeking in Malawi

Ndamvomeleza kutenga nawo mbali mu kafukufukuyu, ndipo ndauzidwa momveka bwino mcholinga chake chenicheni cha kafukufukuyu.Ndipo ndine wamphamvu ndi wanthanzi kutenga nawo mbali mukafukufukuyu.

Ndauzidwanso kuopysa ndi ubwino wake wa kafukufukuyu, ndiponso ndauzidwa kuti ndili ndi ufulu otenga nawo mbali kapena nditha kusiya kutenga nawo mbali nthawi ina iliyonse.

Ndapatsidwa mwayi otha kufunsa mafunso okhudzana ndi kafukufukuyu muchiyakhulo china chilichonse chomwe ndimamva ndi kuyankhula bwinobwino, ndiponso kuonetsetsa kuti ndayakhidwa momveka bwino mafunso anga.

Siginichala ya wotenga nawo mbali

Dzina.....

Siginichala.....Chidindo cha chala



Deti (dd/mm/yyyy):.....

Ndimayankhula chizungu, ndipo ndikhala okonzeka kuchita ntchito ya kalondo-londo mu chizungu

Nambala ya foni (Ngati amayankhula chizungu).....

facilitators' signature

Dzina:

Siginichala.....

Date (dd/mm/yyyy):..... .Malo:.....

Q. Emerging themes from analysis of IDI summaries and related questions for discussion with research assistants

Emergent themes: Condoms, contraception and family planning

a) Condoms

- Majority of men said they do not use condoms:
 - Reduces sexual pleasure and men's performance ("plain sex is sweeter"). Saying that you don't eat a sweet in the wrapper;
 - People wanting to have 'a feel' with each other/"sperms deposited in the body";
 - Men are in a rush to have sex and don't carry condoms
 - Perceived side-effects (gives you cancer and other diseases)
 - Associated with trust: must be unfaithful if wanting to use condoms in marriage – "Are you saying I have slept with someone else? Or what have you done? Tell me" Not necessary in context of family.
 - No fear of diseases?
 - Link to alcohol use: plain more likely if drunk
 - Sometimes plain sex used as a punishment
- Men more likely to use condoms with women outside marriage/with sex worker, "someone they don't know" as "afraid to contract HIV". At same time, sense you have paid for sex, so shouldn't use condom to get maximum benefit
- Men say women are also not keen to use/don't like condoms (as means a lack of trust), and that use of condoms is sometimes determined by women (though men can also dictate). Association of being a prostitute if you use a condom. Women getting side effects from condoms. Though they don't say much on condoms. What they say has an effect
- Misunderstanding on side effects: think condom can burst inside women; crates cancer; manufactured by white with HIV inside
- Freely available condoms are not seen as good quality. They are too oily
- Condoms associated as family planning method
- Some men say they do choose to use condoms: fear of infections, FP method

b) Family planning(FP)/contraception

- FP seen as "its women's responsibility/issue", including child birth. Lack of understanding among men on FP issues. Only women access FP methods
- Men may tell the wife what FP method to use (injection common) and number of children they want, but not engage beyond that. Urban and more educated men more engaged, and say FP is a family issue (not for women only). May be due to economic factors (costs of many children). Broader burden remains with women
- Reasons men are against FP include:
 - association with losing sexual desire ("used to be able to have 5 rounds and because of FP we can't". "wife took the injection, and after seeing effect on my sexual performance I stopped her from going");
 - want to have more children/as many as possible (fertility marker of manhood);
 - misunderstanding around side-effects of FP
 - no-one sick, so why should man waste his time sitting in queue for several hours for FP methods (see health barriers below)
 - Religious reasons of FP being against the bible: people should bear children
 - Women wont give birth again
 - Men are not aware of how to be involved/need more information on available methods. Only condom known as PF method for men
- Men in rural areas also say they have nothing to do/not TV or radio. Boredom among men. Only thing that makes you happy is having sex

- Maybe some women are hiding FP from their partners: one man said his wife hasn't used FP for many years and they have sex all the time and she doesn't get pregnant
- Reasons why against vasectomy:
 - men want to keep options open for having children in future (if remarry following divorced/windowed); ability to have children important marker of manhood (many men referred to this being important to them/what they expected of other men). "What will happens if all his children die";
 - perception it reduces sexual pleasure (doesn't feel the same, weakens your ability);
 - misunderstanding that you can no longer ejaculate, which is symbol of manhood (so will be mocked by women) and have other side-effects; seen as 'non-reversable', health concerns
 - Story of man getting fatter and fatter after vasectomy as sperm kept building up inside their body and they were at risk of exploding!
 - Women are only ones supposed to adopt FP
 - In rural area, many men never met anyone who had had a vasectomy

[The age of respondents, many younger, is something to consider]

- Men say FP is a family issue
- Lack of knowledge: Don't know any FP methods for men. Didn't say much on FP
- Men saying they have inadequate FP options for men. They want to get more involved in family planning.

Questions for meetings with my research assistants

- Clearly pain sex mainly about pleasure/special feel? Women as well as men prefer plain? Side effects?
- Men don't fear diseases 'if plain' (given they fear HIV)?
- How widespread is belief about condom side-effects (burst, cancer, HIV inside, develops sores) among men and women?
- Issue of trust and implication of unfaithfulness regarding condom use. Does wife question just as much as the man?
- Why are condoms used outside marriage with extramarital partners? HIV/STIs, pregnancy prevention? Are they used regularly or only sometimes outside? Sense of getting maximum benefit if you have paid for sex? Men getting STIs from sex workers, so unlikely to be using condoms
- How common that men "judge the looks of a women and that she is negative because she is beautiful and they don't use condoms"?
- How is plain sex used as punishment?
- Are men shy to buy condoms in Malawi? Do people in Malawi carry them around?
- Looks like men's FP involvement is discussing methods/deciding number of children. Most have no interest. Why men don't see their role in FP beyond that? Say women gets pregnant and few FP methods for men.
- Understanding men's objections to FP? Is there still a strong cultural norm around having children? No sense that if you already have children from previous marriage, that is enough?
- How much do you think women hide FP from their partners
- Why do some men say FP is a family issue?
- Are men interested in learning more about FP? Do they feel undermined, as FP messages only reach women? Possibilities to promote vasectomy in Malawi? If it was reversible?

R. NVivo Codebook excerpt for qualitative coding

Nodes\01.MensHealthSexualIdentityGenderNorms\02.05.WorkEconomicStressImpact\02.05.02.EconomicStress		2.5.2	Views on stress due to insufficient income affecting health-seeking	
Nodes\01.MensHealthSexualIdentityGenderNorms\02.05.WorkEconomicStressImpact\02.05.03.PovertyLifeChesp		2.5.3	Poverty/socioeconomic status/life cheap and difficult	
Nodes\01.MensHealthSexualIdentityGenderNorms\02.06.PowerRelations		2.6	Power relations between men and women	power within families, men as head, challenges for women
Nodes\03.FamilyPlanning		3	Family planning	
Nodes\03.FamilyPlanning\03.01.Condoms		3.1	Men and condoms	
Nodes\03.FamilyPlanning\03.01.Condoms\03.01.01.CondomAvailabilityAccess		3.1.1	Availability of condoms/access points	inc secrecy around condoms
Nodes\03.FamilyPlanning\03.01.Condoms\03.01.02.CondomFacilitators		3.1.2	Condoms facilitators and reasons for men to use/opinions on condoms	Can include educated men, for family planning
Nodes\03.FamilyPlanning\03.01.Condoms\03.01.03.CondomBarriers		3.1.3	Barriers/objections to condom use by men (themselves & others)	pleasure, habit, paying, side effects, quality, promiscuity
Nodes\03.FamilyPlanning\03.01.Condoms\03.01.04.DifferentCondomUseTrustFaithfulness		3.1.4	Different condom use in the home and outside/ trust and faithfulness	inc plain sex association with trust and faithfulness
Nodes\03.FamilyPlanning\03.01.Condoms\03.01.05.WomensViewsCondomUse		3.1.5	Women's views/perspectives on condom use and challenges/influences	men's perspectives on women's views & womens own views
Nodes\03.FamilyPlanning\03.02.FPMethodsWomen		3.2	Family planning methods used by women	
Nodes\03.FamilyPlanning\03.02.FPMethodsWomen\03.02.01.FPMethodsUsed		3.2.1	Family planning methods used	
Nodes\03.FamilyPlanning\03.02.FPMethodsWomen\03.02.02.MensViewsFP		3.2.2	Men's views on FP, inc FP as women's issues/responsibility (or not)	general views, FP as women's issue or joint responsibility
Nodes\03.FamilyPlanning\03.02.FPMethodsWomen\03.02.03.FacilitatorsMaleFPInvolvement		3.2.3	Facilitators men's FP involvement: reasons, benefits, areas, economics	inc only as decision-makers on method & no of children
Nodes\03.FamilyPlanning\03.02.FPMethodsWomen\03.02.04.BarriersMaleFPInvolvementImpact		3.2.4	Barriers/men's objections to FP by women/lack of involvement/impact	understanding, pleasure, side effects, children, broader barriers to FP use in Malawi, impact on women (hiding FP)
Nodes\03.FamilyPlanning\03.03.MaleFPOptions		3.3	Male family planning/contraceptive options	
Nodes\03.FamilyPlanning\03.03.MaleFPOptions\03.03.01.ViewsUnderstandingMaleFPMethods		3.3.1	Views/understanding on men using male FP methods	insufficient/unavailable male family planning methods
Nodes\03.FamilyPlanning\03.03.MaleFPOptions\03.03.02.ViewsMensOwnFPConcerns		3.3.2	Men's FP concerns (for themselves), including fertility concerns	
Nodes\03.FamilyPlanning\03.04.Vasectomy		3.4	Vasectomy	
Nodes\03.FamilyPlanning\03.04.Vasectomy\03.04.01.MensViewsVasectomy		3.4.1	Men's views/understanding (or lack of) on vasectomy	
Nodes\03.FamilyPlanning\03.04.Vasectomy\03.04.02.FacilitatorsVasectomy		3.4.2	Facilitators, men's support for/Use of vasectomy/experiences	
Nodes\03.FamilyPlanning\03.04.Vasectomy\03.04.03.BarriersVasectomy		3.4.3	Barriers/men's objections to having vasectomy	pleasure, side effects, myths, children, availability
Nodes\03.FamilyPlanning\03.04.Vasectomy\03.04.04.WomensViewsVasectomy		3.4.4	Women's views on vasectomy	
Nodes\03.FamilyPlanning\03.05.ParentingFatherhood		3.5	Parenting and fatherhood	
Nodes\03.FamilyPlanning\03.05.ParentingFatherhood\03.05.01.MalawiNormsChildrenFatherhood		3.5.1	Malawi norms, expectations around children, parenting/father role models	
Nodes\03.FamilyPlanning\03.05.ParentingFatherhood\03.05.02.MaleInvolvementANC		3.5.2	Involvement of men in ANC services	
Nodes\04.HIV&AIDS		4	HIV and AIDS	
Nodes\04.HIV&AIDS\04.01.HIVTesting		4.1	HIV testing	
Nodes\04.HIV&AIDS\04.01.HIVTesting\04.01.01.FacilitatorsMenTestingHIV		4.1.1	Facilitators/Reasons for men testing for HIV/factors (themselves & others)	inc women's influence, importance of knowing status, couple testing, clandestinely testing
Nodes\04.HIV&AIDS\04.01.HIVTesting\04.01.02.BarriersMenTestingHIV		4.1.2	Barriers/reasons for men avoiding HIV testing or not regularly testing	Fear of testing & being positive, blame women for HIV in home
Nodes\04.HIV&AIDS\04.01.HIVTesting\04.01.03.MenTakingStatusofWifeSexualPartner		4.1.3	Men taking status of their wives/girlfriends as their own and reasons	Men assuming status (often positive) without testing
Nodes\04.HIV&AIDS\04.01.HIVTesting\04.01.04.MAASEHIVTestingResults		4.1.4	Comments on MAASE HIV testing, result findings	
Nodes\04.HIV&AIDS\04.01.HIVTesting\04.01.05.HIVTestingApproachAttitudeonHealthSeeking		4.1.5	Fear of HIV negative/affective approach to men's general health seeking	Including fear of being tested when going to facilities
Nodes\04.HIV&AIDS\04.01.HIVTesting\04.01.06.HIVDeathSentence		4.1.6	HIV as death sentence/psychological: die quicker if you know status	AIDS has no cure, better not to know status, original messages
Nodes\04.HIV&AIDS\04.01.HIVTesting\04.01.07.BehaviourChangeFollowingTestingHIV		4.1.7	Behaviour change following test result (positive or negative)	Related to knowing HIV status
Nodes\04.HIV&AIDS\04.02.HIVTransmission		4.2	HIV transmission	
Nodes\04.HIV&AIDS\04.02.HIVTransmission\04.02.01.MisunderstandingHIVTransmission		4.2.1	Lack of understanding on HIV transmission/seen as invincible	inc beautiful women are HIV negative, status pre-determined
Nodes\04.HIV&AIDS\04.02.HIVTransmission\04.02.02.IgnoranceHIVDiscordance		4.2.2	Ignorance about HIV discordance	
Nodes\04.HIV&AIDS\04.02.HIVTransmission\04.02.03.DeliberatelyInfectingOthers		4.2.3	Men deliberately trying to infect others with HIV	Feel have been deliberately infected, and infect others
Nodes\04.HIV&AIDS\04.03.HIVTreatment		4.3	HIV treatment	
Nodes\04.HIV&AIDS\04.03.HIVTreatment\04.03.01.MensHIVTreatmentExperiences		4.3.1	Experiences & views on men taking/accessing treatment (them & others)	Associations/local understandings of taking treatment
Nodes\04.HIV&AIDS\04.03.HIVTreatment\04.03.02.MenTravelingForART		4.3.2	Traveling elsewhere for ART/hiding HIV treatment	taking treatment clandestinely as concerned to be seen
Nodes\04.HIV&AIDS\04.03.HIVTreatment\04.03.03.ARTAdherenceSideEffects		4.3.3	Treatment adherence / side effect concerns	Physical signs
Nodes\04.HIV&AIDS\04.04.HIVDisclosure		4.4	HIV disclosure	
Nodes\04.HIV&AIDS\04.04.HIVDisclosure\04.04.01.MensHIVDisclosureExperiences		4.4.1	Views/experiences men disclosing HIV status, implications and challenges	Reasons for men avoiding disclosing status/challenges
Nodes\04.HIV&AIDS\04.04.HIVDisclosure\04.04.02.ToWhomMenDisclose		4.4.2	To whom men disclose their HIV positive status	
Nodes\04.HIV&AIDS\04.04.HIVDisclosure\04.04.03.DisclosureDifferencesMenWomen		4.4.3	Differences in/and acceptance of disclosure by men and women	inc differences between men and women disclosing, relationship problems following testing/disclosure
Nodes\04.HIV&AIDS\04.04.HIVDisclosure\04.04.04.WomenHIVDisclosureExperiences		4.4.4	Women disclosing positive status to men and implications	

S. Examples of manual coding IDI and FGD data

Some women think condoms are foreigner and use traditional methods

say one of the women from a certain area say something to do with condoms what does whatever they say affect your condom use?

BAN002: We have different beliefs/views. Some think condoms are from the west and they have nothing to do with us. Some say that we can't use this method [condoms] but we should use family planning methods used by our parents. That is how other people think.

Interviewer: Okay

BAN002: There are a lot of things we can say. That is just in short/brief.

FF uses included in FF discussion

Interviewer: Thank you very much. Are you involved in discussions and decisions at home or in your family about/with regard to contraception/family planning?

BAN002: I participate

Interviewer: Why?

BAN002: It is important for the growth of children and for us to have enough time [space] to do other household activities.

Interviewer: Do you think family planning is only a women's issue

FF to include

BAN002: No. It is for everyone

FF for both

Interviewer: For both men and women? Why?

BAN002: The work is for both of you. Family planning can not take place if one has no partner. It involves two people so they have to agree so that it benefits all of them.

Need 2 people for FF

[Family planning is for both women and men. Family planning can not take place if one has no sexual partner. It involves two people so they have to agree so that it benefits all of them.]

Things included but 90% included for men

Interviewer: Which family planning methods of men do you know?

BAN002: Uhm. But 90% of family planning methods are for women.

FF

Interviewer: Although you have said that 90% of family planning methods is for women, I wanted to know which family planning methods are meant for men?

Men don't use FF

BAN002: Men don't use family planning methods. They just have to listen what the nurse has told their partner about any methods.

[Aaaah men don't use family planning methods. They just listen to what the nurse has told their sexual partner about any family planning methods.]

Interviewer: So you are saying that men do not adopt family planning methods they just listen to what the nurses advise their sexual partners. Thank you. One family planning method for males is a vasectomy, where a man has a simple operation so that he no longer ejaculates sperm during sex. Why do few men want to have a vasectomy?

Challenges of v: many men find to have children - fear of unknown (child men)

BAN002: There are different views with regard to that method [vasectomy]. Some think they will marry again and some fear the unknown [hearsays].

perfect audience for vasectomy

CA_Chichewa Start Date 29/04/11KMT_210311_CH_MFGD_MK_CA_Chi

09: Azibambo ambiri kulera amakuthawa kuti koma amayesa kuti ndi yandani, koma ya azimai. Chocho kuti tizikambirana zolera, angachulukepo ndi azimai azibambo amati 'aa kuleratu ndi kwa azimai' hee. Tsono zimenezi chifuka amakhala pa chipsyinjochifukwa cha ana anja ndiye iye uja ana anja akakwana akaona kuti iii anawa andichulukira abambowa azandithawa ndiye amati iii iai, ine basi anawa anditani? Andichulukira. Ndiye abambo anja akati aaa kukana amati tiyeni tonse tikaphunzire za kulera amati 'iii iai pita iweyo'

Ma lege
responsibility
woman

A lot of men run away from practicing family planning. They take it as the responsibility of a woman. If we can be discussing family planning, there will be more women. Men say, "Family planning is the responsibility of women." She gets under burden because of the children. So when she thinks that the children are enough, the man might run away from her, she says, "The children are enough." So when the man is refusing, she says, "Let's go and learn about family planning together" and he says, "You be the one to go there"

Interviewer: Okay pali paganizo ena?

Okay, are there other views?

11: Zoon ngati program yoti aaa kulera zoonadi kwambiri timasiira azimai koma pa umuthu kumakhala kuti banjamo mukhale ogwirizana ndi chikhuupiliro aaa kunena kuti mukulera mogwirizana zimakhala zithu zabwino chifukwa mutha kupanga ganizo labwino kuti loti muchite zisakho labwino chifukwa chisankho choti ukumuza zako kuti ukupangira muthu. Koma ndimaona ngati kulera kwabwino ndiye kuti mugwirizane. Kaya mukufuna pakhale ana 4 kaya ana awiri program kulera kwabwino ndikuti, ndikumeneke. Ngakhale kuthenetsa kwa abamboko zimenezo zimakhala zithu zabwinonso koma nthawi zambiri abambo sitingatani azibambo ambiri samalora chifukwa kwambiri kutseketsa amagopita ndi azimai kotseketsa chifukwa athuwa ali pa program yoti abambo olo timuthene basi mphamvu zachoka thupi.

Ma lege
responsibility
woman

Yes it is true that we leave the issue of family planning in the hands of a woman. However, it is better when in the family you are co-operative, have faith in one another and you are practicing family planning together because you make good choices because you tell your partner. I feel that for you to practice good family planning it is when you agree, whether you want to have four or two children; that's good family planning. Vasectomy is also good but most of the times we men do not... most men do not accept. Most of the times it is women who go to have loop because these people say, "If a man goes for vasectomy then it means he loses strength in the body."

Ma lege
responsibility
woman

Interviewer: Okay, aaa mukuoneka kuti ambiri mwagundapo njira imodzi. Okay njira imodzi ya abambo yolerera ndi imeneyoyo yotseketsa aaa bamboo akagwiritsa ntchito njira imeneyo sapereka mimba. Ndi chifukwa chiani amuna ambiri sapita kukatenga njira imeneyi ngati yolerera. Mukuganiza kuti ndi chifukwa chiani? Koma mukuidziwa njirai mmene imayendera bwinobwino eti?

T. Demographic details of IMAGES participants

	No of men	Percentage
Total	417	
Location		
- Urban	250	59.9%
- Rural	167	40.1%
Age		
- 18-24 years	166	39.8%
- 25-34 years	159	38.1%
- 35-49 years	71	17.0%
- 50-59 years	21	5.0%
Relationship status		
- Married	178	42.7%
- Not married	83	19.9%
- Single/Not in a relationship	156	37.4%
Education		
- No education/ Any primary	147	35.5%
- Any secondary	228	55.1%
- Any tertiary	39	9.4%
No of children		
- No children	197	47.2%
- 1-2 children	123	29.5%
- 3+ children	97	23.3%
Employment status		
- Employed	183	45.5%
- Unemployed	219	54.5%
Ethnicity		
- Lomwe	207	49.8%
- Yao	63	15.1%
- Ngoni	46	11.1%
- Chewa	35	8.4%
- other	65	15.6%
Religion		
- Protestant	137	33.0%
- Catholic	104	25.1%
- Pentecostal	97	23.4%
- Other (inc Baptist, Anglican)	77	18.6%
Ever HIV Test		
- Yes	312	75.0%
- No	104	25.0%
Ever Had STI		
- Yes	33	8.3%
- No	367	91.6%

U. Demographic details of male in-depth interview (IDI) participants

Interview Code	Age	# of chldn	Marital status	Education level	Occupation	Religion; Ethnicity	Method used with partner/ wife	# of sex. partners (12 mths)	Frequency of condom use during sex (12 mths)	HIV test? If yes, status	Ever had STI?	Used trad. herbs for sex?
Blantyre (urban)												
IDI-BAN-1	39	3	Married	Secondary	Vendor (self-employed)	Muslim; Yao	IUD	2	Occasional use	Yes; negative	No	No
IDI-BAN-2	50	4	Married	Primary	Vendor (self-employed)	Presbyt; Lomwe	Injection	1	Occasional use	Yes; positive	No	No
IDI-BAN-3	20	0	Relatshp	Secondary	Unemployed	Catholic; Ngoni	Condom	2	Always use	Yes; negative	No	No
IDI-BAN-4	19	0	Single	Secondary	Unemployed	Anglican; Lomwe	n/a	1	Always use	Yes; negative	No	Yes
IDI-BAN-5	27	1	Married	Secondary	Vendor (self-employed)	Presbyt; Chewa	None	2	Occasional use	Yes; negative	No	Yes
IDI-BAN-6	36	4	Married	Primary	Unemployed	Adventist; Lomwe	Injection	1	Don't use	Yes; negative	No	No
IDI-BAN-7	25	1	Married	Secondary	Driver/ manual	Presbyt; Lomwe	IUD	3	Occasional use	Yes; negative	No	Yes
IDI-NS-1	22	0	Single	Tertiary	Unemployed	Presbyt; Yao	n/a	None	n/a	Yes; negative	No	No
IDI-NS-2	32	2	Married	Secondary	Vendor (self-employed)	Pentecostal; Sena	Injection	1	Occasional use	Yes; positive	Yes	Yes
IDI-NS-3	22	0	Single	Secondary	Driver/ manual	PIM; Lomwe	n/a	1	Mostly use	No	No	Yes
IDI-NS-4	26	0	Single	Secondary	Unemployed	Pentecostal; Ngoni	n/a	3	Always use	No	No	Yes
IDI-NS-5	28	2	Married	Secondary	Vendor (self-employed)	Catholic; Lomwe	Injection	1	Don't use	Yes; negative	No	Yes
IDI-NS-6	23	0	Relatshp	Secondary	Driver	Catholic; Tumbuka	condom	2	Mostly use	Yes; negative	No	No
IDI-NS-7	30	1	Married	Tertiary	Sales	Adventist; Ngoni	None	2	Mostly use	Yes; negative	No	Yes

Interview Code	Age	# of chldn	Marital status	Education level	Occupation	Religion; Ethnicity	Method used with partner/wife	# of sex. partners (12 mths)	Frequency of condom use during sex (12 mths)	HIV test? If yes, status	Ever had STI?	Used trad. herbs for sex?
IDI-NS-8	32	1	Married	Secondary	Vendor (self-employed)	Pentecostal; Sena	Injection	1	Don't use	Yes; negative	Yes	Yes
IDI-NS-9	25	0	Relatshp	Secondary	Unemployed	Pentecostal; Chewa	Condom	1	Always use	No	Yes	No
IDI-SL-1	29	0	Relatshp	Secondary	Unemployed	Catholic; Lomwe	None	1	Occasional use	No	No	No
IDI-SL-2	35	3	Married	Primary	Vendor (self-employed)	Catholic; Lomwe	Injection	2	Occasional use	Yes; negative	Yes	Yes
IDI-SL-3	42	5	Married	Secondary	Sales	Adventist; Lomwe	None	1	Don't use	No	No	No
IDI-SL-4	25	2	Married	Primary	Sales	Pentecostal; Lomwe	Injection	1	Don't use	Yes; negative	No	No
Chiradzulu (rural)												
IDI-CHI-1	27	3	Married	Secondary	Vendor (self-employed)	Adventist; Lomwe	Injection	2	Occasional use	Yes; negative	No	Yes
IDI-CHI-2	32	4	Married	Primary	Vendor (self-employed)	Presbty; Lomwe	Injection	2	Occasional use	Yes; negative	Yes	Yes
IDI-CHI-3	26	0	Single	Secondary	Volunteer	Muslim; Lomwe	n/a	None	n/a	Yes; negative	No	No
IDI-CHI-4	45	6	Married	Primary	Farmer	Pentecostal; Lomwe	None	1	Don't use	Yes; negative	No	Yes
IDI-CHI-5	26	3	Married	Primary	Vendor (self-employed)	Muslim; Yao	Implant	1	Don't use	Yes; negative	No	No
IDI-CHI-6	21	0	Relatshp	Secondary	Unemployed	Muslim; Yao	condom	1	Mostly use	Yes; negative	No	Yes
IDI-CHI-7	29	2	Married	Secondary	Farmer	Protestant Lomwe	IUD	1	Don't use	Yes; negative	No	No
IDI-CHI-8	23	0	Married	Secondary	Self-employed	Adventist; Lomwe	Injection	2	Don't use	No	No	Yes
IDI-CHI-9	24	1	Single	Secondary	Farmer	Muslim; Yao	n/a	1	Mostly use	Yes; negative	Yes	Yes
IDI-CHI-10	46	6	Married	Primary	Health worker	Catholic; Yao	IUD	1	Mostly use	Yes; positive	Yes	Yes

Interview Code	Age	# of chldn	Marital status	Education level	Occupation	Religion; Ethnicity	Method used with partner/wife	# of sex. partners (12 mths)	Frequency of condom use during sex (12 mths)	HIV test? If yes, status	Ever had STI?	Used trad. herbs for sex?
IDI-LIK-1	30	3	Married	Primary	Self-employed	Presbyt; Lomwe	Injection	2	Mostly use	Yes; negative	Yes	Yes
IDI-LIK-2	27	0	Relatshp	-	Self employed	- Lomwe	condom	2	Occasional use	Yes; negative	Yes	Yes
IDI-LIK-3	30	2	Married	Secondary	Self employed	Muslim; Yao	Injection	2	Don't use	Yes; negative	Yes	Yes
IDI-LIK-4	24	0	Single	Secondary	Unemployed	Presbyt; Lomwe	n/a	2	Always use	No	No	No
IDI-LIK-5	18	0	Single	Secondary	Unemployed	Catholic; Chewa	n/a	3	Occasional use	Yes; negative	No	Yes
IDI-LIK-6	32	3	Married	Secondary	Unemployed	Catholic; Chewa	Injection	1	Don't use	Yes; negative	Yes	No
IDI-LIK-7	30	0	Single	Secondary	Unemployed	Presbyt; Yao	n/a	3	Occasional use	Yes; negative	No	Yes
IDI-LIK-8	27	1	Married	Secondary	Unemployed	Presbyt; Chewa	Injection	2	Occasional use	Yes; negative	Yes	Yes
IDI-LIK-9	31	2	Married	Secondary	Self-employed	Muslim; Yao	Injection	2	Don't use	Yes; negative	Yes	Yes
IDI-LIK-10	30	3	Married	Secondary	Self-employed	Presbyt; Chewa	Injection	2	Occasional use	Yes; negative	Yes	No

Notes: Relatshp = Relationship; Presbyt = Presbyterian

V. Male focus group participants demographic details

Interview Code	Age	# of chldn	Marital status	Education level	Occupation	Religion; Ethnicity	HIV test?
Blantyre (urban)							
FGD-BAN-1	42	2	Married	Tertiary	Teacher	Pentecostal; Lomwe	No
FGD-BAN-2	27	0	Married	Secondary	Business	Anglican; Sana	Yes
FGD-BAN-3	27	1	Single	Secondary	Unemployed	Pentecostal; Lomwe	Yes
FGD-BAN-4	24	0	Single	Secondary	Footballer	Presbyterian; Chewa	Yes
FGD-BAN-5	30	3	Married	Secondary	Painting	Presbyterian; Lomwe	No
FGD-BAN-6	26	2	Married	Secondary	Business	Presbyterian; Lomwe	Yes
FGD-BAN-7	25	0	Single	Secondary	Footballer	Pentecostal; Ngoni	No
FGD-BAN-8	19	0	Single	Secondary	Unemployed	Anglican;	Yes
FGD-BAN-9	20	0	Single	Secondary	Unemployed	Catholic; Ngoni	Yes
FGD-BAN-10	50	4	Married	Primary	Business	Catholic; Lomwe	Yes
FGD -NS-1	28	2	Married	Secondary	Barber	Catholic; Lomwe	Yes
FGD -NS-2	30	1	Married	Secondary	Business	Presbyterian; Chewa	Yes
FGD -NS-3	35	1	Married	Secondary	Business	Adventist; Lomwe	No
FGD -NS-4	32	1	Married	Secondary	Employed	Adventist; Ngoni	Yes
FGD -NS-5	22	1	Single	Secondary	Business	Islam; Yao	Yes
FGD -NS-6	26	1	Married	Secondary	Business	Pentecostal; Lomwe	Yes
FGD -NS-7	21	0	Single	Secondary	Plastics	Pentecostal; Ngoni	No
FGD -NS-8	35	0	Married	Secondary	Logistics	Presbyterian; Lomwe	Yes
FGD -NS-9	24	0	Single	Secondary	Business	Adventist; Chewa	Yes
FGD -NS-10	27	0	Married	Secondary	Unemployed	Pentecostal; Sena	No
FGD -NS-11	32	2	Married	Secondary	Business	Pentecostal; Sena	Yes
Chiradzulu (rural)							
FGD-CHI-1	18	0	Single	Secondary	Unemployed	Adventist; Ngoni	Yes
FGD-CHI-2	25	0	Single	Secondary	Unemployed	Protestant; Lomwe	Yes
FGD-CHI-3	51	5	Married	None	Farmer	Adventist; Ngoni	Yes
FGD-CHI-4	26	2	Married	Secondary	Driver	Islam; Yao	Yes
FGD-CHI-5	24	1	Single	Primary	Unemployed	Presbyterian; Lomwe	-

Interview Code	Age	# of chldn	Marital status	Education level	Occupation	Religion; Ethnicity	HIV test?
FGD-CHI-6	25	1	Married	Primary	Self-employed	Baptist; Lomwe	Yes
FGD-CHI-7	29	3	Married	Secondary	Business	Presbyterian; Lomwe	Yes
FGD-CHI-8	46	4	Married	Primary	Clerk	Catholic; Yao	-
FGD -CHI-9	52	2	Married	Primary	Businessman	Presbyterian; Lomwe	Yes
FGD -CHI-10	24	1	Single	Secondary	Farmer	Islam; Yao	Yes
FGD -CHI-11	25	0	Single	Secondary	Unemployed	Islam; Lomwe	Yes
FGD -CHI-12	40	4	Married	Primary	Farmer	Islam; Yao	Yes
FGD -CHI-13	42	4	Married	Secondary	Unemployed	Catholic; Lomwe	Yes
FGD -CHI-14	27	3	Married	Secondary	Businessman	Adventist; Lomwe	Yes
FGD-LIK-1	23	1	Married	Secondary	Self-employed	Adventist; Yao	Yes
FGD-LIK-2	40	3	Married	Tertiary	Teacher	Catholic; Lomwe	No
FGD-LIK-3	21	1	Married	Secondary	Self-employed	Presbyterian; Lomwe	Yes
FGD-LIK-4	24	0	Single	Secondary	Unemployed	Presbyterian; Lomwe	Yes
FGD-LIK-5	25	2	Married	Primary	Self-employed	Adventist; Yao	No
FGD-LIK-6	22	2	Married	Primary	Self-employed	Presbyterian; Lomwe	Yes
FGD-LIK-7	30	2	Married	Primary	Self-employed	Presbyterian; Yao	Yes
FGD-LIK-8	20	1	Married	Primary	Self-employed	Islam; Yao	No
FGD-LIK-9	18	0	Single	Primary	Self-employed	Catholic; Chewa	No
FGD-LIK-10	32	3	Married	Secondary	Unemployed	Catholic; Chewa	Yes
FGD-LIK-11	23	0	Single	Secondary	Unemployed	Catholic; Yao	Yes
FGD-LIK-12	30	3	Married	Secondary	Business	Adventist; Yao	Yes
FGD-LIK-13	27	2	Married	Primary	Business	Catholic; Chewa	Yes

W. Female focus group participants demographic details

Interview Code	Age	# of chldn	Marital status	Education level	Occupation	Religion; Ethnicity	HIV test?
Blantyre (urban)							
FGD-NS2-1	29	2	Married	Secondary	Volunteer	Pentecostal; Lomwe	Yes
FGD-NS2-2	29	2	Married	Secondary	Housewife	Pentecostal; Lomwe	Yes
FGD-NS2-3	-	3	married	Secondary	Business women	Pentecostal; Lomwe	Yes
FGD-NS2-4	31	2	Married	Secondary	Volunteer	Adventist; Lomwe	Yes
FGD-NS2-5	20	1	Single	Primary	None	Jehovah witness; Ngoni	Yes
FGD-NS2-6	21	1	Married	Secondary	Business women	Pentecostal; Lomwe	Yes
FGD-NS2-7	18	1	Single	Secondary	none	Muslim; Yao	Yes
FGD-NS2-8	23	2	Married	Primary	Housewife	Pentecostal; Lomwe	Yes
FGD-NS2-9	21	0	Married	Secondary	Housewife	Baptist; Yao	Yes
FGD-NS2-10	20	2	Married	Primary	Housewife	Catholic; Lomwe	Yes
FGD-NS2-11	36	4	Married	Secondary	Business women	Presbyterian; Yao	Yes
FGD-NS2-12	19	1	Single	Secondary	Business women	Pentecostal; Ngoni	Yes
FGD-NS2-13	31	1	Single	Primary	Business women	Pentecostal; Chewa	Yes
FGD-NS2-14	25	1	Married	Secondary	Housewife	Muslim; Yao	Yes
FGD-NS2-15	-	5	Married	None	Business women	Presbyterian; Lomwe	Yes
FGD-NS2-16	-	5	Married	Primary	Housewife	Muslim; Yao	Yes
Chiradzulu (rural)							
FGD-CHI2-1	36	5	Married	Primary	Farmer	Muslim; Lomwe	Yes
FGD-CHI2-2	28	3	Married	Primary	Farmer	Pentecostal; Chewa	Yes
FGD-CHI2-3	31	4	Married	Primary	Business women	Pentecostal; Lomwe	Yes
FGD-CHI2-4	31	2	Married	Primary	Business women	Baptist; Lomwe	Yes
FGD-CHI2-5	44	1	Widowed	Primary	Farmer	Presbyterian; Lomwe	Yes
FGD-CHI2-6	34	4	Married	Primary	Farmer	Muslim; Yao	No
FGD-CHI2-7	58	6	Widowed	Primary	Farmer	Muslim; Shona	Yes
FGD-CHI2-8	18	1	Married	Primary	Housewife	Pentecostal; Lomwe	Yes
FGD-CHI2-9	31	5	Married	Primary	Housewife	Pentecostal; Lomwe	Yes

Interview Code	Age	# of chldn	Marital status	Education level	Occupation	Religion; Ethnicity	HIV test?
FGD-CHI2-10	45	9	Married	Primary	Housewife	Pentecostal; Lomwe	Yes
FGD-CHI2-11	26	4	Married	Secondary	Housewife	Muslim; Yao	Yes
FGD-CHI2-12	30	5	Divorced	Primary	Farmer	Pentecostal; Yao	Yes
FGD-CHI2-13	51	1	Married	Primary	Farmer	Pentecostal; Yao	Yes
FGD-CHI2-14	28	3	Divorced	Primary	Farmer	Pentecostal; Yao	Yes
FGD-CHI2-15	59	6	Married	None	Farmer	Pentecostal; Lomwe	No
FGD-CHI2-16	19	1	Married	Primary	Housewife	Pentecostal; Yao	Yes

X. Demographic details of Health Providers and Key Stakeholders

Interview Code	Type of service/ organisation	Location	Urban/ Rural	Sex	Age	Position
Health Providers						
HP1	Public	Ndirande South	Urban	Male	36	In-charge
HP2	Public	Bangwe	Urban	Female	28	In-charge
HP3	Public	Chiradzulu District Hospital	Rural	Male	36	Manager
HP4	Public	Bangwe	Urban	Female	29	Nurse
HP5	Private	Bangwe	Urban	Male	33	Clinician
HP6	Public	Blantyre District Hospital	Urban	Male	30	Officer
HP7	Private	Likoswe	Rural	Male	43	Clinician
HP8	Public	Likoswe	Rural	Male	23	In-charge
HP9	Private	Bangwe	Urban	Female	48	Manager
HP10	Public	Chitera	Rural	Male	42	Nurse
HP11	Public	Chiradzulu District Hospital	Rural	Male	47	Manager
HP12	Public	Chitera	Rural	Male	28	In-charge
HP13	Public	Chitera	Rural	Male	38	In-charge
HP14	Private	Bangwe	Urban	Male	52	Director
HP15	Private	Bangwe	Urban	Male	39	Clinician
HP16	Traditional	Bangwe	Urban	Male	42	Traditional healer
HP17	Public	Bangwe	Urban	Female	40	Manager
HP18	Public	Ndirande South	Urban	Female	40	Nurse
HP19	Traditional	Ndirande South	Urban	Male	61	Traditional healer
HP20	Private	Ndirande South	Urban	Female	20	Co-ordinator
HP21	Public	Ndirande South	Urban	Female	36	Nurse
HP22	Traditional	Chiradzulu	Rural	Male	46	Traditional healer
HP23	Private	Ndirande South	Urban	Male	64	In-charge
HP24	Private	Ndirande South	Urban	Female	43	In-charge
HP25	Private	South Lunzu	Urban	Male	50	Director
HP26	Public	South Lunzu	Urban	Male	34	Deputy In-charge
Key stakeholders						
KS1	Academic	Blantyre		Male	41	Leadership
KS2	NGO service provider	Lilongwe		Female	44	Director
KS3	Government, MoH	Lilongwe		Female	40	Director
KS4	UN agency	Lilongwe		Female	29	Officer
KS5	NGO	Blantyre		Male	32	Manager
KS6	Religion	Blantyre		Male	56	Minister
KS7	Health	Chiradzulu		Male	41	Community advocate

KS8	NGO service provider	Blantyre		Female	39	Co-ordinator
KS9	NGO	Lilongwe		Male	65	Manager
KS10	Government MoH	Lilongwe		Female	47	Co-ordinator
KS11	Health research agency	Lilongwe		Male	49	Director
KS12	Government MoH	Lilongwe		male	28	Officer

Y. Data integration matrix example for my results chapters, version 4 August 2018

Relates research question/s	Quantitative data	Qualitative data	Chapter structure
Chapter: Attitudes of Southern Malawian men towards gender equality and its links to FP			
<p>What is the use and understanding on FP methods among Southern Malawian men?</p> <p>How do the attitudes of Southern Malawian men towards gender equality and decision-making influence their views on family planning and contraceptive use?</p>	<p>- 73% of men in relationship using FP methods with partners (IMAGES)</p> <p>- Types of methods being used with partner (demographics sheet): 80% use female controlled methods, 61.6% the injection. Clear difference b/w married and unmarried, with former relying exclusively on female methods. All condom use for FP was unmarried men. No man had sought a vasectomy</p> <p>-FP use positively associated with older age, number of children, unmarried, testing for HIV, having STI, number of sexual partners and frequency of condom use. No association found with education, employment status, income, religion and ethnicity.</p> <p>Southern Malawian men found to have moderate attitudes about gender equality in general [GEM scores 58% moderate, 40% high, 2% low]</p> <p>- men's more equitable gender attitudes positively associated with FP use: Moderate and high equity men 4.5-5.5 times more likely to use FP than low equity</p> <p>- Less equitable attitudes among men relating to FP. Majority believe it's a woman's responsibility to avoid getting pregnant [GEM]</p> <p>- 44% men said they would be outraged if their wife</p>	<p>- men's reasonable overall awareness of different FP methods, but lack of specific understanding. This was barrier to their support</p> <p>- men said didn't receive FP information, and often learnt from rumours and focused only on FP disadvantages. Men's level of knowledge said to be significant barrier to their support for method use and linked to their belief the best methods available are for women</p> <p>-men limited knowledge of male-specific methods. Majority never heard of vasectomy. Range of knowledge gaps and misinformation on vasectomy</p> <p>- men expressed desire for more information targeted at them around FP</p> <p>- Men head of household in Malawi. Power structures means men expect wives to look after them, and often confide in them. Same time, often don't respect advice of wife, particularly as it relates to FP</p> <p>- FP seen by men as family issue (not just a women's issue). Men clearly not disinterested. However, this did not reflect broader desire for involvement, rather a reflection of desire for authority over family affairs. Women believed</p>	<p>- FP use and understanding among men</p> <p>- Men's gender equality-related attitudes (GEM scores)</p> <p>- Men's attitudes towards responsibility for pregnancy prevention</p> <p>- Household decision-making and couple communication around contraception and FP use</p> <p>- Summary</p>

	<p>asked them to use a condom [GEM]</p> <ul style="list-style-type: none"> - 60% agree that a man should have the final word about decisions in his home (GEM) - Most men believe decisions on use of FP should be made jointly (GEM: A man and a woman should decide together what type of contraceptive to use) - On topic of who in your family usually has the final say regarding the health of women at home, 56% of men say women's health is joint decision, 35% man's decision alone, only 3% female partner alone and 6% others - Where women had final say on their health at home, or joint decision-making (compared to where man alone had final say on women's health), 2.1 to 2.25 times more likely to use FP 	<p>men saw FP as primarily women's issue</p> <ul style="list-style-type: none"> - Ultimate burden of FP responsibility remains with women. Men may be involved in decision-making and communication, but not beyond that. Few accompanied their partners to clinics - Men talked about the 'authority' men had over women with respect to decision-making - FP decisions should be taken together. Men desired to be more involved in decision-making, and that their lack of involvement was often causing 'problems' within relationships and families. Most men said they were involved in FP decisions at home, either on whether to use FP or the method. Men's desire for involvement often to control decisions, than support women. Women said men rarely positively support FP decision-making, so they may access methods clandestinely. - FP negotiation. Women often do not have ability to negotiate contraceptive use with their partners, and to insist on condom use - Effective communication between partners around FP was found to be crucial. This was the primary way in which men were involved in FP. A lack of sufficient communication was identified. Men expressed anger when women ask about using methods. Men expressed feeling 'excluded' on the issue, leading to quarrels, and men often then discussed with their friends. Men and women believed more FP information should reach men. 	
<p>Chapter: Social construction of manhood in Southern Malawi and FP links</p>			

<p>How does the social construction of manhood among Southern Malawian men impact on their approach to family planning and contraceptive use?</p>	<ul style="list-style-type: none"> - 78% of men disagreed with statement 'To be a man, you need to be tough' (GEM) - 63% disagreed that 'If someone insults me, I will defend my reputation, with force if I have to' - 90% of men agreed with statement 'I would never have a gay friend', highlighting how masculinities is conceptualised as heterosexual and a rejection of difference - 85% men with children overall responsibility to provide for the family - 64% of all men said they provide main source of income for the home; their partner was only 1% 	<ul style="list-style-type: none"> -men talked about the need for them to be unemotional, not cry, be strong, etc - FP emasculating men was key objection among men to partner using methods - men disagreeing with statement in qualitative 'looking after one's health means you are not a real man' - subsequent statements and FGD comments highlight clear association between role of man as strong (acting tough) and enduring illness/being immune. Men should not be weak. This also affected their HIV health-seeking. Women confirmed this belief. - men worried about perception of others and how health-seeking would affect their responsibilities and status in community, highlighting how these norms are policed by the community [- men made distinction between serious health issues (STIs) and less serious (FP), which we not prioritized] - men's lack of support-seeking for erectile dysfunction/concerns relating to maintain erection. This concern was never discussed with one's partner, and men lacked related knowledge and support. Associated shame. - men's responsibility for family/being breadwinner seen as central part of being man in Malawi. Men were concerned to fulfil this role. Felt pressure to do so. - brought unacknowledged power and agency for 	<ul style="list-style-type: none"> - Do men need to be 'strong'? - Masculinities and perceptions of health/health-seeking - Men's role as the economic provider and its links to FP - Narratives on fertility - Narratives on Infidelity -Summary
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		<p>men, though men discussed avoiding health care due to their 'responsibilities'. They prioritized this over health. Described themselves as 'capital'</p> <ul style="list-style-type: none"> - men made distinction between serious ailments, which prevented them for working, and should be addressed. FP was not prioritized in this context. - financial challenges of having multiple children key motivator for men's support of FP use by their partner. At same time, women confirmed being breadwinner effected men's engagement specific engagement in FP - men spoke positively about potential of vasectomy, though hadn't had this procedure themselves. Suggests untapped potential. - Strong norms around between being a man and bearing children (even if you already have many children), agreed to by both men and women - Norms around male fertility central to men's objections to FP use their partner, and to objections to vasectomy. Central reason for women's hostility also to vasectomy - Infertility conceptualized as problem with the women, not the man. Traditional herbs/healers often used by men for infertility concerns. - Key objection for FP use and vasectomy was female infidelity - Relationship stability concerns reason for objection to vasectomy among men 	
<p>Chapter: Meanings Southern Malawian men ascribe to sex and FP links</p>			

<p>How do the meanings Southern Malawian men ascribe to sex influence their approach to family planning and contraceptive use?</p>	<ul style="list-style-type: none"> - 55% of men agreed men need sex more than women do (GEM) - 60% agreed men are not open to talk about sex with their partners, they just do it (GEM) - 50% of men agreed men are always ready to have sex (GEM) - 54% men believed they should be embarrassed if they are unable to get an erection during sex (GEM) - 60% of men were found to have used traditional medicine for sexual enhancement (higher percentage in rural areas) - 21% of men had 2 or more sexual partners in last 12 months (16%, 2-3 partners; 5% 4 or more). Significant proportion of married men had more than one partner. More than one partner significantly associated with age, education and lower GEM scores - 45% said don't use condoms, and 35% only occasionally use. Few men always or mostly used condoms. Use negatively associated with being rural, married and positively associated with education, younger age, increase in sexual partners, testing for HIV and having an STI (IMAGES and demographic data). 	<ul style="list-style-type: none"> - sex presented as uncontrollable urge among men/marker of masculinity in Southern Malawi - men need multiple rounds - FP affecting men's sexual strength was key reason for objection to use, and to vasectomy - men's use of traditional medicine for sexual enhancement. Women said men were concerned to 'perform' well, but did not think maintaining an erection was a concern for men. - Having multiple concurrent partners seen as part of being a man (most in qualitative had ever had MCPs). Key factor for younger men was peer pressure. Common among married men. Men tend to blame women – their FP use (and lack of openness and satisfaction, as discussed below). - Sex taboo subject between partners. Pretend to know about it, often leading to misconceptions. Men supposed to initiate such conversations. Women who do are seen as promiscuous - lack of openness between sexual partners identified/often not discussing such issues together. At same time, men worried about their partners 'looking down on them' on sexual performance - lack of openness also negatively impacts on HIV and STI behaviours, such as men assuming HIV status of partner without testing - openness linked to greater sexual satisfaction. Lack of openness associated with men having multiple sexual partners, as discussed above - men often instead confided in their friends 	<ul style="list-style-type: none"> - Men need more sex and multiple partners -Communication and openness among sexual partners - Men's sexual pleasure and FP use - Preference for unprotected sex /limited condom use - Narratives on sexual health clinics -Summary
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		<p>around sex. Young men could encourage each other to engage in risky sexual behaviours</p> <ul style="list-style-type: none"> - sexual satisfaction seen as critically important and a largely a man's issue. Principally described at penetrative sex with ejaculation without protection. Women confirmed sexual satisfaction important to men, and they focus more on men's pleasure. Man seen as 'key player' here - sex expected within relationships, particularly marriage, and women should not deny men sex. Women often no choice, given their economic circumstances. Women's pleasure often presented in terms of male ejaculation - lack of sexual satisfaction identified as key challenge in relationship, and reason for MCPs. Men said satisfaction reduces their sexual partners (though women contested this) [and protective factor for STIs] - FP methods, particularly barrier methods, reducing sexual pleasure was primary objection among men to use - Concerns around sexual pleasure were the foremost objection men gave for objecting to FP. This was confirmed by women. This included effects on libido, side effects, and impotence (with its related stigma). Key reason also for men's objection to vasectomy. - Majority of men expressed strong preference for unprotected sex versus condomized sex, referring to enhanced sexual pleasure and desire to mix bodily fluids. Said women also prefer 	
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		<p>unprotected sex, if given choice. Married men may behave differently with outside partners, but also said use of condom was a 'loss' if you're paying for sex. Women confirmed this behavior.</p> <ul style="list-style-type: none"> - condoms perceived primarily for HIV/STI prevention, though men know could be used for dual protection. Those men who used condoms as principle FP method were unmarried. - married men made distinction between condoms and contraception: condom use with extra marital partner and unprotected sex with primary partner. Association between condom use and lack of trust (being unfaithful) in marriage, also confirmed by women. Challenges women face negotiating condom use. <p>- FP clinics overwhelmingly perceived as spaces for women. Men highlighted a range of barriers within such health services. Led to suspicion among men</p>	
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Recommendation

Impact (E) life cycle approach - ge symbol not FS use, no reliable system

(A) address generations.

(B) - improve decision-making slow cycle or intervention

(A) improve work

(B) - engage men: a woman's health, give their input in decision-making.

(D) - address work + income (helps many men, then? Pro-velocity to FS?)

(C) - improve men's health early for SH

(A) - great MCR. ?

? (F) - Gender promotion. - ge, HIV, STI. Gender promotion helps to reverse FS use intensity??

(F) - Difficult (bring) to cadres formation + increased women + ne. Specifically get used.

(C) Addressed plane: more likely to use FS

Swedish (F) using communication + across my context. (more related to seed + delta)

- addressing HIV risk.

(D) - Reciprocity work + men's responsibilities

(B) - Recruit men into the health system, give them limited time (and compensation based on income of things to women)

? (- family structure changes?)

Swedish (E) improve general communication slow cycle. (after time for HIV free only)

(C) - Improve seed substitution - does this reduce men's?

(D) Assist men to understand women's seed pleasure.

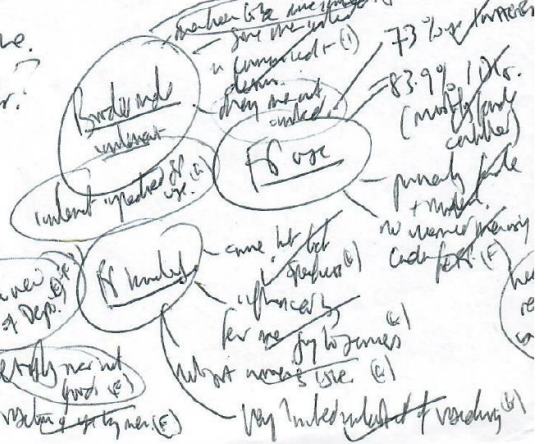
Recruit - Greater seed on men's use of reduced labor.

(C) - Gender equality education.

(B) - Reduced approaches to FS/SH.

(C) - FS programs to address seed pleasure.

Recruit a seed pleasure



AA. Ethical approval letters

UCL RESEARCH ETHICS COMMITTEE
GRADUATE SCHOOL OFFICE



Dr Sarah Hawkes
Institute of Global Health
30 Guilford Street
UCL

26th March 2013

Dear Dr Hawkes

Notification of Ethical Approval

Project ID: 4259/001: To explore the links between men's attitudes and behaviours, their health-seeking behaviours and their vulnerabilities in Sub-Saharan Africa

I am pleased to confirm that your study and the proposed amendments you have suggested to the aims, objectives and research methodology have been approved by the UCL Research Ethics Committee for the duration of the project i.e. until July 2019. You have confirmed that the main focus country will now be Malawi

Approval is also subject to the following conditions:

1. You must seek Chair's approval for proposed amendments to the research for which this approval has been given. Ethical approval is specific to this project and must not be treated as applicable to research of a similar nature. Each research project is reviewed separately and if there are significant changes to the research protocol you should seek confirmation of continued ethical approval by completing the 'Amendment Approval Request Form'.

The form identified above can be accessed by logging on to the ethics website homepage: <http://www.grad.ucl.ac.uk/ethics/> and clicking on the button marked 'Key Responsibilities of the Researcher Following Approval'.

2. It is your responsibility to report to the Committee any unanticipated problems or adverse events involving risks to participants or others. Both non-serious and serious adverse events must be reported.

Reporting Non-Serious Adverse Events

For non-serious adverse events you will need to inform Helen Dougal, Ethics Committee Administrator (ethics@ucl.ac.uk), within ten days of an adverse incident occurring and provide a full written report that should include any amendments to the participant information sheet and study protocol. The Chair or Vice-Chair of the Ethics Committee will confirm that the incident is non-serious and report to the Committee at the next meeting. The final view of the Committee will be communicated to you.

Reporting Serious Adverse Events

The Ethics Committee should be notified of all serious adverse events via the Ethics Committee Administrator immediately the incident occurs. Where the adverse incident is unexpected and serious, the Chair or Vice-Chair will decide whether the study should be terminated pending the opinion of an independent expert. The adverse event will be considered at the next Committee meeting and a decision will be made on the need to change the information leaflet and/or study protocol.

On completion of the research you must submit a brief report (a maximum of two sides of A4) of your findings/concluding comments to the Committee, which includes in particular issues relating to the ethical implications of the research.

With best wishes for the research.

Yours sincerely

Professor John Foreman
Chair of the UCL Research Ethics Committee

Cc:
Tim Shand, Applicant
Professor Anthony Costello, Head of Department

UCL Research Ethics Committee, c/o The GraduateSchool, North Cloisters, WilkinsBuilding
University College London Gower Street London WC1E 6BT
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e-mail mohdoccentre@gmail.com
**All Communications should be addressed to:
The Secretary for Health**



In reply please quote No. MED/4/36c

MINISTRY OF HEALTH
P.O. BOX 30377
LILONGWE 3
MALAWI

21st May 2015

Tim Shand
Institute of Global Health

Dear Sir/Madam,

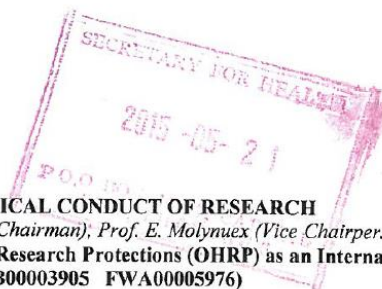
Re: Protocol # 1267: Men sexual/HIV attitudes, behavior and health seeking in Malawi

Thank you for the above titled proposal that you submitted to the National Health Sciences Research Committee (NHSRC) for review. Please be advised that the NHSRC has **reviewed** and **approved** your application for **continuation** to conduct the above titled study.

- **APPROVAL NUMBER** : **NHSRC # 1267**
The above details should be used on all correspondence, consent forms and documents as appropriate.
- **APPROVAL DATE** : **21/5/2015**
- **EXPIRATION DATE** : **This approval expires on 21/05/2016**
After this date, this project may only continue upon renewal. For purposes of renewal, a progress report on a standard form obtainable from the NHSRC secretariat should be submitted one month before the expiration date for continuing review.
- **SERIOUS ADVERSE EVENT REPORTING** : All serious problems having to do with subject safety must be reported to the National Health Sciences Research Committee within 10 working days using standard forms obtainable from the NHSRC Secretariat.
- **MODIFICATIONS**: Prior NHSRC approval using standard forms obtainable from the NHSRC Secretariat is required before implementing any changes in the Protocol (including changes in the consent documents). You may not use any other consent documents besides those approved by the NHSRC.
- **TERMINATION OF STUDY**: On termination of a study, a report has to be submitted to the NHSRC using standard forms obtainable from the NHSRC Secretariat.
- **QUESTIONS**: Please contact the NHSRC on Telephone No. (01) 789314, 0888344443 or by e-mail on mohdoccentre@gmail.com
- **Other**:
Please be reminded to send in copies of your final research results for our records as well as for the Health Research Database.

Kind regards from the NHSRC Secretariat

FOR CHAIRMAN, NATIONAL HEALTH SCIENCES RESEARCH COMMITTEE



PROMOTING THE ETHICAL CONDUCT OF RESEARCH
Executive Committee: *Dr. B. Chilima (Chairman); Prof. E. Molyneux (Vice Chairperson)*
Registered with the USA Office for Human Research Protections (OHRP) as an International IRB
(IRB Number IRB00003905 FWA00005976)



UNIVERSITY OF CAPE TOWN
Faculty of Health Sciences
Human Research Ethics Committee



Room E52-24 Old Main Building
Groote Schuur Hospital
Observatory 7925
Telephone [021] 404 7682 • Facsimile [021] 406 6411
Email: nosi.tsama@uct.ac.za
Website: www.health.uct.ac.za/research/humanethics/forms

24 June 2014

HREC REF: 322/2014

Dr C Colvin
Division of Social & Behavioural Sciences
Public Health & Family Medicine
Falmouth Building

Dear Dr Colvin

PROJECT TITLE: MEN'S SEXUAL HEALTH/HIV ATTITUDES, BEHAVIOURS AND HEALTH-SEEKING IN MALAWI (PhD Candidate -T Shand)

Thank you for submitting your study to the Faculty of Health Sciences Human Research Ethics Committee for review.

It is a pleasure to inform you that the HREC has **formally approved** the above-mentioned study.

Approval is granted for one year until the 30th June 2015.

Please submit a progress form, using the standardised Annual Report Form if the study continues beyond the approval period. Please submit a Standard Closure form if the study is completed within the approval period.

(Forms can be found on our website: www.health.uct.ac.za/research/humanethics/forms)

Please note that the ongoing ethical conduct of the study remains the responsibility of the principal investigator.

We acknowledge that the PhD student, Mr T Shand is also involved in this study.

Please quote the HREC reference no in all your correspondence.

Yours sincerely



PROFESSOR M BLOCKMAN
CHAIRPERSON, FHS HUMAN ETHICS

Federal Wide Assurance Number: FWA00001637.

Institutional Review Board (IRB) number: IRB00001938

This serves to confirm that the University of Cape Town Human Research Ethics Committee complies to the Ethics Standards for Clinical Research with a new drug in patients, based on the Medical Research Council (MRC-SA), Food and Drug Administration (FDA-USA), International Convention on Harmonisation Good Clinical Practice (ICH GCP) and Declaration of Helsinki guidelines.

The Human Research Ethics Committee granting this approval is in compliance with the ICH Harmonised Tripartite Guidelines E6: Note for Guidance on Good Clinical Practice (CPMP/ICH/135/95) and FDA Code Federal Regulation Part 50, 56 and 312.

AB. Secondary analysis of male responses to Malawi DHS data

Note that these results are not included in the Malawi DHS report.

My analysis of men's responses to the statement 'Women who use contraception may become promiscuous' within the last two Malawi DHS surveys (2010 and 2015) find that about 30% of men agree with this statement.⁷⁸ The support for this statement increased 19.3% between these surveys, from 27.18% in 2010 to 32.43 in 2015. See table 19 below.

Table 19: Male responses to Malawi DHS question on whether women who use contraception may become promiscuous

Q. Women who use contraception may become promiscuous	Malawi DHS 2010		Malawi DHS 2015	
	N	%	N	%
Disagree	5,088	72.82	4,952	67.57
Agree	1,899	27.18	2,377	32.43
Total	7,175	100%	7,329	100%

My analysis of the responses to the statement 'Contraception is women's business and a man should not have to worry about it' within the last three DHS surveys in Malawi (2004, 2010 and 2015) find that around 70% of men have consistently disagreed.⁷⁹ This figure has remained stable since 2004, as table 20 below demonstrates.

Table 20: Male responses to Malawi DHS question on whether contraception is a women's business

Q. Contraception is women's business and a man should not have to worry about it	Malawi DHS 2004		Malawi DHS 2010		Malawi DHS 2015	
	N	%	n	%	n	%
Disagree	2,229	72.56%	5,008	71.36%	5,164	70.31%
Agree	843	27.44%	2,010	28.64%	2,181	29.69%
Total	3,072	100%	7,018	100%	7,345	100%

⁷⁸ I undertook this secondary analysis using DHS Malawi survey files in STATA version 13, accessed 25 July 2017. Note that this formulation of question was not asked in the 2004 Malawi DHS survey

⁷⁹ I undertook this secondary analysis using DHS survey files in STATA version 13, accessed 25 July 2017