WOMEN'S EMPOWERMENT, SPOUSAL COMMUNICATION AND REPRODUCTIVE DECISION-MAKING IN MALAWI

A thesis submitted in partial fulfilment
of the requirements of
the Degree of Doctor of Philosophy

by

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To my dad (Kampheleni Luke Pius Chimbiri), my mum (Deliya Filemoni),

and my two lovely daughters (Golda and Bridget).

ABSTRACT

This study is focused on the relationship between women's power, spousal interactions and reproductive decision-making. It examines the nature of Reproductive Decision-Making Processes (RDMP) and the effect of spousal interactions and power relations on women's capacity to make autonomous reproductive decisions or to negotiate desired reproductive outcomes. The study questions *whether or not women's empowerment and spousal communication really matters for the spread of family planning in Malawi?*

The major findings of the study show that social dynamics at the national, the community, the lineage and the family levels affect the nature of RDMP and their outcomes. A number of indices are identified as having a significant impact on women's power to participate in RDMP and influence their outcomes. These factors include *non-egalitarian lineage or marriage system, women's perceived autonomy, spousal communication about family planning and exposure to modern ideas and lifestyles.*

This study demonstrates that changes in the social context, particularly in the lineage power structures and relationships, influence women's capacity to participate in deciding to space births, stop child bearing and use family planning methods. For example, the social change that has been taking place in Malawian societies has had an impact on family dynamics and structures. Urbanisation has continuously attracted men and women to migrate to cities leading to the fragmentation of lineages. De facto female-headed households have been on the increase. This has allowed married women to consider making autonomous reproductive decisions to space births using modern contraceptive methods. The reproductive decision-making power of lineage heads has been weakened. Nevertheless, married women are still not able to make autonomous decisions or convince their husbands to use modern contraceptive methods for the purpose of limiting family sizes.

The empirical findings of the study provide a paradox for research and public policies. Contrary to theoretical beliefs and the 'Cairo Model', less gender egalitarian lineage and marriage systems permit married women to make autonomous reproductive decisions, whereas more gender egalitarian lineage and marriage systems enable married women to negotiate desired reproductive behaviours and outcomes. In order to meet the needs of these categories of married women, public policies will require analyses that would provide in-depth understanding of the relationship between social change, spousal power relations, reproductive decision-making and family planning.

The few reproductive decision-making power variables identified in this study: *lineage, type of union, perceived autonomy, perceived negotiating power, spousal communication and exposure to modern ideas*, have only measured the degree of women's reproductive decision-making power. A more in-depth understanding of why most married women do not have the capacity to make autonomous decisions or to influence their husbands to use modern family planning methods for limiting family sizes is essential. This thesis has partially brought about that understanding. But more in-depth analyses of the impact of men's power, women's power, couple power, higher levels of spousal communication and levels of socio-economic development on the nature and outcomes of reproductive decision-making processes is called for. There is need to develop more cultural and socio-economic-based women's power measures that would allow for more gender and cultural-sensitive research, analyses and policy planning and implementation.

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[1] Chichewa

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LIST OF TABLES

LIST OF FIGURES

LIST OF MAPS

ACRONYMS

AIDS	Acquired Immunity Deficiency Syndrome
CBD	Community-Based Distributors
CBO	Community-Based Organisation
CCAM	Chitukuko Cha Amayi M'Malawi (A Malawian women's organisation)
CCAP	Church of Central African Presbyterian
CPR	Contraceptive Prevalence Rate
CSP	Child Spacing Programme
DEVPOL	Development Policy
DHS	Demographic and Health Survey
ESCAP	Economic and Social Commission for Asia and the Pacific
ECE	Economic Commission for Europe
FAO	Food and Agriculture Organisation
FLE	Family Life Education
FPP	Family Planning Progammes
GDP	Gross Domestic Product
GABLE	Girls Attainment of Basic Literacy and Education
GAD	Gender and Development
HIV	Human Immunodeficiency Virus
ICPD	International Conference of Population and Development
IMF	International Monetary Fund
IMR	Infant Mortality Rate
IUSSP	International Union for the Scientific Study of Population
KAP	Knowledge Attitude and Practice
PAP	Poverty Alleviation Programme
MCH/FP/RH	Maternal and Child Health, Family Planning and Reproductive Health
MDIC	Malawi Diffusion and Ideational Change
NAS	National Academy of Sciences
NIDL	New International Division of Labour
PAP	Poverty Alleviation Policies
PGR	Population Growth Rate
RDM	Reproductive Decision-Making
SAP	Structural Adjustment Policies
STAFH	Support to AIDS and Family Health
STD	Sexually Transmitted Diseases
TA	Traditional Authority
TMCSM	Traditional and Modern Child Spacing Methods
TFR	Total Fertility Rate
UPE	Universal Primary Education
UN	United Nations

UNESCO	United Nations Education, Scientific and Cultural Organisation
UNFPA	United Nations Fund for Population Activities
USAID	United States Agency for Information and Development
WFS	World Fertility Survey
WB	World Bank
WID	Women in Development
WAD	Women and Development

GLOSSARY OF MALAWIAN TERMS

Banja	A clan name or a sexual relationship
Chilangizo	Counselling
Chikamwini	Refer to *xurilocal* marriage
Gule wa Mkulu	A traditional mask dance practised among the Chewa people of Central Region
Kadzilange	Literally means 'counsel yourself', which ideologically refers to the principle of *laisser faire.*
Kadzionere	Literally means 'go and see for yourself', which ideologically refers to the principle of *laisser faire.*
Kulera	Generally refers to child caring but has been extended to mean *child spacing*
Mbumba	A term used in matrilineal Chewa societies to refer to women who are dependants of their brothers or matrilineal male relatives
Nyumba	A household (a physical unit)
Ukwati	An officiating of a marital relationship
Nkhoswe	A term used by matrilineal Chewa societies to refer to a man on whom his sisters and her offspring depend for support
Vimbuza	A traditional cult dance practised among the Tumbuka people of the Northern Malawi

DEFINITIONS OF ANTRHOPOLOGICAL TERMS

Patrilineage or

Patriliny A system designed to maintain property rights within a kinship group through the patrilineal uncle.

Matrilineage or

Matriliny A system designed to maintain property rights within a kinship group through the matrilineal uncle.

Marriage Within the African context, marriage refers to a definitive transfer of the rights of ownership from one lineage or kinship to another.

Virilocal or

Patrilocal marriage A marriage system that places emphasis on wife joining her husband to provide bride service to his parents-in-laws and produce children who serve as sources of human capital and investment for the patrilineage.

Uxorilocal or

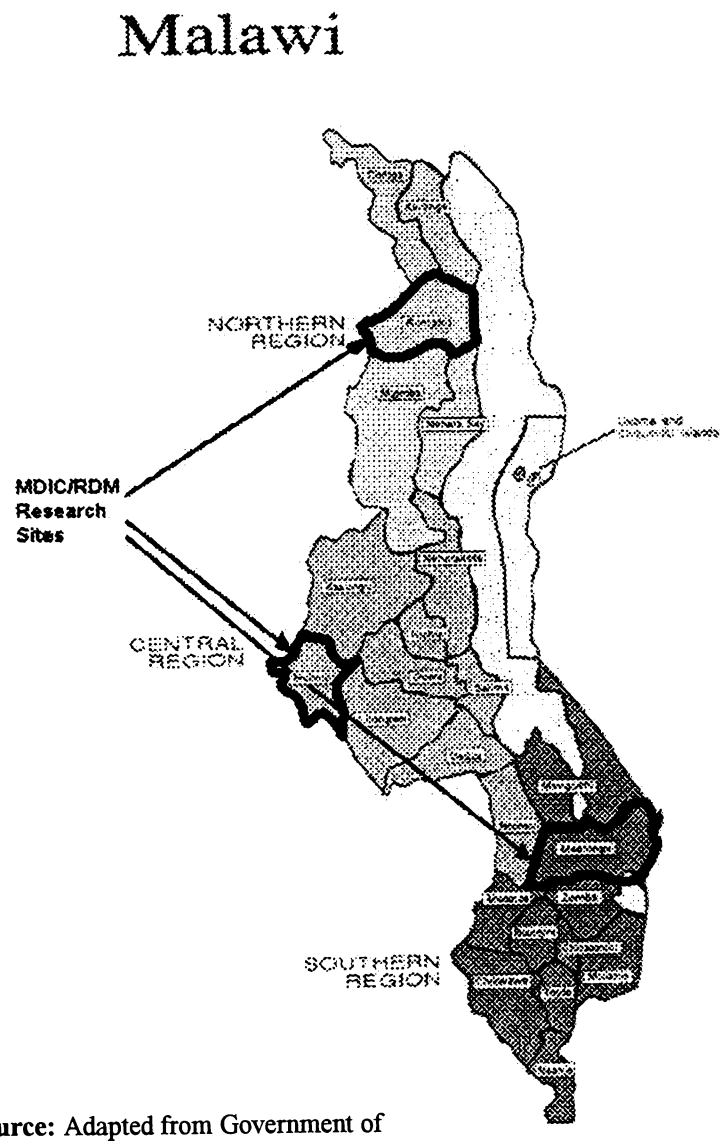
Matrilocal marriage A marriage system that places emphasis on husband joining his wife to provide bride service to his parents-in-laws and produce children who serve as sources of human capital and investment for the matrilineage.

Neo-nuclear family A family structure, which comprises a couple and children including siblings of the couple and key members of the lineage.

Nucleation of family The shift from an extended family structure (kinship, couple and children) and system to a nuclear family (couple and children) structure and system.

PART I: THE STUDY CONTEXT

Map 1.1: Sites for Malawi Diffusion and Ideational Change Sample Survey and Reproductive Decision-Making Ethnographic Research, 1998



Source: Adapted from Government of Malawi, 1994a

CHAPTER 1

INTRODUCTION

Purpose and nature of the study

This thesis examines the power of women to participate in Reproductive Decision-Making Processes (RDMP), an issue that has theoretical, substantive and methodological implications. It is also an issue at the forefront of discussion in international fora on women, development and population change.

My inspiration to conduct a study on RDMP was drawn from a debate, which occurred at the 1994 International Conference on Population and Development (ICPD) in Cairo. This discussion had practical implications that were subsequently written into plans of action. Three themes relevant in this thesis were highlighted at that conference. First, recognising that, as changes were occurring in family structures and dynamics, there was a need to provide couples or individuals with reproductive choices to enable them to maximise their well being including their reproductive health. Second, there was a need to integrate population policies explicitly into development plans that gave real and sensitive consideration to the roles and statuses of women. Third, there was a need to empower women, an intervention, so the conference argued, that is central to development. These themes

are also central to development-related fertility studies, yet the question remains whether or not research analyses are adequately reflected in policy. Indeed, some gender issues are only now being analysed in a profound way (Dharmalingam and Morgan, 1996; Mason, 1997; Thiriat, 2000; Locoh, 2000; Mason and Smith, 2000; Ezeh and Gage, 2001). Therefore, it can be argued that the consensus enunciated at the conference can be effectively implemented only if much more is known about the different perceptions about women's power and the locus of reproductive decision-making power. In sum, there is a need to provide an evidence-base for what is probably the conference's most publicised conclusion:

> In order to achieve sustainable development for all men and women, the status of women must be improved. It is especially important to ensure that women are able to fully participate at all levels of society. For too long, women have been denied the same rights and opportunities as men. As a direct result, women's health and well being have been jeopardised and the whole development process has been held back. Thus the ICPD Program of Action recognises the improvement of the role and status of women as an important end in itself. The support of men is essential in order to achieve this goal (Sadik, 1994: 3).

There are thus three objectives of this study. First, it explores whether or not the degree of women's power, viewed in terms of spousal power and/or the autonomy of wives within the family, either to make autonomous reproductive decisions or to negotiate their reproductive desires is a pre-requisite for the spread of family planning in Malawi. Second, it examines the relationship between women's empowerment, spousal power relations, spousal communication and RDMP. To do this, it empirically identifies measures of women's power, of spousal interaction and of RDMP. Third, it elaborates and refines theories relating to women's power in

RDMP and spousal communication. Clearly, these must take into account not just micro-level social interaction, the central focus of this thesis, but also, as secondary concern, those meso- and macro-level factors that have an impact on family dynamics. Although the thesis is looking at women's empowerment in practice, this factor is only measured indirectly. But such measurement is far from simple. Above all, the phenomenon it is identifying and documenting is not simply a function of micro-level factors. This is because the social interactions within the family occur in a context that is confounded by factors operating in the socio-cultural environment of the family: in the lineage, the community and/or the wider nation-state.

This study is situated in Malawi, a landlocked country situated in Southern Africa (Figure 1.1). It is an appropriate site for this study for two reasons. The Government of Malawi has placed social development issues at the top of its national agenda for research and policy implementation (Government of Malawi, 1997a). By the end of the 1990s, estimated Gross Domestic Product (GDP) per capita stood at US $ 166 (Government of Malawi and World Bank, 1997). Total Fertility Rate (TFR) at 6.7, Infant Mortality Rate (IMR) at 142 per 1,000 live births and life expectancy is at 40 (United Nations, 1996). If we accept the thesis put forward at the Cairo conference (noted above), then central to the implementation of change in these indicators is development that has as a central focus the empowerment of women. An empirical analysis of a situation that is so extreme permits a rigorous assessment of the significance of empowerment factors that might permit changes in the status of women.

That said, this thesis is not merely empirical in orientation. Indeed it focuses more on theoretical questions than would be typical for many studies in this field of research. This is because it was found necessary for a number of reasons to develop an appropriate theoretical framework.

First, a review of the Malawi literature showed that there are only limited number of studies that have attempted to inter-relate issues of spousal communication, spousal power relations and RDMP per se at the S*tate*, *community-lineage* and the *family-couple-individual* levels. As noted above, understanding the interaction between these levels is essential for an analysis of spousal communication in RDMP. In this thesis the State level will be referred to as *macro*, the community-lineage level as *meso* and the family-couple-individual level as *micro*.

Second, there is a relative gap in theories of social interaction applied to development-related fertility studies. In part, this is because empirical evidence relating to the impact of macro- and meso-level factors on micro-level behaviours is not well elaborated.

Third, we still need empirical evidence that might increase the explanatory power of studies on the reproductive attitudes, choices, decisions and practices of people, particularly those in poor countries like Malawi. For example, such evidence is required to test the theoretical framework for RDMP that would take the power of

social interaction into account. Since quantifiable measures of women's empowerment and the impact of social interaction at the micro-level are non-existent for Malawi, there is a need to collect new information on these factors.

In passing, one might note that in this thesis, s*ocial interaction* will be used in a rather narrow sense. Here it refers to the two-way process of *role-taking* and *role-making* through which individuals evaluate, validate and weigh new actions against old ones in an attempt to reach a mutual agreement over rights and duties (Turner, 1988). Following the lead of Bongaarts and Watkins, social interaction also encompasses the notion of social influence by which individuals have an impact on each other's attitudes and behaviours. In their definition, explicit elements include communication (exchange) of information, evaluation of the information exchanged and the way in which the actors in this process influence each other (Bongaarts and Watkins, 1996).

Fourth, this thesis takes into consideration the current thinking that an appropriate framework for fertility analysis should be a multi-dimensional approach (Labourrie-Racapé and Locoh, 1998), but this thesis recognises that such an approach is still under debate (Basu, 1997b). Therefore, the method mix approach that will be used for analysis in this thesis will provide more theoretical and empirical justification for a multi-dimensional approach to development-related studies on fertility. Such an approach will have to integrate selected aspects of sociological, anthropological,

feminist, and development approaches into demographic research and public policy planning and implementation.

The focus of the thesis is on reproductive decision-making processes, a phrase that normally refers to communication about the timing of the first and the spacing of subsequent births, to limiting family size, and to the use of contraceptive methods. In this thesis, RDMP will refer to spacing and limitation, to the decision whether or not to stop child bearing and to agreement about whether or not to use family planning methods to achieve these ends. *Family planning* is the reproductive strategy that individuals, couples and groups or organisations employ to meet the reproductive goals emanating from RDMP.

In this thesis, RDMP is seen as occurring within the context of spousal communication and spousal power relations. *Spousal communication* will be defined here as those dynamics involved in spouses exchanging information and ideas through overt or covert means while simultaneously perceiving, interpreting and signalling their own activities and those of their partners (Pearson et al., 1995). *Power* will be conceived as a complex set of ever-changing relations of force by which modes of decision-making are influenced (Grosz, 1992:87). Spousal power relations will therefore be conceptualised as a complex set of behaviours involving communication relating to obligatory tasks (Lukes, 1974). Obligatory tasks are those responsibilities that one is expected to undertake as a leader of kinship group or in his/her capacity as a member of the kinship group. Spousal communication and

spousal power relations are the channels through which women's empowerment and RDMP occur. Although in this thesis, women's empowerment, spousal communication and RDMP will be analysed as separate processes, it must be noted that these processes do overlap.

Also central to this thesis is the phenomenon of *women's empowerment*. In this thesis, *women's empowerment* is perceived as a process leading to the pooling of resources (material, financial, ideological and intellectual) (Brohman, 1996) to develop the capacity to bring about structural and functional changes (Batliwala, 1994; Labourrie-Racapé and Locoh, 1998). In this context, *structural changes* are viewed as being related to the patterns of organisation of social institutions and *functional changes* as being related to the roles (expected or perceived) and behaviours of members of those social institutions. Viewed this way, *women's empowerment* would, therefore, increase the resources available to women and would involve changes in the power structures between men and women leading to shifts in traditional gender roles in decision-making processes. The outcome variable, as it were, is a degree of power or capacity in any social exchange.

The model of empowerment just outlined is one that privileges manifest aspects of social behaviour and intervention. This thesis must investigate, however, whether there is also a more latent dimension. This has been analysed by Dyson and Moore (1983) in a seminal paper that defines the capacities emanating from latent processes

not as empowerment but as "autonomous". Figure 3.2 in this thesis adapts this notion to employ it in the context of reproductive decision-making.

Study rationale and theoretical foundations of the research problem

The impetus for this study comes from the continuing need for a clear understanding about fertility patterns in developing countries, especially in Sub-Saharan African region. Fertility levels in this region are still considered to be very high apart from the fertility declines being experienced in South Africa, Zimbabwe, Botswana and Kenya in Southern Africa and Ghana in West Africa (Locoh and Hertrich, 1991; Cleland *et al.*, 1991; Caldwell and Caldwell, 1997; Brass et al., 1997). Although these shifts could be a sign that the African sub-continent is experiencing the dawn of fertility transition, there remain two outstanding issues about how that might be triggered and what path it might follow.

First, demographers have different views regarding whether or not fertility transitions in Sub-Saharan Africa should be expected to follow the classical Western model. It has been argued that the fertility declines being experienced by these few countries may not be a sign of widespread, lasting and uniform fertility transition in the region (Locoh, 1991; Cleland *et al.* 1991; Caldwell *et al.*, 1992; Bongaarts and Watkins, 1996). However, it appears that the fertility transition in this region could be of a new type that may be significantly different from the Western model (Caldwell *et al.*, 1992; Caldwell and Caldwell 1997).

The second issue, which is directly relevant to the present thesis, is the fact that there is still no consensus regarding what factors support the persistent high fertility in the region (Caldwell and Caldwell, 1997). Up to the late 1980s, the thinking was that the nations of sub-Saharan Africa continued to have high levels of fertility because they had special characteristics. Generally, pre-fertility transition countries in that region were characterised by traditional social systems and religion. Norms were grounded by the importance of ancestry and descent, by the maintenance of polygyny, and by the lineage rules of inheritance that encouraged women to have many children. Through motherhood a married woman was ensured social and economic security. Men had no other possible investments for the future, apart from benefits gained through their wives and children. Family Planning Programmes (FPP) did not exist in many areas or, if in existence, were ineffective (Caldwell *et al.*, 1992). Prevailing at the time was the view that fertility decline would be an outcome of the replacement of traditional values, practices and structures with modern values and structures through the diffusion of Western ideas (Cleland and Wilson, 1987). Underpinning this view was the modernisation theory prevailing in the period 1950s through to 1970s.

In the 1960s and 1970s, most theoretical and policy perspectives on development being applied to developing countries like Malawi were adapted from the West because the Western experience was seen as the appropriate model. The classical analyses emphasised the more macro-level dimensions of economic, socio-political development and to a lesser degree *underdevelopment*. That paradigm, which

classical development theories referred to as the lack of change in social, economic, demographic and political structures as well as functions (Chirot, 1977), was used as a baseline for explanations of the lack of fertility transition in sub-Saharan Africa. Development, defined in this way, was thus seen as inseparable pre-requisite of fertility decline (Chapter five).

Underlying the analyses in this thesis, in contrast, is the postulate that the classical modernisation perspective, as used to explain the relationship between fertility levels and levels of development, has ignored some important aspects of intra-familial dynamics. The focus of theory relating to this has instead been on macro-level structural changes. In contrast, the way in which social interactions occur within families, between cognate kin and affines, between people of different generations, and between spouses, went largely unrecognised (Labourrie-Racapé and Locoh, 1998; Locoh, 2000). The effects of these interactions on RDMP have been unexamined.

This thesis is based around the argument that the influence of the nature of spousal interaction is a key element in RDMP. In this study therefore, it is postulated that changes in the management of particular social interactions within the community and the family (notably the way in which reproductive decision-making power is exercised within the conjugal unit) are likely to have a major impact on fertility transition in Malawi (and indeed all other countries in sub-Saharan Africa). This is

because, as some demographers have noted, the forces of social interaction are likely to influence fertility decline (Watkins, 1987; Bongaarts and Watkins, 1996).

Attempts have been made to examine the role of women's empowerment and social interaction (including spousal communication) in demographic processes and their outcomes. So far, the interest on social interactions has been focused on interrelation between people and institutions (Tienda, 1991; Mason, 1991; Watkins, 1991), social networks (Bongaarts and Watkins, 1996; Watkins et al., 1997; Kohler *et al.*, 2001). Other studies have attempted to examine the role of spousal communication in family planning (Ezeh 1993a, 1993b; Biddlecom *et al.*, 1996; Blanc *et al.*, 1996). Some studies have also examined the impact of women's autonomy and power on modern contraception (Dyson and Moore, 1983; Mason, 1986; Basu, 1992; Dharmalingam and Morgan, 1996; Mason and Smith, 2000).

The impetus for studies on spousal communication came from the criticisms that fertility studies and FPP focused on women, theoretically implying that issues of fertility and family planning were uniquely women's problems (Watkins, 1993; Watkins *et al.*, 1997). It is clear that there is a need for more studies that can link gender and power relations, spousal communication, RDMP and their outcomes. Chapters three and four cover discussion on how the limited research and public policy foci on issues of social change at the macro-level have contributed to the neglect of the impact of forces of social change on women's empowerment and the nature of RDMP at the micro-level.

Postulates, scope and organisation

In this thesis, it is argued that in order to understand and address issues related to the nature of RDMP and fertility patterns in sub-Saharan Africa, studies on fertility and development, including those linked to public policy and programme strategies, must employ multi-dimensional approaches. These approaches should take into account the experiences of individual women and couples along with the historic and social development context within which they are occurring. But such an approach cannot rely entirely on quantitative survey and secondary data.

Underlying this general argument are three more specific assumptions. First, it is assumed that the micro-level, defined here in terms of the neo-nuclear family, has features similar to those of the macro- and meso-level structures and functions. For example, the power and gender structures that are characteristics of national and community-level institutions are similar to those of the neo-nuclear family. In a neo-nuclear family, defined as a family structure that comprises a couple and children including siblings of the couple and key members of the lineage, men are in control of significant resources and decision-making. Similarly, men are in control in national and community-based institutions and husbands are in control of significant resources and decision-making within marriage.

Second, it is assumed that the forces of interaction of macro-, meso- and micro- level changes affect the traditional power and gender structures. Individual women and

couples become empowered to make autonomous economic and reproductive decisions for their survival and that of their families.

Third, it is assumed that the power-relationship between men and women, as manifested through communication, is a major component of gender stratification systems. In turn, these are seen as key determinants of the locus of reproductive decision-making power.

In these assumptions, the term *gender system* is employed. These are social stratification systems through which men and women are assigned different roles in the social division of labour and in the control of different kinds and amounts of resources (Mason, 1986). In gender systems, power takes on the generic attributes characteristic of stratification systems in general: the capability to influence overt decision-making, the capability to control resources (including knowledge, finances and material) and the capability to influence how people perceive their own interests. Power relations are therefore strategies that individuals and institutions use to impose obligatory tasks through either overt or covert communication (Lukes, 1974:13).

Starting from these assumptions and in order to set a framework by which we can gain an understanding about the nature of spousal interactions and power relations and women's power in RDMP within the conjugal unit, it is postulated:

a) That, the greater the "gender egalitarianism" of a lineage system, the more will be the probability that equitable, effective and/or productive spousal communication and women's empowerment will take place.

b) That the forces of social change will empower individual married women to perceive that they have the capacity to make autonomous reproductive decisions or to negotiate their reproductive desires.

c) That shifts in the paradigms underpinning public policies that attempt to address issues of *fertility, gender and development* (individually or in combination) will effect changes in lineage systems, in power and communication relationships, and, in individual or group statuses.

Logit analytical models will be used to analyse the impact of changes in spousal power relationships, spousal communication and the locus of reproductive decision-making power on women's empowerment to make autonomous reproductive decisions and to negotiate their reproductive desires with their husbands. The methodology involves the following steps:

a) Identifying and constructing variables that measure or describe the relationship between women's empowerment, spousal communication and reproductive decision-making power.

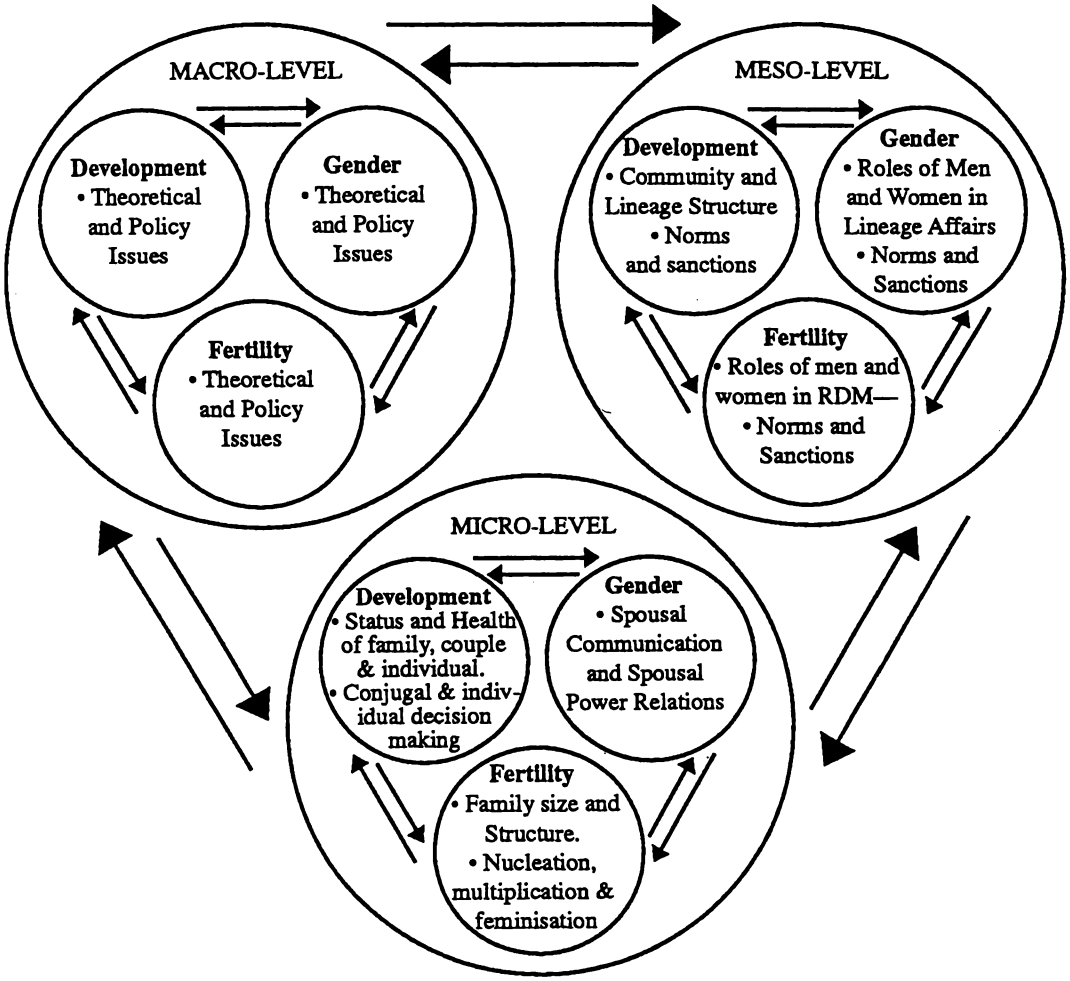
b) Exploring the relationships between, on the one hand, women's empowerment, lineage systems, spousal communication, and spousal power relations and on other hand, RDMP and their outcomes.

c) Measuring the forces of interaction and the outcomes of these between, on the one hand, empowerment factors operating at the micro-meso- and macro-levels and, on the other hand, women's reproductive decision-making power.

In order to undertake such a complex analysis, theoretical questions (Figure 1.1) are identified and used to conceptualise issues (conceptual, substantive and methodological) relevant in the areas under study. In addressing the theoretical questions identified as important for this thesis, a problem is encountered: there is a tendency in prevailing fertility, gender and development theoretical paradigms and policies to rely on what is virtually an ideology rather than a real evidence-base (Grimes, 1994; 1997b). This raises questions about the effectiveness of current approaches used to study and analyse linkages in the fields of fertility, gender and development. In particular, the question arises firstly about the omission of intra-familial dynamics in research, policy and program approaches. In addressing this question, however, a more fundamental one, referred to earlier, emerges: the lack of reference to latent behaviours and autonomy. Instead, there is a focus on the manifest processes of empowerment.

These theoretical questions form the basis of Part I of the thesis because, inter alia, the present study is heavily grounded in theory. These questions are then tested using empirical evidence. The methodology used involves the collection and interpretation of both quantitative and qualitative data and attempting to measure and interpret both objective and subjective changes within the family, particularly on wives.

Figure 1.1 Theoretical questions at macro-, meso- and micro-levels



Source: Present Author

Structure of the thesis

This study will be in four parts:

a) Part I (Chapters one and two) sets out the study's context. It is a description of the research problem and of the social, cultural, economic, demographic and policy environment of Malawi.

b) Part II (Chapters three to six) provides a description of macro- meso- and micro- level issues in the fields of fertility, gender and development and their theoretical underpinnings, with reference to development (as a process of social change) and reproductive decision-making experiences in Malawian communities. In that section, it is argued that Western concepts, theories and policies of development have had a major influence on the development concepts, theories and policies operating in Malawi (See Annex I).

   Part II therefore explores the linkages between conceptual, theoretical and policy issues of fertility, gender and development identified earlier in Figure 1.1. It goes stepwise through these issues starting with those related to gender and development at the macro-level, and working through the meso- to the micro-level covering issues of women's empowerment, spousal communication and reproductive decision-making and finally a synthesis of those identified issues.

Thus Chapter three outlines the way in which, in the context of gender analysis, prevailing development paradigms have influenced the conceptualisation of the term *development* as applied both in theory and praxis from the 1950s through to the 1990s. This chapter is also a description on how these paradigms underlie the existing explanations of the role of the community, the lineage, the family, the couple and the individual in development processes. It is focused on the relationship between issues of gender and development. Specifically it covers in detail the relationship between the predominant theoretical paradigms, public policy formulation, and processes of social change in Malawi along with their outcomes. It will also assess how these outcomes have led to the redefinition of the roles and statuses of women, women's relative power in RDMP and the significance of spousal communication.

Chapter four is a discussion of the issues emerging from the redefinition of the relative amounts of powers men and women can bring to RDMP, and the integration of fertility and development in theory and public policy. The last section of this chapter is a synthesis of the issues identified in chapters two and three, which will be used to elaborate a theoretical framework that will be developed in that chapter.

Chapters five and six are a discussion of the data and methodology used in this study. The second of these chapters also presents preliminary analyses of

the differences (by lineage and type of union) in wives' reports about their perceptions that they have the power to make autonomous reproductive decisions or negotiate desires of reproductive outcomes.

c) Part III covers the findings from the empirical analyses conducted in this thesis. This comprises three Chapters seven to nine, which cover the identified elements of women's empowerment, spousal communication and RDMP. These include those variables indicating women's perceptions about their power to make autonomous decisions or to convince their husbands to space births, to stop childbearing and to use modern contraceptives.

Chapter seven is a discussion of factors that influence women's perceptions about their power in deciding to delay births and stop child bearing. In Chapter eight, the factors that facilitate or hinder women to develop the capacity to recognise that they have the power to negotiate their fertility and contraceptive desires with their husbands are described. Chapter nine discusses the factors that affect the probability that married women could have the power to make autonomous decisions to use modern contraceptives without their husbands' knowledge.

d) Part VI of the thesis (Chapters ten and eleven) is a synthesis of the identified theoretical issues including the research findings. That section also presents conclusions and implications drawn from the empirical evidence analysed in

the thesis. Firstly, it illustrates how a multi-dimensional approach reveals the nature of processes of change. Secondly, it synthesises the impact of the forces of social interaction (operating within the conjugal unit in different marital contexts) on the capacity of married women to make autonomous reproductive decisions, to negotiate their reproductive desires and to use modern contraceptives overtly or covertly. Thirdly, it discusses whether or not women's empowerment to make autonomous reproductive decisions or to negotiate their reproductive desires has a significant impact on RDMP and their outcomes, particularly family size limitation. Chapter ten is a discussion of the factors that influence wives to consider engaging in covert or current use of modern contraceptive methods. The final one, Chapter eleven is a synthesis of all findings, from which conclusions and the implications are drawn for research and public policies that attempt to integrate fertility, gender and development.

CHAPTER 2

WHAT DO WE KNOW ABOUT MALAWI?

Introduction

This chapter is a description of a number of important aspects of Malawi and its people. It covers the historic background of the country in terms of its political, socio-economic, socio-demographic, socio-cultural and policy trends and characteristics from the macro-, meso- and micro- level perspectives.

Malawi is a landlocked country situated in Southern Africa, with a total surface area of 119,484 square kilometres, 20 percent of which is covered by water (Government of Malawi, 1987). Administratively, the country is divided into three regions (north, centre and south). According to 1998 national census, the total population is 9.8 million with low levels of masculinity. Sex ratios were 90 males per 100 females in 1966, 93 in 1977, 94 in 1987 (Government of Malawi, 1994c) and 96 in 1998 (Government of Malawi, 1998b). The age-sex structure has a disproportionate distribution, with higher masculinity ratios in urban areas, particularly in the central and southern regions. However, the sex ratios and age structures are equal in rural areas in all the three regions (Government of Malawi and United Nations, 1993; Government of Malawi, 1994c, 2000).

Malawi was a British protectorate from 1891 to 1964 when the country attained independence and became a Republic. After thirty years of autocracy from 1964 to 1994, it became a democratic Republic. Generally, Malawi still records poor social, health and economic indicators (Government of Malawi and United Nations, 1993; Government of Malawi, 1996; 1999). Fertility and mortality levels are high while economic and social development levels are low. In an attempt to improve the standard of living and quality of life of its people, the Government of Malawi has been formulating development policies and programmes within the economic, agriculture, health, education, and population sectors for several decades (Government of Malawi, 1994).

Ethnic and cultural background of Malawians

Ethnicity and lineage systems

The factor 'culture' here defined as an attribute determined by communication through language, ethnic and geographic proximity varies by region and district in Malawi. Ethnically, the Malawi population is composed of more than 20 ethnic groups that migrated into the country between the 15th and 19th century. The major ethnic groups are the Tumbuka, the Ngoni and the Tonga in the north, the Chewa and the Ngoni in the centre and the Yao, the Lomwe, the Sena and the Mangánja in the southern region (Pachai, 1973). The Tumbuka, currently found in the north, originated from the northwest (Zambia and Tanzania) and settled in parts of Mzimba and Rumphi towards the end of the 15th century. The Tonga migrated into northern Malawi around the 18th century and occupied the Western lakeshore area (Karonga

and Nkhatabay). The Ngoni originate from South Africa. They arrived in Malawi after the 1820s (Thompson, 1998). This group then migrated from the northern region and settled in Mchinji, Dowa and Ntcheu districts in the central region. The Yao originated from Mozambique and migrated into most parts of Mangochi, Machinga, and Chiradzulu districts (Pachai, 1973). The Lomwe also originated from Mozambique and settled in Mulanje, Thyolo, and parts of Chiradzulu and Nsanje districts. The Sena, also originated from Mozambique, are mostly found in Chikwawa and Nsanje districts. The Mangánja originally found in the central region migrated southwards into parts of Chiradzulu and Thyolo districts.

All ethnic groups in the north practice *patriliny,* a system whereby descent is traced through the father and sons, and sons or male relatives inherit property. Marital residence is patrilocal (among the husband's family). *Bride price* payment serves as compensation to the bride's parents for the loss of their daughter and as a guarantee that the husband will fulfil his obligations. Bride price is also referred to as bride-wealth, which is payment for the acquisition of rights to reproduction. It marks the transfer of these rights or any offspring of a woman between kinship groups (Lesthaeghe1989a). The payment is tendered in material goods such as livestock or money. As a result, divorce is close to impossible. Polygynous unions, which are a common practice, are the outcomes of preferential rules, which allow men to marry more than one woman among the patrilineal groups and govern the marriage of widows. Levirate rules, for example prescribe the *inheritance* of widows by a brother of the deceased husband (Murdock, 1959). Today, levirate rules are less likely to be

applied due to the deepening AIDS problem and economic recession. This is because the remarriage of widows is not just a formality but it is a sexual relationship that is demonstrated by the birth of a baby. Therefore, on the one hand, for fear of contracting HIV/AIDS, in case the deceased died of AIDS, the deceased husband's relatives may not be keen to inherit the widow as a sexual partner. On the other hand, with shrinking significant family resources (ie. Land and cattle) and the lack of other sources of income, it is unlikely that remarriage of widows by male relatives of the deceased husbands will be affordable[2]. Then more of these widows are likely to manage their own households and would therefore be required to own and control some of the property such as land to use it for the survival of her children and herself.

In the central region, the two major ethnic groups (the Chewa and the Ngoni) practice different cultural systems. Until recently, the Chewa people practiced matriliny, a system whereby descent was traced through the mother's matricaln but adoption of their personal praise name is through their father's matriclan (Marwick, 1965). Later, Schoffeleers (1968) argued that clan inheritance of the Chewa was in fact patrilineal from historical times. This is because in practice, it was the brother of the mother who owned and controlled the inherited property and any significant family resources including land (Phiri, 1983). Thus inheritance was matrilineal

[2] During 1998 field research in Rumphi (in the northern region), the author witnessed a funeral ceremony of a man who used to work in one of the big cities in Malawi. Three days after burial, there was a meeting between the deceased relatives and the widow's relatives. The discussion was focused on who was prepared to take care of the widow and the children. Nobody offered and yet there were at least three male relatives who were eligible to inherit the widow. After asking for a volunteer for three times, one elderly man (not likely to be eligible) stood up and said that "taking care of the widow and the children is the responsibility of all the relatives of the deceased. So, we all should take charge of assisting her and the children". After the ceremony, one of the eligible men came to the author and said: "Do you know, these days nobody can inherit a widow because

through the maternal uncle. Material gifts for marriage were tendered in the form of a *bride service* such as the husband building a house for the parents of the bride. The Ngoni people, who are also found in central region, practised the patrilineal system and are patrilocal. Due to close contact between the Chewas and the Ngonis, a mixed cultural system developed and the matrilineal system became weaker. Matrilineal inheritance changed locally into patrilineal inheritance. Marital residence may be matrilocal or patrilocal and only token gifts are given at marriage. In the south, the Yao, Lomwe and Mangánja are predominantly matrilineal and matrilocal. These ethnic groups still practice the strong matrilineal system. They follow matrilineal inheritance but adoption of clan name is through the father's clan for the Mang'anja and through the mother's clan for the Yao and Lomwe. Only the Sena are strictly patrilineal and patrilocal.

Language and religion

Apart from the lineage systems, there are also regional and district variations in terms of religious beliefs and language used for communication within households. In post-colonial era, the Banda regime regarded national unity and one language as priorities. *Chichewa* was declared the national language and a medium for instruction. English became the official language. By the year 1998, approximately 5.7 million (57 percent of the total population) reported using *Chichewa* as their language of communication in their households. The other languages most

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one would not know what killed the deceased. Furthermore, it is economically difficult these days to manage your own children. Adding on another lot is impossible".

commonly used as a medium of communication in households were Chinyanja (14 per cent), Chiyao (10 per cent) and Chitumbuka (9 per cent).

Regional and district level variations were evident. In the northern region, the most popular language for communication within households was Chitumbuka (65 percent). In the central region Chichewa was widely used, with 91 percent of the population using it as a medium of communication in their homes. In the southern region, however, Chichewa (42 percent) followed by Chinyanja (26 percent) and Chiyao (19 percent) were the commonly used languages within households.

In terms of religion, Malawi has three major religious groupings. The 1998 population census showed that 7.9 million people (80 percent) were Christians and 1.3 million (13 per cent) were Moslems. About 55 percent of the Malawian population is Protestant, some 20 percent Catholic, an additional 20 percent Moslem, and approximately five percent follow traditional religious practices (Government of Malawi and United Nations Children's Fund, 1998: 5). The proportions in the northern, central and southern regions were 96, 83, and 73 percent respectively while about 1, 7, and 21 percent of the populations in the three respective regions were Moslems (Government of Malawi, 2000a).

The Traditional Leadership

In the colonial period of the Nyasaland protectorate, the British used indirect rule and the organisation of Government structures was based on the traditional leadership

structures of chiefdom. The post-colonial Government structure had the Head of State occupying the Office of the President and the chair of the Cabinet. Under the cabinet were the Regional Administrative Offices, the District Administrative Offices, the Traditional Local Authorities and Village Chiefs, which were subordinated to the Cabinet. This system diluted the powers of traditional leaders. The President became the locus of decision-making at the macro-level.

Cultural change

Cultural changes have been taking place in Malawi due to several factors. These include contact with Christianity and Islam, tribal intermarriages, migration, and wage employment. The transformation of the traditional cultural systems has led to the development of more 'common cultural and social practices' (Kishindo *et al.,* 1998). The traditional cultural practices include initiation ceremonies carried out in camps[3], disease and death related beliefs, early sex, early marriage; the employment of *fisi,* the practice of levirate rules, payment of bride price, and the practice of matriliny. Kishindo *et al.,* 1998) provide evidence of these practices being less favoured these days than in the past. The *fisi* term is used to refer to a man in two contexts. It refers to a man who becomes a surrogate husband where the husband is impotent or he has gone away from home for a protracted length of time. This is because people fear promoting immorality. They are also concerned about unplanned

[3] Traditional initiation ceremonies continue to take place but in fewer camps than before. This is because many parents encourage their children to continue with school. These initiation ceremonies differ by ethnicity. Among the Tumbukas in the North, initiation ceremonies do not exist. But in the centre and south they do. In central region there are there are different types of initiation ceremonies for boys and for girls in different age groups. The age groups range from 8-10 years, 11-15 and 15 plus (ready to marry). In southern region too the initiates differ by age groups. The age groups determine the type of instruction that the initiates receive at each stage. Between 8 and 10 years, the initiates are taught obedience. Between age of 11 and 15, they are taught about their physiological development. From age 15 onwards, they are taught about sexual and marital life.

pregnancies and large family sizes, the possible spreading of Human Immunodeficiency Virus (HIV) or Acquired Immunity Deficiency Syndrome (AIDS), perpetuation of low academic achievement among women, and the promotion of violence and *witchcraft*. However, initiation ceremonies and traditional practices that encourage abstinence and respect for elders have remained strong. Above all, matrilineal and patrilineal systems with no restrictions in sexual behaviour and cross-marriages are still favoured.

Although production and social security are still organised around the extended family system (Government of Malawi and United Nations, 1993) traditional roles are being gradually eroded. Traditional leaders, including chiefs and members of a lineage, no longer have total control over family matters. Social changes caused by education, migration, religious contacts, the decline of mortality, the worsening economic crisis and recently the environmental and AIDS crisis (Kandawire, 1979; Phiri, 1983; Locoh, 1997) have put pressure on traditional family roles. The division of labour within the family is now no longer clear since traditional gender roles have been changing as men and women embrace modern lifestyles when they migrate to cities. There has been a consequent increase in numbers of female-headed households (Government of Malawi/United Nations, 1993; Food and Agriculture Organisation, 1994; Locoh, 1997, 2000). In spite of women being denied of decision-making powers, some women have assumed men's responsibilities as breadwinners, a shift that is taking place in most countries in sub-Saharan Africa (Locoh, 1996).

Changes in gender roles have in turn led to shifts in patterns of family sizes and structural organisation. These changes are discussed in detail in Chapter three.

Demographic and Economic Trends

Demographic and Health Indicators

Viewed from an international perspective, Malawi's population has steadily increased in the past years. The total size of the population increased from four million in 1966, to 5.5 million in 1977, eight million in 1987 and to 9.8 million in 1998. The population growth rate increased from 2.9 percent during the period 1966-1977 to 3.7 during the period 1977-1987 but had dropped to 2 percent by 1998. Between 1987 and 1998, the population count increased by 24 percent. The population growth rate rose from the early 1960s until the late 1970s with a steep rise between the 1970s and the1980s due to a large influx of Mozambican refugees into Malawi. Among the factors contributing to the drop in the1990s is the repatriation of the Mozambican refugees (Government of Malawi, 1984, 1987b, 1996a; 1998b; 2000a).

Malawi's population density has increased from 43 per hectare in 1966 to 105 in 1998. At regional level, the 1998 census showed that the northern region (46) was the least densely populated whereas the southern region (146) was the most densely and the central region stood at 113. At the district level Rumphi (27) was the least densely populated and Chiradzulu (308) was the most densely populated (Government of Malawi, 1987b, 1994c, 1995a, 2000a).

Table 2.1 suggests that TFR was estimated to have declined marginally below that of 1960, from 7 births per woman between 1960 and 1965 to 6.7 in 1998 (United Nations, 1996; Government of Malawi 1994a, 2000b). This downward trend is expected to continue. TFR is estimated to reach 5.1 in 2025 (Government of Malawi, 2000c).

Table 2.1 Estimates of socio-demographic indicators for Malawi, Botswana, Kenya and Zimbabwe, 1960-2000

	1960-65	1965-70	1970-75	1975-80	1980-85	1985-90	1990-95	1995-00
				Malawi				
PGR	2.38	2.56	2.98	3.29	3.17	5.06	0.72	2.54
TFR	7.00	7.20	7.40	7.60	7.60	7.40	7.20	6.69
IMR	204	197	191	177	163	154	148	142
e°								
Males	37.80	38.90	40.30	42.30	44.20	44.20	41.40	40.30
Females	39.10	40.20	41.70	43.70	45.70	45.60	42.40	41.10
Both	38.40	39.50	41.00	43.10	45.00	44.90	42.00	40.70
				Botswana				
PGR	2.68	2.97	3.50	3.54	3.46	3.33	2.62	4.45
TFR	6.90	6.80	6.60	6.37	5.80	5.24	4.85	4.45
IMR	113	105	88	76	64	57	55	56
e°								
Males	45.9	48.4	51.5	54.6	57.5	58.9	52.4	48.9
Females	49.2	51.8	55.0	58.2	61.8	62.8	55.8	51.7
Both	47.5	50.1	53.2	56.4	59.8	61.0	54.3	50.4
				Kenya				
PGR	3.14	3.30	3.56	3.82	3.56	3.33	2.91	2.22
TFR	8.12	8.12	8.12	8.12	7.50	6.80	5.40	4.85
IMR	118	108	98	88	81	75	71	65
e°								
Males	44.0	46.5	49.0	51.5	53.8	54.0	52.7	52.3
Females	48.0	50.5	53.0	55.5	58.0	57.5	55.4	55.7
Both	45.9	48.4	51.0	53.4	55.8	55.7	54.1	54.5
				Zimbabwe				
PGR	3.17	3.27	3.10	2.97	3.27	3.21	2.54	2.09
TFR	7.50	7.50	7.20	6.60	6.19	5.50	5.20	4.68
IMR	106	101	93	86	76	70	70	68
e°								
Males	44.9	47.4	49.8	52.0	54.0	54.6	49.6	47.6
Females	48.1	50.7	53.3	55.6	57.8	58.0	51.9	49.4
Both	46.5	49.0	51.5	53.8	55.9	56.3	50.7	48.5

Source: United Nations (1996).

Note: PGR = Average annual population growth rate (percentage per year).
TFR = Total fertility rate (expressed as number of births per woman).
IMR = Infant mortality rate (expressed as number of deaths per 1,000 live birth).
e° = Life expectancy (the average remaining life time, in years, for a person who survives at the beginning of an indicated age-interval.

Regional level variations in fertility levels exist but not to a large extent. In 1987, southern region recorded 7.1 births per woman and the north 7.3 births per woman and the highest rates were in the central region, 8.1 births per woman (Government of Malawi, 1987c). In the year 2000, southern region had a TFR of 6.0 births per woman, central region 6.8 and northern Region 6.2. District-level differentials were however substantial. The highest TFR was in Mangochi, 7.4 births per woman and the lowest in Blantyre, 4.3 births per woman. The 2000Malawi DHS report shows that TFR stands at 6.2, 6.8 and 6.0 in the north, the centre and the south respectively. At district level, Kasungu has the highest TFR (7.0). Mchinji and Rumphi have a TFR of 6.8 (Government of Malawi, 2000b). Malawi is therefore expected to remain a very high fertility population in the next decade.

The health situation in Malawi initially improved after independence. Nevertheless, the current health indicators of Malawi are considered to be poor compared to other countries in the region (See Table 2.1). The United Nations (1996) estimates show that the Infant Mortality Rate (IMR) for Malawi was 204 per 1000 births in the early 1960's dropping to 142 per 1000 births in the late 1990s. The countries that have started experiencing fertility decline (Botswana, Kenya, and Zimbabwe) were estimated to have had IMR of 113, 118, and 106 respectively in the early 1960s and subsequently experienced a significant drop to below 100. Life expectancy was expected to increase from (45.9, 46.5, 47.5 respectively) in the early 1960s to well over 50 by the year 2000 (United Nations, 1996). For Malawi, it was estimated to rise to a peak (49) between 1985 and 1990 and is expected to drop to 40 by 2006 and

to steadily rise to 47 by 20025 (Government of Malawi, 2000c). To the surprise of policy makers, program implementers and researchers, MMR in Malawi almost doubled since the 1992 DHS. It has increased from 620 in 1992 to 1120 in 2000 (Government of Malawi, 2000b). This is an indication that many countries in the AIDS belt of East and Southern Africa experienced a decline in mortality much earlier than Malawi resulting in an increase in life expectancy. However, due to the deepening AIDS crisis, life expectancy in most countries in the AIDS belt of East and Southern Africa is expected to drop drastically. The AIDS crisis is likely to affect mortality as well as fertility levels, thus leading to a drop in population growth. Although census data show that the Malawian population has steadily been increasing from 5.6 million in 1977 to almost 8 million in 1987 and to 9.8 million in 1998 (Government of Malawi 1987b and 2000a), there are signs of a drop in population growth in the past decade. This is likely to be due to a drastic increase in AIDS-related adult deaths.

So many factors are likely have contributed to the downtrend of life expectancy in Malawi. Among many other possible factors, the economic crises worsened by Structural Adjustment Policies (SAPs) introduced in the 1980s, persistent drought and the growing prevalence of AIDS contributed to the worsening of the health of most Malawians. Although Malawi seemed to experience economic growth in the 1970's, increase in poverty levels and the diminishing of government sponsored welfare have occurred since the 1980's. In the following sections, some of the

contributing factors to poor health, socio-economic and socio-demographic indicators are discussed in some detail.

Fertility Regulation and the Child Spacing/Family Planning Program

Deliberate family size limitation has been rare in Malawi for a long time until recently when the policy and socio-economic environment put more pressure on individuals and couples. In the pre- and early post-independence era, traditional elders and the Government advocated only child spacing methods. These were the practices of prolonged postpartum sexual abstinence and breastfeeding including the use of traditional contraceptive medicines. The traditional contraceptive methods ranged from oral solutions of herbs to *coitus interruptus* and strings (Zulu 1996 and 1998). Other traditional practices were withdrawal (Srivastrava and M'Manga 1991), *abortion* and *ejaculation between bent knees*[4]. The goal of these traditional child spacing methods was not to reduce the number of pregnancies but rather to ensure the survival of as many children as possible (Lesthaeghue, 1989). Over time, these traditional practices are slowly declining due to, among other factors, scarcity of herbs with the widespread deforestation, erosion of values of these taboos and the spread of modern child spacing/ family planning methods.

According to findings in a study on ethnic variations in the practice of postpartum abstinence there were ethnic-based differences in the rationale for these practices.

[4] The author learnt about this during several interviews and informal discussions with women (aged 40 and above) in 1990, 1998, and 1999. They indicated that elders used to tell young wives to help their husbands during the period of postpartum abstinence by allowing them to ejaculate between bent knees. This was aimed at preventing the husbands from going for other women. The elders also used to tell the young mothers about some herbs, whose solution they could use as 'emergency

Each ethnic group had its own definition and timing of its child-strengthening rituals that couples were required to perform before resuming sex. Observance of postpartum abstinence did not change much between the 1980s and the 1990s. Women in the north abstained much longer than women in the centre and south. This fits in very well with polygyny. Attrition rates for the first six months were evident in all the three regions but much higher in central region. In the next six months, the rate of decline in abstinence was much faster in the south than the north. By the end of the first year 60 percent of the mothers in the north were still abstaining compared to only 20 percent in the other two regions. After 24 months, 30 percent of the mothers in the north were still abstaining but only 10 percent were in the centre and south (Zulu, 2001).

These attrition rates in traditional contraceptive practices are in line with the thinking that as populations modernise, there is more *contraception substitution* through shortening of periods of postpartum abstinence and lactation and increased use of modern contraceptive methods. In fact, consistent with the postulate that contraception tends to rise as fertility declines (United Nation Fund for Population Activities, 1993), Malawi's downward fertility trend suggests a steady increase in the use of modern contraceptive methods.

In pre-Cairo Malawi, the autocratic Government did not advocate family planning but child spacing only, which was based on traditional child spacing practices. In

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contraception' in the morning after non-protected sex. But with the substitution of these traditional practices with modern contraception, these traditional practices are less frequently used these days than before.

post-Cairo Malawi under a democratically elected Government, family planning was no longer illegal. It was encouraged particularly among married men and women. Nonetheless, child spacing continued to be more widely practiced than family planning despite very high levels of knowledge about the availability of modern family planning methods. Overtime however the use of modern contraceptive methods has been on the increase although at a very slow pace.

The 1992 MDHS showed that about 41 percent of currently married women reported to have ever used any contraceptive method. About 31 percent reported to have ever used any traditional method and only 19 percent reported to have ever used any modern method. Among currently married men, 57 percent reported to have ever used any contraceptive method, 30 percent to have ever used any modern method and 42.5 percent to have ever used any traditional method. But at the time of the 1992 survey lower proportions of the currently married women and men reported using any contraceptive methods, an indicator of high levels of discontinuity of contraceptive use. Only 13 percent of currently married women reported using any contraceptive method, 7.4 percent were using any modern method and 5.6 percent any traditional method. As for currently married men, 25 percent reported using any contraceptive method, 12.5 percent reported using any modern method and 12.6 percent any traditional method (Government of Malawi, 1992).

A similar pattern is reflected in the 2000 MDHS report. Higher proportions of currently married women and men reported to have once used modern and traditional

contraceptive methods but lower proportions reported to be using any at the time of the survey. About 52.4 percent and 78.7 percent of currently married women and men respectively reported to have ever used any contraceptive method. Among these, only 45 percent and 65.5 percent of currently married women and men respectively had ever used any modern contraception. And only 18.7 percent of currently married women compared to 51.9 percent of currently married men reported to have ever used any traditional method. At the time of the survey, however, only 30.6 percent of women in marital unions reported using any contraceptive method, with 26 percent using any modern method and 4.5 percent any traditional method. As for married men, 29 percent reported using any method, with 21.6 percent using any modern method and 7.4 percent using any traditional method (Government of Malawi, 2000b). The most commonly used methods in the 1980s and the 1990s were the pill and the injection for modern methods and postpartum abstinence and withdrawal for traditional methods.

The attrition rate for postpartum abstinence and other traditional contraceptive methods is faster than the rate of adoption of modern contraceptive methods. As such, unmet need for contraception is likely to be very high. The 2000 MDHS report shows that 30 percent of married women have unmet need for family planning services, 17 percent for child spacing and 13 percent for limiting family size[5]. The 26

[5] Unmet need for spacing includes pregnant women whose pregnancy was mistimed, amenorrhoeic women whose last birth was mistimed, and women who are neither pregnant nor amenorrhoeic and who are not using any method of family planning and say they want to wait two or more years for their next birth. Also included in unmet need for spacing are women who are unsure whether or not they want another child and those who want another child but are unsure when to have the birth. Unmet need for limiting refers to pregnant women whose pregnancy was unwanted, amenorrhoeic women whose last child was unwanted, and women who are neither pregnant nor amenorrhoeic and who are using any family planning method and who want no more children (Government of Malawi, 2000b: 91).

percent modern contraceptive prevalence rate among currently married women is too low to have any substantial impact on fertility levels, hence the estimated slow decline in fertility. Consistent with the low contraceptive prevalence rate are too early, too many and too frequent pregnancies, which are believed to contribute to the persistent high maternal mortality rates (United Nations, 2001). In response to the ICPD call to "make quality family planning services affordable, acceptable and accessible to all who need and want them, while maintaining confidentiality", the provision of quality reproductive health care became the key to reducing maternal mortality. Reproductive health care was conceived to include family planning, ante-natal care, safe delivery, post-natal care and management of pregnancy-related complications, abortion and diseases of the reproductive system and diseases including Sexually-Transmitted Infections (STIs) (United Nations, 2001:21).

The extent to which this steady decline in fertility levels is a result of the family planning program is not certain. This is because child spacing and family planning service provision has been sporadic because of policy-related and attitude problems. Child spacing services were first introduced in 1960s by American Peacecorps but were short-lived due to lack of Government support and people's negative attitude towards Government's intervention in child spacing practices. There were rumours that Government was sterilizing people (Government of Malawi 1996b, Zulu 1996). Policy issues related to the Child Spacing/Family Planning Program is discussed in more detail in the policy section that follows.

A five-year National Child Spacing Program was re-instituted in 1982 as a component of Maternal and Child Health Program to reduce maternal and infant morbidity and mortality through family planning. This was then followed by another five-year phase of National Child Spacing Program was launched in 1988 and extended to 1995 to further expand family planning services and intensify technical and managerial training in family planning. Included in this program were the introduction of Community-Based Distribution (CBD) and social marketing of modern contraceptives, informing, educating and communicating to communities and community leaders about family planning (Government of Malawi/World Bank, 1997).

Major problems related to family planning services include poor quality of services, availability of services only a few times a week, long waiting times to obtain services, lack of privacy and space, lack of modern equipment, shortage of trained personnel, lack of supervision, and shortage of contraceptive supplies. Large proportions of the population have to travel long distances to access modern health services. About 43.4 percent of all health facilities and only 1.4 percent of all mobile clinics offer family planning services (Government of Malawi/World Bank, 1997:15). This suggests that the Malawi population has less than average access to family planning services. Chapter five provides a detailed discussion of the contrasts in access to modern health services between administrative areas in terms of time and distance to the nearest modern health facility.

Socio-economic indicators

Malawi ranks among the poorest countries in the world. About 65.3 percent of the population (6.3 million) are poor. The key causes of poverty are limited access to land, low education, poor health status, limited off-farm employment and a lack of access to credit. Sector analysis of poverty shows that social, human capital and income indicators are very poor (Government of Malawi, 2002).

Malawi's economic situation was good between 1975 and 1985 after which it worsened (Harrigan, 1991). The worsening economic situation was due to the external shocks Malawi has experienced since the 1980s. These included deteriorating terms of trade, rises in the price of imported fuel following oil crises, external transport problems due to the insurgency in Mozambique, persistent adverse weather conditions and rising foreign and domestic debts (Harrigan, 1991). Amidst all these shocks, inflation rates have remained high, implying that commodity prices increased. GDP growth fluctuated in the 1980s and 1990s. Real GDP growth rate rose from 3.3 percent in 1988 to 7.8 in 1991. But the gains from this growth were short-lived due to external shocks (droughts and the reduction of external support between 1992 and 1994). GDP growth rates were -7.9 percent in 1992 and –11.6 percent in 1994 and recovered to 14.5 percent in 1996. Between 1997 and 2000, the average growth was only 2.6 percent and 1.8 percent in 2001 (Government of Malawi, 2002). Due to this poor economic growth performance, there was hardly any improvement in the economic status of individuals or households. Life became more difficult economically particularly for the populations who live in dire poverty.

Malawi's economy is based on agriculture, which contributes 90 percent of the Gross Domestic Product (GDP) per capita. A *Situation Analysis of Poverty in Malawi* showed that about 56 percent of Malawi's farming households are primarily subsistence producers working on smallholdings of less than one hectare. The report indicates that these smallholder farmers are disadvantaged in terms of off-farm sources of income, access to agricultural inputs, adoption of new technologies and level of education. As a result, they produce low yields and live in perpetual poverty. The smallholder farmers include the core poor among whom the report asserts female-headed households represent 42 percent (Government of Malawi and United Nations, 1993: 11).

Also contributing to the low productivity of poor smallholder farmers is landholding capacity, which is only 0.185 ha for poor households and 0.282 ha for the non-poor households. At the regional level, households in the northern and central regions have larger landholding sizes (0.2 for the poor and 0.3 for the non-poor) than the populations in the southern region (0.15 ha for the poor and 0.2 ha for the non-poor) (Government of Malawi, 2000c). Due to their poor socio-economic status, smallholder farmers deploy themselves as casual labourers throughout the year in order to increase their incomes.

Aggregate socio-economic indicators of individuals and households reveal that 65 percent of the Malawi population has access to clean sources of water, six percent

has access to sanitation facilities, 66 percent live in traditional structures, 28 percent of women and 16 percent of men have no education, and 44 percent of women aged 15-49 are not currently working (Government of Malawi 1996, 1999a, 2000a, 2000b). There are regional differences due to problems unique to each region, which could be aggravated by a lack of access to services and insufficient inputs (Government of Malawi, 1996).

Social indicators for all districts in the northern region except Chitipa are significantly above average. According to a Government Malawi Survey, the northern region has a tradition of performing very well in the education sector and the southern region records the lowest performance in that sector. Only 28 per cent of the school-going age group in the northern region, 45 percent and 44 percent in the central and southern regions respectively are illiterate (Government of Malawi, 2000a).

This suggests that generally, the populations in the southern and central regions have less comparative advantage of exposure to modern ideas and life style than their counterparts in the northern region. This is strange considering that the more modernized centres (Blantyre and Lilongwe) are situated in the southern and the central regions. Higher probability of northerners migrating to the centre and south or to South Africa and bordering countries in search for higher education and white collar/wage employment could explain these contrasts. As exemplified by the Tonga (van Velsen 1960), it has been a tradition of northerners to migrate to large cities in

the centre and south or to South Africa and neighbouring countries (Zambia, Tanzania, Mozambique and Zimbabwe) and send periodic remittances to their families (wives, children and lineage members) or return to the village periodically with money or property (modern household items) or even retire back home[6]. Consequently, the northerners have been developing their homes (by building modern houses) either upon return or through periodic visits to the villages.

Poverty, gender and social welfare

The most vulnerable groups in a time of continuous deprivation are female-headed households who are disadvantaged in terms of land, labour, income and other services since these resources are traditionally under the control of men. The report on *Situation Analysis of Poverty in Malawi* (Government of Malawi, 1993: 11) shows that 70 percent of these households do smallholder agricultural work and represent 42 percent of the core poor. According to the Poverty Analysis of the Integrated Household Survey, the mean per capita landholding size for poor households with land is 0.185 ha, while it is 0.282 ha for the non-poor (Government of Malawi, 2000c).

One of the major factors that contributed to the increase in female-headed households in Malawi is the abandonment of women and children due to the migration of husbands in search of employment. Historically, during the colonial times as well as after independence, it was a tradition for Malawian men to emigrate

[6] In fact one can easily notice the effect of migration among northerners. A large proportion of northerners (return migrants in

to nearby countries (Zimbabwe, South Africa and Zambia) to work in the mines. The Government of Malawi (1984) estimated that close to half a million Malawians were outside the country in 1966. However, since the 1980s, migrant labour in the destination countries declined as those countries increasingly resorted to using local labour (Zulu, 1996)[7]. Internal migrant labour movements have since increased (Government of Malawi and United Nations, 1993; Food and Agriculture Organisation, 1994).

Some men (particularly the smallholder farmers) migrate to tobacco estates where they work as tenants[8]. Out of the little income they make, they have to pay back the loans that they receive in the form of food and agricultural inputs such as fertilisers. The poverty analysis report indicates that apart from migrating to estates, men also migrate to cities and towns within Malawi in search of wage employment. Of course the migration of single women as well as families has been on the increases. But often, these groups become the *urban poor* as they struggle to survive. Some of them engage themselves in informal income generating activities. A large share of their income is spent on food alone, leaving them with little for other expenses such as housing, education, health services, transport and almost no saving (Government of Malawi and United Nations, 1993). As a result, they cannot afford to remit adequate money to their families that remain in the village and the women and children become increasingly vulnerable, and have to struggle to survive in the villages. This

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particular) are more comfortable to communicate in English with visitors than in any other language.

[7] For a detailed discussion of the decline in international migrant labour in Malawi, see Velsen (1960). Gregory and Mandal (1987); Christiansen and Kydd (1983).

exposes many women and children, living in rural settings, to all sorts of dangers including nutrition, health, illiteracy, and Sexually Transmitted Diseases (STD) or HIV/AIDS. The poverty analysis report also indicates that with the AIDS epidemic spreading in Malawi, the number of orphans is increasing dramatically. As such the proportion of the vulnerable is on the increase, with females constituting the largest. Thus dependency ratio is expected to remain very high (Government of Malawi, 2000c).

The poverty situation is directly linked to the worsening AIDS pandemic in the country. The poor (mostly women) are more vulnerable to HIV infection because of poor access to modern health care facilities, low income levels that forces them into engaging in survival strategies, which put them in high risk of HIV/AIDS, and poor access to information about HIV/AIDS issues. Recent data suggests that HIV infection is high among populations of 15-49 age groups, 25 percent in urban areas and 13 percent in rural areas. Younger females (aged 15-24) are about 4 to 6 times more likely to be infected than their male counterparts (Government of Malawi, 2002).

[8] Tenants are individual men and their families who are given farm inputs including land on loan for cash crop production. At the end of each farm season, the owner of the farm sells all the produce and deducts the entire loan. The balance, if any, is what

The policy environment

Economic development Policies

Malawi has gone through three phases of policy development since independence in 1964. The first phase was from 1964 to the early 1980s when the Government employed mixed economic policies. The then ruling regime believed that neither capitalist nor socialist economic models were appropriate to Malawi's needs (Short, 1974). At the time most African countries, which had just attained their independence, were practising nationalism. This was a phase of nation building. The socio-political and intellectual environment at the time conditioned the policies that the Government of Malawi pursued, which, it was claimed, was oriented to Malawian culture. Phiri (1996) has argued that the definition of Malawian culture then was limited to one cultural group, the Chewa. Phiri (1983) pointed out that the importance of culture to national development must be appreciated and that the definition of culture must be more comprehensive and representative. He proposed the conceptualisation of national development from a cultural perspective that views development as a multi-faceted concept involving the restructuring of political, economic, cultural and intellectual relationships. But Malawi's development policies at that time were focused more on restructuring political and cultural relationships and less on economic and intellectual restructuring within the country.

The second phase was from the early 1980s to the early 1990s when the Government formulated sector-specific policies. These sector policies were developed into a

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the tenant earns.

statement of Development Policies (DEVPOL) for the decade 1987 to 1996. This was used as a mechanism for the implementation of the Structural Adjustment Policies (SAPs) that were introduced in Malawi in the 1980s (Government of Malawi, 1987a; Harrigan, 1991). Unfortunately, the outcome was disappointing. Malawi, like many other Third World countries, was torn between responding to the demands of the global economic reforms on the one hand, and meeting the objectives of their existing development strategies on the other hand. The World Bank identified six structural weaknesses in the Malawi economy. These included "the slow growth of smallholder exports, the increased reliance on tobacco as an export crop, the dependence on fuel and on a declining stock of domestic fuel wood, the rapid deterioration in parastatal finances, the increasing budget deficits and the inflexible government pricing system" (Harrigan, 1991: 213). The overall aim of SAPs was to achieve macro-economic stability and private (formal) sector growth (Government of Malawi, 1995d). Restructuring of the Malawi economy had implications for all other policy areas including agriculture. Unfortunately, the World Bank's prescriptions and the Government's post-independence development policies were at odds. The Government had to struggle to meet dual conflicting objectives: achieving food self-sufficiency and increasing export revenues; achieving health and education for all and cutting Government expenditure through cost sharing.

The third phase of development policies in Malawi started in the 1990s when the Government defined poverty alleviation as the central objective of the national development policy. The Poverty Alleviation Program (PAP) was the means for

addressing the central objective of development policy, which was *to reduce poverty and inequalities in resource allocation*. PAP was aimed at directing development projects set out in policy instruments such as the Statement of Development Policies. The PAP focused on addressing four identified poverty-inducing factors: low agriculture production, low income, low education and poor health. The PAP was targeted at all population groups living in poverty: the poor smallholder farmers, women in poverty, estate workers, tenants, casual workers, children in poverty, youth in poverty and the urban poor (Government of Malawi, 1995d).

As a component of PAP, the Government of Malawi established a *Vision 2020* development program, which was aimed at reforming development sectors to improve their efficiency and performance. *Vision 2020* was conceptualised within the existing frameworks of DEVPOL and PAP with an emphasis on decentralization, cost-sharing and gender sensitivity (Government of Malawi, 1999c). This implies that the third phase of development policies was an extension of the previous phases with some reinforcement in efficacy. In fact, the emphasis on decentralisation, cost sharing and on gender falls within the requirements of SAPs and contemporary development paradigms that demand a focus on participation of the poor (of which women form the majority). In fact the Government, in collaboration with its development partners, was engaged in the process of developing a Malawi Poverty Reduction Strategy (MPRS) to guide development practitioners in all efforts towards reducing poverty. The overall goal of MPRS is "to achieve sustainable poverty

reduction through socio-economic and political empowerment of the poor" (Government of Malawi, 2001a).

Population Policy

Historically, Malawi went through several phases of population policy development different from those for economic and social development. Prior to the mid-1980s, Malawi had pronatalist policies. Until the mid-1980s, the Government of Malawi viewed the country's high fertility levels and population trends as necessary and satisfactory for the development of the country (Zulu, 1996). The Government's position was reinforced by the belief of the ruling regime about the importance of respecting the right of families to have as many children as God gives them[9] (Phiri, 1996). Implicitly, a large population was seen as a resource for development. As mentioned earlier in the chapter, in the early 1960s, the *American Peace Corps* introduced the Child Spacing Program (CSP) in Malawi[10]. The then leadership abandoned the program because the Malawi public suspected it to be anti-natalist (Government of Malawi, 1996b). This is because the general public feared that the Government wanted to reduce population size through mass sterilisation (Demographic Unit *et al.*, 1987; Government of Malawi, 1996b). In response, the Government banned contraceptive service provision in all Government institutions and only private clinics could provide contraceptive services except in cases when childbearing threatened the life of the mother (WSSI, 1985 cited in Zulu, 1996).

[9] For more details, see Ngwazi Dr. H. K. Banda, *Speeches for the period 1964- 1971*, Blantyre: Department of Information.

The decision about the non-provision of modern contraceptive services in all health centres and hospitals was revisited in the early 1980s. By this time the Government was convinced that the country's rapid population growth was unsatisfactory and very high (United Nations Population Fund for Population Activities, 1990/91). The Government therefore saw the practice of family planning as a critical factor in the socio-economic development and well being of every Malawian, especially women (Government of Malawi, 1996b). As a result, a child spacing program was re-introduced in 1982. This only became operational in 1984 with a clear objective of promoting child and maternal health and not limiting family sizes or lowering the population growth rate (Demographic Unit *et al.,* 1987; Government of Malawi 1986, 1987a).

The Ministry of Health implemented the child spacing program as part of its maternal and child health program. The program focused on an awareness theme aimed at informing, educating and communicating to mothers the disadvantages of: childbearing at a young age, close birth spacing, too many births and child bearing at an advanced age. In other words, the Government was advocating family planning using child spacing terminology. As a result, *Kulera*, a Chichewa term, which refers to *childcare*, was the slogan used for child spacing campaigns. In order to have a wide dissemination of this advocacy the Government took a multi-disciplinary approach. A number of Government institutions were responsible for implementing an "Information, Education and Communication" (IEC) component of the child

[10] There are many versions as to who introduced modern contraception in Malawi. According to a chronography compiled by Susan Watkins in 1999, there is evidence that the Peace Corps introduced these methods. For more information, refer to a 1971

spacing programme[11]. Due to this intensive child spacing IEC programme, the knowledge level about any contraceptive method rose as high as 94.6 percent in 1992 and 96.8 for all women in the year 2000. Despite the high knowledge level, the Contraceptive Prevalence Rate (CPR) has been increasing at only a slow pace. The large gap between knowledge and use was a concern to the Government for a number of reasons. The Government believed that the uncontrolled population growth rate led to a scarcity of resources such as; land for expansion of agricultural produce, a lack of hospitals and schools, and the economic deterioration of the 1980s (Government of Malawi 1992, 1994a, 1987a, 1995; World Bank, 1995).

By the 1970s, the Government became convinced that the country did not have adequate arable land for its growing population. The Government believed that the country was suffering widespread environmental degradation due to population pressure (Mlia and Kalipeni, 1987; Chipande, 1988; House and Zimalirana, 1992; Kalipeni, 1992). There is evidence of internal migration from more to less densely populated areas (Kalipeni, 1996) and the increased use of marginal lands (Food and Agriculture Organisation, 1994). Land re-distribution is a politically very sensitive issue and the Government of Malawi has always been reluctant to respond to suggestions that people be relocated from densely populated areas to less densely populated ones. It was only in 1996 that the Government (under the influence of the donor community) instituted a commission for land redistribution. However, no

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speech of the Minister of Health, Department of Information: Blantyre, Malawi.

[11] These included the Department of Information, the Ministry of Women and Children Affairs, the Ministry of Youth, the Ministry of Education and Culture, and the National Family Welfare Council of Malawi.

relocation of populations has ever taken place. Some people have been shifting of their own accord through informal negotiations or purchase (informal source)[12].

Due to the three-way crisis (economic, environmental and population) that Malawi and other developing countries were experiencing in the 1980s, Malawi, along with all other developing countries, revisited its position regarding the relationship between population growth and development. The Government of Malawi endorsed the position of Third World countries at the 1984 Mexico City population conference and the 1994 Cairo conference (Government of Malawi, 1994c). By this time, the public and the Government population technical groups used the concepts of child spacing (*kulera*) and family planning interchangeably. Coincidentally, the traditionally-oriented ruling regime had just been replaced by a democratic Government, which swiftly adopted the use of the term *family planning* with a claim that 'it was too late for Government to reinforce family planning' and not just *child spacing*. The Government therefore endorsed and launched the newly formulated population policy immediately after the Cairo conference in 1995. The Malawi's national population policy is focused more on non-demographic objectives. It aims at:

> Improving the standard of living and quality of life of the Malawian people while ensuring that the future growth of the country's population is kept within manageable and sustainable bounds. The policy proposes to lower fertility,

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[12] During the 1999 revisit to the research sites, I had a discussion with two chiefs, one in Mchinji Central Region and the other in Rumphi Northern Region. They both indicated that they do get people from some parts of Central Region and Southern Region who come to ask for land for settlement. These people, they said, bring with them almost a whole village with a claim that they do not have enough land for cultivation in their present location. The chiefs indicated that some of the emigrants pay money and some do not. However, they also indicated that these days, the chiefs no longer have enough land to distribute even to their own people. In this context, it is difficult to accept other settlers.

> infant, child and maternal mortality rates and adolescent marriages and unwanted pregnancies while maintaining the right of each individual and couple to decide for themselves the number of children they wish to bear. The policy's targets include reducing population growth rate and increasing modern contraceptive use (Government of Malawi, 1995b: 17-19).

The policy seeks to achieve a lower population growth rate, which is compatible with the attainment of the country's social and economic development objectives. It aims at achieving the following demographic goals and targets by the year 2002: to reduce the annual population growth rate from 3.2 percent to 2.4 percent; the TFR from 6.7 to 5.0 births per woman; the rate of infant mortality from 134 to 100 deaths per 1,000 live births; the maternal mortality rate from an estimated 620 to 200-300 deaths per 100,000 births; the number of adolescent pregnancies by 50 percent; and to increase life expectancy at birth from 47 to 50 years for men, and 49 to 53 years for females (Government of Malawi, 1995b:18-19).

According to Zulu (1996:21), the attainment of these goals and targets will depend on the level of demand for fewer children, the translation of this demand into effective contraceptive use, and the successful provision of services. This suggests that the success of the policy will depend on the balance between the supply of and demand for family planning as well as the balancing population and available resources and the reduction of poverty. In the population policy, the family planning goals and targets that reflect this balance include:

> To increase the CPR from approximately 7 percent to 28 percent; to increase the numbers of Government and private hospitals providing comprehensive family planning services from 3 to 25 and from 8 to 30,

> respectively; to increase the number of operational sites for large private sector companies and estates providing core family planning core family planning services from 4 to 24; to increase the number of Community-Based Distributors (CBD) of modern contraceptives from 3 to 350; to increase the number of users of modern methods of family planning (orals, condoms, foaming tablets, injectables, IUDs, Norplant, female and male sterilisation) from 68,000 to 680,000 with an encouragement for the use of natural family planning, safe traditional methods, and male sterilisation (vasectomy) (Government of Malawi, 1995b).

Furthermore, the Government saw the need to revise its contraceptive policy and guidelines to fit within its declaration to maintain the rights of individuals and couples to decide on the number of children that they wish to have. Prior to the launching of the national population policy in 1995, the contraceptive policy and guidelines had restrictions on the age, sex, parity and marital status of those who could access family planning services. The young and the unmarried were not allowed to receive modern contraceptive methods. The contraceptive service provision was also focused on women, especially those, whose husbands gave consent or those who sought contraceptive services together with their husbands. Only women, who were still menstruating, were allowed to receive modern contraceptive methods. This was due to the fear that those not menstruating could be pregnant and could therefore abort due to the intake of contraceptives. Also women with parity below three were not allowed to receive semi-permanent and permanent contraceptive methods (i.e. depo provera, loop, sterilisation) for fear of inducing sterility.

The first contraceptive policy and guidelines were therefore in line with the pro-natalist social development policies prevailing at the time. With a revised government position, all restrictions were lifted from the contraceptive policy and guidelines. The Government advocated the provision of family planning services to anybody who asked for them. The earlier contraceptive policy and guidelines restricted child spacing/family planning service provision to married women only. The revised policy and contraceptive guidelines allow all women including adolescents and men to access child spacing/family planning services whenever they seek them. People had to receive proper counselling about the technicalities of all available contraceptive methods prior to any use (Government of Malawi, 1996b).

The Government of Malawi linked population and contraceptive policies with development policies. With the common objective of population and development policies "to improve the standard of living and quality of life of the Malawian people", the national population policy also aims at achieving development-related goals and targets. These include increasing the net enrolment ratio from 53 percent to 85 percent in primary school; reducing female illiteracy from 68 percent to 30 percent; and raising the growth of formal and informal sector employment to at least 5 percent per annum (Government of Malawi, 1995b). In an attempt to meet these objectives, the Government of Malawi introduced, in phases, the integration of population education into the school curriculum, nurse-training curriculum, and agricultural extension curriculum (Government of Malawi, 1987a).

In order to effectively implement the Cairo plan of action, the Government of Malawi and its development partners got engaged in the process of revising the first population policy. In this process, three gender-based pre-requisites were identified as important. First, the empowerment of women to bring women's and girl child's social status and economic opportunities at par. Second the strengthening of men's and boy's reproductive and familial roles. Third, to instil into the society the recognition and understanding of the social function of motherhood, fatherhood, parenthood and socialisation in so far as they influence gender roles, attitudes and behaviours (Government of Malawi, 2001b: 16).

Socio-Cultural, Socio-Economic and Legal Status of Women

In pre-colonial times, communities in Malawi were primarily agricultural although some practised hunting and gathering in view of game animals and forests for which some parts of the country were famous (Murdock, 1959). Therefore cultivation of traditional food crops was widespread until the introduction about cash crops by colonial rulers (Phiri, 1983). Division of labour was more equitable in pre-colonial era than in post-colonial era since men could hunt and clear the fields for food crop production whereas women gathered wild food items and did the planting and weeding of food crops. But the introduction of cash cropping discriminated against women. It was mainly men who were introduced to and educated on cash cropping and employed on estates, which produced cash crops for export. Food crop production remained a women's affair. When men migrated to work in the estates or mines (for those who migrated to South Africa and other neighbouring countries), some women were left in the village but in some cases some went with their

husbands (van Velsen 1960, Phiri 1983, Vaughan 1987, FAO 1992). Therefore, gender roles and the status of women started to change.

As discussed earlier in the chapter, essentially there are only two marriage systems in Malawi- the patrilineal and the matrilineal one. In the former, as will be discussed in more detail in Chapter three women have a lower status than in the latter. This is because in the patrilineal marriage system, men are in control of land and lineage property including women and children. But in the matrilineal marriage system, women are in control although the male kinsmen are the de-facto heads of lineage. Legally, therefore, in a patrilineal marriage system, women do not have rights to land nor any lineage property including children. But in a matrilineal system, women do have legal rights to land and family property including children.

Over time, the various ethnic groups got into contact with other cultures. Christian dogma and colonial policies conflicted with traditional norms and values. The missionaries and colonial Government courts supported women to fight against polygyny (Phiri 1983, Vaughan 1987, Kaler 2001). The coming of missionaries and colonial maters to Malawi therefore meant the introduction of constitutional law in Malawi.

Under the constitutional law, a woman has her own legal rights. A man and a woman above the age of 21 have the same legal status and capacity. As such, they can both have property in their own right. On marriage, a woman does not lose her rights to

own property. Malawi has different marriage arrangements: marriages under the Marriage Act, marriage under the Customary Law, Asiatic marriages and Foreign Customary Law marriages. These marriages produce different attributes to women's rights, obligations, duties and consequences (National Commission on Women in Development, 1993). Because of a lack of standardised legislative procedures for marriages and divorces, women continue to face discriminatory practices in relation to distribution of family property and custody of children in the event of husband's death or marital dissolution. Issues pertaining to legal status of women include the dual existence of statutory and customary laws and practices, lack of information and awareness amongst the majority of women of their legal rights and provisions, the strong influence of culture, customs, religion and attitudes of society (Government of Malawi, 1993).

Women's status and their role in decision-making processes will remain low unless legislation is revised to ensure gender equality. These changes are gradual because of lack of clear understanding of gender issues among policy-makers. For example in the 1980s and the early 1990s, under the influence of the organisation of women's development in Malawi, the Government revised the law of matrimonial property inheritance to a 50/50 percent split between late husbands' relatives and wife/children. This law was later on revised to a 70/30 percent split.

Another example is the integration of Girls Attainment of Basic Literacy and Education (GABLE) into the national education policy. With the introduction of

Universal Primary Education (UPE) coupled with GABLE efforts, the enrolment of girls in school improved substantially but drop out rates did not. The high school dropout among girls is partly due to early pregnancies, early marriages, and child labour (Government of Malawi, 1995a). These factors are gender-based and therefore reflect gender un-egalitarianism of societal norms, policies and laws concerning age at entry into marriage, child labour, and unwanted pregnancies.

Summary and conclusions

This chapter has described the socio-cultural, socio-economic, socio-demographic and policy context, in which individuals and couples in Malawi make reproductive decisions. Two important points are worth noting. First, that change has been universal in Malawi. Second that the government has continuously been confounded by the need to meet people's needs whilst also meeting the demands of the aid giving nations. The population of Malawi has been experiencing cultural, economic, demographic and policy change. Aside from the observed micro-level changes, at the macro and meso-levels, the family and the community have also undergone changes due to: interactions between different cultural groups through intermarriage, labour migration, colonisation and religious influences.

The socio-economic environment has shifted from traditional familial production towards capitalist agricultural production. Since Malawi is a landlocked country with no natural minerals and a completely agro-based economy, subsistence farming has remained the main economic activity for most of the Malawian population. As a result the Government of Malawi has always found itself torn between achieving the

needs of its population and meeting the restructuring demands of the global economic order. The Government has consequently had to go through various stages of policy development in an attempt to meet the two contradicting demands. It integrated social and economic development policy issues into population and contraceptive policies in an attempt to balance population and available resources for the well being of the nation. In addition to responding to economic demands from within and outside the country, the Government of Malawi has been responding to demands for gender equality, poverty reduction and the prevention of the widespread of HIV/AIDS through the integration of gender issues into public policies, the revision and enforcement of legislation, and the revision of the guidelines for social service provision.

PART II: THEORETICAL AND METHODOLOGICAL BACKGROUND TO THE STUDY

CHAPTER 3

THE RELATIONSHIP BETWEEN DEVELOPMENT AND WOMEN'S EMPOWERMENT

Introduction

This chapter is a literature review. It identifies the theoretical foundations of the research questions and issues raised in Chapters one and two. The analysis of the literature review will be in terms of Western theoretical thought because contemporary scholarship in the field of development has been dominated by Western thinking. This chapter provides a theoretical base for an understanding of the research and policy environment in which Reproductive Decision-Making Processes (RDMP), the phenomenon under focus in the present study has been taking place in Malawi.

The discussion in this chapter suggests that effective research and public policies reflect empirical analyses at all levels of aggregation in society. Currently accepted theories, paradigms, policies and programme strategies are ideologically driven. *Ideology* refers to the manner of thinking by which individuals live as products and agents of their cultures (Grosz, 1992). *Paradigms* refer to perspectives or propositions within which an enquiry is undertaken (Watkins, 1993).

As postulated in Chapter one, changes in development theories, paradigms, policies and program strategies will cause changes in social organisational structures and functions, social relationships and knowledge or experiences of individuals. Using Malawi as an example, shifts that have taken place in the conceptualisation of development, as a process of social change will be discussed. Through this discussion, it will be argued

a) That the conceptualisation of development has historically been more focused on structural than on functional changes in a society. *Structural changes* are those related to patterns of organisation of social institutions, whereas *functional changes* are those related to roles and behaviours of members of those social institutions that in turn make those institutions functional;

b) That the acceptance of particular development paradigms has led to a failure to understand the importance of the dynamics of the family, the failure to understand the significant role of the forces of social interactions in development and the failure to incorporate these into development research and policy planning and implementation and finally; and

c) That the lack of recognition of the role of social interactions in development has meant the omission of changing communication and power relationships between lineage members and between spouses from development-related studies.

This chapter is presented in three sections. The first section is a discussion of macro-level issues, which cover the conceptual and policy issues related to the classical and contemporary views of development that prevailed and dominated the development discourse in the period 1950s to 1990s. The second section covers meso-level issues related to the role of the community and the lineage in community development. The third section identifies issues related to the well being and status of the family and show how these are causing social change, which is in turn changing the identities of reproductive decision-makers and the paths of reproductive decision-making in Malawian communities.

Macro-level issues of development

From the 1950s through to the 1970s, scholars and policy-makers sought to understand why many countries remained underdeveloped and what could facilitate their development process (Chirot, 1977). Since then, debates about what constitutes the processes of development have persisted. *Development* is defined as a process by which people shift from their old lifestyle (economic and social) to a new lifestyle, with changes in their respective roles, statuses, perceptions, attitudes, expectations, desires, tastes and demands along with changes in their organisational structures and functions. The theoretical discussions in this chapter will be focused on the evolutionary views of development, which were instrumental in the process of public policy formulation in developing countries such as Malawi. In these discussions reference will be made to selected feminist and ethno-methodological theoretical paradigms, which had little influence in traditional research and policy, but which

currently introduce a new perspective which recognises the critical role of social interactions in research and public policy formulations (See Annex I).

Classical views of development and public policy

A number of different theoretical paradigms have driven development theory and *praxis* over the years. In the classical definitions *development* referred to structural changes intended to improve people's quality of life while maintaining stability in society (Hoogvelt, 1978). The dominant classical development paradigms focused on the evolutionary change of the macro-economic structures. In the 1970s some scholars began to shift the focus to the necessity of achieving changes in social relations (Chirot, 1977; Brohman, 1996; Roberts and Hite, 2000).

Liberalism was the dominant underlying theoretical paradigm in the period 1950s to the 1970s. Under liberalism, the representative government employed public interventionist policies. Countries such as Malawi were operating under colonial and postcolonial policies while undergoing colonial and post-colonial type of development (see Annex I). This process of development involved the industrialisation of agriculture, the introduction of schools and of a monetary economy. The state was the locus of macro-level decision-making and this had its trickle-down effects on micro-level decision-making. The liberals saw change as a gentle evolutionary process that would not produce conflict but would maintain social order. Their conceptualisation of development was based on the idea that the development path of Western countries was the model for Third World countries.

The thinking was that Third World countries were underdeveloped because the traditional political as well as economic structures or systems were deficient. Following the Western model, these countries had to develop modern, rational business systems and ethics, which would enable them to accumulate capital, invest it and consequently achieve rapid economic growth. A democratic political system was seen as the best suited for this (Chirot, 1977: 2-3).

This development model was driven by the theory of modernisation, which was based on a structural-functionalist view of change, underpinned by the view that, for a society to develop, it had to experience macro-economic growth (Rostow, 1960; Chirot, 1977; Todaro, 1977; Roberts and Hite, 2000). Consequently, the theoretical focus was on economic structural changes, which would include changes in technological, in the accumulation of capital, in values, norms, beliefs and customs, in social structures and in the internal diffusion of key ideas about development (Hoogvelt, 1978; Brohman, 1996; Todaro, 2000). Development was therefore viewed as a process of modernisation, and as a simultaneous shift from a state that was believed to be unacceptable to one that was believed to be acceptable. *Modernism, Westernisation, industrialisation, urbanisation, interactionism and diffusionism* were used as synonyms.

The liberal and modernist views of development treated change as uni-directional and societies, households and individuals as homogenous. But societies; communities, families and individuals are heterogeneous and they are likely to have

different experiences of change. From this argument, it will be postulated that a range of processes of change mediated through processes of social interactions, affect any processes of human development. An alternative view suggested by the current author is that a context specific view of development would facilitate the conceptualisation of societies and culture and the nature of economic as well as reproductive decision-making as heterogeneous.

Between the 1950s and 1970s, Marxist and Dependency theorists highlighted the existence of unequal power relations between nations and unequal economic production relations between individuals and groups, thus providing a platform for the questioning of the nature of decision-making (Weber, 1964; Chirot, 1977). Feminist ideas had limited influence until the 1970s, when the modernisation paradigm was believed to have failed as an explanation of underdevelopment and as a solution. As a follow-up to the liberal development paradigms, the feminist paradigm questioned the under-representation of women in state bureaucracies and decision-making processes. Specifically liberal feminists with the pioneering work of Esther Boserup in the 1970s demanded that women's rights must be equated to human rights (Boserup 1970, 1975). They brought to the centre of the development debate the issue of gender inequality in economic and reproductive decision-making, particularly at the macro-level. In this way, a feminist influence started to permeate through development and population policy formulation. Instrumental to the process of public policy formulation were Women in Development (WID) strategies, which were driven by liberal feminist views. Specifically, WID encouraged policy makers

to recognise the value of women as producers as well as reproducers (Visvanathan *et al.*, 1997).

The contemporary views of development and public policy

The strategies emerging from the liberal development paradigms had different theoretical follow-ups in the 1980s and the 1990s. Neo-liberalism, one of the offshoots of structural-functionalism (also referred to as neo-classical, public choice or free-market economics) viewed development as involving radical macro-economic restructuring. The restructuring approach to development demanded the privatisation of state-owned enterprises, the promotion of free trade, the expansion of exports and the welcoming of investors from developed countries (Brohman, 1996; Todaro, 2000). Neo-liberals argued that an environment that permitted free markets to flourish would stimulate economic efficiency and economic growth (Adepoju, 1993; Brohman, 1996). Emerging from the neo-liberal development paradigms were neo-liberal policies. The effects of the restructuring policies were disappointing as poor economies deteriorated rather than improving. In an attempt to mitigate these effects, neo-liberals advanced structural adjustment policies (World Bank, 1984).

Structural Adjustment Policies (SAPs) were seen as the appropriate economic recovery measures but their outcome was deepened economic recession, which worsened the poverty situation and created greater inequalities in resource allocation. This was worsened, particularly for the poorest groups in developing countries such as Malawi, with the advent of external shocks such as the oil crisis of the 1970s,

drought, famine and civil wars (United Nations, 1990; Brohman, 1996; Todaro, 2000). The distribution of labour was adversely affected as the productive and reproductive roles of families and their members were disrupted (United Nations, 1990). Cuts in public expenditure led to the reduction of access to social services such as education, health and public transport, and further marginalized the poor (Adepoju, 1993).

In an attempt to address these issues, in the 1990s neo-liberals introduced the idea of *human face* restructuring, which was translated to *Poverty Alleviation Policies* (PAPs). PAPs were introduced in Malawi and many other developing countries with the poor (specifically women, children and the old) as the target group. But the economic performance at all levels of production deteriorated further, as market economies became more competitive at the global level. This was called *globalisation*. The thinking at the time was that the effects of the economic crises since the 1970s would create interdependent relationships and global economic interdependence would be inevitable (Todaro, 1977).

Since then, the world economic structures have been adapting to *globalisation*. Through globalisation, all parts of the world are interdependently integrated (Diaz, 1996; Portes, 2000). Nations, societies, communities, families and individuals have to compete and survive in the global market economy. They have to create their own trans-national trading groups. Almost every transaction is commodity-based. Donor aid for PAPs has conditions attached. These include requirements to decentralise and

national budget cuts through the introduction of *user fees*[13]. It is argued that globalisation would make nations solve their own economic and social problems by liberalising their trade and privatising state enterprises. This has not, however, been accompanied by an improvement in the terms of trade on which poor countries typically depend. The poor nations have remained at a low comparative advantage with the rich nations because of their lack of resources, including capital for investment. Through globalisation, the expectation that nations solve their own social and economic problems has been extended to the micro-level. Individuals and neo-nuclear families are expected to solve their own social and economic problems.

Indeed, the *public choice* principles have pushed individuals and neo-nuclear families into making economic as well as reproductive choices and decisions that would ensure their survival. This is because the privatisation of state enterprises has led to the reduction or complete removal of subsidies for social services. The locus of decision-making, which traditionally lay with the lineage heads and shifted to the State with the introduction of capitalism, is now shifting to the couple and the individual within neo-nuclear families. Neo-nuclear families, large or small in size, have to struggle to survive the neo-liberal public-choice principles that have permeated into the management of family affairs. Consequently, family structures and functions are undergoing changes.

Conceptually, the dominant development paradigms assumed that the household in developing countries like Malawi consisted of a nuclear family (husband, wife, and

[13] These are payments for social services such as health and education.

children) and that within each household there was a clear division of labour with a male *breadwinner* and a female *homemaker* (Brohman, 1994). Some authors have criticised the dominant development paradigms for using the terms *family* and *household* interchangeably (Shultz, 1974; Caldwell et al., 1982; Kabeer, 1994). This usage is based on the micro-economic model of the household, which treats the household as an altruistic collective of individuals, in essence assuming that a household acts like an individual. This model continues to be used today. The household is seen as an aggregation of individual utilities with a joint welfare function, with individual incomes going into a common budget, individual members being a single decision-making unit and individual family labourers forming an abstract pool of household labour (Becker, 1965, 1981; Sen, 1990). Such a conceptualisation not only ignores co-operation and conflict among household members (Becker, 1981), but also ignores individual women's needs, interests and preferences (Evans, 1991; Moser, 1989; Wolf, 1990). In response to these criticisms, Becker (1981) extended his definition of the family to include the kinship group and recognised the multiplicity of types of families.

The Malawian context offers a classical conceptualisation of the *household* and the *family* similar to that used to describe Western families in prior to the 1970s. A household, which is locally known as *nyumba or khomo,* is a physical structure, which accommodates *extended*, *polygynous* or *monogamous* family structures. An *extended* family comprises two or more families of different generations united by kinship ties, common residence or a single head (Caldwell, 1982). A *polygynous*

family comprises a man and two or more wives while a *monogamous* family comprises a man with one wife (Murdock, 1959: 25-26; Phiri, 1983).

A family is derived from a *marriage*, which is a contract between two lineage groups. As a social structure a family has its functional roles within the community and the lineage. Family members have a central role in the *social production* and the *social reproduction* of the society. S*ocial production* refers to the maintenance of the lineage, which in turn provides for the continued maintenance of the means of subsistence. S*ocial reproduction* refers to the production of the means of subsistence through the production of human beings (Cordell *et. al.*, 1987:22). The development experience of the Malawian people and the types of changes that have taken place are discussed in detail later in the chapter.

Apart from the liberal development theorists, liberal feminists also had some influence on policy approaches. Liberal feminists argued that as women are as rational as men, they must be recognised as equal citizens and empowered to have control over their own fertility and to have rights to land and other resources (Tinker, 1997). The theoretical path advanced by liberal feminism was elucidated in the Women in Development (WID) and in Women and Development (WAD) approaches. These were driven by Boserupean thinking that women's roles as traditional workers and producers needed to be recognised in policy because they contribute to economic and social changes (Boserup, 1989). WID approach was therefore focused on the need to integrate women into economic systems, to

emphasise women's productive role and development strategies that would minimise disadvantages of women in the productive sector (Visvanathan, 1997) but enhance their economic autonomy (Sen, 1981). As was the case with SAPs, WAD strategies were focused on the structures of production and ignored issues of gender and power relations. As some critics observed, development strategies in the 1980s failed to make significant progress toward improving the status of women (Moser, 1989; Chinery-Hesse et al., 1989). At that time, poor nations responded with the creation of women's organisations aimed at creating gender awareness. In Malawi for example, a women's organisation called *Chitukuko Cha Amayi* M'Malawi (CCAM) influenced the Government to review its policies. The new policies were to ensure women's equal rights with men, women's access to public choices including protection, respect and survival (National Commission on Women in Development, 1993).

The demands by CCAM reflected the need for *women's empowerment* through a *gender-relations* approach. As discussed earlier in this Chapter, *gender-relations* approach is embedded in traditional social organisational structures in which dependency relationships are rooted. In these structures, men depend on their women for labour and women depend on their men for social and economic security. In contemporary development discourse *women's empowerment approach* is defined in economic and social terms. From an economic perspective *empowerment* refers to the pooling of resources (including material, financial, ideological and intellectual) and the consequent achievement of a collective capability to survive (Brohman, 1996). From a feminist and sociological perspective, *empowerment* entails the access

to and control of both material and informational resources to bring about structural and functional change (Batliwala, 1994; Labourie-Racape and Locoh, 1998); and the transformation of structures that perpetuate gender and social inequalities.

Women's empowerment is central to development in Malawi. Empowerment requires the pooling of resources to enable the poor and powerless, particularly women, to develop the capability to make rational economic and reproductive decisions in order to improve their status and well being. Within contemporary development thinking empowerment is stressed in what are termed alternative development paradigms known as *Participation* and *Gender and Development* (GAD). Proponents of *Participation Approach*, who still follow the neo-liberal principles of public choice and rationalisation, promote the role of the community in development planning and implementation (Boserup, 1989). Neo-liberal feminists, however, expanded the participatory view of development and called for researchers and policy makers to recognise firstly the reproductive and productive roles of women and secondly the relationship between family life and the organisation of political and economic structures (Kabeer, 1994). The neo-liberal feminists, through their advocacy of GAD, have influenced development theorists and policy-makers to incorporate aspects of gender relations in their approaches. GAD introduced a *gender-relations* approach to development suggesting the transformation of power relations between men and women (Visvanathan, 1997) and the treatment of women as change agents (Kabeer, 1994).

Despite the advocacy for the *gender-relations* approach, the focus of neo-liberal feminists has been the emancipation of women aimed at enabling women to make their own reproductive choices and achieve the right to determine their own survival and well being. As other scholars have observed, the *gender-relations* approach has often been regarded as marginally important in development as well as in population research and policy (Basu, 1996; Pressier, 1997).

Although the analysis in this study will be grounded in neo-liberal principles, which view development as a *structural* change, this view will be modified to include *functional* changes. This is because structural and functional changes are symmetrical since structural change, which involves reorganisation of elements constituting those structures, will lead to the disruption of gender, power and communication relationships. Consequently, the functions of those organisational structures will change since they have to adapt to the new situation. For example, when the husbands migrate to the cities in search of wage employment or for trading, they are no longer available to provide labour for agricultural production in the village. Thus changes occur in the structure of the labour force within the lineage and the neo-nuclear family. It then falls on to the women (and children) to produce both cash and food crops (a functional change) but as the women have childcare and household work to do, the level of agricultural (cash and food crop) production decreases (Phiri, 1983). The result is a food shortage at the household level, which produces poor nutrition and an unhealthy labour force that perpetuates the impoverishment of families and the country as a whole.

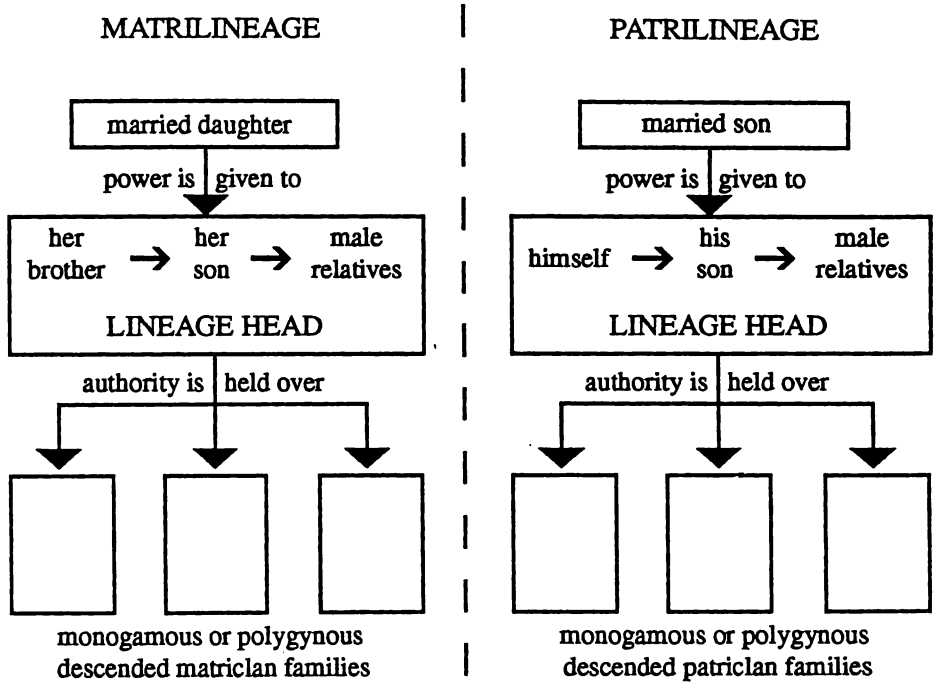
The structural changes underpinned in neo-liberal theoretical paradigms are likely to lead to changes in structures and functions of social institutions including gender, productive and reproductive roles of members of those structures as well as communication and power relationships. The emerging global interdependence emanating from the neo-liberal development paradigms are just one example of those types of changes at macro-level. Although development studies and analyses have often focused on macro-level structural changes, meso- and micro-level structural and functional changes have taken place simultaneously. But little or no attention has been given to their contributions in development processes. Functional changes in community structures, such as the lineage and the neo-nuclear family, will affect the conjugal roles of men and women, and their respective participation in reproductive decision-making processes. The recognition of such changes is essential in development-related research as well as in the planning and implementation of development-related policies such as population policies.

Meso-level development issues: lineage fragmentation and power dilution

Lineage refers to a line of inheritance (of family name or family wealth) that is passed on from parents to children. Societies in Malawi comprise two distinct traditional lineage systems termed *matriliny* and *patriliny* (See Figure 3.1). M*atriliny* and *patriliny* are gender stratification systems that assign different roles to women and men in the social division of labour and accord them different statuses and power to control different kinds or amounts of family resources (Weber, 1964; Mason,

1986; Marshall, 1998). If social change involves changes in structures, functions and relationships, then an understanding of the nature of the two lineage systems (matriliny and patriliny) is essential. Underlying this argument is the assumption that the characteristics of a lineage system (traditions, customs, norms and sanctions) influence the direction or type of social changes.

Figure 2 Traditional lineage and power structures in Malawi



Source: Present Author

Traditionally, in Malawi, the lineage system affects the type of union, marital relationship and location of marital residence, the exercise of domestic authority and the control or custody of children (Murdock, 1959; Radcliffe-Brown and Forde, 1967). In traditional Malawian societies, the family was an integral part of a lineage, which was the larger social unit to which the family was affiliated.

A matrilineage is a system designed to maintain property rights within a kinship group through the maternal uncle. When a *daughter* marries and her *brother* becomes the head of her family with control over all assets. If he dies her *son* or her *male relatives* assume control (see Figure 3.1). Matrilineal societies in Malawi (the Chewa, Yao, Lomwe, and Mang'anja) placed emphasis on *chikamwini,* meaning a matrilocal (uxorilocal) marriage, whereby the husband joined his wife and provided bride service (erecting a hut, cultivating the garden and making various handicrafts) for his parent-in-laws. This also involved matrilineal inheritance of children (ie. labourers) and family wealth (Schoffeleers and Litt, 1968; Phiri, 1983). Women and their children were therefore sources of *human capital* and *investment* for the matrilineage while the women and children depended on the lineage for protection and survival.

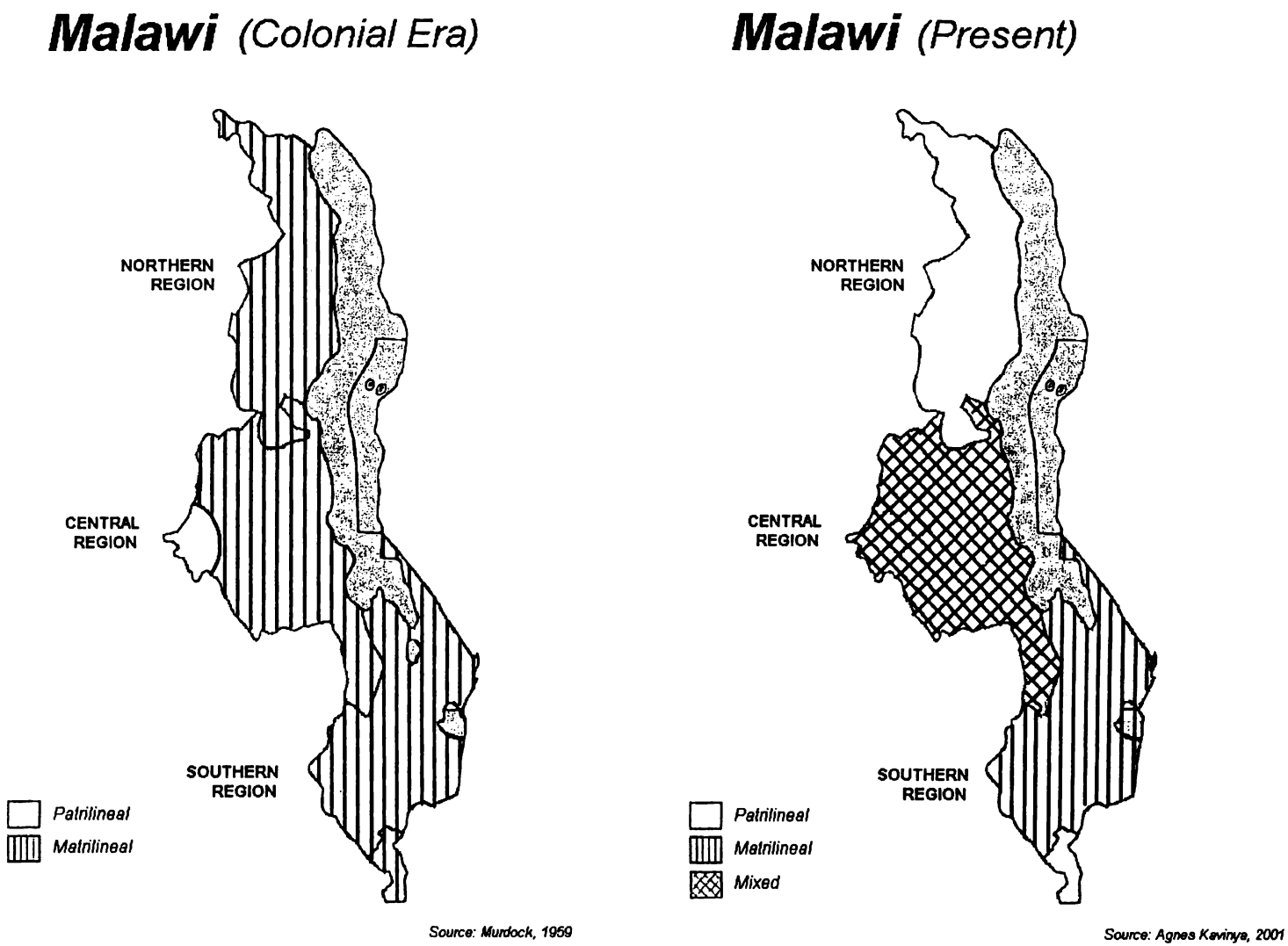
In matrilineal families such as the Chewa families, the locus of all economic and reproductive decision-making power lay with the woman's relatives (Phiri, 1983). Therefore, the matrilineage defined the rights and obligations of the individual family or household, gave it the sense of belonging, provided it with both social and

material security, and defined its status within the larger community. The women constituted the *mbumba* (dependants) and the men acted as the *nkhoswe* (guardians). This type of relationship made women dependent on male kinsmen (Schoffeleers and Litt, 1968; Phiri, 1983) through the creation of a hierarchical pattern of gender relations reinforced by rules of marital residence.

Patriliny is a parallel system to matriliny. It also assists to maintain property rights within a kinship group through the paternal uncle. In patrilineal systems the husband controls the lineage assets. If the husband dies, the control passes to his son or his brother (See Figure 3.1). Common characteristics of patriliny include patrilineality, patrilocality (virilocality), and the practice of polygynous or levirate marriages. In pre-colonial times, traditional societies in Malawi were overwhelmingly matrilineal (See Map 3.1). However, with social change over time, in modern Malawi, the Tumbuka, the Ngoni and the Tonga and the Sena have assumed patrilineal systems. One notable social change that Christianity induced in traditional societies is the shift from polygyny to monogamy.

The senior (male) members of a lineage acted as overseers of the organisation and functioning of the family and its members (Phiri, 1983). Lineage functions included regulating marriage and inheritance and managing life crisis situations including religious activities. The lineage therefore mediated production and reproduction from its members. It was then the basic economic and social unit of the society and was the locus of economic as well as reproductive decision-making.

Map 1.1: Changes in the nature of lineage systems in Malawi from pre-colonial period to the present.



As described in the section that follows, the lineage depended on women and children as an investment and a source of human capital, while the women and children depended on the lineage for protection and survival. The traditional lineage system was therefore constructed on a mutually dependent relationship. Although the individual and the lineage communally owned the means of production (i.e. land) and the produce (Senghor, 1965), the decision-making was male dominated. This is because it was the husband or his sons or his male relatives (in a patrilineage) and the wife's brother or her son or male relatives (in a matrilineage) who had authority. This mutually dependent relationship still exists although it is less important now. The argument in this thesis is that the lineage and neo-nuclear families had and continue to have a central role in development processes. Ignoring the dynamics within these structures renders development-related studies and analyses short of adequate explanations of the nature of decision-making processes and resultant behavioural patterns.

Social change and the lineage in Malawi

Traditional communities in Malawi have been experiencing changes from matrilineal/matrilocal to patrilineal/patrilocal lineage systems (van Velsen, 1960; Vaughan, 1987) and from extended families to monogamous neo-nuclear families (Kandawire, 1979; Phiri, 1983). The social system of the first settlers in the northern region, the Tumbuka, was derived from an *avunculocal* marriage in which residence

was matrilocal *(uxorilocal)*. This practice required a man to return to his mother's natal home at puberty or at marriage (Fox, 1967).

In Malawian societies, matriliny still survives except in the northern region where it was completely replaced by patriliny (See Map 3.1). Prior to 1780 the Tumbuka adhered to matrilineal descent, inheritance, succession and matrilocal *(uxorilocal)* bride-service. Between 1780 and 1800, Arab ivory traders invaded the Tumbuka and introduced patriliny and bridal gift. The bridal gift allowed the husband to take his wife to his own village and gave him rights to inherit and succeed there. The line of inheritance and succession was through brothers and sons. Later the Ngoni, who had an even stronger patrilineal system migrated from South Africa and also invaded the Tumbuka lands. The Tumbuka then adopted the full-fledged South African *lobola* (bride price) (Murdock, 1959). Today, the Tumbuka have strongly rooted patrilocal *(virilocal)* kinship structures and patrilineal systems[14]. Also the Tonga, who were formerly matrilineal, experienced many changes in their matrilineal rules, so that patrilateral kins came to play a pivotal role in kinship production and reproduction relationships (van Valsen, 1968). Today, the Ngoni in the centre and the Sena also practise patriliny.

However, as discussed in Chapter two, in the central and southern regions, the majority of ethnic groups practised and continue to practice matrilineal systems. Although matriliny survives, the current matrilineal systems are weaker and more

[14] For the sake of consistency and simplicity, hereinafter, the terms *matrilocal* and *patrilocal* will be used for marital residence instead of *uxorilocal* and *virilocal* respectively.

mixed than the traditional ones (Zulu 1996, 1998). Confirming the occurrence of family changes in sub-Saharan Africa, van Velsen (1960), Vaughan (1987), Kandawire (1979) and Phiri (1983) found that lineage systems in Malawi have experienced changes in family structures and functions with consequent changes to gender roles and power relations. These changes have been associated with the influence of intruding patrilineal people, new religions, colonial administration and the modern capitalist economy. Kandawire (1979) argued that matriliny ceased to exist as a viable social and economic unit in Malawi as early as the 1960s. He stated that the nuclear family[15] (father, mother and children) became the basic unit of production and consumption. But Kandawire's view ignored the continuing role of the family in processes of social reproduction. Nevertheless, the observed changes of family structures in Malawi are consistent with Goode's argument that, as societies develop (modernise), most tribes become gradually incorporated into modern economies (predominantly patriarchal) and matrilineal systems slowly diminish (Goode, 1982: 118).

An important idea emerging from this literature review is that changes not only occur in family structures and their functions but also to relationships between the lineage and family members. Apart from its control over social reproduction, the lineage was also important for social production in traditional Malawian societies. As is the case in other sub-Saharan African societies, the lineage has lost much of the direct control over production it once had, although it still regulates the inheritance of property and forms the basis of family enterprises. Lineage relationships were, and still are, central

[15] Kandawire used the term nuclear family within the Western conceptualisation of the family.

to processes of the division of labour, reproduction of labour force and the distribution of resources. The lineage therefore contributes to the maintenance of social structures. Whitehead (1975) pointed out that since kin aid, in terms of monetary and moral support, acts as a welfare system; kin relationships are an important apparatus of social production because they contribute to the position of women in the household. Whitehead (1975) further noted that kin relationships have negative and positive effects on women, in that, although they contribute to women's subordination, women use kin ties with female kin to improve their position through networks of mutual economic and moral support. One would therefore argue that while kin ties often strengthen lineage ideologies they also improve women's status in some ways. As Caldwell (1992) argued, women's status is higher in a matrilineal than in a patrilineal society. This is because kin ties are more likely to be in existence and to be stronger in the matrilineal societies than in the patrilineal ones.

With capitalist development on the rise, the strength of the lineage in Malawi has been weakening. The economic importance of the lineage in the transmission of property (especially land) has been undermined by the wholesale appropriation of land by the colonial and post-colonial State and capitalist enterprises (Stivens, 1984)[16]. The redistribution of land to traditional land tenure systems and state legal structures in the post-colonial era revitalised kin relations. This was the case in southern Malawi where women lost their economic status when land was leased by large estate owners and regained it when land was re-allocated (Vaughan, 1987).

[16] Maila Stivens's study carried out in Malaysia could be applicable to the Malawi context because the characteristics of Malaysian societies are similar to those of Malawian societies. They have bi-lateral systems where matriliny and patriliny co-

Furthermore, in colonial times women had their social status lowered due to land and employment policies, which made them more reliant on the psychological, moral, material and financial support of female kin ties (Vaughan, 1987; Locoh, 1997)

These changes have had a lasting effect on kin relations and lineage affairs. Traditionally, kin relations were for marriage, procreation, inheritance of property and the reproduction of the lineage labour force. An individual was held in a tight network of vertical and horizontal communities, which bound and supported him through their collective nature (Senghor, 1965). As it happened in developed countries, the relegation of the lineage to the domestic sphere followed the decline of the lineage as a productive unit. The weakening of lineage has consequently produced disjointed family units. The members are united by descent but operate as single production and reproduction units for the survival of individuals and the neo-nuclear family. These disjointed families will be referred to as *neo-nuclear* families because they maintain their kinship ties.

Neo-nuclear families are characteristic of contemporary Malawian communities. These families have triple roles. They act as producers (for capitalist and familial production for the economic survival of the neo-nuclear family), as reproducers of the reserve army of labour (for capitalist and familial production) and as consumers of products of global multi-national companies. The dilution of the functions of the lineage is within the predetermined effects of ideological principles underlying the

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exist. Similar to Malawian traditional communities, the introduction of colonialism, capitalism, and new religious doctrines were responsible for the social changes experienced by Malaysian communities (Stivens, 1984).

concept of the monogamous family and the public choice or free market principles underpinned in the process of globalisation. These emerging issues may be accommodated within Caldwell's intergenerational wealth (*support*[17]) flow theory.

Through *Wealth Flows*[18] theory, Caldwell (1982:338) showed that the movement towards a capitalist economy causes a decline in the importance of familial production, a growth in internal family egalitarianism, and a reversal of intergenerational support flows from the traditional *young-to-old* to the modern *old-to-young*. These changes are accompanied by changes in societal attitudes towards *male-female* and *parent-child* relationships. Caldwell (1982) argued that community elders kept the gap between spouses and between parents and children deliberately wide in order to weaken both their *emotional* relations and their capability to make independent decisions. This meant that spousal communication was not encouraged. Caldwell (1982) further argued that the intergenerational shift in support-flows leads to the strengthening of spousal as well as parent-child relations while the influence of the lineage heads weakens. The familial production system is undermined as capitalist production increases thus making high fertility uneconomic. In this scenario, Caldwell (1982) pointed out that the link between economic and reproductive decision-making gets broken as the lineage decision-making and power structure shatters. Due to the pressure from the forces of social and economic change in society, Caldwell (1982) noted that emotional relations between spouses become

[17] The term *support* will be used instead of the term *wealth* throughout the thesis to ensure that material and non-material (including financial) transfers are taken into consideration.

[18] Caldwell defined *wealth flows* as all the money, goods, and services and guarantees that one person provides to another. He used the term *wealth* instead of *income* so as to emphasise the fact that transactions were not all monetary. He noted that at any given time these transactions were not all material (Caldwell, 1982: 333).

stronger with consequent agreement that the needs of children come first. Consequently, spousal communication is likely to increase.

Studies conducted in sub-Saharan Africa including Malawi confirm Caldwell's theory. Alex Weinreb (1999), in a study he conducted on *Intergenerational Transfers* in Malawi, found that currently, intra-familial material transfer relationships are more frequent with parents and siblings than with other lineage members. Weinreb postulated that patrilineal and patrilocal men are more likely than are women to consider the needs of their paternal relatives (i.e. uncle, aunt) because they live among them and have more interactions with them. This is consistent with findings of the Economic and Social Commission Asia and the Pacific (ESCAP) studies (1986) that lineage ideology incorporates a sense of family obligation and responsibility[19]. According to ESCAP findings, frequency of interaction between lineage members also maintains the dependency relationship between the members. ESCAP and Weinreb's findings concur in the argument that the nature and direction of *support* transfers in both matrilineal and patrilineal systems is focused on the patri-kins. This pattern suggests consistent male dominance and the maintenance of lineage links as a *safety net*.

While the role of the lineage in community development has been weakening that of the neo-nuclear family has been strengthening. Weinreb's findings and the evidence of community and family change suggest that the reversal of traditional support

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[19] See ESCAP/United Nations (1986.)

flows is in transition in Malawi. The flow is still from *young-to-old* but includes flows between *siblings* and flows to a few selected *members of the lineage* as stipulated in Caldwell's *Wealth Flows* theory. Few support flows occur from the neo-nuclear family to the extended family and more support flows occur to intra-familial members. Therefore, the shrinking support flow from *children-to-lineage heads* (paternal aunt and maternal uncle) and the strengthening support flow from *children-to-parents* and *sibling-to-sibling* are signs of the transition in family organisational structures and their functions in Malawi but different from that which took place in the West. Some scholars have argued that this marks the beginning of the process of nucleation of the family in sub-Saharan Africa (Kandawire, 1979; Weinreb, 1999) but no adequate evidence exists yet (Locoh, 1997; Vignikin, 1997). According to Phiri (1983), migrant labour facilitated the beginning of the nucleation of the family in that when migrant husbands took their wives away to the city with them, the husbands had the sole responsibility to take care of their wives and children. Phiri (1983) further noted that the partial nucleation of the matrilineal Chewa family, for example, was also facilitated when migrant husbands took their wives to the husband's natal home on return to the village. These changes created a favourable environment for the shift in the locus of decision-making from the old to the young. The outcome was change in power structures and power relations between lineage members, between spouses and between parents and children.

Micro-level development issues: family change in structure and well being

Social change has caused fragmentation of the traditional lineage system, which has led to power being devolved from lineage heads to couples and individuals that now make reproductive and economic decisions mainly in their own interest and partially in the interest of the neo-nuclear family. The social changes affecting Malawian societies and other countries in sub-Saharan Africa include schooling, decline in mortality, urbanisation, migration and the food crisis. More recently the economic crisis (Locoh, 2000) the AIDS crisis, the refugee influx (Pilon and Vignikin, 1996), the environmental crisis (Cassen *et al.,* 1994) and democratisation (Miller, Watkins and Zulu; 2001; Frederiksen, 2000) have reinforced these changes. Schooling leads to migration of the educated away from the village to find wage employment. Decline in mortality produces population growth, thus putting pressure on family resources. Urbanisation exposes migrants to new ideas and reduces lineage control. The food crisis has arisen from reduced productivity caused by environmental degradation due to population pressure. The economic crisis has produced high inflation rates, low employment opportunities and low earnings. The AIDS crisis has reduced the labour force due to a dramatic increase in adult mortality. The influx of refugees has resulted from political instability in neighbouring countries and has put pressure on the already limited resources. The environmental crisis has led to the reduction of land-holding capacity leading to a reduction in subsistence productivity[20]. Democratisation has brought about popular demand for egalitarian

[20] Environmental crisis is an outcome of most land that belongs to the lineage, which is either sold or allocated for cash cropping, removal of forest cover leading to reduced land for subsistence farming. As a result, crop rotation or fallow agricultural practice is no longer possible. Consequently, soil fertility has been reduced. Chiefs or lineage heads have no more excess land to allocate to newly married couples, which forces the young couples to migrate. Those remaining in the village

decision-making, particularly the participation of women, the youth and the poor. These are the social changes leading to fragmentation of lineage structures and reducing their power.

Figure 3.2 shows the cause and effect by which social change has empowered individuals (particularly women) and couples while also affecting the processes of reproductive decision-making in Malawi. While the traditional lineage system was a social manifestation of collectivism in the form of mutual caring and support that ensured individual well being (Senghor, 1965), it is slowly losing this function. From her knowledge of the country, the author observes that child fostering is no longer a lineage responsibility but has become more of a neo-nuclear family affair. Also, since the lineage head no longer has the resources to bestow on neo-nuclear family members, migration has become a means of survival for neo-nuclear families. Most of the gifts (money or material items) sent back to the village by migrants now go to their village-based family members, with smaller amounts going to the lineage heads.

The gifts going to the lineage heads maintain land rights, kinship links and a share of control over lineage wealth and become part of the donor's survival strategy. The lineage dependency relationship is not expected to completely disappear because it may serve to ameliorate the economic, environmental, food and AIDS crises. The end result of social changes is increasing autonomy in decision-making and identification of survival strategies by individuals, conjugal-units and network

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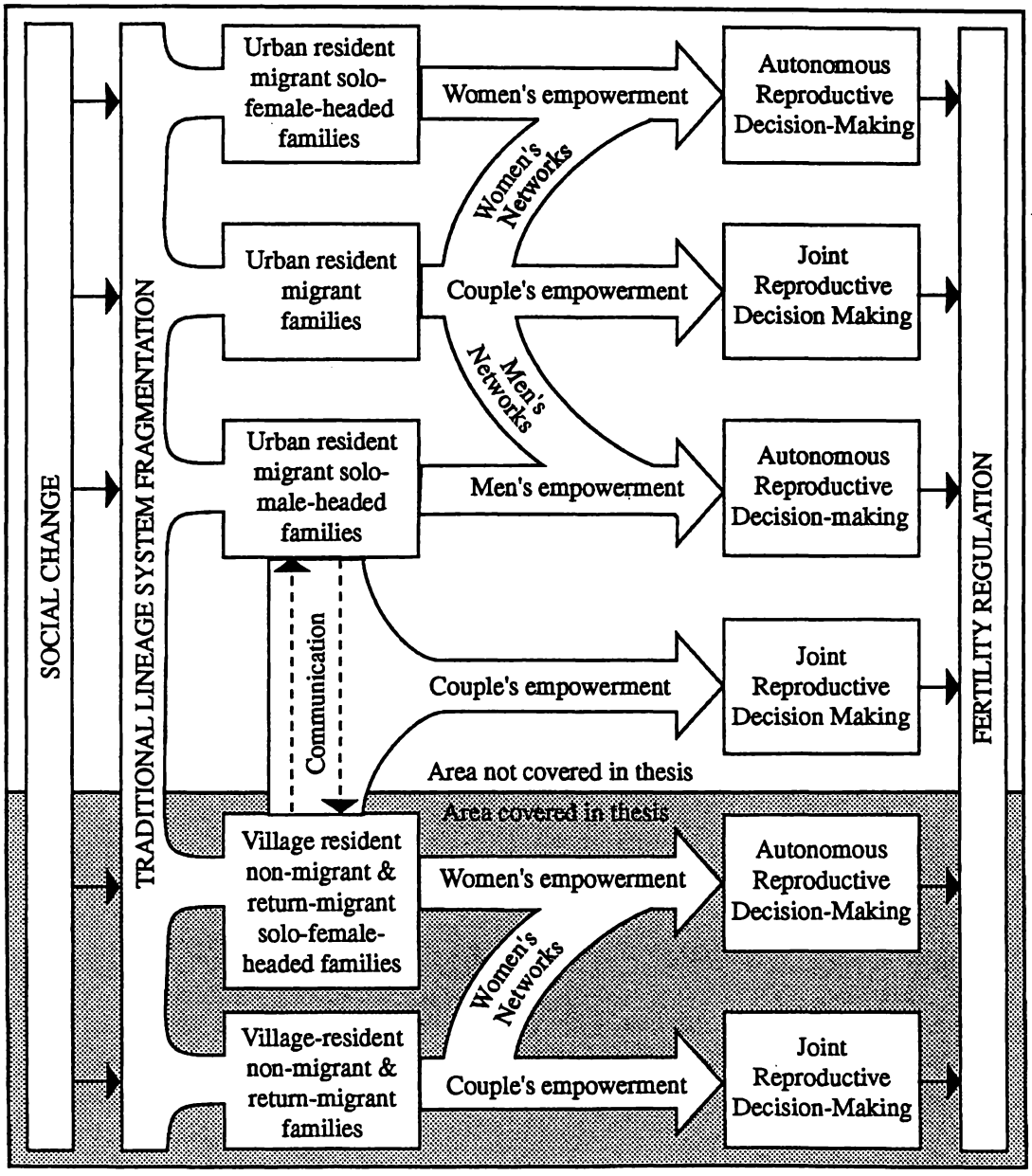
have insufficient production to feed themselves adequately. Even natural resources (traditional food items, meat, medicinal plants) from the forest are no longer available due to the disappearance of natural forests.

groups. Neo-nuclear family goals have shifted their efforts from ensuring survival of the lineage to ensuring the survival of the neo-nuclear family or the achievement of its higher status.

Figure 3.2 Fragmentation of the traditional lineage system and the empowerment of women and couples



Source: Present Author

Hence the social changes are fostering the empowerment of individuals (women as well as men), couples and neo-nuclear families. As defined in earlier in the chapter, empowerment is conceived as a process through which individuals or groups of people improve their capability to survive through pooling resources, which enable them control the means and ends of productive and reproductive activities. In Malawi, individuals, couples and network groups have taken over the power of economic as well as reproductive decision-making from the lineage heads. As Locoh (1996, 1997 and 2000) has observed, the lineage structures are in the process of fragmenting, leading to changes in women's conjugal roles and the disruption of traditional marital power relationships. *Women's conjugal roles* are those roles, which arise from women's position as partners to males for a multiplicity of purposes including procreation, sexual satisfaction, domestic services, financial or material support, economic co-operation, and companionship (Oppong and Abu, 1985). Power and gender structures including communication networks inherent within traditional lineage systems are becoming weaker while those between spouses, female kin and between children and their biological parents are becoming stronger. The outcome has been the multiplicity of paths and loci of reproductive decision-making.

Also the shift from a familial subsistence system to a capitalist production system is bringing about changes in the production relationships, the division of labour and assignment of roles between husbands and wives. Cash crop production in rural Malawi is changing women's status and disrupting spousal power relations. With the

introduction of cash cropping, women have remained in domestic activities and subsistence farming while men have been encouraged to seek wage employment away from the village, with the result that women have become more dependent on men[21] (Phiri, 1983; Vaughn, 1987; Locoh, 1997). Agricultural production has been decreasing as the labour force has been diminishing due to the absence of the men. As the rural economic situation has been worsening and survival is becoming more difficult each day, more men and women (single or married) are migrating to cities and other places where economic activities are centred.

The neo-liberal, public choice and free market principles that have been translated into restructuring, structural adjustment and poverty alleviation policies are further reinforcing these rural-urban circular movements as people struggle to survive. Separations between husbands and wives, between parents and children and between members of the lineage have increased. Consequently conflicts between spouses, between kinship members and between the old (parents) and the young (children) have also been increasing (Schoffeleers and Litt, 1968; Phiri, 1983).

These negative social changes have since the 1970s been observed in Ghana (Pool, 1972; Oppong, 1989), in Upper Volta and Niger (Pool, 1972) and in Kenya (Frederiksen, 2000). Incidences of divorces are increasing (Alam *et al.*, 1992) leading to a rise in the proportions of de facto female-headed (and possibly male-headed) households and a rise in levels of vulnerability particularly among women

[21] Very little is known about the effect of cash crop production on spousal power relations. There is need for more investigation of gender issues related to the prioritisation of cash crop production and the marginalization of subsistence farming.

and children (Government of Malawi and United Nations, 1993). Along with this is increasing degree of autonomy in deciding about when and who to marry (Pool, 1972; Ezeh, 1993; Frederiksen, 2000).

Individual men (migrant or non-migrant, single or married) are also getting empowered as they make more and more independent economic and reproductive decisions free of lineage control. Some of them make autonomous decisions to migrate in search for money and to accumulate their own wealth since lineage wealth can no longer support them adequately. Other individuals engage in trading for periods up to months and move between neighbouring countries and between rural and urban centres. Some migrant men make decisions independently or jointly with their wives, to leave their wives and children in the village. This is because either they cannot afford large families in cities or towns due to low wages (Alam *et al.*, 1992) or they want to maintain their lineage links. The village-based wives and children are engaged in subsistence farming, which subsidises the husband's remittances if any are sent.

The separation of husbands and wives serve as an involuntary family planning mechanism through sexual abstinence. Sometimes migrant husbands resident elsewhere make independent decisions to re-marry and ultimately have many children (Alam *et al.*, 1992). Migrants are likely to make autonomous decisions because they get exposed to new ideas in the cities or towns and are likely to loose their sense of traditional norms and sanctions about reproductive behaviours (Pool,

1972; Dyson and Moore, 1983; Caldwell and Caldwell, 1978). As has been observed in some studies (Van Valsen, 1968; Phiri, 1983; Vaughan, 1987; Government of Malawi, 1993), migrant husbands are expected to send remittances home for the support of their wives and children including their lineage members. But in cases where they do not send enough remittances or any, the maternal or paternal kin have to provide all the support and protection to the wife and children. Also divorce may be precipitated if the village-resident women are caught having extra-marital sexual relationships (Phiri, 1983), which they may do in order to seek moral and financial support as they struggle to survive with their children in the resource-poor villages wages. This means solo women resident in the villages also make independent economic and reproductive decisions.

However, some men do migrate taking their wives and children with them. According to the author's knowledge of the country, these migrant families often employ male or female house-workers (from the village), who help with household chores and baby-sitting. This employment pattern coupled with the gradual increase in basic education (particularly among women) has led to an increase in numbers of single women and men who migrate to cities for wage employment or to form small businesses and so take sole control over their own destiny.

While empowering men (married or single) social change has also been empowering women (as individuals or groups). Village-based wives of migrant husbands make independent economic and reproductive decisions in order to cope with the economic

hardships in the village while their husbands are away and unable to send adequate support. As Vaughan (1987) and Locoh (1997) have observed, between the Mang'anja and Yao, solo women identify women's networks with female kin as one of the survival strategies in times of economic and food crises. The female kin are a source of support (moral, financial and material) and potential partners for small businesses (i.e. brewing beer, distilling *Kachasu*[22]and selling local produce). This type of women's networking is also likely to take place in urban centres.

Today, these solo women are faced with the challenge to identify survival strategies that can free them from the risk of contracting HIV/AIDS. They fear contracting HIV from their mobile husbands or mobile sexual partners. These women often find themselves in a dilemma as to whether or not to continue with child bearing. They are faced with situations where they have to negotiate stopping child bearing through condom use, a process that is very difficult for women in societies where spousal discussion of sexual and reproductive issues is not encouraged and social interactions are gender biased (Alam *et al.*, 992).

Migration, on which most Malawian individuals and families have for long depended for their economic survival, has therefore become a major cause of social crises in Malawi and many countries in sub-Saharan Africa. A recent follow-up to family change is an increase in the urban poor who are mostly single migrant women. These women are considered to be autonomous since they make independent economic and

[22] This is a strong alcoholic drink, which is similar to gin. Since the colonial era it has been prohibited because it is so strong that some people die after drinking it. My observation during a recent field research trip is that the practice of *Kachasu* distilling

reproductive decisions as they struggle to survive in the city. Coupled with the economic crisis, migration has not only changed lineage and spousal relations but has also eroded traditional moral values. Elders lament that young people of today are uncontrollable, as a result marital instability is on the increase (Alam et. Al, 1992; Kaler, 2001).

Another development emanating from the impact of these changes is the reversal of gender roles. For example, one of the outcomes of restructuring is retrenchment of employees, which is producing higher proportions of the unemployed either from the downsizing or lack of employment growth. As a result, there is an increase in informal income generating activities either across the border or within cities, towns and villages and consequently an increase in the levels of circular and return migration. When migrants are retrenched or cannot find employment or when they retire from their jobs, they return to the village. As has been noted by some scholars (van Valsen, 1968; Locoh, 1996), these return migrants do not fit into the traditional power structure anymore because the village residents (which include wives of migrants) have taken total control of all the processes of development in the village. In the absence of husbands or older lineage members, village-resident solo women have become heads of households and have sometimes assumed lineage leadership. They have been making independent decisions in response to developments in the village.

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has been resumed; a sign of limited sources of income these days and an indicator of acute poverty.

So the autonomous paths of decision-making take place among single and married migrant men and women, solo men and women, rural-resident non-migrant families as well as urban-resident migrant families. Due to adverse economic conditions, couples in the villages also break away from the traditional power structures and no longer abide by traditional norms, values and sanctions on reproductive issues. This is particularly so these days as couples increasingly think that they cannot afford large families (FAO, 1994). Wives of migrant husbands, other solo women including wives of non-migrant husbands are all likely to support each other in making autonomous economic and reproductive decisions. Women whose husbands are non-resident in the village often tend to be totally dependent on their husbands in times of famine (Vaughn, 1987) but some identify female-kin networks as a source of support. This explains the issue mentioned earlier in this chapter that there is an increase in numbers of women who are involved in informal economic activities.

Summary and conclusions

The discussion in this chapter has covered issues related to the impact that classical and the contemporary theoretical paradigms of development and gender were instrumental in the formulation of public policies in Malawi, but failed to empirically take into consideration important meso-, and micro- level issues when planning and implementing research and policy. Four major issues have emerged out of this discussion. Firstly, is the fact that to-date neo-liberal paradigms, which are based on neo-classical economic principles of public choice and the free market, have remained as the dominant paradigms. Although these paradigms were focused on

macro-level issues, analogous micro-level theories that addressed issues related to the neo-nuclear family co-existed. Competing with these theoretical paradigms were the neo-liberal feminist theories that questioned the prevalent economic and social order of state structures and the lack of participation of women.

Secondly, the dominant and critical development paradigms tended to focus on structural changes and gave little attention to the nature of the internal dynamics and functional changes of the community-based structures (ie. the lineage). It has been argued that structural and functional changes are symmetrical, and therefore have a role to play in development processes. This is because any change within an organisational structure is likely to lead to change in the functions of that structure as well as its elements. The discussion in this chapter has revealed how the traditional gender and power structures including conjugal roles have been transformed over time despite the parallel male dominated control in matrilineal and patrilineal systems as well as in State structures.

Thirdly, social changes (schooling, decline in mortality and urbanisation including economic, food, environmental and AIDS crises) have an influence on social interactions. A variety of factors interact and cause changes in family dynamics leading to changes in communication and power relationships between spouses and members of the neo-nuclear family or the lineage. These types of changes bring about changes in economic and reproductive decision-making paths.

Social changes therefore empower both men and women to fully justify their autonomous economic and reproductive decisions, free of lineage control. This empowerment is also extended to solo women who take on men's responsibilities as *providers* and role models for their children. Conjugal and gender roles are then reversed. Individual spouses (migrant or non-migrant, urban-resident or rural-resident) especially solo women strive to ensure their individual survival as well as that of members of the neo-nuclear family including their siblings and partially that of lineage heads.

Fourthly, both research and public policies have failed to adequately reflect family dynamics. These include the strengthening of spousal communication and women's networks. The strengthening of spousal communication leads to joint decision-making in the absence of which autonomous decision-making takes place. Women's networks, particularly female-kin networks are also likely to mediate solo women's autonomous decision-making.

CHAPTER 4

DEMOGRAPHIC CHANGE, SPOUSAL COMMUNICATION AND REPRODUCTIVE DECISION-MAKING PROCESSES

Introduction

This chapter begins by looking at the way in which the locus of power in Reproductive Decision-Making Processes (RDMP) has been studied as a male dominated process. This perspective has omitted the consideration of social change and its effect in destabilising the traditional power structures. The outcome of this social change has been a shift in power to individuals (of both sexes) and couples as described in Chapter three. This empowerment has led to demographic changes including the nucleation of families, changes in spousal power relations, changes in spousal communication relationships, and changes in the locus of power in RDMP. These changes are likely to lead to a further demographic change, namely reduction in family size. To take account of the empowerment factors that have led to these demographic changes a framework is developed at the end of this chapter.

As defined in Chapter one, *power* is a complex set of ever-changing relations of force by which modes of decision-making are influenced (Grosz, 1992:87). Assuming that power only exists when there is resistance (Foucault, 1982), *power relationships* are behaviours involving communication about family obligations and

divisions of labour. It is assumed that relationships of dominating power serve as strategies of control within relationships of communication (Foucault, 1982). Focusing on intra-familial relationships of communication, *spousal communication about family planning* is defined as a process through which spouses overtly or covertly exchange information, ideas and signals about reproduction and through social influence, affect each other's conceptualisation and evaluation of reproductive issues. These definitions will be used to show the relationship between demographic changes and women's power to make autonomous reproductive decisions or negotiate desired reproductive outcomes.

The chapter is structured around three sections. The first section is a discussion of conceptual issues related to fertility change and population policies. In that discussion, it will be argued that neo-Malthusian thinking has driven the prevailing fertility transition theories and population policies (See Annex I). It will also be argued that popular fertility theories and population policies focused on aggregated macro-, meso- and micro-level changes, and as a consequence, have omitted some qualitative changes that might explain the differences in the pace or direction of fertility change at the micro-level.

The second section is a discussion about meso-level issues of fertility. These issues relate to the shift of power in RDMP from the lineage heads to the couple or the individual woman and how neo-classical theories of fertility ignored the interactive effect between this shift in power and demographic changes. The discussion will first

argue that the omission of cultural variables from fertility analyses led to this oversight. Secondly, it will be argued that some contemporary demographic research methods that incorporate anthropological and feminist research approaches confirm the importance of cultural variables in fertility analyses.

The third section will illustrate how fertility change was expected along with change in ideas, as an outcome of the diffusion of Western ideas such as equity, equality, freedom of expression and women's empowerment. In that section, it will be argued that these new ideas were expected to lead to changes in the values, preferences and aspirations of individuals and couples. In that section, it is postulated that the power of women to make autonomous reproductive decisions or to negotiate desired reproductive outcomes brings about changes in family sizes.

Finally, the major issues identified in Chapter three and in the present chapter are synthesised into a theoretical model for RDMP. The model takes into consideration the effect of social changes on spousal power relations, spousal communication and RDMP. Employing the RDMP model, the degrees of women's power to make or influence reproductive decisions will be measured in the analytical chapters.

Macro-level issues of fertility change

Fertility change

In the nineteenth century, Thomas Malthus warned that population would gradually grow unless it is interrupted by various checks, which could be preventive or positive. He defined preventive checks as those habits, which would put a prudential restraint on marriage and population. To Malthus, positive checks are causes of prematurely shortened duration of human life (ie. Severe labour, bad and insufficient food, poor clothing due to poverty, bad nursing of children, infanticide, plagues, wars and famine).

Malthus further warned that public relief would not aid poverty and suffering of the labouring masses. Rather, it would stimulate population growth. He argued that *despotism*, *depression* and *ignorance* would make people ready to accept low standards of comfort and respectability and that *civil liberty*, *political liberty* and *education* would make people acquire property and aspire for respect, virtue and happiness for themselves and their children. To Malthus, a combination of varying levels of political, economic and social development of populations and varying prevalence of moral restraint habits and mortality would produce great differences in different countries and at different periods in the character of checks that keep population down to subsistence level (Malthus, 1830).

Neo-Malthusians, aimed at avoiding catastrophe, put in place policies that would encourage the use of modern contraception in order to lower fertility and ultimately limit the sizes of populations (Dixon-Mueller, 1993). With those two scenarios (the Malthusian and neo-Malthusian), policy-makers asked for fertility studies to be carried out to demonstrate the relationship between development and fertility, on which they would base their family planning programmes. Fertility and development research was therefore built on the principle of cost-benefit analysis and population control.

Fertility studies have tried to find out what factors could influence transition from a high to a low fertility society in developing countries such as Malawi. The concept of fertility transition was drawn from the classical demographic transition theory (See Annex I), which suggests that as a society develops (modernises), economic and social changes first lead to a decline in mortality and subsequently a decline in fertility (Coale, 1973:53). The main theme underlying fertility transition is that social changes alter the economic factors affecting human reproduction. Classical and contemporary fertility transition theories view fertility decline as an outcome of a process of rationalisation. These theories assume that as new sources of income, investment and insurance arise, parents in pre-industrial societies cease to treat children as sources of labour, investments, insurance and as sources of physical and political influence for the family (Cleland and Wilson, 1987). This process of change brings about changes in communication and emotional relationships between kin and couple, between spouses and between parents and children (Caldwell, 1982).

What is happening in Malawi and many other sub-Saharan African countries is that economic conditions are not conducive to large family sizes, hence the fertility decline despite the rise in mortality. During the time when the modernisation theory was popular (1950s-1970s), fertility change was viewed in terms of fertility rise or decline. Within that theoretical thinking, macro-structural changes would render a society traditional, transitional or modern. A traditional society was seen as one that had elevated levels of mortality with high fertility as a rational response to prevailing circumstances aimed at ensuring the survival of the human species (Lorimer, 1954; Piché, 1979). A traditional society was characterised by a physical and social organisational capacity to maintain high rates of reproduction (Notestein [1964], 1983), a single economic system, a subsistence production system, a network of relatives, and a net support flow from children-to-parents.

A society in transition was characterised by neo-nuclear families with support flow still in the direction of children-to-parents (Caldwell, 1976). It was seen as one that was experiencing rapid transformations in ways of life especially in terms of childbearing. In a transitional society, ideal family sizes changed a little and high fertility remained rational since children still ensured availability of labour, old age security, political and economic power and the survival of the lineage or family name.

A modern society was seen as one that had low mortality and low fertility, with small family sizes derived from individuals' or couples' rational reproductive choices and decisions following changes in fertility desires. Demographic scholars believed that for fertility decline to take place in these societies there had to be a shift from traditional to modern systems, structures and practices.

Aggregate changes that were thought to bring about fertility decline in sub-Saharan Africa, were shifts in the duration of postpartum sexual abstinence, breast-feeding practices, an increase in women having secondary and higher education levels, a sustained economic development and an increase in age at marriage (Caldwell and Caldwell, 1992). Sterility-inducing diseases arising from increased urbanisation were also thought to decrease fertility (Mauldin and Berlson, 1978; Zulu, 1996). Other societies with persistent poverty were unlikely to experience fertility decline because they continued to have high levels of mortality (van de Kaa, 1996). In spite of social and economic changes, however, many societies in sub-Saharan Africa preserved traditional social structures that underpinned high fertility (Caldwell, 1990; Mauldin and Berelson, 1978). Based on a study in Zaire, Romaniuk (1980) observed that as these societies undergo socio-economic transformation, behavioural reproductive checks that keep childbearing performance below its potential are weakened or completely removed. In consequence, people develop motivation for small family sizes and adopt modern contraception, which is facilitated by family planning programmes.

The Princeton Fertility Project has provided clear evidence that some macro-level aggregated changes are critical in explaining fertility behavioural patterns at the micro-level (Watkins and Coale, 1986). As observed by Bongaarts and Watkins (1996) and Locoh and Villain (1998), the first countries to begin a sustained fertility decline in any geographic region would do so only after high levels of development had been attained. Human Development Indices (HDI), which integrate life expectancy, education (literacy and enrolment) and real gross domestic product are used to measure levels of development.

Bongaarts and Watkins (1996:674) found out that countries with a Human Development Index (HDI) below 0.30 (most of Africa) were likely to be pre-transitional. Those with an HDI at an average of 0.54 (including a few countries in sub-Saharan Africa) could be in transition and those with their HDI above 0.75 (as with most developed countries) were most likely to be post-transitional. For example, Zimbabwe was in transition by the year 1976 with HDI of 0.50 followed by Botswana and Kenya in 1984 with HDI at 0.61 and 0.52 respectively (Bongaarts and Watkins, 1996:649). In sub-Saharan Africa, with the exception of Kenya, Zimbabwe and Botswana, most countries continue to have low levels of development, low levels of participation of women in higher education and continue to suffer from a wide range of crises. They have poor quality of family planning services and high levels of uncertainty about child survival (Caldwell, 1991; Caldwell and Caldwell, 1992; Locoh, 1994; Kirk and Pillet, 1998).

It is worth noting that the composites of HDI are all aggregate measures of social and economic structural changes. This means that HDI can only be used to measure development at macro-levels and not necessarily at meso- and micro-levels. There is a need to develop indices that measure development at community and family levels. This is because a higher level of female education is considered to be the most significant determinant of reproductive behaviour (Caldwell, 1968; Caldwell, *et al.*, 1992; Jejeebhoy, 1995).

Population policies

Traditional family planning has had an impact on the conceptualisation of population policies. The idea of family planning was introduced in 19th century (Fryer, 1965). In that era, the eugenicists were advocating fertility control among the poor and the disabled in order to protect society (Correa, 1994). Advocacy for family planning grew from neo-Malthusian thinking and feminists' movements for women's sexual and reproductive rights. Under the influence of neo-Malthusian thinking population control was seen as the solution to the problem of overpopulation. The American Birth Control League established by Margaret Sanger in the 1920s introduced the term *birth control* (Dixon-Mueller, 1993:32). In 1952, the Birth Control Federation of America was renamed the International Planned Parenthood Federation (IPPF) and *birth control* became *family planning* within the private sphere of marriage. Symbolically, *responsible (planned) parenthood* and *family planning* reflected a move towards the strengthening of the family as a unit rather than the emancipation of women (Dixon-Mueller, 1993:32:41-42).

At the 1994 Cairo conference, ideological shifts occurred, which ushered in more new terminology. *Population control* was replaced by *gender inequalities* and the improvement of women's *reproductive health* (Basu, 1997). *Population policy* became *population policy-related. Family planning* became *reproductive health* (van de Kaa, 1996). *Reproductive health* refers to the ability of women and men to live through their reproductive years and beyond with reproductive choices, dignity, and childbearing free of sexually transmitted diseases and risks.

These shifts in ideology and terminology have had both positive and negative implications for population research and policy. Firstly, they paved the way for the integration of gender issues into fertility research, population policy and programmes. Secondly, the Cairo call to recognise the family as the basic social unit of society and the rights of individual women and couples to make independent reproductive choices meant that RDM was to be recognised within a meso-context of community norms and sanctions. *Family planning* and *birth control* were used as synonyms and yet the former refers to operational activities that involve the diffusion of birth control techniques through population policies and programmes whereas the latter refers to techniques that were used to prevent conception (contraception) or to interfere with implanted foetus (abortion).

The introduction of family planning to Third World countries led to the development of population policies that were limited to contraceptive services, albeit often, within

the context of maternal and child health programmes (at least from the 1980s). However, the Cairo conference had two factions with different family planning goals: pro-Malthusians with demographic goals and anti-Malthusians with non-demographic goals. The Cairo Plan of Action revealed that neo-Malthusianism is still alive. The International Monetary Fund (IMF) restated that decreases in population growth (demographic goals) were the key to development and that; family planning was the best policy to achieve this (Grimes, 1994). Yet the anti-Malthusians demanded in the Cairo Plan of Action that population policies should be more focused on reproductive health.

However, the reproductive health approach ignored other pressing demographic issues emerging out of social changes, a concern, which re-emerged at the 1999 African population conference. The outcome was a consensus that a multi-dimensional policy approach to fertility was desirable. The 1999 African Population Conference saw the need to expand the scope of population policy by taking into account the challenges of pervasive poverty, low participation of the poor in population programme design, low institutional capacity, and insufficient resource allocation (Union for African Population Studies, 1999).

As a result of these ideological and terminological shifts, more heated debates have occurred. Some demographers are of the view that gender issues should not be central in population policy (van de Kaa, 1996; Cleland, 1996) because feminist agendas ignore or minimise population growth and its presumed consequences

(Westoff, 1995). The fear of most demographers is that the *reproductive health* policy focus could jeopardise the scientific nature of demography and could sideline the importance of macro-structural changes in fertility and development (van de Kaa, 1996; Basu, 1997). The major issue behind this debate is how to address gender inequality along with poverty, which affects both men and women. Issues of gender inequality are issues of family, community, national and international importance. In order to address gender issues along with issues of poverty, it has been argued that a multi-dimensional approach is essential. Indeed as some demographers have argued, the traditional family planning approach (Watkins, 1987; Caldwell, 1992; Pritchett, 1994); the women's empowerment approach (Johansson, 1992) the reproductive health approach (Basu, 1997) and to population policy may not in fact reduce fertility by themselves.

Meso-level issues of reproductive decision-making and demographic change

The disintegration of the locus of reproductive decision-making power

The principle role played by traditional social organisational structures in RDMP in sub-Saharan Africa has been well documented for decades because of their support for high levels of fertility. The areas of family organisation that have been considered essential for an understanding of the nature of RDMP in sub-Saharan Africa include lineage systems of descent; kinship networks, child fostering and the nature of conjugal bonds (National Research Council, 1993). Out of the earliest studies on the relationship between the family and fertility, Lorimer (1954) observed that extended

families had the tendency to promote high fertility. Caldwell (1982:9) indicated that since the *neo-nuclear* family was subordinated to and incorporated in wider kinship groups, high levels of reproduction were made possible. This was because economic costs of child-care were shared with lineage members; marriage occurred early and childbearing as well as having a male offspring raised the status and position of the young wife (Mauldin and Berelson, 1978). In traditional societies, couples or family members were conceptually isolated from any communication with their broader family, their community and their socio-cultural milieu on these issues (Caldwell, 1982; ESCAP, 1986).

Other factors of family organisational structure that are related to fertility include forms of marriage, family size, living arrangements; marriage duration, late entry into marriage, old age or widowhood, grand-parental status, daughter status, and husband's absence from home. These factors also affect the nature and locus of decision-making about family size and fertility controls (Caldwell, 1982:11).

The role of the lineage (or the fragmented parts thereof) in RDMP was not recognised in the neo-classical micro-economic theories of fertility, which followed the Beckerian view of the household decision-making structure (Becker, 1965). Household structures were treated as homogenous, male dominated and remote from the broader family and community. Underlying such paradigms was the notion that small families were more liberal and egalitarian and that the maintenance of the

extended family system was a barrier to the acceptance of family planning (ESCAP, 1986).

This thesis supports the observations made by Becker (1981) and Watkins (1993) that the homogeneous treatment of the household decision-making structure in fertility research ignores the conflicts between family members (ie. husbands and wives). Social changes, as discussed in Chapter three, are diluting the strength of traditional norms and sanctions on spousal communication and spousal power relationships in relation to reproductive issues. This weakening of people's acceptance of traditional norms could be captured in fertility analyses and public policies if cultural variables are included in analytical frameworks of demographic processes.

Prior to the 1980s, *culture* was treated as a non-demographic explanatory variable for fertility and was often omitted from fertility analyses (Kertzer, 1995). This was so because fertility research was focused on measuring the impact of economic development on fertility patterns (Greenhalgh, 1995). Nevertheless, a few fertility analysts who incorporated institutional factors into their fertility models always found significant correlation between cultural variables and fertility (McNicoll 1984, 1994; Cain 1981, 1986; Lesthaeghe, 1980). The Princeton Fertility Project re-emphasised the importance of *culture (defined* as language, ethnicity, and geographic region) and indicated that fertility was significantly related to *culture* (Watkins, 1986; Greenhalgh, 1995).

Other studies also observed that persisting cultural values, (Kertzer, 1995) would facilitate or delay the process of fertility decline (McNicoll, 1994). Quoting Reher (1988), Kertzer (1995) further noted that the cultural variable explains the persisting family systems and their impact on how people react to political, economic and environmental forces. Carter (1995) observed that in traditional societies, fertility choices and decisions were passive because they were based on cultural norms and sanctions. In contrast, micro-economic theorists viewed high or low fertility levels as outcomes of deliberate choices in response to circumstances (Easterline, 1978).

These observations are consistent with the fertility context of Malawi and other countries in sub-Saharan Africa. Although the power of the lineage heads is becoming weaker in the modern societies of sub-Saharan Africa, persisting lineage networks might perpetuate higher levels of fertility. As Caldwell and Caldwell (1987) observed, attitudes that are driven by ancestral beliefs are vested in maintaining the continuity of the family line and remain deep-rooted in even the educated or urbanised Africans. African women (educated or not, urban-resident or not) might not limit their reproduction out of respect for relatives (National Research Council, 1993). Whilst traditionally, people's lineage orientation accepted the social, religious and cultural importance of the lineage systems, as discussed in Chapter three, the processes of social change have undermined this acceptance. Institutions such as polygyny can no longer support large families. Conjugal and neo-nuclear family ties will need to be strengthened to empower them to make autonomous reproductive decisions in their own interest.

In traditional societies of sub-Saharan Africa, the conjugal bond was thought to be relatively weak (Caldwell and Caldwell, 1991). It was believed that the weakness of the conjugal unit would inhibit discussion about fertility in general, raise mutual suspicions and render less likely any mutual agreement between the spouses about family planning (Mott and Mott, 1985 cited in National Economic Council, 1993). In modern sub-Saharan Africa, as shown in Chapter three, the conjugal bond is getting stronger in some cases and falling apart in others. There are two outcomes. Firstly, individuals, particularly women are getting empowered to make independent reproductive decisions or to negotiate their reproductive desires through spousal communication. Secondly, couples are getting empowered to discuss reproductive issues and make joint reproductive decisions (which was traditionally a taboo). The same circumstantial pressures acting on individual women and couples are active on the lineage networks working against their support for high levels of fertility.

In the present economic crisis, people can see a benefit in limiting family size. However, the effects of social change on the family may negate this (National Research Council, 1993). Pool (1979) observed that family planning has the potential to upset the customary balance of social control between men and women. In fact, in other studies conducted in West Africa (Oppong 1987, 1989; Locoh, 1994, 1997, 2000) it was also noted that the outcomes of social change have brought about changes in patterns of mutual obligation between kin relations and an increase in neo-nuclear or individual responsibilities (particularly women). Arranged marriages

are no longer practical (Pool, 1979; Ezeh, 1993) as social interactions have become more open to gender equality (Frederiksen, 2000). Nevertheless, gender inequality persists in RDMP and their outcomes (Miller, Watkins and Zulu, 2000). Recently, a few studies have shown increasing evidence that women's power and autonomy in RDMP helps reduce fertility when other pressures favour these changes (Basu, 1992; Cain, 993; Jejeebhoy, 1995; Dharmalingam and Morgan, 1996; Mason, 1997).

Micro-level issues of demographic change in relation to women's empowerment, spousal communication and reproductive decision-making power

Family change: structures, spousal communication patterns and reproductive decision-making power

Fertility change in sub-Saharan Africa was expected along with ideological, social and economic changes caused by the shift from familial peasant production to a capitalist production system. This shift was to be a product of more general modernisation that involved the importation and diffusion of Western ideas through the media and educational systems. The thinking was that these information systems would propagate age and sex equality. Underlying these systems were ideologies, which would end the benefits of high fertility, create demand for egalitarian ethics, increase children's education, raise the position of women and legitimise discussion of sexual and reproductive issues (Caldwell and Caldwell, 1978; Caldwell, 1980).

In traditional societies in sub-Saharan Africa, economic decision-making was not separated from RDMP. This is because high fertility was needed to support economic

production patterns while maintaining the lineage power structures for material advantage, which in most cases favoured the old, especially males (Caldwell, 1978). The patriarch owned and controlled the means of production (land and labour) including the distribution of the produce (consumption)[23] since lineage systems gave men unchallenged decision-making power. However, in Malawi females traditionally controlled RDMP (Srivastrava and M'Manga, 1991; Kalipeni and Zulu, 1993; Zulu 1996, 1998). Childbearing and contraception were considered to be the women's domain (Alam *et al.,* 1992; FAO, 1994) and men were only consulted out of courtesy. In West African traditional societies, women were economically autonomous as they had well-defined economic spheres, had primary responsibility for their children and many women managed polygynous units single-handed (Caldwell, 1976).

In the 1970s, fertility studies conducted in sub-Saharan Africa identified a variety of demographic changes as the outcome of social changes taking place at the micro-level. Marriages were postponed to allow for further education and improved employment prospects. Contraception and abortion replaced postpartum sexual abstinence. Women were no longer prepared to accept being in a subordinate role. Overcrowding due to too many children caused poor sanitation (Caldwell and Caldwell, 1978). These social changes involved advancing ones' financial position whilst putting ones' emotional life on hold. According to Caldwell, in the sub-

[23] Caldwell (1978) explained that men controlled consumption which involved controlling the kind and amount of food eaten, precedence in feeding, the clothing customarily worn, use of house space and facilities, access to transport, decision-making power and services. They also controlled labour, which involved the amount of work done, the kind of work done, working time and access to leisure. According to Caldwell (1978), patriarchs were those men who controlled the access and distribution of family resources including labour.

Saharan experience (as opposed to the Western) emotional independence was to precede economic independence as a pre-condition for fertility decline (Caldwell, 1976).

Those couples that were exposed to modern (Western) ideas through education or urbanisation were seen as *innovators* or agents of demographic change (Caldwell and Caldwell, 1978; Gregory and Piché, 1979; Watkins, 1987). Based on a study conducted in West Africa, such couples voluntarily chose to limit their fertility. They had small families, which were child-centred and emotionally close as a result of changes in spousal and parent-child emotional relations and the nucleation of the family (Caldwell and Caldwell, 1978). This meant that fertility decline was not only a result of mortality decline but was also an outcome of changes within the community and the family in particular.

By the 1980s some scholars believed that attitudes to modern contraception, social organisational norms and sanctions had to change along with individual values, tastes, preferences and aspirations (Bongaarts 1983, 1987; Watkins, 1987; Caldwell, 1992; Locoh and Villain, 1998). Most of these changes would be the outcome of changes in status of women. These would involve an increase in the proportions of women with higher levels of education, increased levels of women's participation in non-manual occupations and increased freedom for women to discuss reproductive issues (Caldwell, 1992; van de Kaa, 1996; Kirk and Pillet, 1998).

Such changes bring about shifts from the communal goal of survivorship to goals directed towards the welfare and the development of the individual, and from institutional control to rational choice by the couple (Notestein [1964] in van de Kaa, 1996) and by the individual. The outcome would be a shift of the locus of reproductive decision-making from the meso-level to the micro-level. These changes would affect intergenerational *support flows* and strengthen spousal and parent-child emotional relations at the micro-level (Caldwell, 1982) leading to small family size desires and ultimately a decline in fertility. Fertility declines that have been observed in Kenya, Zimbabwe and Botswana have been attributed to a number of factors. These include the increased proportion of women with higher education and the lowering of child mortality, reduced desired family size, strong family planning program efforts and increased contraceptive use (Cleland et al., 1991; Bongaarts and Watkins, 1996; Caldwell, 1997; Kirk and Pillet, 1998).

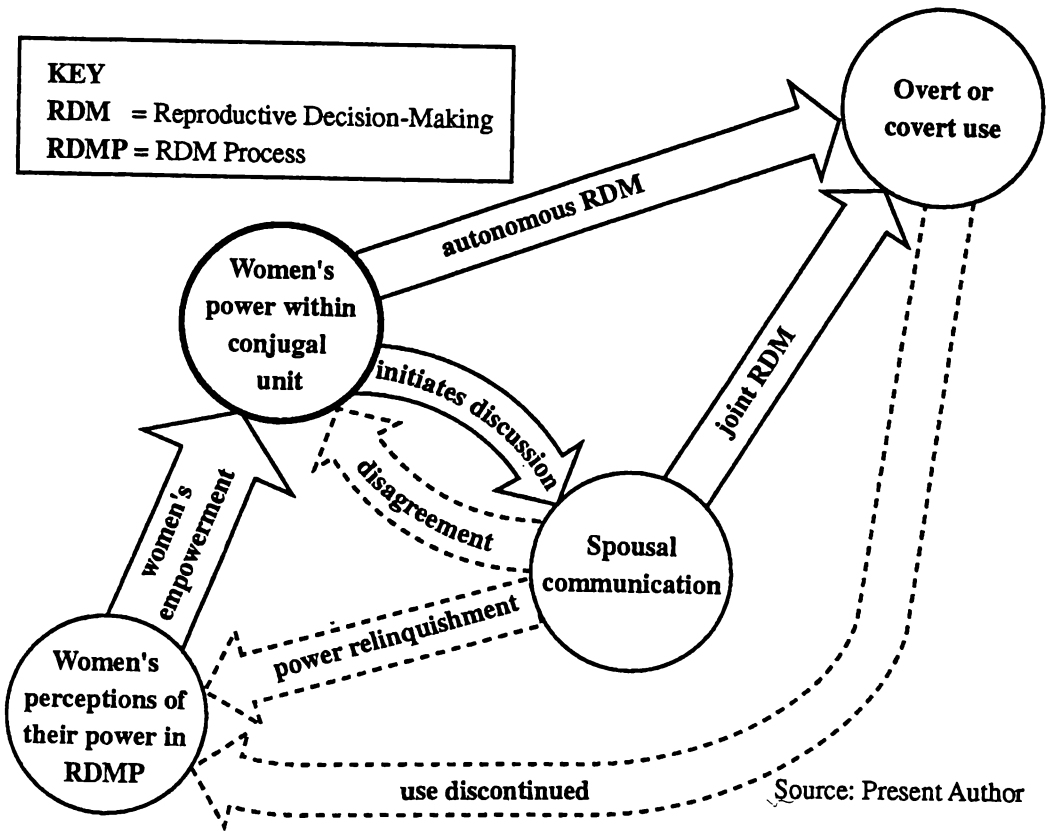
Recent observations on family organisational changes in Malawi and many other countries in sub-Saharan Africa suggest that the following changes have contributed to the transformation of family structures, sizes and intra familial relations. These changes include: a decline in number of children born to couples, decrease in nuptiality, increase in divorce rates, increase in female-headed households and changing migration patterns (Avramov, 1992: 297). The other factors include improvement in schooling and child survival, increased urbanisation, persistent economic crisis (Locoh, 1994, 1997) AIDS (Gage, 1997) and environmental crises (Cassen *et al.*, 1994). As a result, there is an increase in the feminisation of

households, leading to an increase in numbers of *de facto* female-headed households (Avranov, 1992; Gage, 1997). Structural changes in the neo-nuclear family bring about changes in the status and well being of individuals, particularly women and the elderly (Gage, 1997). These changes also lead to modifications of traditional gender roles (Tracuzzi, 1997; Locoh, 1994, 1997, 2000; Thiriat, 2000). These modifications include the weakening of traditional norms and sanctions, changes in power and communication relationships between members of the lineage, between neo-nuclear family members and between spouses. With the weakening of the lineage power structure, and the gaining of more freedom of choice by women, traditional women are likely to become open about their reproductive desires. This means that social change has empowered individuals (particularly women) to either make autonomous decisions or to negotiate their reproductive desires with their spouses, leading to increased spousal communication and joint couple decision-making. Figure 4.1 presents the shifts in women's power to make autonomous reproductive decisions or participate in reproductive decision-making.

Based on Figure 4.1, women have four pathways to their participation in RDMP. Firstly, married women perceive that they have the power to make the decisions to delay births, to stop childbearing or to use modern contraception. Secondly, married women perceive that either they have the capacity to negotiate desired reproductive behaviours and outcomes or not. Thirdly, they discuss with their husbands about family planning and if the discussion ends in agreement, wives participate in joint couple reproductive decision-making processes. Fourthly, if the discussion ends in

disagreement, they may opt to make autonomous reproductive decisions or they may give up family planning.

Figure 4.1 Dynamics of women's power to participate in reproductive decision-making processes



Towards a Reproductive Decision-Making Theoretical Framework

In the neo-classical micro-economic theories reviewed in Chapters three and four, Reproductive Decision Making (RDMP) was analysed in terms of the reasoning that individuals and couples were applying in making economic and fertility decisions. Since the predominant theories of fertility assumed that men were the heads of households and the sole decision-makers, women were presumed passive in RDMP. Because scholars and policy makers held this misconception they believed that fertility research, population policies and programmes should be directed at women with the aim of changing their attitudes and practices with regard to contraception (Piché, 1979; Watkins, 1993; Dixon-Muller, 1993). Women were chosen as respondents because their reproduction could be directed to them. Some feminist critiques argued that women were seen as the cause and solution to the problem of overpopulation (Kabeer, 1994). And yet, literature covered in this chapter related to RDMP in Malawi and other countries in sub-Saharan Africa, shows that women have always been in control of contraceptive decision-making but not necessarily of fertility or economic decision-making.

The exclusion of men's views in fertility studies and in family planning programmes produced misleading results for two reasons. First there is empirical evidence that both men and women have influence on RDMP, in most African countries (Srivastrava and M'Manga, 1991; Ezeh, 1993; Kalipeni and Zulu, 1993; Karra et al., 1997; Zulu 1996, 1998). Second, we should take into consideration the obvious fact that the process of reproduction involves men as well as women (Biddlecom et al.,

1996; Sporton, 1999). A woman's focus approach to issues of fertility ignores issues of conflict, co-operation and communication that exist between men and women (Watkins, 1993).

Contemporary fertility studies employ multi-dimensional approaches, which take into account a combination of macro-, meso- and micro-level factors (Mason, 1991; Greenhalgh, 1995; Kertzer, 1995; Labourie-Racape et Locoh, 1998). These studies have supported the use of anthropological perspectives in demographic research. Multi-dimensional approaches were earlier tested in a number of fertility studies conducted in Europe as well as in sub-Saharan Africa and Asia (Knodel and van de Walle, 1979; Lesthaghe and Surkyn, 1988; Lesthageghe, 1989; Caldwell 1982, 1988 and Watkins 1987, 1990, 1991). More recently, feminist perspectives that focus on the status of women, women's empowerment, gender stratification systems and fertility have gained acceptance (Dyson and Moore, 1983; Mason 1986, 1987; Basu, 1992; Dharmalingam and Morgan, 1996; Mason and Smith, 2000).

There is recognition of the need to use a *gender-relations* approach that analyses the impact of spousal power relationships on demographic processes (Watkins, 1993; Mason, 1994; Cain, 1994; Kabeer, 1994; Greenhalgh, 1995; Carter, 1995; Riley, 1997). Between researchers and policy-makers, there is growing consensus that there is a need to refocus demographic research (Cassen, 1994; Basu, 1997) and evaluate the relationship between *fertility, environment and quality of life* (Sala-Diakanda, 1999). These new approaches have challenged the prevailing neo-classical micro-

economic theories of fertility, which focused on the economic calculus of fertility decision-making (Leibenstein, 1975; Easterline, 1978; Friedman and Crimmins, 1985) and neglected the impact of contextual and historical developmental factors on family decision-making processes.

Chapters two to four have shown that the prevailing lack of understanding about fertility patterns in Malawi and other countries in sub-Saharan Africa is in part due to the lack of understanding of the relationship between women's power, spousal communication, RDMP and fertility change. In those chapters, social change was identified as the main explanatory factor of this type of relationship.

Scholars and policy-makers have recently reached a consensus that a multi-dimensional approach to fertility studies and population policy is essential. This consensus suggests that changes in the surrounding environment, changes in intra-familial relationships and changes in research and policy will influence each other. Three issues have led to this consensus. First there was the failure of the dominant theoretical paradigms to take into account the impact of social and demographic changes on family dynamics. Second, there was the growing recognition of the significant relationship between social change, family change and demographic change as reflected in the Cairo plan of action. Third there was the growing recognition of the fragmentation of the traditional family structure, the resultant multiple reproductive decision-making paths, changing spousal power and communication relationships and their potential impact on demographic processes.

The literature review in earlier chapters further shows that neo-liberal macro-economic development policies have had major impacts on family life. At the macro-level, shifts in public policy have caused changes in the structure and function of the lineage system, the neo-nuclear family and the conjugal unit. Social changes appear to have had contradictory effects on gender and power relationships within the lineage and the neo-nuclear family. The women's quality of life has worsened, forcing them into autonomous reproductive decision-making and clandestine family planning activities.

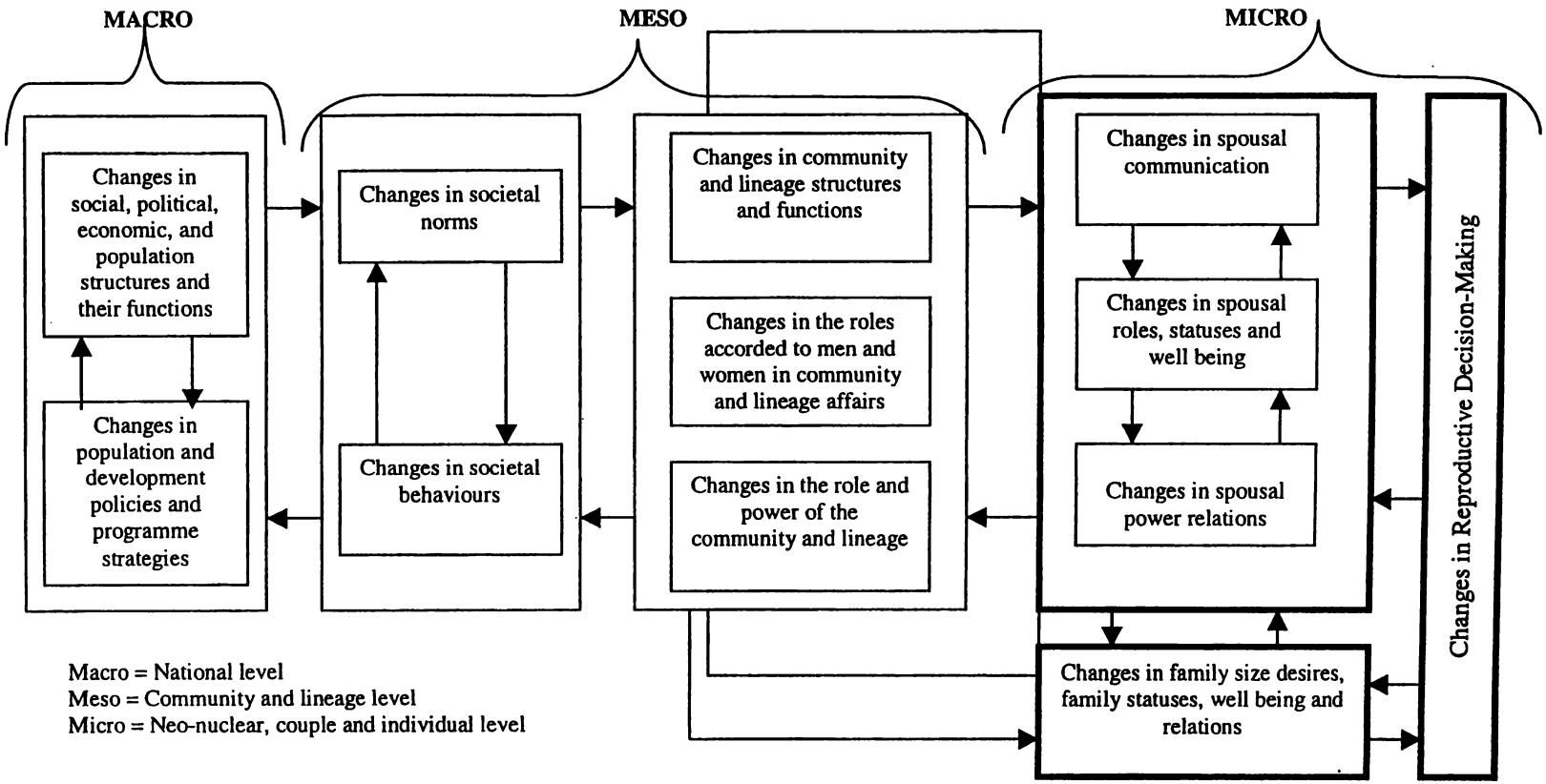
Despite the criticisms and alternative policy approaches advanced by feminists and other social analysts, public policy has only given limited attention to the status of women relative to men. The gender insensitivity of development policies originates from the classical conceptualisation of development, which gave little attention to the impact of the processes of social change on gender roles, the status of women and power relations between men and women.

The effects of the neo-liberal research and policy approaches along with other social forces have moved through communities and impacted on the extended family. Social changes have destabilised societal norms and sanctions, weakening lineage power and leading to partial family nucleation. The ideologically driven public policies have affected the nature of spousal communication, spousal power relations and RDMP through mass education, the globalizing market economy, family planning programmes, religious doctrines and gender training programmes. Through

these channels of communication, a diffusion of new ideas about family planning, gender equality and freedom of choice and expression has taken place in communities and neo-nuclear families. As a result, traditional norms and sanctions are slowly eroding away as the neo-liberal family planning programmes challenge the traditional conjugal power relations. Furthermore, increasing migration leading to a change from traditional extended polygynous and monogamous family units to *neo-nuclear* and *de facto* single-female/male-headed family units has produced conflicts between neo-nuclear family members. These changes have altered spousal power and communication relationships and led to a multiplication of reproductive decision-making paths.

In general, the statuses of families have shifted from being traditionally well off and self-sufficient. Families have become transitional, poverty-stricken, dependent on Government handouts, prone to AIDS and in need of survival strategies. These crises have thrown families out to their own resources. As a result, spousal and parent-child communication relationships have strengthened. Roles of neo-nuclear family members have shifted from the passive to the voluntary characterised by autonomous and joint reproductive decision-making. The influence of the lineage has declined. Neo-nuclear families are now able to think individually about the advantages of smaller family sizes and fertility decline becomes possible. This is consistent with the postulate by Caldwell (1976) that emotional independence must precede fertility decline.

Figure 4.2: A Theoretical Framework for Reproductive Decision-Making Processes



Source: Present author

Summary and conclusions

This chapter has identified four major issues related to fertility research and population policy. These four issues are terminological ambiguities in research and policy, ideological conflicts, research and policy approaches, and research foci. These are theoretical and empirical issues drawn from literature review on Malawi and other developing countries, particularly those in sub-Saharan Africa.

The first issue is related to terminological ambiguities, which originated from the definitions of development, the family, the household, demographic transition, fertility transition, and fertility change, Planned Parenthood, birth control, family planning and reproductive health. Underlying micro-economic theories of fertility, which drove population policy formulation, were the paradigms of neo-liberalism and neo-Malthusianism. The precondition for fertility decline was viewed as the shift from a traditional society to a modern one. One school of thought believed that if people were to adjust to change (economic, social, political and environmental) they would have to become rational. Being rational meant reducing family size through family planning as a means to achieve an affordable number of children. The other school of thought believed that people have always been rational, as they have always responded to circumstantial pressures. Within this school of thought, high fertility was rational because it was required for the survival of the lineage. This adaptation would involve modernisation by shifting from familial to capitalist production systems, which would make large families less desirable. Couples would identify new sources of investment and insurance other than women and children.

The kinship primacy would be eroded and replaced by the neo-nuclear family. Finally, as families become more child-centred and in-ward looking, spousal relationships would be strengthened. These conditions of fertility decline prescribed for sub-Saharan Africa and other developing countries were expected to follow the Western model of demographic transition.

But the reality has confounded this theory. It has been observed that the sub-Saharan African transition is unique because, based on the few countries that are at the onset of transition (Zimbabwe, Kenya and Botswana), the trend has been different from the Western model. This is for two reasons. First that fertility decline occurred ate all ages and parities. Second that many contraceptives were used outside marriage as well as within it. Africa's fertility decline has been characterised by mortality decline along with a slight fertility rise that is followed by a slow decline. Accompanying these changes are the changes in lineage systems, family relationships and power structures including the nature of RDMP. The persisting economic, environmental, AIDS and food crises in the region do not appear to favour high fertility. Instead, along with low HDIs, lowering of desired family size can be observed. Apart from macro-level changes influencing fertility transitions in sub-Saharan Africa, there is evidence that changes at the meso- and micro-levels also play an important role in inducing fertility change.

The fertility histories of countries in sub-Saharan Africa suggest that numerous factors may explain the nature of fertility change in the region. Fertility change rather than fertility decline would be the appropriate term to explain fertility patterns in sub-Saharan Africa because fertility levels are likely to fluctuate in response to differing circumstances (Cleland et al., 1991; Kirk and Pillet, 1998). Nevertheless, studies on fertility and development conducted between the 1960s and the 1970s focused on exploring factors that determine fertility decline rather than fertility change. As a result, the emphasis was placed on demand factors of fertility because scholars and policy-makers sought to identify areas of intervention to facilitate fertility decline and ultimately reduce population growth rate. In research terms these were seen as explanatory factors. The social changes were viewed as factors that would create a demand for family planning.

A number of changes were identified as explanations for fertility change in sub-Saharan Africa. These included an increase in education levels, income levels and age at marriage. Also change was expected in mortality levels and the practices of postpartum abstinence and breastfeeding practices. Furthermore, there had to be an improvement in industrialisation, urbanisation, income distribution and the status of women. Other changes involved shifts in population density, religious and ethnic affiliation shift from familial to capitalist production, from traditional to Western lifestyle and from extended to nuclear family structures. Individuals or couple had to change their perceptions about advantages of small families and disadvantages of large families. A change in the value of old age security would lead to reversal of

intergenerational support flows. These changes may not bring about fertility decline unless changes in traditional norms and sanctions, desires, expectations, preferences, and values about family sizes have taken place at individual and couple levels.

The second issue is related to the emphasis placed on fertility control, which was driven by the neo-Malthusian thinking that advocated *population control* through widespread family planning programmes. Neo-Malthusianism was implicit in population policies and program strategies. *Family planning* was the traditional approach to population policy between the 1960s and the 1970s, then MCH/FP approach in the 1980s and recently the reproductive health approach, which was proposed in the Cairo Plan of Action. There are debates as to whether the traditional family planning approach or the reproductive health approach would jeopardise issues of demographic, gender and economic development. The shift from idealism to realism among African leaders (since the 1980s) led to formulation of population policies with demographic goals. This paved the way to the consensus on the need for a clear understanding of the relationship between fertility, environment and quality of life with a focus on women's empowerment. This consensus led to yet another consensus on the need for a multi-dimensional approach to fertility analyses.

This consensus leads us to the third issue related to change in the nature and focus of research and policy approaches by the turn of the 21st century. Following the consensus at the 1999 African Population conference, a multi-dimensional approach was recognised as the most appropriate for fertility analysis in Africa. This approach

would capture cultural variables including other qualitative changes that have often been neglected in fertility models and policy approaches. These include biological (sterility and fecundity), psychosocial (norms, expectations, perceptions, values, desires, preferences and tastes) and interaction (spousal communication relations, lineage and spousal power relations, couple-kin communication, couple-neighbour communication, peer communication networks) factors. Social changes have affected these factors including traditional social structures leading to the qualitative changes namely: the fragmentation of the lineage, the weakening of lineage control and the dilution of traditional norms and sanctions.

The fourth issue is that the Western ideas and technology about modern contraception has been the research focus. Due to differences in the pace and level of development, fertility change in sub-Saharan Africa is expected to vary across groups with different cultural identities, socio-economic status and religious affiliations. Since the spread of fertility transition depends on forces of social interaction between countries and groups with similar cultures, histories and languages, the influence of demographic innovators on other members in their communities depends on their proximity in culture, history, and language. Using the *Reproductive Decision-Making Theoretical Framework* developed in this chapter, this study focuses on RDMP as the dependent variable to examine the nature of RDMP and its outcomes.

CHAPTER 5

DATA AND SAMPLE CHARACTERISTICS

Introduction

This chapter outlines the types of data that will be analysed in this thesis. Sample survey and ethnographic interviews are the primary data source whereas existing reports on anthropological studies and sample surveys are the secondary data source. Primary data were collected from three districts, one in each of the three regions of the country: Rumphi (mainly constituting the Tumbuka Christian people), Mchinji (mainly constituting the Chewa Christian people) and Balaka (mainly constituting the Yao Islamic people). Only data from two sites (Rumphi and Mchinji) will be used for analysis.

The discussions in the rest of the chapters will refer to the Tumbuka respondents as patrilineal wives or husbands and the Chewa respondents as matrilineal wives or husbands. It will be assumed that the weak matrilineal system practised by the Chewa is more egalitarian than the patrilineal system of the Tumbuka. In order to measure the impact of lineage and gender systems on processes of women's empowerment, spousal communication and decision-making, the best comparison would have been that between the Tumbuka and the Yao because they both have strong lineage systems. But these two ethnic groups differ in their religious beliefs, which are cultural in nature and are likely to have a different impact on the two

ethnic groups. For that reason, religion will be the controlling variable in the comparative analysis between the Tumbuka and the Chewa ethnic groups.

Gender being central to this thesis, the two lineage systems will be considered as gender stratification systems. *Matriliny and patriliny* are gender variables to represent the two lineage systems of the Chewa and the Tumbuka ethnic groups respectively. As was noted in the literature review in Chapters two to four, gender has its macro- and meso- level manifestations, but it must have its most critical role at the micro-level since it determines spousal roles and relationships. This argument is based on the definition of gender as the differentiation between males and females in biological as well as functional terms. A *gender-relations approach* will be used to explore the power of women relative to men in Reproductive Decision-Making Processes (RDMP) within matrilineal and patrilineal marriage systems.

In order to explore the relationship between the two lineage systems, women's empowerment, spousal communication and RDMP, a comparative methodology will be employed using the binary logit model, which is used to analyse dichotomous dependent variables. The main dependent variable will be *Reproductive Decision-Making Power.* As a gender focused analysis, the comparison will be focused on women's perceptions about their power in deciding to *delay births* and *stop child bearing* first: among monogamous wives and second: among polygynous wives. This separation is important because *lineage-based marriage systems* are central in the

processes of constructing gender roles and spousal power relations in African societies.

The primary data that will be used for analysis will be drawn from two data sets. These will include Malawi Diffusion and Ideational Change (MDIC) Sample Survey with 532 matched couples and RDM ethnographic interviews with 32 unmatched couples. Secondary data will be drawn from reports and other research works on census data, Knowledge Attitude and Practice (KAP) Survey, Malawi Demographic and Health Survey (MDHS), and United Nations estimates and projections. Some of the secondary data will be drawn from anthropological and historical studies on Malawi and other sub-Saharan African countries.

Relevant Socio-Cultural Characteristics of the Chewa and the Tumbuka People

Language and culture

It will be assumed that communities who live within geographic proximity are likely to share the same culture. In the present study, culture will be conceived in terms of communication between people who share the same language and ethnicity. This is the case with most communities in Malawi. As discussed in Chapter two, the majority of the population in the northern region belong to the Tumbuka ethnic group because 65 percent of the total population in that region use *Chitumbuka* as the medium of communication in their households. According to figures in Table 5.1, Rumphi has the highest proportion of the population (90 percent) that uses Chitumbuka as the medium for communication within the household. The

populations in the other districts in the northern region use Tumbuka and other languages. The population in Rumphi is therefore homogenous in terms of language, ethnicity and culture.

Table 5-1 Percent distribution of populations using Chichewa and Chitumbuka as a medium for communication within households by regions and districts in which MDIC took place, Population and Household Census 1998

Language spoken within households /Region/ District	Chichewa (%)	Chitumbuka(%)	Total Population (N)
Northern Region	**5.0**	**65.0**	**1,233,560**
Rumphi	5.0	90.0	128,360
Central Region	**91.0**	**3.0**	**4,066,340**
Mchinji	92.0	0.0	324,941
Southern Region	**42.0**	**0.0**	**4,633,968**
Balaka	52.0	0.0	253,098

Similarly in the centre, the *Chichewa* speaking people are the majority (Chapter two). At the district level (Table 5.1), 92 percent of the population in Mchinji use *Chichewa* language in their homes. The Mchinji population is therefore as homogenous as the Rumphi population. In the southern region, quite a few districts have high proportions of their populations using *Chichewa* as the language of communication in their homes. In Balaka, slightly over half the population (52 percent) use Chichewa as a medium of communication in their homes.

Under the assumption that communities within geographic proximity share the same cultural values one could therefore argue that the two population clusters (Tumbuka and Chewa) sampled in two districts of Rumphi and Mchinji will be representative of the total populations in those districts. It follows that culturally the Chewa people in

Mchinji and the Tumbuka people in Rumphi will be expected to be homogeneous in their socio-cultural characteristics and behavioural patterns.

Lineage, marriage systems and beliefs

As discussed in Chapter two, the Tumbuka people practise a strong patrilineal/patrilocal system while the Chewa people practise a less rigid matrilineal/matrilocal system. The two ethnic groups have similar socio-cultural characteristics such as rites of passage, religious beliefs and matrimonial practices of monogamy and polygyny. They both have an exogamous marriage system. While the Tumbuka men pay large sums of money as bride-wealth (about MK 1,000.00), the Chewa men pay little sums (about MK100.00) as a token[24].

Although both the Tumbuka and the Chewa ethnic groups adopted Christianity, they nevertheless maintained most of their traditions and customs. As discussed in Chapter two, these ethnic groups have maintained their spiritual dances of *Gule wa Mkulu* for the Chewa people and *vimbuza* for the Tumbuka people but in fewer camps. While Christianity advocated for the elimination of initiation ceremonies and polygyny, these practices have persisted. Some segments of the Chewa people continue to initiate their boys and girls through traditional camps but others have co-opted the initiation of girls and boys into their Church groups (Phiri, 1998).

[24] The bride price amount quoted here was an average amount. The exchange rate then (January 1997) was Malawi Kwacha (15.00) to 1 US$ (Zulu, 2001:471). Sometimes, the bride price among the Tumbuka men is paid in form of a number of cows that are an equivalent of the amount of money required.

Marriage systems among the Tumbuka have remained strong, whereas the marriage system of the Chewa has become less rigid than before. At national level, polygyny has remained prominent particularly among the Tumbuka people and to a lesser extent among the Chewa people. At national level, polygyny has slightly declined from 21 percent of women in polygynous unions in 1992 to 17 percent of women in polygynous unions in 2000. The practice of polygyny is most prevalent in the north with 26 percent of the women being in polygynous unions in 2000 (Government of Malawi 1992, 2000b). As for the Chewa in the centre, polygyny continues at a smaller scale. Malawi DHS suggests that only 18 percent of women in central region were in polygynous unions in 2000. A detailed discussion on levels of polygyny contrasted between the Chewa and the Tumbuka at regional and district levels is presented later in this chapter.

The Rationale for Polygyny

There are special conditions under which women become polygynous. Some are young women who get married to an older man already having one or more wives and some are divorcees or widows being remarried to another married man. The remarriage of divorcees is common among the Chewa people whereas remarrying of widows is most prevalent among the Tumbuka people. This is because marital instability is less common among the Tumbuka people than the Chewa people (Kaler, 2001). The most frequently mentioned cause for increased marital instability is infidelity (of either husband or wife) and in some cases failure of husband to provide financial and material support to wife and children (FAO, 1994; Kaler,

2001). A special characteristic of polygyny that is worth noting is the residential pattern of polygynous households. Traditionally, post-marital residential pattern of members of matrilineal descent group (like the Chewa people) was to live together in a cluster of huts. A cluster consisted of the hut of a grandmother and those of her married daughters and granddaughters with their husbands and unmarried children. This tendency is thwarted these days by other factors such as shortage of land, attractions of agricultural development schemes and wage employment. Now a husband can take his wife and children to either his village of origin (patrilocal) or to a new settlement. The contact with patrilineal people (the Ngoni who also influenced the Tumbuka) has reinforced the patrilocal residence and patrilineal inheritance among the Chewa ethnic groups (Schoffeleers, 1968; Phiri 1983). Thus the nature of polygyny by the Chewa could be similar in some aspects to that practised by the Tumbuka people.

The rationale behind polygyny among patrilineal people (the Tumbuka people) is labour, accumulation of family wealth and protection of that wealth including rights and control over women and children. Polygyny provides social security to the lineage members as well as the women and children. This is characteristic of the patrilineal marriage system whereby the man brings his wife to his natal home after paying bride price (patrilocal residence), which marks the transfer of reproductive rights and rights of control over the woman and her offspring to patrikin. Inheritance at divorce or death of husband is patrilineal. Often divorce is avoided because the matrikins are expected to pay back all the bride-wealth and also because the patrikins

are likely to lose most of the family wealth including their rights over children. It is this drive to protect and maintain family wealth and rights to women and children, which supports the institution of polygyny.

The residential pattern of the Tumbuka people consists of scattered huts belonging to a grandfather, his married sons and their wives and unmarried children. For polygynous households, each wife manages her own household unit and has her own granary[25]. These units are within ten metres radius from each other. Surrounding the huts are cultivation fields for each household. Due to patrilineal inheritance of names, a typical Tumbuka village comprises monogamous or polygynous households using the same clan name.

One can therefore conclude that the polygyny practised in Malawi is not the stereotype one known in some parts of the world. In a stereotype polygynous society, it is the economic power that matters. Wealthy men have the power to attract and afford many wives even if co-residence and sexual activity within the marriage is minimal (Lesthaeghe, 1989). The polygyny practised among the Tumbuka people is typically patrilineal and residential in nature. It serves to strengthen and ensure patrikins' rights and obligations to secure family wealth and clan name including land and the human capital (women and children). Among the Chewa people, some polygynous husbands maintain all wives either in one house (each one occupying one room) or in different households within five to ten metres radius. These follow

[25] This is a grass-made storage of maize, the staple food in Malawi. Each polygynous woman therefore has to ensure food security for her household.

the patrilineal type of polygyny. But many practise the non-residential type, whereby the wife remains in her natal village and the husband commutes from one village to another.

Although monogamy appears to be more prevalent than polygyny, the two are not completely two discrete groups in nature. They have a lot in common in terms of power relations, power structures and marital norms and values. At any time a monogamous union is likely to become polygynous. What is surprising is that even some Christians are in polygynous unions. This is reflected in tables and discussion on socio-cultural characteristics of the MDIC sample later in this chapter.

In terms of religion, the largest proportions of the Chewa and Tumbuka populations are Protestants followed by Catholics. The Protestant Church of Scotland first settled in northern Malawi and slowly spread southwards. The Catholic Church came to central region much later. The two faith groups introduced schools, hospitals, missions and roads. The Church of Scotland stressed on education whereas the Catholic missionaries placed much emphasis on spreading Christianity.

The Tumbuka people have completely adopted education as their primary goal in life. One could argue that the Tumbuka people take education as their passport to the 'better world' (the outside world) where jobs and markets are in abundance and life is easier than in the undeveloped remote areas. Comparatively, the Chewa people have not performed very well because the ancestral spiritual dance group (*Gule wa*

mkulu) does not encourage parents to send their children to school. Although the Tumbuka people also had *vimbuza* ancestral dance (Kamlongera et al, 1992), this did not have much negative impact on parents sending their children to school. More Tumbuka school-going populations enrol and remain in school while less Chewa school-going populations do. In spite of the fact that Mchinji has a larger school-going population aged 5-29 years (183,137) than Rumphi (73,064), a larger proportion of the Chewa school-going population (59 percent) is not attending school whereas only 43 percent is not attending school among the Tumbuka school-going age groups (Government of Malawi, 2000a).

Based on various studies on macro and meso-level social indicators, it is becoming more evident than before that the two population groups under study have large socio-economic contrasts. They do not have equal access to social services and record different levels of social development indicators, both at national (macro-) and individual/household (micro-) levels.

From a geographic perspective, due to the hills and valleys characteristic of the northern region, the Tumbuka people in Rumphi would be expected to have less access to social services compared to the Chewa people in the plains of Mchinji. Communication infrastructure should be less developed in Rumphi than in Mchinji. This should have been the case considering that during Banda's reign, it was believed that central region (Banda's natal home region), was favoured in terms of development inputs. But in real terms, not much development took place in the

central region. Due to unavailability of data on annual allocations of development budget by district or annual district development plans, it is difficult to assess the extent to which the level of aggregate development in a district is due to national development efforts. Probably, other factors would explain these contrasts between Rumphi and Mchinji. Aggregate individual/household-level development would be responsible for the macro-level performance of a district or region.

Relevant Socio-Economic Characteristics: the Chewa and the Tumbuka people

Both the Tumbuka and the Chewa people practice near-subsistence familial production and small-scale cash crop production. There are fewer large-scale Tobacco Estates in Mchinji than in Rumphi. Wealthier individuals (who are either political leaders or businessmen) own the large-scale tobacco estates in Mchinji[26]. These are usually settlers from elsewhere. In Rumphi, it is different. Mostly, ordinary people do own the tobacco estates. They have developed over time. People from the southern region and the central region used to migrate to the north to work in the farms as tenants[27]. Rumphi has very suitable land for tobacco growing and therefore tobacco farming has been very profitable. Also indicative of the high economic productivity of the Tumbuka people is the high macro-level performance of their administrative areas in education, immunization and access to safe water. But poor access to safe sanitation and malnutrition levels are universal. This means that most

[26] For example during the Banda regime, Tobacco growing licences were restricted. Only large-scale farmers could secure them. In fact, Banda's ruling party owned quite a few Tobacco Estates in Mchinji, Kasungu and parts of Zomba in the South. Banda claimed that Malawians would learn cash crop farming through tenancy at these farms. But in fact tenants in tobacco farms have never gotten out of the circle of poverty and dependency at the farms.

[27] Until in 1999, when Dr. Bakili Muluzi won the second democratic elections, tenants in Rumphi and many other parts of the northern region were either the Chewa people or the Yao people. After the elections, there was conflict between the Yao people, who mostly support the ruling party and the Tumbuka people who mostly support one of the opposition parties: the Party of

of the Chewa people as well as the Tumbuka people have poor nutrition and unsafe sanitation. Thus they are prone to high morbidity. If mother's education has a significant impact on these two indicators and the northern Tumbuka region records the highest levels of education, then gender differences in the education levels might explain the poor nutrition and sanitation among the Tumbuka populations.

In the education sector, Rumphi has the lowest illiteracy rate nation-wide. It records only 22 percent illiteracy rate whereas Mchinji records 47 percent and Balaka 35 percent (Table 5.2). Although this is an aggregate measure of illiteracy at district-level, it reflects the education status of individuals within those districts.

Table 5-2: Percent distribution of school-going population aged five years and over by regions and districts in which MDIC survey took place, Malawi Population and Household Census, 1998.

	Number of persons aged 5 years or over, illiterate	Total Population	% Distribution illiterate
Northern Region	**289515**	**102448**	**28.0**
Rumphi	23599	106172	22.0
Central Region	**1526400**	**3358250**	**45.0**
Mchinji	126156	266744	47.0
Southern Region	**1692543**	**3890748**	**44.0**
Balaka	73660	211274	35.0

What is puzzling is the fact that Rumphi has the highest levels of education and has better social indicators despite its hilly geographic features and rigid lineage and marriage system. This suggests that the population in Rumphi has more access to social services than the other districts in the centre and south. Regarding health services, Rumphi is more accessible to modern health services than Balaka and

Alliance for Democracy (predominantly supported in the northern region). As a result of the conflict, most of the tenants returned to their natal homes.

Mchinji. About 22 percent of the Rumphi population and almost 25 percent of the Mchinji population have to travel over eight kilometres to go to a health facility. The average distance per capita to a health facility in Rumphi is 5,432 metres (80 minutes) and 6,449 metres (98 minutes) in Mchinji (Government of Malawi, 1999b). Based on these figures, one could argue that Rumphi has a relatively higher comparative advantage to accessing modern health services let alone family planning services than Mchinji. In fact very high population proportions of women in Rumphi reported having had the assistance of a nurse or a midwife and very low proportions reported to have delivered at home. The opposite was true for Mchinji (Government of Malawi, 1995a).

According to the Poverty Analysis of the Integrated Household Survey, the northern region has only 10.6 percent of Malawi's poor people compared to 40.2 percent in the central region and 49.2 percent in the southern region (Government of Malawi, 2000c). The survey report indicates that poor households have more dependents for every worker in the household than non-poor households. Then the Tumbuka people in the north are likely to have much less dependents than the Chewa people and others in the centre and south. The low proportions of dependents in the north could also be due to the high levels of migration of the northerners to central and southern regions in search for higher education and better jobs. Similar to the Tonga (van Velsen, 1960) labour migration has become a Tumbuka culture and the migrant Tumbuka men often send remittances and gifts to their family members back home. They also periodically return home and build permanent structures hence the higher

prevalence of permanent structures in most districts in the north. This is because most of them maintain kinship network back home under the assumption that when they become unproductive in the cities, they would retire back home.

MDIC Sample Survey: Sampling Procedures

The survey data to be analysed in the present thesis will be drawn from a Malawi Diffusion and Ideational Change (MDIC) project funded by the Rockfeller Foundation. The project aims at examining the role of social networks in changing attitudes and behaviour regarding family size, family planning and HIV/AIDS in Malawi. A Joint University of Pennsylvania/Malawian team conducted the research under the directorship of Susan Watkins and Eliya Zulu as principle investigators. The MDIC research study was formulated around the assumption that social interactions play a critical role particularly at the early stages of a fertility transition, which, according to some scholars, could be the case of Malawi (Kirk and Pillet, 1999).

The two sites chosen for the analysis are rural sites, which were also sampled for other studies conducted earlier (Srivastava and M'Manga 1991; Alam *et al.*, 1992; Zulu, 1996). The earlier studies chose these areas because of their socio-cultural characteristics, which were representative of the three regions. The principle investigators of the MDIC study also chose the Rumphi in the north, Mchinji in the

centre and Balaka[28] in the south because they wanted to measure changes in the use of various child spacing/family planning methods in these districts. MDIC survey tried to use the same household listings used by the earlier studies, but some of them were missing. Using new neighbouring Census Enumeration Areas (CEAs), the sample was randomly chosen from a list of eligible women that was generated from a complete household listing that they conducted a week prior to fieldwork. Considering that the villages were all of different sizes and that they needed to draw a sample that would allow comparisons at the individual, village, and regional levels, MDIC survey employed different sampling proportions in each of the villages in the two districts. For the MDIC survey, a higher proportion of eligible women were sampled from smaller villages than larger ones because there were so many small villages. The sampling fraction was therefore inversely proportional to the size of the village.

At the household level, random sampling was used for the selection of eligible women for interviewing. Every eligible woman, polygynous or monogamous, had the same probability of being selected for interviews. In contrast, male respondents were selected for interviews only if they were married or living with a woman at the time of the survey. Therefore, each married man had at least one of his wives sampled and interviewed. But the selection of male respondents through a reference woman meant that men theoretically had twice the chance of being selected. This means that to test the representativeness of the sample, we must work through the

[28] In southern region, the earlier studies were conducted in Chiradzulu. But MDIC changed to Balaka, where GTZ had conducted another study related to Community Based Distribution (CBD).

female sample. Figures in Table 5. 3, comparing MDIC and MDHS show that the sample of women is reasonably representative of the most critical analytical variable: the female polygyny (28.5 and the 19.9 percent of female being polygynous in Rumphi and Mchinji respectively).

Table 5-3: Levels of polygyny[29] in MDIC sites compared with levels in Malawi Demographic Health Survey, MDIC 1998 and MDHS 2000.

Geographic Area	POLYGYNY	
	MDIC, 1998	MDHS, 2000
Northern Region	28.5	25.9
Central Region	19.9	18.1

Since this thesis is focused on examining the levels of women's power in participating in reproductive decision-making processes, the MDIC sample was merged into matched couple data. It was felt that the matched couple data would enabled us gauge the effect of informal conversation networks on spousal sexual and fertility behaviour and examine the extent of informal conversations between husbands and wives on these issues. But the matched couple data further raises the sample of polygynous men. This aspect should be taken into consideration when interpreting the results presented in the subsequent chapters because the samples being analysed are not representative of the Malawi population but of homogenous ethnic groups that are concentrated in one area. The Tumbuka sample is representative of most of the Rumphi population, which is predominantly patrilineal and polygynous. The Chewa sample is also representative of most of the Mchinji population, which is predominantly matrilineal and monogamous. The rest of the

analysis will use matched couple data to allow us link the wives' and husbands' responses and characteristics.

Husbands and wives were interviewed separately, not within each other's hearing. This raises the issue of referent wife to which husband's responses refer. For polygynous husbands, it was important to restrict their responses about dealings with their spouse to one of their wives. This was done by randomly assigning the reference wife prior to interviewing. Therefore each polygynous wife had an equal chance of being a referent wife (For details, see http://www.pop.upenn.edu/networks/field/sampling/sample_mdic.html)

The sample is overwhelmingly rural since over 85 percent of the population of Malawi live in rural areas (Government of Malawi, 1993). Within the context of the present study, the two sampled sites in Rumphi and Mchinji represent two homogenous cultural groups because the sampled and interviewed populations in the two districts were generally Tumbuka and Chewa respectively. Therefore, even though the matrilineal system of the Chewa is weak and the patrilineal system of the Tumbuka is strong, the analysis of the two cultural groups would allow for a comparison of the processes of change in those populations and the impact of these changes on the nature of RDMP.

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[29] For MDIC Survey, levels of polygyny were calculated using women's reports.

The MDIC sample comprises women of reproductive age (15-49) and their husbands. Out of a total of 1172 females and 958 males sampled in the three sites, 1029 and 705 females and males were interviewed respectively. The Chewa female sample (542) represents one-fifth of the total population in Mchinji and the Tumbuka sample (487) represents two-fifth of the Tumbuka population in Rumphi. These numbers are not very different and yet Rumphi is least densely populated administrative area in the country. According to the 1998 census, Rumphi has a population density of 27 and Mchinji has a population density of 97 (Government of Malawi, 2000a). The two samples are therefore not representative of the national population.

In this thesis a sample of 1064 matched husbands and wives (532 matched couples) will be drawn from the sample of Rumphi and Mchinji. The numbers of male respondents sampled was fewer than that of females because it was expected that some husbands would be away due to extensive internal migration in Malawi and it was also expected that other female respondents would be separated, divorced, widowed or in polygynous unions.

Analysis will be focused on individual married women. But some husbands' responses to a few selected questions will also be used for analysis. The criteria used to match the couples were as follows. At data collection stage, a woman of reproductive age was identified from each household and using the wife as a reference, her husband was identified and a couple was interviewed. At data analysis

stage, in order to attach cultural identity for a particular union, a single composite variable: *lineage* was developed for the couple. This identity was based on the fact that marriage procedures are often based on the wife's culture. This means that rules of marital residence and inheritance follow the wife's lineage principles. When the ethnic identities of spouses were coded in this way, fifty percent of the 532 couples shared Tumbuka identity, while a further forty-six percent shared Chewa identity. About two percent of the cases comprised a Tumbuka wife and a Chewa husband, while for about three-percent, the wife was a Chewa and the husband was a Tumbuka. This suggests that most couples belong to the same lineage.

The MDIC data were collected in summer of 1998. A total of three weeks (five days for interviewer training and 18 days of interviewing, data entry and checks) were spent in each site. The process of data collection involved individual interviews using questionnaires, one for female respondents and another for male respondents (See Annexes II & III). The questions were of the closed-ended type in a form demanding responses of *Yes/No or Agree/Disagree* type except in a few cases where respondents were allowed to give multiple answers but still closed-ended. In order to check the complete reliability of data, the principal researchers and field supervisors field-edited the answers and sometimes went back to the respondents for confirmation. In addition, data entry was done right in the field so that any errors of consistency could be checked right away.

One important feature of the data collection procedure used for the MDIC sample survey was the fact that interviewers were locally recruited. This meant that interviewers were not complete strangers to the respondents because they shared both culture and language. The research team was aware of possible interviewer-effects due to factors such as age and gender differences between interviewer and respondents. These interviewers underwent a week's training program on the objectives, content and interviewing techniques of the study.

Recognising the shortcomings of recruitment of interviewers, it should be noted that the sharing of cultural knowledge and experiences between interviewers and respondents serves to reduce the social distance between the researcher and respondent but risks lack of co-operation from respondents who may fear that their cases may be gossiped about. In fact there were a few cases where some sampled individuals refused to be interviewed arguing that the interviewers were too young to talk with them about sexual and reproductive matters. Some respondents were also uncomfortable to be interviewed by somebody of a different sex from them. However, estimated interviewer effects were similar in magnitude to the MDHS, which does not use locally recruited interviewers (See www.pop.upenn.edu/networks).

The Process of Collecting Ethnographic Data

The author conducted the RDM ethnographic interviews with the help of a male research assistant. The ethnographic study aims at exploring the factors (demographic, economic and cultural factors) that influence women's participation in RDMP. As discussed in Chapters three and four, quantitative data is an aggregation of factors and therefore do not provide adequate explanations for qualitative issues such as changes in social relationships, interaction processes, power and gender relationships. Although recently there are attempts to measure power and gender relations by measuring women's autonomy, actual measures have not yet been established. For this reason, a combination of survey and ethnographic data is inevitable. Ethnographic data will provide information about the historic development of the social, cultural and economic context as well as information on the nature of processes of interaction and change. This is possible because ethnographic data is drawn from stories about individual life experiences.

RDM ethnographic interviews were therefore designed to collect as much stories of respondents' reproductive experiences as possible. Since ethnographic interviews are unlikely to provide background information about respondents, few survey questions paralleling the MDIC sample survey about the lineage, religion, marital status, age, education level, and number of children surviving were developed to go along with the ethnographic interview topic guidelines. The same sites that were selected for the MDIC project were also selected for the RDM research project. The very small RDM sample survey was not used as a measure of levels and patterns of behaviours but as

a means to relate characteristics of individual respondents and the information given in ethnographic interviews. It was therefore decided that ethnographic data would be used to complement MDIC data during data interpretation. The MDIC data was found to be more appropriate than the DHS data because it has a wider coverage of questions relating to socio-economic, socio-demographic, psychosocial, gender and spousal communication issues, which will be useful for analysing the nature of RDMP between spouses.

Individual married men and women interviewed under the RDM ethnographic project were picked based on informed consent and availability. The author and her research assistant walked through a set of villages in each of the three sites and interviewed eligible men and women who accepted to be interviewed. Eligible respondents were those who were in reproductive age group and currently married. The respondents were not matched couples. Samples of five young men and five young women (aged 15-34) and five older men and five older women (aged 35-50) were interviewed from each site, making a total of 60 respondents from the three sites. Out of the sixty interviews, only thirty-two individual interviews were used for analysis since the analysis will compare only two ethnic groups from two sites. Therefore only interviews with 16 Tumbuka and 16 Chewa respondents (eight husbands and eight wives for each site) will be used for analysis. Four interviews were discarded due to poor quality[30].

[30] The poor quality interviews were those for which respondents seemed unwilling to discuss their reproductive history and were either saying 'no' or 'I don't know'. This was very common among the male respondents. The author's research assistant had to track them down because many of them were not found at home very early in the day. It is possible that their absence implied that they did not want to be interviewed and this could affect the quality of these interviews.

The research assistant for the RDM research project was trained on the job. At the end of each field day, we listened to and discussed recorded interviews. Gaps in the interviews were identified and further probing questions were included in a revisit and other subsequent interviews. Narrative interviewing techniques were employed using open-ended and unstructured questions. This approach permitted open discussion with the respondents.

The interviews were focused on three main themes: family size, family planning and Sexually Transmitted Diseases including AIDS. First, the respondents were asked to give a lifetime account of their reproductive experiences. Other questions that followed were on conversations about family size, family planning and AIDS with spouses, friends, community elders and religious leaders (See Annex IV).

The RDM ethnographic research project had another component that was used to collect data on changes in kinship relationships, family formation patterns and lineage systems. Although existing anthropological sources could possibly have provided some of the needed information, it was felt that fresh interviews with a few people from the sites under study would provide current views regarding changes in social organisational structures and their functions including people' reproductive behaviour. Special kinship interviews were therefore conducted with a few older men and women aged fifty years and above.

The topic guidelines were designed under the assumption that social structures and systems are expected to evolve over time. As discussed in chapters three and four, social interaction processes are likely to bring about change in social organisational structures, lineage power relationships, and family formation patterns leading to changes in the nature of RDMP and ultimately behavioural change. In order to capture these processes of change, the following topics were discussed with older men and women: changes in patterns of family formation, lineage and kinship structures, marital residence and relative powers of husband and wife in reproductive decision-making processes in the past and the present (See Annex IV).

Sample characteristics and eligibility for logistic regression analysis

The eligible sample for analysis comprises a sub-set of couples that reported they had at least one live birth or have not had any child but married for less than five years. This sample excludes couples that had been married for more than five years but have had no live birth because they are assumed to be infecund. It is assumed that failure to have a child within the first five years of marriage might reflect low fecundability due to biological reasons or venereal diseases.

Also excluded from the data subset are those women who were not pregnant at the time of the survey and reported that they could no longer get pregnant, including those who were pregnant at the time of the survey but felt that they could not get pregnant again. The assumption is that these women might not converse about contraception with their partners since they are infecund or they think they are. The

respondents, who said that they did not know whether they wanted another child or not, were included in the sample with those wanting another child. This is because as shown by some studies conducted in sub-Saharan Africa, the responses *don't know* or *up-to-God* to the question *would you like to have another child* often mean that they do not mind having as many children as *God gives them* (Caldwell 1968, 1977; Pool, 1968).

The responses *don't know* and *up-to-God* will be coded as indicating the desire to have many children, that is a number exceeding what is considered to be *ideal family size.* According to Caldwell (1977), the concept of *ideal family size* within the sub-Saharan African region is difficult to interpret because it is used in relative terms (Caldwell, 1968). However, Malawians conceive a family size of five as ideal, above five as large (or too many) and below five as small (or fewer) (Government of Malawi, 1992; FAO, 1994).

A description of the demographic, socio-economic and cultural characteristics of the MDIC sample survey respondents is presented here. The meso-level variable *(lineage)* will be used to represent a gender stratification system. *Matriliny* will represent the Chewa ethnic group and *patriliny* will represent the *Tumbuka* ethnic group. When interpreting the analytical results, we should take note that historically both the Tumbuka and the Chewa practised strong matrilineal/matrilocal lineage/marriage systems. But since the 19th century, the Tumbuka completely adopted patriliny. The Chewa ethnic group has steadily been shifting from

matrilineal/matrilocal to patrilineal/patrilocal society. Since the two ethnic groups practise polygyny, *type of union* and the *lineage system* will be considered as proxies for meso-level variables related to the wider family group. As discussed in Chapters three and four, the wider family (kin) group plays an important role in the construction of gender roles, gender relationships, and spousal power and communication relationships. It is assumed that differences in responses by type of union (monogamy and polygyny) and by lineage are bound to affect the nature and levels of spousal communication, RDMP and their outcomes.

A description of the characteristics of respondents from each lineage system and type of union will be presented separately. Apart from comparing the structural organisation of the family, a comparison of the functions of the family including the relative reproductive and productive roles of husbands and wives as members of the family will also be made. Husbands' responses and wives' responses will be treated separately because MDIC did not have gender questions for the male respondents except for one. The comparative analysis will be based on the conventional demographic thinking that women's fertility behaviour depends on their perceptions about their husbands' opinions. Perceptions of patrilineal and polygynous wives and perceptions of matrilineal and monogamous wives will be contrasted. The effect of other husbands' characteristics on women's reproductive decision-making power will be captured through regression analysis.

Sample characteristics by lineage

Patrilineal versus matrilineal couples: their socio-demographic characteristics

As discussed in earlier chapters, the characteristics of the patrilineal and matrilineal families differ in many ways. Based on data displayed in Table 5.4, the MDIC sample comprises a slightly larger proportion of older couples than younger ones most of whom married later than the age of 20. If the two societies under analysis employ egalitarian ethics in matters of reproduction, it could be argued that above fifty percent of the MDIC sample could be changing their reproductive behaviours due to delayed entry into marriage.

Table 5-4: Selected demographic characteristics of respondents by lineage system, MDIC Survey 1998

Characteristics	Patrilineal Husbands % (N=273)	Matrilineal Husbands % (259)	Patrilineal Wives % (273)	Matrilineal Wives % (259)
Current age				
30 plus	74.7	59.8	45.8	30.9
Below 30	25.3	40.2	54.2	69.1
Age at current marriage				
25 plus	48.7	40.9	16.1	13.1
20-24	44.0	45.2	22.7	19.7
17-19	6.2	8.5	36.3	38.2
13-16	0.7	1.5	22.0	13.9
12 and below	0.4	3.9	2.9	15.1
Desired family size				
5 and above	75.2	51.2	62.6	48.8
Below 5	24.8	48.8	37.4	51.2
Number of children surviving				
6 and above	35.5	21.7	14.4°	15.0°
2-5 children	48.9	50.0	60.4°	50.4°
0-1 child	17.6	28.3	25.2°	34.6°

Note: Chi^2 = significant at < 0.05 except where the symbol ° is used. Chi-square tests for the following contrasts were done separately: patrilineal vs matrilineal husbands and patrilineal vs matrilineal wives.

But the wider gender differences in current age at entry into marriage (in favour of men) are an indication that traditional norms of male dominance in RDMP, based on sex and age, prevail in the patrilineal and the matrilineal societies in Malawi. Table 5.4 shows that about 75 percent of Tumbuka men are over 30 years old and 60 percent of Chewa men are. This means that the Tumbuka husbands are older than the Chewa ones, an indication that Tumbuka couples have a wider husband-wife age gap.

These results confirm the observations made by Kirk and Pillet (1999) and Cohen (2000) that prevalence of teenage marriages particularly among women are still predominant in Malawi. In fact more wives than husbands entered into current marriage between the age of 12 and 19. A very minimal lineage difference exists. A remarkable difference is between the wives. A slightly larger proportion of patrilineal wives (22 percent) reported having 13-16 years of age at current marriage compared to only 14 percent of matrilineal wives. The early teenage is the puberty age, when traditionally girls are considered ready for marriage and therefore ready for child bearing (Alam et al., 1992; Schatz, 2002).

Over fifty percent of patrilineal couples have a husband-wife age gap of four years and above. This reflects the late entry into marriage typical of patrilineal and polygynous men. Patrilineal males have a late age at entry into marriage and a large marital age gap with their wives because they have to provide for needy wives such as the widows or divorcees. This confirms DHS findings that men in northern Malawi enter into marriage much later than their matrilineal counterparts in the

centre and south (Government of Malawi, 2000b). In fact a large proportion of the matrilineal couples have close marital age gap, which suggests that the difference in age at entry into marriage of males and females is minimal (Table 5.5). This is likely to have an impact on individual fertility levels.

Table 5-5: Percent distribution of respondents by husband-wife age gap and lineage system, MDIC Survey 1998

Characteristics	Patrilineal couples % (N=273)	Matrilineal couples % (259)	Total % (N= 532)
Husband-wife age gap			
10 years and above	50.4	49.6	100 (N=135)
7-9 years	59.3	40.7	100 (N=108)
4-6 years	51.3	48.7	100 (N=156)
Less than 3 years	45.9	54.1	100 (N=133)

Note: Chi^2 is **not** significant at < 0.05. The chi-square test was done for the contrast between patrilineal and matrilineal couples.

Generally, over half of the respondents (about 60.0) reported having a desire for large families. Ethnic differences are quite significant with more patrilineal couples than matrilineal ones reporting a desire for five or more children. This is consistent with the existing evidence that patriliny is directly correlated with large family size desires. Gender differences also exist. The analysis falls within the conventional belief that most men sub-Saharan Africa desire more children than do women. These desires are also reflected in the number of children ever born to each individual.

As Table 5.6 suggests, generally women start child bearing much earlier than their male counterparts. This is in line with the gender differences in age at entry into marriage, which translates into gender differences in the pattern child bearing by generations. Interestingly, there are no major lineage differences.

The highest proportions of the wives are those aged between 20 and 29 years having ever had one to five children born. Their male counterparts also aged 20-29 are concentrated in the range of one to two children only. Among those wives aged 30 years and above, the concentration is among those who have had three or more children and it is skewed towards those having six or more children. But for the husbands, the story is different. Childbearing is concentrated among age groups of 30 years and above. Those husbands aged 30-39 have had three to five children ever born. Then the 40 plus years old have had six or more children ever born.

Table 5-6: Percent distribution of patrilineal and matrilineal wives and husbands by number of children ever born and age groups, MDIC 1998

Children ever born/ age groups/Lineage	Less than 20 years (%)		20-29 years (%)		30-39 years (%)		40-49 years (%)	
	Patri wives	**Matri wives**	**Patri wives**	**Matri wives**	**Patri wives**	**Matri wives**	**Patri wives**	**Matri wives**
None	38.5	44.0	7.6	6.1	0.0	0.0	0.0	0.0
1-2	57.7	56.0	42.4	45.0	4.4	6.6	5.3	2.4
3-5	0.0	0.0	49.2	45.8	40.7	47.5	13.2	7.1
6+	3.8	0.0	0.8	3.1	54.9	45.9	81.6	90.5
(N)	**(26)**	**(25)**	**(118)**	**(131)**	**(91)**	**(61)**	**(38)**	**(42)**
	Patri husbands	**Matri husbands**	**Patri husbands**	**Matri husbands**	**Patri husbands**	**Matri husbands**	**Patri husbands**	**Matri husbands**
None	100.0	75.0	16.2	19.6	1.1	1.2	0.0	0.0
1-2	0.0	25.0	57.4	53.3	17.9	12.0	2.0	0.0
3-5	0.0	0.0	25.0	25.0	50.5	61.4	10.1	12.2
6+	0.0	0.0	1.5	2.2	30.5	25.3	87.9	87.8
(N)	**(1)**	**(4)**	**(68)**	**(92)**	**(95)**	**(83)**	**(99)**	**(74)**

Note: Chi-square significant at <0.05. Chi-square was tested for the following contrasts separately: patrilineal vs matrilineal wives and patrilineal vs matrilineal husbands.

The concentration of high levels of fertility among older men aged 30 years and above and among younger women aged 20-39 raises a few critical gender issues. First that Malawi has a very young female population, which is expected to constantly produce a larger proportion of young women ready for marriage. The

1998 census report reveals that the median age of the Malawi population was 18 years and that about 51 percent of the population were females (Government of Malawi, 2000a). Due to the persistent high fertility levels in Malawi, the young female population is expected to grow and therefore constantly provide a supporting environment for polygyny.

In terms of achieved fertility (as depicted in Table 5.4), the largest proportion of the sample (about 53.0) reported having had 2-5 children surviving. Gender and lineage differences in reported large family sizes are evident with a large proportion of the husbands reporting to have had more than five children. About 36 percent of the patrilineal husbands and about 22 percent of the matrilineal husbands reported having five or more children surviving and only about 15 percent among the wives did. These gender and lineage differences in achieved fertility reflect polygyny and large husband-wife age gap, which are the characteristics of patrilineal marriages.

Patrilineal versus matrilineal couples: socio-economic characteristics

Table 5.7 depicts some socio-economic attributes of the sample under study. Spousal capability to earn money and couple's ownership of certain household amenities such as a bed and a mattress, a radio, a bicycle, a pit latrine, a glass lamp and a house roofed with iron sheets are indicators of high socio-economic status by rural standards in Malawi. A household that has at least one or more of these amenities is seen as well off. There are marked ethnic differences in the ownership levels of the rest of the amenities. The patrilineal couples appear to be wealthier than the matrilineal ones. More patrilineal couples than matrilineal ones reported having one

or more beds and mattresses, a radio, a pit latrine, a glass lamp and a metal roofed house. Matrilineal couples reported having more bicycles than did the patrilineal couples. This is probably because of differences in terrain since the Tumbuka people are located in a valley whereas the Chewa people are located on the plains.

Table 5-7: Selected socio-economic characteristics of respondents by lineage system, MDIC Survey 1998

Characteristics	Patri Husbands% (N=273)	Matri Husbands % (N=259)	Patri Wives % (N=273)	Matri Wives % (N=259)
Doing income generating activities				
Yes	97.1	100.0	78.8	73.4
No	2.9	-	21.2	26.6
HH has one or more beds and mattresses				
Yes	39.6	14.7	34.4	9.3
No	60.4	85.3	65.6	90.7
HH has a radio				
Yes	76.2	65.3	70.3	54.8
No	23.8	34.7	29.7	45.2
HH has a bicycle				
Yes	49.8	72.6	45.4	68.3
No	50.2	27.4	54.6	31.7
HH has access to a pit latrine				
Yes	91.6	73.7	87.5	63.7
No	8.4	26.3	12.5	36.3
HH has a paraffin glass lamp				
Yes	56.0	30.1	50.9	22.4
No	44.0	69.9	49.1	77.6
Roof material				
Metal	10.3	10.3	10.3	3.5
Grass	89.7	89.7	89.7	96.5

Note: All values have Chi^2 = significant at < 0.05. Chi-square tests for the following contrasts were done separately: patrilineal vs matrilineal wives and patrilineal vs matrilineal husbands.

It is important to note that very low proportions have a bed and a mattress or a house roofed with corrugated iron sheets. These are the most expensive items. The low proportions are indicative of the income levels of most respondents. Almost all husbands indicated that they were involved in income-generating activities and fewer wives did. In terms of lineage, slightly more patrilineal wives than matrilineal ones reported performing income-generating activities. The fact that most couples reported doing income-generating activities and living in houses of high economic status is an indication that most rural Malawians survive on low income.

When one reviews the reports by spouses, one would not expect that spouses coming from the same household would give contradictory reports about available household amenities. Surprisingly, Table 5.7 shows gender differences in reporting the availability of household amenities. In each case, higher proportions of husbands reported having household amenities than did their wives. Either of the two could be lying. The husbands could be over reporting and the wives could be underreporting. Since ownership of the radio, a bed, mattresses, etc. are indicators of wealth and modern life style; it is possible that men over-report in order to identify themselves with modernisation (Miller, Watkins and Zulu, 2001).

Patrilineal versus matrilineal couples: socio-cultural characteristics

Table 5.8 shows that most respondents in the sample are Protestants with a slightly higher proportion of Catholics among the patrilineal couples than the matrilineal ones. This is because as discussed in Chapters two and three, the Presbyterian

Church of Scotland was the first to seek converts among the populations in northern rural areas of Malawi, starting from the 1870s (Pachai, 1973; Thompson, 1998). Both the Catholic and the Presbyterian churches instituted schools throughout the country either independent of or in collaboration with the Government. Western religion has therefore contributed to the diffusion of Western ideas in Malawi either through schools or religious doctrines.

In terms of schooling, the majority of the respondents reported to have attended school, but very few had attained higher than primary education[31]. Only three respondents reported that they had secondary education and only one had university education. These respondents will be included in the category of those having more than six years of schooling.

The general picture of education pattern is that there is a huge difference in illiteracy levels by lineage. The striking difference is among wives with matrilineal wives being more illiterate (about 38 percent) than are the patrilineal ones (about 4 percent). This suggests that one out of 25 patrilineal wives is illiterate against two out of five matrilineal wives. This further confirms the observation van Velsen (1960) made on the Tonga (one of the strongly patrilineal groups in north Malawi) that men are more educated than women are and that due to this male bias in education levels, migration is male dominated. This gender gap in literacy levels has persisted. Among

[31] Please note that Malawi has very high levels of rural-urban and urban-rural migration. This is mainly because rural Malawi is still underdeveloped (less urbanised) and therefore has fewer paying jobs, prospects for businesses, higher education institutions etc. Most people migrate to cities in search of paying jobs, higher education and trade. Those involved with trading sometimes operate their small businesses in rural areas and therefore engage in circular migration.

the patrilineal couples, more wives than husbands reported having had over six years of schooling among female respondents may reflect the fact that most educated men (with at least eight years of education) migrate to cities.

Table 5-8: Selected socio-cultural characteristics of respondents by lineage system, MDIC Survey 1998

Characteristics	Patri Husbands % (N=273)	Matri Husbands % (N=259)	Patri Wives % (N=273)	Matri Wives % (N=259)
Religion				
Catholic	14.3°	18.9°	14.7	22.0
Protestant	80.2°	73.7°	81.7	70.3
Other	5.5°	7.3°	3.7	7.7
Years of schooling				
Above 5 years	56.4	40.9	63.0	21.6
1-5 years	40.7	41.0	33.0	40.5
None	2.9	10.2	4.0	37.8
Ever lived in city/town				
Yes	61.2°	60.6°	40.7°	42.5°
No	38.8°	39.4°	59.3°	57.5°
Type of union				
Monogamous	66.4	88.8	69.6	83.7
Polygynous	33.6	11.2	30.4	16.3

Note: Chi^2 = significant at < 0.05 except where the symbol ° is used. Chi-square tests for the following contrasts were done separately: patrilineal vs matrilineal husbands and patrilineal vs matrilineal wives.

In this thesis, return migration status will be used as an indicator of individuals' exposure to urban lifestyles and modern ideas. It is assumed that if individuals reside in urban areas for at least six months, they undergo social learning and acquire knew knowledge. Data presented in Table 5.8 indicates that about 50 percent of the respondents have once in the past lived in a big town or city for over six months since the age of fifteen. This means that over half of the respondents in the sample are return migrants suggesting that a reasonable proportion has been exposed to urban lifestyles. What is important for the analysis in this thesis is the taste of urban

lifestyle, which they are likely to display back in the village. It is important to take note that while there is clear gender difference in return migration status, there are no differences between the two lineage systems. This is because, as discussed in Chapter two, labour migration has become a Malawian culture.

As discussed in Chapter three, Malawi, like most developing countries in Africa, Asia and the Pacific Region still contains a diversity of family forms. Analytical results displayed in Table 5.8 show that 77 percent of the respondents are living in monogamous unions and only 23 percent in polygynous unions. Although the proportion that is polygynous is small (which is an artefact of data collection as discussed earlier in this chapter), the number is still significant and it is likely to affect gender and power relationships. The patrilineal husbands (33.6 per cent) are more polygynous than are the matrilineal husbands (11.2 per cent). Based on these figures, over 50 percent of patrilineal wives are in polygynous unions at any point in their lifetime.

Apart from differences based on lineage system, the results in Table 5.8 also reveal significant gender differences in reports is evident by type of union. It could be speculated that gender differences in research responses are indicative of gender stratification ethics operating within a lineage system. Men are also likely to under-report their polygynous status, particularly among the matrilineal men because they keep some of their permanent sexual relationships (quasi-marital unions) discrete[32].

[32] From the author's observation as a Malawian grown up into adulthood in Malawi, quite a good proportion of men, particularly those in societies that do not tolerate polygyny (ie. Matrilineal societies and Christian communities), often have

But the polygynous statuses of the respondents could only be true at the time of survey. This is because men often marry more women if they have, according to them, a lot of money (Alam *et al.*, 1992). However, with the fluctuating economic situation in Malawi, the polygynous statuses of men are likely to fluctuate too. The status of monogamy is therefore fluid.

Sample characteristics by type of union

Existing theoretical and empirical evidence suggest that gender system and types of union are important elements of the processes of construction of gender (Chapters three and four). Some scholars have argued that polygyny and patriliny, which are directly related (Brown, 1981; Boserup, 1997), are likely to have significant relationship with spousal communication and contraception and ultimately fertility (Caldwell, 1967, Pool, 1968). It is essential to know the characteristics of polygynous respondents because these characteristics could, through their interaction with the nature of polygyny, affect RDMP and their outcomes. The analyses in this thesis will be based on the comparison between monogamous and polygynous couples in two different lineage systems. Such a comparison is thought to provide a clear understanding of the marital context in which individual wives or couples make reproductive decisions.

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sèveral quasi-marital unions, which start as permanent extra-marital sexual relationships. Children are born into these conjugal relationships and such men operate like polygynous husbands. This might explain the gender differences in reported polygynous unions.

Monogamous versus polygynous couples: socio-demographic characteristics

Data presented in Table 5.9 show that out of the respondents who reported to be polygynous, more husbands (86.7 per cent) than wives (61.6 per cent) are aged 30 and above. The husbands are also older at entry into marriage, with the largest proportion of polygynous husbands (58.3 per cent) reporting to have entered into the current marriage at the age of 25 and above. Polygynous wives too entered into the current marriage at later ages, which suggests that probably most of these were divorcees or widows remarrying. Consequently, marital age gap between husbands and wives is often large in polygynous unions as it is in patrilineal unions.

Table 5-9: Selected socio-demographic characteristics of respondents by gender and type of union, MDIC Survey 1998

Characteristics	Mono Husbands% (N=405)	Poly Husbands% (N=125)	Mono Wives% (N=405)	Poly Wives% (N=125)
Current age				
30 plus	61.7	86.7	31.4	61.6
Below 30	38.3	13.3	68.6	38.4
Age at current marriage				
25 plus	40.7	58.3	9.4	31.2
20-24	48.5	31.7	21.2	21.6
17-19	7.1	8.3	40.0	28.8
13-16	1.2	0.8	19.8	12.8
12 and below	2.4	0.8	9.6	5.6
Desired family size				
5 and above	56.5	86.4	53.6°	63.2°
Below 5	43.5	13.6	46.4°	36.8°
Number of children surviving				
6 and above	49.0	51.0	70.1	15.3
2-5 children	83.2	16.8	73.6	26.4
0-1 child	95.0	5.0	84.7	29.9

Note: Chi2 = significant at < 0.05 except where the symbol ° is used. Chi-square tests were tested for the following contrasts separately: monogamous vs polygynous husbands and monogamous vs polygynous wives.

As observed in other countries, women's late entry into marriage and their polygynous status would have an impact on fertility levels at individual level but not necessarily at society level (Pebley and Mbugua, 1989). In contrast, a large proportion of wives reported to have entered into the current marriage between age the age of 17 and 19 (40 percent among monogamous wives and 28.8 percent among polygynous wives).

In most African societies, age is a strong predictor of power relations within sexual and marital relations. Girls are presumed ready for childbearing and marriage at puberty. This presumption is based on traditional norms that are made by elders (often male elders in consultation with female elders) and not based on informed choices by the individual girls.

The gender difference in age at entry into marriage is also reflected in the large marital age gap between husbands and wives. Although the cross-tabulation results are not significant for marital age gap and marriage/lineage system, they are significant for marital age gap and type of union. But since patriliny is a strong predictor of polygyny, the distribution pattern of the results are in the same direction for the cross-tabulation of husband-wife age gap by lineage and the cross-tabulation of husband-wife age gap by type of union (Tables 5.5 and 5.10). Generally, polygynous couples (who are most likely to be patrilineal) are more likely to have large marital age gaps compared to monogamous couples (who are most likely to be matrilineal). About 39 percent of all polygynous couples had ten or more years of

marital age gap compared to only 21 percent of monogamous couples. The opposite was the case for monogamous couples with the highest proportions having close marital age gap of less than 6 years.

Within the polygynous unions, wife's rank is a predictor of marital age gap. From our sample, higher order wives have a large marital age gap. This is probably because polygynous husbands delay entry into marriage since bride price payments are likely to amount to several years of earnings (Boserup, 1997). Therefore polygynous husbands are likely to be order when they inherit their deceased brothers' wives or divorcees.

Table 5-10: Percent distribution of monogamous and polygynous respondents by husband-wife age gap, MDIC Survey 1998

Characteristics	Husband-wife age gap				
	10 years or over (%)	7-9 years (%)	4-6 years (%)	Below 3 years %	Total (%)
Monogamous Wives	21.1	20.5	31.1	27.2	100(N=405)
Polygynous Wives	39.2	19.2	24.0	17.6	100(N=125)
First Wives	26.0	20.0	32.0	22.0	100(N=50)
Second, other wives[33]	48.0	18.7	18.7	14.7	100(N=75)

Note: Chi^2 = significant at < 0.05.

But both first wives and monogamous wives have very close marital age gaps because first wives were monogamous before they became polygynous. Therefore, monogamous and first wives entered into their first marriages at very young age. Age at marriage is therefore another predictor of marital age gap. Based on the argument raised earlier, there is a very close link between wife's rank and age at entry into

[33] Hereinafter, second, other wives will be referred to as second+ wives.

marriage and marital age gap. It is argued here that in Malawi, median age at first marriage for females is 18 and 23 for males (Government of Malawi, 2000b), it follows that marital age gap must be close for first and monogamous wives. As for second+ wives, with delayed marriage of polygynous husbands, marital age gap is likely to be large. Through remarriage of divorcees and widows (Kaler, 2001 and Schatz, 2002), second+ wives have a higher age at current marriage of 25 years or over (46.7 percent). One can therefore conclude that early marriage is universal in Malawi. This is because except for the remarriage of divorcees and widows, polygynous men also marry very young women as monogamous men do.

Table 5-11: Percent distribution of monogamous and polygynous wives by age at current marriage, MDIC 1998

Type of union	Age at current marriage			
	12-19 years old (%)	20-24 years old (%)	25 years and over (%)	Total (%)
Monogamous Wives	69.4	21.2	9.4	100 (N=405)
Polygynous Wives	47.2	21.6	31.2	100 (N=125)
First wives	80.0	12.0	8.0	100 (N=50)
Second+ wives	25.3	28.0	46.7	100 (N=86)

Note: Chi^2 = significant at <0.05.

Indeed as Table 5.11 suggests, the largest proportions of the female sample under study are monogamous and first wives with age at current marriage ranging between 12 and 19 years old. Sixty-nine percent of the monogamous wives and 80 percent of the first wives entered into current marriage between the age of 12 and 19. This proves the theory that early marriage for the female population is universal in Malawi. Therefore early marriage for females and polygyny are the best 'seedbeds' for high societal fertility.

Table 5-12: Percent distribution of monogamous and polygynous wives by husband-wife age gap and age at current marriage, MDIC 1998

Union type/age at current marriage	Husband-wife age gap	
	Less than 10 years (%)	10 years or over (%)
Monogamous wives		
Less than 20 years old	90.3	86.2
Twenty or more years old	9.7	13.8
(N)	(308)	(58)
Polygynous wives		
Less than 20 years old	67.1	66.7
Twenty or more years old	32.9	33.3
(N)	(76)	(42)
First wives		
Less than 20 years old	91.9	88.9
Twenty or more years old	8.1	11.1
(N)	(37)	(9)
Second wives		
Less than 20 years old	43.6	60.6
Twenty or more years old	56.4	39.4
(N)	(39)	(33)

Chi-square values were **not** significant at <0.05.

As depicted earlier in this chapter (Table 5.4), early marriages are highly prevalent in the patrilineal and matrilineal societies. Results displayed in Tables 5.11 and 5.12 show that monogamous, polygynous and first wives entered into their current marriages between the ages of 12 and 19. And since median age at first marriage for men is 23 (Chapter two), the proportions of those marrying at less than 20 years of age and having less than ten years of marital age gap are not very different from proportions of those who entered into current marriage within the same age range and having ten years or more of marital age gap. The former scenario means that age at first marriage for husband and wife were close. But for the latter, their husbands must have entered into first marriage quite old and these are likely to be the patrilineal husbands.

Since age at first marriage is lower for women than for men, early debut in child bearing is prevalent among women[34]. When we compare number of children ever born to monogamous and polygynous wives, controlling for age group, the results are not very clear (Table 5.13).

Table 5-13: Percent distribution of monogamous and polygynous wives by number of children ever born and age groups[35]

Union type/ age group	Number of children ever born				
	None (%)	1-2 children (%)	3-5 children (%)	6 or more children (%)	Total (%)
Monogamous wives					
Less than 20 years old	40.0	57.8	0.0	2.2	100 (45)
20-24 years old	10.5	67.5	21.9	0.0	100 (114)
25-29 years old	2.0	21.4	71.4	5.1	100 (98)
30-34 years old	0.0	9.3	61.1	29.6	100(54)
35-39 years old	0.0	0.0	20.5	79.5	100(44)
40 years or over	0.0	4.0	12.0	84.0	100(50)
Polygynous wives					
Less than 20 years old	50.0	50.0	0.0	0.0	100(6)
20-24 years old	7.7	53.8	38.5	0.0	100(13)
25-29 years old	8.3	16.7	75.0	0.0	100(24)
30-34 years old	0.0	5.9	58.8	35.3	100(34)
35-39 years old	0.0	0.0	21.1	78.9	100(19)
40 years or over	0.0	3.4	6.9	89.7	100(29)

Note: Chi-square values were significant at <0.05.

This is partly confounded by the coding of age categories since some of the age categories had very small numbers. But at the key ages between 20 and 24 years, there are differentials that are intuitively reasonable. Higher proportions of polygynous wives in that age category (38.5 percent) had 3-5 children compared to monogamous wives of the same age category (21.9 percent). Type of union therefore determines the number of children a woman is likely to give birth to in her lifetime. These results concur with the results of studies conducted in Cameroon, Ghana,

[34] Due to gender difference in age at entry into marriage and age at start of childbearing, the analysis of the link between type of union, age group, and number of children ever born will be restricted to women because their situation is less complicated than that of the men.

[35] This analysis was restricted to wives because the husbands' analysis was too complicated particularly due to their polygynous status.

Ivory Coast, Kenya, Lesotho and Senegal (Pebley and Mbugua, 1989) that polygyny does increase fertility at societal level because of its accumulative effect.

Since marriage is considered to be highly desirable in Malawi (Shatz, 2002; Bracher, Santow and Watkins, 2002), there is a continuum between monogamy and polygyny, which means most divorcees and widows have short intervals between marriages. Fertility is likely to be consistently high in Malawi because marital instability is increasing (Schoffeleers and Litt, 1968; Phiri 1983; FAO, 1994) and many divorcees and widows remarry early (Kaler, 2001; Shatz, 2002). Since the reproductive and productive importance of women is still valued in Africa (Caldwell and Caldwell, 1989) and most African women still seek social and economic security from marriage (Locoh, 1991; Boserup, 1997), most women in reproductive age group make nearly complete use of their reproductive age span. This is plausible because the traditional concept of marriage is that marriage is for procreation (FAO, 1994). Therefore early first marriage and early remarriage of divorcees or widows into polygynous unions translate into high fertility amongst most women of reproductive age group.

Table 5-14: Percent distribution of wives by wife's rank and number of children ever born, MDIC 1998.

Characteristics	Number of children ever born				
	None (%)	1-2 children (%)	3-5 children (%)	6+ children (%)	Total (%)
Monogamous Wives	7.9	32.3	35.3	24.4	100 (N=405)
Polygynous Wives	4.8	13.6	39.2	42.4	100 (N=125)
First wives	4.0	10.0	32.0	54.0	100 (N=50)
Second wives	7.9	32.4	35.1	34.7	100 (N=75)

Note: Chi^2 = significant at < 0.05

In fact Table 5.14 shows that polygynous wives and particularly the first wives have given birth to more children than monogamous or second wives in their lifetime. Fifty-four percent of the first wives have had six or more children born followed by second+ wives (34.7 percent). What is evident is that polygynous wives are likely to have large family sizes. But since median age at marriage is 18, every woman of reproductive age is likely to have large family sizes because they start child bearing very early and they are likely to become polygynous at anytime. So if child bearing is a source of power, apart from the long marriage durations that first wives experience, for fear of their husbands taking on a second+ wife, first wives are likely to give birth to as many children. Polygyny is therefore a proxy for women's power within marriage.

Monogamous versus Polygynous Couples: their socio-economic characteristics

As noted earlier, the type of polygyny practiced in some parts of Malawi is directly related to social security of individuals and the extended family. Although most of the polygynous husbands are not as wealthy as those found in West Africa, socio-economic status of the household is linked to the probability of a man having more than one wife. The bed, mattress, bicycle and radio are items that are, by Malawian village standards, considered as indicators of wealth and therefore often controlled by men. Figures displayed in Table 5.15 suggest that polygynous households are wealthier than monogamous ones.

Table 5-15: Selected socio-economic characteristics of respondents by type of union, MDIC Survey 1998

Characteristics	Mono Husbands % (N=)	Poly Husbands % (N=)	Mono Wives % (N=)	Poly Wives % (N=)
Doing income generating activities				
Yes	98.3°	99.2°	74.3°	82.4°
No	1.7°	0.8°	25.7°	17.6°
HH has one or more beds and mattresses				
Yes	22.2	44.2	20.2°	28.8°
No	77.8	55.8	79.8°	71.2°
HH has a radio				
Yes	66.3°	85.8	62.2°	64.8°
No	33.7°	14.2	37.8°	35.2°
HH has a bicycle				
Yes	58.8	67.5	57.0°	55.2°
No	41.2	32.5	43.0°	44.8°
HH has a paraffin glass lamp				
Yes	40.5	52.5	37.3	36.0
No	59.5	47.5	62.7	64.0
HH has access to a pit latrine				
Yes	79.5	94.2	73.1	84.8
No	20.5	5.8	26.9	15.2
Roof material				
Metal	6.3°	6.7°	6.7°	8.0°
Grass	93.7°	93.3°	93.3°	92.0°

Note: Chi^2 = significant at < 0.05 except where the symbol ° is used. Chi-square tests were done separately for the following contrasts: monogamous vs polygynous husbands and monogamous vs polygynous wives.

Specifically, polygynous husbands reported this. A larger proportion of polygynous husbands compared to monogamous husbands reported owning a bed, a mattress, a radio and a bicycle. Although the numbers of polygynous couples are very few, that ethnic differences in reports suggest that type of union is more correlated with economic status than lineage system. Since more patrilineal husbands than matrilineal ones reported to be polygynous, one can conclude that lineage and type of

union are significantly related to socio-economic status of the household. We cannot say much about the gender differences in these reports since the wives' reports are not significant.

Monogamous versus Polygynous Couples: socio-cultural characteristics

In terms of religion, the largest proportion distribution of the sample comprises the Protestants (76.60 per cent) almost equally distributed between the monogamous and the polygynous couples (Table 5.16). Illiteracy level is very high (a total of 40 percent) with close to the same proportions of husbands and wives but relatively higher among polygynous couples.

Table 5-16: Selected socio-cultural characteristics of respondents by type of union, MDIC Survey 1998

Characteristics	Mono Husbands %	Poly Husbands %	Mono Wives %	Poly Wives %
Religion				
Catholic	17.5	13.6	18.8	16.0
Protestant	76.5	78.4	75.6	78.4
Other	5.9	8.0	5.7	5.6
Years of schooling				
>5 years	10.6	7.2	20.7	18.4
1-5 years	41.7	39.2	39.0	29.6
None	47.7	53.6	40.2	52.0
Ever lived in a city				
Yes	37.5	44.0	59.5	56.0
No	62.5	56.0	40.5	44.0

Note: All Chi^2 values are **not** significant. Cross-tabulations and chi-square tests are for monogamous against polygynous husbands and for monogamous against polygynous wives.

In terms of migration status, however, more husbands than wives reported having been to the city relatively more monogamous couples than polygynous ones. These results confirm the point raised in Chapter two that in Malawi, more men than women migrate to cities and further suggest that more monogamous husbands than

polygynous ones currently resident in the village are return migrants. The fact that a larger proportion of wives compared to husbands reported having had over five years of schooling is another indication that men with education level equal to or above senior primary education often migrate to cities in search of wage employment.

Summary and conclusions

The discussion in this chapter has covered sources of data, the type of data to be use for analysis and the type of respondents that will be analysed in the rest of the thesis. There are two primary data sources and a variety of secondary data sources. The MDIC sample survey data will be the main source of quantitative data of matched couples. The other set will be drawn from the RDM ethnographic interviews with unmatched couples. The secondary data source will be in form of literature review. All these data will be focused on two lineage systems (a more rigid patrilineal system and a less rigid matrilineal system) to be treated as gender stratification systems. The less rigid matrilineal system will be identified as a more gender egalitarian society than the more rigid patrilineal system. A further division by type of union will be used to seek a clear understanding of the effect of the different marital contexts on wives' relative powers in RDMP. This distinction is important because polygyny is a function of patriliny, which suggests that type of union is also a women's power variable. It will also be used to capture the effects of wife's rank, which will be treated as a control variable.

A discussion of the socio-economic, socio-demographic and socio-cultural characteristics of respondents has shown that there are huge gender and lineage differences in the respondents' reports. These differences are consistent with the theoretical beliefs that men and women's views about family life issues always differ. The assumption is that lineage differences represent gender differences and are likely to affect women's empowerment, spousal communication and RDMP and their outcomes.

Consistent with theoretical understanding about men and men's views about family life issues, in this chapter, husbands are generally older than are wives since men marry much later than do women. Marital age gaps are significant in both monogamous and polygynous unions but the largest marital gaps are in polygynous unions particularly among higher-order wives. This is mainly because early marriages and early remarriage of divorcees and widows are encouraged. Since age and sex are traditional measures of who makes family decisions, theoretically, men have always been in control of RDMP (Chapter four).

Male dominance in RDMP has also been reflected in husbands' predominance in desire for many children, number of children ever born and in the achievement of large family sizes. Although men delay their debut in childbearing, they still have high chances of maintaining high levels of fertility because of polygyny, which is supported by the large young female population. As expected, the patrilineal husbands are more polygynous than are the matrilineal husbands.

A similar pattern of reporting is evident with socio-economic and socio-cultural issues. Polygynous husbands' reports about household socio-economic status reflected higher economic status than did wives' reports. This reveals the inconsistencies that exist between husbands' and wives' views and power in decision-making about family life issues. As noted in literature review, husbands are more likely to over-report on wealth indicators because they want to pioneer access to modern lifestyles and ideas. This is also a legacy of the impact of social change on families, which has favoured men. Men were the first to be educated and to be employed in the cities, which led to male dominated migration.

The analysis in this chapter shows that indeed more husbands than wives migrate to the cities. This is also reflected in the small numbers of husbands (resident in the village) who reported having more than five years of schooling. This is because most highly educated husbands are likely to have migrated to cities. Social change is also reflected in the high numbers of Christians (particularly Protestants) among the respondents. One would therefore argue that the sample that will be analysed in this thesis is overwhelmingly rural, uneducated, poor and therefore traditional. The few return migrants (about half the sample) will serve as change agents in demographic behaviours.

CHAPTER 6

METHODOLOGY

Introduction

This chapter is a discussion of the variables that will be used for all analyses in this thesis. That discussion will cover the construction of women's empowerment variables and the coding of ethnographic data. Women's power variables identified in MDIC sample survey will be used to run logistic regression models and those derived from RDM ethnographic data will be used for ethno-methodological analyses. Women's power variables will be considered as those factors that influence women to perceive that they have the capacity to make autonomous reproductive decisions and to negotiate desired reproductive behaviours and outcomes.

Desired reproductive outcomes and behaviours will refer to the psychological dimensions related to the number of children that individuals want to have and to the mechanism by which they can meet those fertility goals. These will include the desire to space births, to stop child bearing, to limit family size and to use modern child spacing and family planning methods. The analyses will consider desired reproductive outcomes to be the driving force of Reproductive Decision-Making Processes (RDMP).

A few selected women's power variables will be treated as predictors of women's power to make or participate in RDMP. These will be used as dependent variables. Dependent variables will be women's perceptions of the degree of their power to make autonomous reproductive decisions or to negotiate desired reproductive outcomes. Women's perceptions about reproductive decision-making power are conceptualised as women's awareness, by the senses, that they have the capacity to make reproductive decisions or to negotiate desired reproductive behaviours and outcomes. Logistic regression analyses will be employed to force an interaction between the indicators of women's power (the dependent variables) and their predictors (the independent and control variables). The impact of this interaction will be measured as estimated odds ratios, which will be used to explain the probability of married women being empowered to make autonomous reproductive decisions or to negotiate their reproductive desires. Empirical evidence derived from ethnographic interviews and theoretical issues derived from literature review will be used for an in-depth explanation of the logistic regression analyses.

This chapter will be presented in four sections. The first two sections will discuss the criteria for the selection and the coding of dependent and independent variables including control variables. This will be a discussion of the questions from which the variables will be drawn and the analytical methods that will be used for the analyses in the rest of the analytical chapters.

In the third section, wives' perceptions about the degree of their power to make autonomous reproductive decisions will be discussed. That discussion will show the levels of autonomy that wives are likely to derive from the generic ethics of lineage and marriage systems. In the section that follows, it will be argued that women's acquisition of reproductive decision-making power in patrilineal and matrilineal monogamous or polygynous unions depends on different types of factors. The discussion in this section is aimed at providing an understanding of the types and levels of women's power inherent in two different lineage systems and marital contexts.

Construction of variables for logistic regression analyses

In order to analyse the interaction of variables, a multivariate technique, termed logistic regression analysis, which is commonly used in social sciences to analyse dichotomous dependent variables will be employed (Aldrich and Forrest, 1984; Hosmer and Lemeshaw, 1989). The estimated parameter values are presented as odds ratios: a value > 1 indicates an increased likelihood (compared to the reference category) of experiencing an event, whereas the value <1 signals a reduced likelihood (compared to the reference category) of experiencing an event.

Dependent variables

In this thesis, seven main dependent variables (all dichotomous) will be identified as indicators of women's power in making autonomous reproductive decisions or in influencing RDMP within the conjugal unit. These will include: *wives' perceptions*

that they have the capacity to make autonomous decisions to space births; wives' perceptions that they have the capacity to make autonomous decisions to stop child bearing; wives' perceptions that they have the capacity to make autonomous decisions to use modern contraceptives without their husbands' knowledge; wives' perceptions that they have the capacity to negotiate with their husbands the desired reproductive behaviours and outcomes. The perceived negotiating power will be measured using the following dependent variables: *wives' perceptions that their husbands would agree to use modern contraceptive methods and wives' perceptions that there is nothing they can do to change their husbands' mind if their husbands do not want to use modern contraception).*

Women's power variables will be conceived as those variables, which show the ability of individuals to have control over their own lives (World Health Organisation, 1998). These will also be conceived as *status* variables because they are related to economic, social and political status of individuals (Oppong, 1989). The term *women's autonomy indicators* will be used to refer to those women's power variables that reflect the degree of autonomy that married women have in RDMP. Theoretically, *women's autonomy* is defined as women's ability - technical, social and psychological to pool resources (information, material or financial) and use them as the basis for making and acting upon decisions about their private concerns and those of their spouses and kin (Dyson and Moore, 1983:45). In this thesis, women's autonomy will be viewed as an outcome of the process of women's empowerment (as defined in Chapter three). The analyses in this thesis suggest that women's

empowerment does not only refer to access to or ability to control significant family resources but it also refers to the acquisition of the power to control significant family resources and the enactment of such powers.

The women's power dependent variables to be used for analyses in this thesis will be drawn from three sets of sample survey questions (See Table 6.1). The selection of those questions will be based on the assumption that married women who think that they have the capacity to decide to space births, to stop child bearing and to use modern contraception covertly have the latent power to control the outcomes of RDMP. Those who think they can negotiate the desired reproductive behaviours and outcomes through overt spousal communication have the manifest power to control the outcomes of RDMP.

The first group of dependent variables, which will be used as indicators of women's autonomy, will be constructed under the assumption that women's perceptions of their capacity to make autonomous decisions: to space births, to stop child bearing or to use modern contraceptives covertly entails women's acquisition of the power to have indirect control over reproductive decisions. It will be assumed that women will acquire the latent reproductive decision-making power when they perceive that they have the capacity to make autonomous decisions to space births, stop childbearing and to use any contraceptive method.

Table 6-1: Questions used to construct women's power variables as dependent variables, MDIC Survey 1998

Survey questions	*Response Categories*
Indicators of autonomy	
Whether wife thinks she will delay the next birth if decides to	(Disagree = 0, Agree = 1)
Whether wife thinks she will stop child bearing if she decides to	(Disagree = 0, Agree = 1)
Whether wife thinks if she wants to she can use modern contraceptives without her husband's knowledge	(Disagree = 0, Agree = 1)
Indicators of negotiating power	
Whether wife thinks she can change her husband's mind if he does not want to use modern contraceptives	(Disagree = 0, Agree = 1)
Whether wife thinks husband would agree to use modern child spacing and family planning methods	(No = 0, Yes = 1)
Indicators of acquired power	
Whether wife reported having ever used modern contraceptive method without her husband's knowledge	(No = 0, Yes = 1)
Whether wife reported currently using any modern contraceptive method	(No = 0, Yes = 1)

The second group of dependent variables, which will be indicators of women's negotiating power, will be constructed under the assumption that women's perceptions of their capacity to negotiate desired birth intervals, desired number of children and desired contraception will translate into women's ability to influence the outcomes of RDMP. In order to measure women's perceived power to negotiate with their husbands the desired reproductive behaviours and outcomes, women's perceptions that they could have their husbands' agreement to use modern contraception and women's perceptions of their capacity to convince their husbands to use modern contraceptive methods will be treated as indicators of women's manifest power to participate in RDMP. The assumption is that perceived spousal agreement to use family planning methods encourages married women to seriously consider using modern contraceptives.

In fact empirical evidence suggests that wives negotiate their desires to use modern contraceptive methods (Blanc *et al.,* 1996; Biddlecom *et al.,* 1996; Wolf, *et al.,* 2000). It could also be argued that wives do negotiate their desires to limit family sizes when they negotiate their desires to use modern contraceptive methods. It is assumed that these negotiations take place during couple discussions, which take place only if wives perceive husbands' agreement to practise modern contraception or if wives perceive that they have the capacity to convince their husbands to use modern child spacing or family planning methods. Within that context, the following variables will be used as dependent variables: *wives' perceived spousal agreement and wives' perceived power to convince husband to use modern family planning methods.*

The third group of dependent variables will be developed under the assumption that married women will use modern child spacing or family planning methods if they have acquired the latent power that develops in them the capacity to make autonomous reproductive decisions or the capacity to negotiate desired reproductive behaviours and outcomes. Indicators of women's acquired power to use modern contraceptives will be treated as measures of the outcome of women's empowerment. As shown in Table 6.1, the women's acquired power variables will include; *women's ever use of modern contraception covertly and women's current use of modern contraception.*

In the analyses, it will be argued that if wives have acquired the power to make autonomous reproductive decisions, they will be empowered to practise modern

contraceptives covertly. Secondly, it will be argued that if married women think that they do not have the capacity to convince their husbands to use modern contraception they will be more likely to use modern contraceptives covertly. This means that covert contraceptive users are more autonomous than current users. Thirdly, it will also be argued that the higher the degree of capacity that married women think they have to negotiate desired reproductive behaviours and outcomes the more likely they will use modern contraceptives overtly. Fourthly, within the context of overt spousal communication, it will be argued that if wives have acquired the manifest power to convince their husbands to use modern child spacing or family planning methods, they will develop the capacity to practise family planning overtly.

Women's *current use of modern contraceptive methods* and *ever use of modern contraceptives covertly* will be used as indicators of women's acquired power to participate in RDMP. This argument is based on the assumption that the sustenance of modern contraceptive use (current use) is an indicator of women's power to make reproductive decisions or to negotiate desired reproductive behaviours. However, current use of modern contraception will be considered as an indicator of women's latent power to participate in RDMP. For logistic regression analyses, the positive responses to the questions: *Whether wife has ever used modern contraceptive methods without her husband's knowledge* and *whether wife is currently using any modern contraceptive method* will be coded as 1 and the negative ones as 0 (to used as the reference category for odds ratios).

Independent variables as direct predictors of women's empowerment

The following variables will be used as independent variables and as predictors of women's power to participate in RDMP: *wives' lineage, wives-to-husband communication about desired family size or about modern contraception, wives' perceptions about their freedom of movement* and *wives' exposure to modern ideas and life styles*. Since it is a theoretical belief that the lineage plays a central role in the construction of gender roles and spousal power and communication relations, *patrilineal* and *matrilineal* lineage systems will be used as cultural contextual variables to represent the two ethnic groups: *Tumbuka* and *Chewa* respectively. This will be under the assumption that in the weak matrilineal system practised by the Chewa people, wives are likely to have higher degrees of power to participate in RDMP than are wives in the strong patrilineal system typical of the Tumbuka. For logistic regression analyses, the *matrilineal* category (the Chewa) will be coded as 0 (to be used as a reference category for logistic regression analyses). The thinking is that a matrilineal system applies more gender egalitarian ethics than a patrilineal system and that matrilineal wives are likely to be less subordinated than the patrilineal ones.

The variable *spousal communication* will be drawn from wives' responses to the following questions: *whether wife ever talked with her husband about desired family size; whether wife ever talked with her husband about using modern child spacing or family planning methods*. Other studies that have dealt with spousal communication about family planning have often treated spousal communication as an independent

variable and as a direct determinant of modern contraception (Jolly, 1976; Salway, 1994; Blanc *et al.,* 1996; Biddlecom *et al.,* 1996; Wolf *et al.,* 2000; Feyisetan, 2000). The analyses in this thesis will first prove the hypothesis that difficult spousal communication will make wives use modern contraceptives covertly (Biddlecom *et al.,* 1996). Beyond this, it will be argued that covert contraceptive use is an outcome of women's lack of negotiating power. Women who lack negotiating power use their perceived autonomy in making reproductive decisions to consider using modern contraception covertly.

Secondly, it will be argued that successful overt spousal communication empowers wives to influence joint reproductive decisions and use modern contraceptives overtly. In this case, spousal communication about family planning (about desired family size and about using modern contraception) will be used as intermediate variables for women's power to make autonomous reproductive decisions or to have some control in RDMP within the conjugal unit. It is assumed that individuals communicate their reproductive desires including their approval and disapproval about societal norms for family size and contraception through overt or covert spousal communication. For this reason, it will also be assumed that wives are empowered to negotiate desired reproductive outcomes (through overt spousal communication) when they perceive that they could have their husbands' agreement (through covert spousal communication) to use modern contraceptives.

The analyses in this thesis will also attempt to measure the extent to which wives' perceptions about their freedom to go to the health centre or to the market empower them to make autonomous reproductive decisions, to negotiate their reproductive desires and to use modern contraceptives. S*eclusion of women* is a common practice that restricts women's movement in most traditional lineage systems, particularly patrilineal ones that are predominantly under Islamic influence (Dyson and Moore, 1983; Basu, 1992; Kabeer, 1994; Renne, 1999).

Table 6-2: Questions used to construct independent variables, MDIC Survey 1998

Survey questions	***Response categories***
Women's power variables	
What ethnic group does wife belong to?	(Chewa = 0, Tumbuka = 1)
Whether wife has ever talked with her husband about desired family size	(No = 0, Yes = 1)
Whether wife informs her husband about her earnings	(No = 0, Yes = 1)
Whether wife thinks it is acceptable for her to go to the health centre without informing her husband	(Disagree = 0, Agree = 1)
Whether wife thinks it is acceptable for her to go to the market without informing her husband	(Disagree = 0, Agree = 1)
Whether wife has ever lived in the city for more than six months since the age of 15	(No = 0, Yes = 1)
Whether household has metal or grass roof material, radio and bicycle.	(Metal roof only or a thatched roof and/or a radio/bicycle, bicycle and radio only = 1; grass roof only, grass roof and/or radio/bicycle = 2)

Although no record could be found regarding the practice of seclusion in Malawian traditional lineage systems, the nature of division of labour in Malawian societies, with women predominantly in domestic work and subsistence farming, is characteristic of a particular type of women's *seclusion*. It will be assumed that women's freedom of movement within the community will empower wives to have

freedom of association and expression. This will in turn empower them to make autonomous reproductive decisions or to negotiate desired reproductive outcomes. For logistic regression analyses, the meso- (community) level proxy variables will be drawn from the questions: *whether wife thinks it is acceptable for her to go to the health centre without informing her husband* and *whether wife thinks it is acceptable for her to go to the market without informing her husband.* The negative responses will be coded as 0 to be used as the reference category for logistic regression analyses.

Women's exposure to urban lifestyle also predicts women's empowerment to make autonomous reproductive decisions or negotiate their reproductive desires. This is because women who have lived in urban centres have been exposed to new ideas such as gender equality, freedom of choice and freedom of expression. It will be assumed here that married women who are return migrants in the village are likely to be assertive about their reproductive rights. They will have acquired the manifest power to express their desires and negotiate with their husbands the desired family sizes and desired contraceptive behaviours.

Considering that migration and urbanisation affect the nature of spousal communication and RDMP (Chapters three and four), *exposure to urban lifestyle* will be used as a proxy for migration, which is a macro-level indicator of development. This is under the assumption that migration is likely to influence women's perceptions about their power to participate in RDMP and affect their actual

reproductive behaviours. The variables: *exposure to urban lifestyle* will be drawn from the question: *whether wife has ever lived in a city or a town for over six months since the age of 15?* The negative responses will be coded as 0 and will be used to compare the likelihood of those who were at one time urban residents to perceive that they have the capacity to make autonomous reproductive decisions or to negotiate their reproductive desires against those who were not.

Control variables as indirect predictors of women's power

In the logistic regression models to be run in this thesis, a number of variables will be controlled for (See Table 6.3). These are variables that have theoretical relevance to the relationship between women's empowerment, spousal communication and family planning. The control variables will include *wife's current age, wife's rank, wife's desired family size, husband's desired family size, infant or child death, wife's reported household economic status, wife's income generating status, wife's years of schooling, husband's years of schooling, husband's exposure to urban life style, wife's religion.*

Based on the theoretical relationship between *age* and decision-making power (as discussed in Chapter four), *wife's current age* will be categorised as an indirect predictor of women's empowerment. This variable will also be used to cover the effects of the age gap between spouses. This is because it is assumed that the larger the marital age gap, the older the husband is, and the more likely he will have control over reproductive decision-making power. A discussion on the importance of age

depicted from the correlation between *age at entry into current marriage, wife's rank* and selected *women's power variables* will be discussed in more detail later in this chapter. This discussion has theoretical relevance in the understanding of the influence of *wife's rank* and *age at entry into current marriage* on women's capacity to make autonomous reproductive decisions or to negotiate reproductive choices.

For regression analytical purposes, current age of wives will be divided into two categories (below 30 years and 30 years plus) with the category of younger wives treated as the reference category. This is because some of the categories of *12-19, 20-29, 30-39 and 40+* had very few numbers. The two categories will be employed under the assumption that the younger the wives are the less likely that they will think they have the power to make autonomous reproductive decisions or to talk to their husbands about their reproductive desires. This is because traditional norms demand that wives listen to and are submissive to their husbands. Nevertheless, polygynous wives often make independent decisions because they run their own individual household units. This is also because the first wives are likely to have stayed long in marriage and may have reduced frequencies of co-residence and sexual activity with their husbands. The second and other higher order wives are likely to have entered into the polygynous marriage at an older age and after being divorced or widowed (Lesthaeghue, 1989). As discussed in Chapter five, the primary goal for remarriage is to keep in marriage since being married is seen as moral. Sex and child bearing are secondary goals. Among the patrilineal people, remarriage is also a means for protecting and maintaining family wealth within the lineage.

Table 6-3: Questions used to construct control variables, MDIC Survey 1998

Survey questions	*Response categories*
Women's power variables	
Whether husband has more than one wife?	(No = 0, Yes = 1)
If in polygyny, whether wife is the first or second+	(No= 0, Yes = 1)
What religion are you?	(Catholic = 1; Protestant = 2; Other = 3)
Whether currently doing any income generating activities?	(No = 0, Yes = 1)
How many years of schooling did you (wife or husband) complete?	(Below six years = 1; 6 years and above = 2)
Whether husband has ever lived in the city for more than six months since age 15	(No = 0, Yes = 1)
Socio-demographic variables	
What is wife's current age (subtract the year wife was born from the year the survey was conducted)	(< 30 years = 1; 30 and above = 2)
How many living children would wife like to have in her lifetime?	(Below 5 = 1; 5 and above = 2)
How many living children would husband like to have in his lifetime?	(Below 5 = 1; 5 and above = 2)
How many children were born minus how many children are still living?	(No death = 1; At least one death = 2)

Wife's desired family size and husband's desired family size will be used to measure spousal demand for children. This will be based on the assumption that spousal reproductive desires and expectations (which create demand for children) are likely to affect each other through spousal communication. It will also be assumed that family size desires of each spouse could represent individuals or lineage level of demand for children. These variables will be drawn from wives and husbands' responses to the question: *if you had a choice, how many children would you like to have in your lifetime?*

Infant and child death will also be considered as a proxy variable for macro-level indicators of mortality trends, which are conditions for fertility change. Since the overall dependent variable for the present thesis is reproductive decisions, it will be considered that infant and child deaths are conditions that may influence the types of

reproductive decisions that be made at the micro-level. Considering that infant and child mortality in Malawi is largely affected by the quality of life (Madise, 1993), the socio-economic status of the household will be considered as an indirect predictor of women's power to make reproductive decisions or to influence joint couple reproductive decision-making.

Economic status of the household will be employed as a proxy for meso-level economic performance because it is an indicator of the well being of the family. A composite variable; *household economic status* will be constructed in two categories (high and low status). This will merge the women's reports about house roofing material and the possession of either a bicycle or a radio. It is important to note here that the absence of a bicycle may reflect its unsuitability for people living in hilly places rather than their capacity to afford it. This is likely to be the case for the patrilineal (Tumbuka) couples whose terrain is hilly.

A household that was reported to have a metal roofed house only, a metal roofed house plus a radio and/or a bicycle, a thatched roof plus a bicycle and a radio will be considered to have a high economic status. The households that were reported to have a grass-thatched roof and a radio or a bicycle, or a thatched roof only will be categorised as having a low economic status. Recognising that rural households in Malawi are generally poor as indicated in Chapter two, the high economic status of households will be in relative terms based on village standards. The use of ownership of these household amenities as empowerment variables will be based on the

assumption that status is an indicator of income levels of individual members of the family.

In fact, to some extent, economic status of the household depends on the performance of income-generating activities of any member of the family. *Wife's performance of income-generating activities* will be used as a predictor of women's economic power, which is assumed to have some influence in women's autonomy in reproductive decision-making (Dyson and Moore, 1983; Dharmalingam and Morgan, 1996;). Since economic decision-making is not separate from RDMP (Chapter four), women who have economic decision-making power are likely to have the power to make autonomous reproductive decisions or negotiate desired reproductive behaviours and outcomes. Some studies have also observed that women's autonomy in reproductive decision-making is derived from women's economic decision-making power (Vaughan, 1987; Basu, 1992; Mason, 1997). It will be assumed that *wife's performance of income-generating activities* would allow wives develop the capacity to make autonomous reproductive decisions or to influence joint couple reproductive decisions. The variable *wife performs income-generating activities* will be employed as a proxy for *income per capita*, which is an indicator of macro- and meso-level economic performance. There will be two categories. The negative responses will be coded as 0 to be used as a reference category for logistic regression analyses.

Existing theoretical evidence also suggests that high female education levels correlate with modern contraception and fertility decline (Caldwell *et al.*, 1992a; Jejeebhoy, 1995). But in the MDIC sample survey, only three respondents reported to have had secondary education and one reported to have reached university level. In this thesis, there will be two categories for the education variable: *below six years and six years plus*. The *six years plus* category will be coded as 0 for reference. The available data on schooling show that rural Malawi has not yet attained what is conventionally seen as one of the pre-conditions for fertility change[36]. It will be argued that wife's education level is likely to affect her perception of her power to make reproductive decisions or her capacity to negotiate desired reproductive outcomes with her husband through overt spousal communication.

In the logistic regression models, the *husband's years of schooling* will be included This will be under the assumption that the more educated a husband is, the more likely he will be open to overt spousal communication about family planning and to modern contraception. The husband's openness to couple discussion will enable his wife to negotiate desired reproductive behaviours and outcomes. It will be assumed that a husband who has stayed in school for more than six years will be more exposed to modern ideas and will be more likely to discuss reproductive-related issues with his wife. He will be relaxed with traditional norms about gender and power relations. As indicated in Chapters three and four, the higher the education

[36] This argument must be taken with caution considering that Malawi is still overwhelmingly characterised by rural-urban migration. When individuals get at least secondary education level, they are likely to migrate to urban centres for further education or to seek employment. The absence of secondary and higher education level holders may also reflect the unavailability of secondary schools in rural areas. From my personal experience, secondary schools are close to non-existent in

level, the more likely individuals will migrate to cities or towns within Malawi or in neighbouring countries and get exposed to new ideas.

Husband's exposure to urban life style will also be used as a control variable to capture the effect of husbands' exposure to modern ideas on wives' perceptions that they have the power to participate in RDMP. It will be assumed that a husband who is a return migrant in the village is likely to be open to overt spousal communication about family planning and will encourage his wife to practice modern contraception. It is thought that a modern husband is likely to perceive and appreciate the advantages of having small families and of using modern contraceptive methods. As was the case with *wife's exposure to urban lifestyles*, *husband's exposure to urban life styles* will also be divided into two categories and the negative response will be treated as the reference category.

Apart from education and migration, religion also exposes individuals to new ideas about family life. *Religion* will be used as a proxy for change. As discussed in Chapters two and three, Western Christian religious beliefs (Catholicism and Protestantism) that were introduced in Malawi by missionaries contributed to family change. Furthermore Islam, which was introduced by Arab traders, also brought about community/family change. While Christianity encouraged monogamy, Islam and other traditional ancestral beliefs encouraged polygyny. The variable: *religion* will be the proxy for faith and will be in two categories because the sample that will

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rural areas. Due to time and other logistical reasons, it was not possible to get data on the distribution of secondary and other tertiary education institutions in rural Malawi.

be analysed in this thesis has very insignificant numbers of Moslems. The category *Catholic* will be coded as 0 for reference. The second category will comprise *Protestants* (which includes all other protestant churches, the Islamic church and traditional religions).

Despite the widespread social change that is taking place in Malawi and its effect on the family structure, monogamy and polygyny have continued to co-exist. This is an indication that societal norms for polygyny have remained strong. For some men, monogamy is by individual choice whereas for others it is an influence of their religious beliefs. In traditional and modern societies, polygyny has always been a symbol of economic status. The more money a man has, the more likely he will have many wives. This suggests that prevalence of monogamous unions is likely to be fluid depending on the fluctuation of the economic conditions in Malawi.

For the logistic regression analyses, polygyny and monogamy will be considered as proxies for meso-level contextual variables. This is because polygyny and monogamy are directly related to family organisational structure, gender and power structures, age, and societal norms and sanctions. All the analyses in this thesis will be controlled for polygyny and monogamy because it is assumed that type of union is an empowering context for married women. The analyses will be measuring the degrees of women's power and autonomy in these two different marital contexts, which may be driven by different gender egalitarian ethics inherent in different lineage systems.

Coding of ethnographic data

A list of themes and sub-themes will be used for qualitative analysis (See Tables 6.4 and 6.5). Firstly, the themes and sub-themes will be drawn from literature review to put the analyses into context. The analyses will be focused on comparing how qualitative changes that are taking place in the two lineage systems would permit married women or render them powerless to make autonomous reproductive decisions or to negotiate desired reproductive behaviours and outcomes.

Table 6-4: Themes and sub-themes drawn from literature review

Structural themes	*Functional themes*
Gender structure	**Economic functions**
Strong patrilineal system	Familial production
Weak matrilineal system	Capitalist production
Family structures	**Family functions**
Extended	Social production
Neo-nuclear	Social reproduction
	Capitalist production
	Consumption
Types of unions	**Social interactions**
Monogamy	Social networks
Polygyny	Kin-couple communication
Levirate	Spousal communication
Power structures	**Reproductive Decision-Making**
Old-young	Lineage-controlled
Parent-child	Joint couple
Husband-wife	Autonomous

Based on data displayed in Table 6.5, the two main themes that will be drawn from RDM ethnographic interviews are *fertility* and *contraception*. The will further be coded into sub-themes. The sub-themes will include perceived large or small family sizes, perceived advantages and disadvantages of these, perceived advantages and disadvantages of traditional and modern contraception, overt or covert spousal

communication about family size or family planning and perceived women's power to make autonomous reproductive decisions or to participate in RDMP (See Table 6.5).

Table 6-5: Themes and sub-themes coded from RDM ethnographic data

Fertility-related themes	*Contraception-related themes*
Large family size (above five)	**Traditional contraception**
Perceived advantages	Perceived advantages
Perceived disadvantages	Perceived disadvantages
Small family size (below five)	**Modern contraception**
Perceived advantages	Perceived advantages
Perceived disadvantages	Perceived disadvantages
Spousal communication about desired family size	**Spousal communication about modern contraception**
Overt	Overt
Covert	Covert
Decision-making about spacing or limiting births	**Decision-making about using modern contraception**
Joint couple	Joint couple
Autonomous	Autonomous

The above-listed themes and sub-themes in Table 6.6 will be used to explain the relationships between the following changes: the structural and functional changes of the family, the shift from traditional to modern contraception, the shift from the desire for large families to the desire for small families, the shift from covert to overt spousal communication about family planning, the shift in women's perceptions about their power to make or influence reproductive decisions and the shift from contraception for only child spacing to contraception for family size limitation.

The RDM ethnographic data will be categorised by region, age and sex. The regional variables (North and Centre) will be used to represent the two lineage systems. *Young women and men* will be those aged 15-34 and *older women and men* will be

those aged 35-49. *North Young Women and Men* will refer to patrilineal young couples, *Central Young Women and Men* to matrilineal young couples, *North Older Women and Men* to patrilineal older couples and *Centre Older Women and Men* to matrilineal young couples.

Wives' reports about their perceived autonomy in reproductive decision-making

This section is a discussion of the levels of wives' perceived autonomy in RDMP and wives' perceived power to talk to their husbands and convince them about using modern contraceptives. A comparison between patrilineal and matrilineal wives will show how wives in a strongly patrillineal and in a weakly matrilineal society differ in their levels of perceptions about their autonomy and negotiating power in RDMP. A comparison between monogamous and polygynous wives will demonstrate how the two different marital contexts matter for women's perceptions about their autonomy and negotiating power in RDMP. This discussion will give a picture of the degrees of autonomy and negotiating power that may already exist among married women in the two lineage and marriage systems.

Patrilineal versus matrilineal wives: perceived autonomy

Displayed in Table 6.6 are cross-tabulation results of women's reports about their perceptions that they have the power to make autonomous reproductive decisions and negotiate their reproductive desires through talking to their husbands. Significant results show that patrilineal wives are more autonomous than are matrilineal wives.

Over 60 percent of patrilineal wives reported to sense they have the power to make autonomous decisions to space births and use modern contraceptives covertly.

Table 6-6: **Patrilineal versus matrilineal wives:** percent distribution of wives' perceptions about their power to make autonomous reproductive decisions and to use modern contraceptive methods, MDIC Survey 1998

Variables	Matrilineal wives % (N=254)	Patrilineal wives% (N=278)	Total % (N=532)
Wife perceives she has the power to stop child bearing			
No	62.9	61.2°	62.0
Yes	37.1	38.8°	38.0
Wife perceives she has the power to space births			
No	54.9	32.4	43.2
Yes	45.1	67.6	56.8
Wife perceives she has the power to use modern contraceptives covertly			
No	60.7	33.6	46.5
Yes	39.3	66.4	53.5
Wife ever used modern contraceptives covertly			
No	98.8	95.0	96.8
Yes	1.2	5.0	3.2
Wife is currently using modern contraceptives overtly			
No	67.3	64.7	66.2
Yes	32.6	35.2	33.8

Note: All other values have chi^2 = significant at < 0.05 except for those with the symbol °.

This is also reflected in their reported actual use of modern contraceptives. Relatively, lower proportions of patrilineal wives reported to be using contraceptives overtly and relatively higher proportions reported to have once used contraceptives covertly. Consistent with the findings in literature review, patrilineal wives appear to be more secretive than are matrilineal wives.

Monogamous versus polygynous wives

According to cross-tabulation results presented in Table 6.7, polygynous wives appear to be more autonomous than are monogamous wives. About 46 percent of the polygynous respondents compared to 35 percent of the monogamous ones reported they sense they have the power to make autonomous decisions to stop child bearing whenever they want to. Also a relatively higher proportion of the polygynous wives (62 percent) and a relatively lower proportion of the monogamous wives (50 percent) reported they perceive they have the power to use modern contraceptives without their husbands' knowledge. Reported actual current use of modern contraceptives also shows a higher prevalence among polygynous wives than monogamous wives, with seven percent of polygynous wives reporting to have once used modern contraceptives covertly and only two percent among monogamous wives.

There are two possible explanations for polygynous wives to perceive they have the power to make autonomous reproductive decisions and to use modern contraceptives whenever they want to. Firstly, as pointed out in Chapter four, polygynous wives already have acquired autonomy since they manage single household units independently. Secondly, polygynous wives are more likely to perceive spousal disagreement to use modern contraceptives than are monogamous wives because of the rigid norms associated with polygyny. This aspect is discussed in detail later in the chapter.

Table 6-7: **Monogamous versus polygynous wives**: percent distribution of wives' perceptions about their power to make autonomous reproductive decisions and to use modern contraceptive methods, MDIC Survey 1998

Variables	Monogamous wives% (N=398)	Polygynous wives % (N=122)	Total % (530)
Wife thinks she can to stop child bearing whenever she wants to			
No	64.6	54.1	62.1
Yes	35.4	45.9	37.9
Wife thinks she can space births whenever she wants to			
No	45.5	35.8	43.3
Yes	54.5	64.2	56.7
Wife thinks she can use modern contraceptives covertly			
No	49.4	37.6	46.6
Yes	50.6	62.4	53.4
Wife has ever used modern contraceptives covertly			
No	98.0	92.8	96.8
Yes	2.0	7.2	3.2
Wife is currently using modern contraceptives overtly			
No	67.7°	61.6°	66.2
Yes	32.3°	38.4°	33.8

Note: All other values have chi^2 = significant at < 0.05 except for those with the symbol °.

Wives' reports about the degree of their perceived power to participate in reproductive decision-making processes

Considering that the analyses in this thesis will be focused on perceived women's empowerment, it is important to know the levels of empowerment that wives perceive they already have access to. A comparison of the levels of empowerment perceived to be available to patrilineal and to matrilineal wives will demonstrate how lineage principles relate to levels of empowerment that women observe and experience in patrilineal and matrilineal societies. A comparison between the levels

of empowerment perceived to be available to monogamous and to polygynous wives would demonstrate the extent to which the two marital contexts are empowering.

Patrilineal versus matrilineal wives

Data in Table 6.8 show that only wives' perceptions about their freedom of movement and wife-to-husband communication about desired family size have a significant relationship with lineage. While more patrilineal wives (about 25 percent) than matrilineal wives (lower than 15 percent) reported that they think it is acceptable for them to go to the market or the health centre without informing their husbands, the opposite is true for wife-to-husband communication about desired family size. Patrilineal wives think they have more freedom of movement and social interaction outside the home than have matrilineal wives.

Matrilineal wives appear to be more empowered to talk to their husbands about fertility issues than are patrilineal wives. More matrilineal wives (about 58 per cent) reported having talked to their husbands about desired family sizes than did patrilineal wives (about 46 percent). This suggests that matrilineal wives are more likely to perceive they have the power to negotiate their reproductive desires than are patrilineal wives.

Table 6-8: **Patrilineal versus matrilineal wives**: percent distribution of wives' perceptions about their freedom of movement and to negotiate their reproductive desires, MDIC Survey 1998

Variables	Matrilineal wives% (N=254)	Patrilineal wives % (N=278)	Total % (N=532)
Wife thinks it is acceptable for her to go to the market without husband's permission			
No	94.9	73.4	83.7
Yes	5.1	26.6	16.3
Wife thinks it is acceptable for her to go to the health centre without husband's permission			
No	85.8	74.8	80.1
Yes	14.2	25.2	19.9
Wife thinks husband could agree to use modern contraceptives			
No	29.5°	37.4°	33.7
Yes	70.5°	62.6°	66.3
Wife thinks she can not convince her husband to use modern contraceptives			
No	46.1°	53.2°	49.8
Yes	53.9°	46.8°	50.2
Wife talked with husband about desired family size			
No	42.1	54.5	48.6
Yes	57.9	45.5	51.4
Wife talked with husband about using modern contraceptives			
No	37.4°	43.3°	40.5
Yes	62.6°	56.7°	59.5
Wife informs husband about her earnings			
No	2.2°	3.2°	2.7
Yes	97.8°	96.8°	97.3

Note: All other values have chi^2 = significant at < 0.05 except for those with the symbol °.

But chi-square tests of the cross-tabulations about wives' perceptions about their husbands' agreement to use modern contraceptives and wives' perceptions that they have the power to convince their husbands to use modern contraceptives are not significant. What appears to really matter for married women to sense they have the

power to negotiate desired reproductive outcomes and behaviours is the actual discussion about desired family size.

Consistent with the discussion about traditional power structure in Chapter three and the nature of power relations within monogamous and polygynous unions in Chapter five, these lineage-based differences in perceived power to interact freely outside or inside the home demonstrate the influence of different levels of polygyny on the status of women in the two marriage systems. Theoretically, one would expect that in the matrilineal society where women's status is more marked, women would be more likely to express themselves and have freedom of movement than in the patrilineal society where restrictive traditional norms are still strong. With high levels of polygyny among the patrilineal wives, as one Tumbuka polygynous wife mentioned in an interview: "We the co-wives fear each other. We are each other's guard"[37]. But results from the cross-tabulations in Table 6.8 suggest that it is the patrilineal wives who have more freedom of movement and association. As pointed out in Chapter five, this is likely to be an effect of the nature and level of development of the communities. The markets and health centres are within shorter distances in Rumphi (among the Tumbuka) than in Mchinji (among the Chewa).

Monogamous versus polygynous wives

An analysis of cross-tabulation results presented in Table 6.9 show that only spousal communication has a significant relationship with type of union. Only monogamous

wives reported high levels of spousal communication about family planning. This implies that that monogamous unions are more empowering for wife-to-husband communication about family planning than are polygynous unions.

About 55 percent of monogamous wives reported having had a conversation with their husbands about their desired family sizes. As for wives talking to their husbands about using family planning methods, 63 percent of the monogamous wives compared to only 49 percent of the polygynous wives reported to have done so. Interestingly, there is very little difference in reported wife-to-husband communication about earnings between monogamous and polygynous wives. While 98 percent of the monogamous wives reported that they inform their husbands about their earnings, 96 percent of the polygynous wives did.

These findings suggest that wife-to-husband communication about desired family size is more of a serious issue than wife-to-husband communication using family planning methods or about earnings. On the one hand, one could argue that if monogamous wives are more likely to report having had conversations with their husbands about family planning, they are more empowered than are polygynous wives to negotiate their reproductive desires.

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[37] This was a young woman in her late twenties and was the second wife. She mentioned this when she was asked about whether married women do have extramarital affairs. So she indicated that it is very difficult for married women, particularly those in polygynous unions to go out freely for fear of their co-wives reporting against them.

Table 6-9: **Monogamous versus polygynous wives**: percent distribution of wives' perceptions about their freedom of movement and their power to negotiate desired reproductive outcomes, MDIC Survey 1998

Variables	Monogamous wives% (N=405)	Polygynous wives% (N=125)	Total % (N=530)
Wife thinks she is free to go to the market without husband's permission			
No	84.4°	80.8°	85.6
Yes	15.6°	19.2°	16.4
Wife thinks she is free to go to the health centre without husband's permission			
No	80.5°	78.4°	80.0
Yes	19.5°	21.6°	20.0
Wife thinks husband would agree to use modern contraceptives			
No	31.4	40.8	33.6
Yes	68.6	59.2	66.4
Wife thinks she has the power to convince her husband to use modern contraceptives			
No	47.9°	55.2°	49.6
Yes	52.1°	44.8°	50.4
Wife talked with husband about desired family size			
No	45.5	58.4	48.6
Yes	54.5	41.6	51.4
Wife talked with husband about using modern contraceptives			
No	37.3	50.8	40.5
Yes	62.7	49.2	59.5
Wife informs husband about her earnings			
No	2.0	3.9	2.5
Yes	98.0	96.1	97.5

Note: All other values have chi^2 = significant at < 0.05 except for those with the symbol °.

On the other hand, one could also argue that this is due to the influence of different levels of polygyny. Theoretically, in a society where polygyny is less practised, women will acquire the power to negotiate desired reproductive outcomes whereas in

a society with high levels of polygyny, women will not negotiate desired reproductive outcomes because it will be contrary to normative behaviour.

If one reviews these findings critically, one is likely to conclude that spousal communication about family planning (particularly about desired family size) is a stronger predictor of women's empowerment in RDM than spousal communication about earnings. It would be more difficult for wives to raise issues of family size or contraception than issues of money. This would further suggest that women's economic power might not necessarily empower wives to negotiate their desired reproductive outcomes and behaviours but negotiating power might. Therefore women's acquisition of negotiating power really matters for women's participation in RDMP. The question is what factors (endogenous or exogenous) would facilitate the process of acquiring negotiating power.

Age at Entry into Marriage and Wives' Perceptions about their Power to make Autonomous Reproductive Decisions or to Negotiate Reproductive Desires

Age at entry into marriage, as discussed in Chapter five, is one predictor of women's power in marriage. The relationship between age at entry into marriage and women's decision-making power can be measured using *wife's rank* as a proxy for women's power. As indicated in Chapter five, in the two societies under study, there are the first wives; second+ wives in polygynous union and the monogamous wives, who may become polygynous at any time. It will be assumed that the nature of power relations would be similar, within polygynous and monogamous unions particularly

in patrilineal societies, because of the continuum between monogamy and polygyny in those societies. The discussion in Chapter five suggests that the higher-order wives are most likely to be divorcees or widows. Therefore, if we compare proportions of the three forms of wife's rank by age at entry into that marriage, we would be able to deduce the marital status of women at the time of entry into the current marriage[38].

Patrilineal vs matrilineal wives: age at entry into marriage and women's perceptions about their power to make autonomous reproductive decisions

First and foremost, it should be noted that as discussed in Chapter five, the largest proportion of the sampled wives (comprising first wives) entered into the current marriage (monogamous or polygynous) at a very young age (Chapter five). This reflects the national average age of entry into marriage, which stands at 18, as presented in Chapters two and five. The results discussed in this section are therefore weighted more towards the first wives because the sample is disproportional.

Results displayed in Tables 6.10-6.12 are consistent with the reported degrees of perceived wives' autonomy in deciding to delay births, stop child bearing and use contraception secretly discussed earlier in this chapter. Surprisingly, the systematic pattern of the results suggest that it is the patrilineal wives, particularly those in polygyny who are more likely to consider themselves autonomous in making some reproductive decisions than the matrilineal and monogamous wives.

[38] Of course the best situation would have been to ask each female respondent her marital status at the time she went into the current marriage. But since MDIC, 1998 data did not have such a question this interpretation will be based on existing theoretical understanding of polygyny, marital status and age at entry into marriage.

Table 6-10: **Patrilineal versus matrilineal wives:** percent distribution of wives who perceive they have the power to make autonomous decisions to stop childbearing if they want to by age at entry into current marriage and wife's rank, MDIC Survey 1998

Variables	Matrilineal wives % (N=259)			Patrilineal wives % (N=273)		
	Age at entry into current marriage					
	12-19 yrs	20-24 yrs	25+ yrs	12-19yrs	20-24 yrs	25+ yrs
Wives' perceptions that they have the power to stop child bearing if she wants to						
Monogamous Wives						
Monogamous Wife						
Perceives has **no** power to stop childbearing if she wants to	65.8	57.1	58.8	65.6	71.4	52.4
Perceives has the power to stop childbearing if she wants to	34.2	42.9	41.2	34.4	28.6	47.6
(N)	**(152)**	**(42)**	**(17)**	**(125)**	**(42)**	**(21)**
Polygynous wives						
Polygynous wife						
Perceives has **no** power to stop childbearing if she wants to	57.9	28.6	62.5	48.7	70.0	47.6
Perceives has the power to stop childbearing if she wants to	42.1	71.4	37.5	51.3	30.0	52.4
(N)	**(19)**	**(7)**	**(16)**	**(39)**	**(20)**	**(21)**
First Wife						
Perceives has **no** power to stop childbearing if she wants to	53.8	33.3	50.0	46.2	100.0	50.0
Perceives has the power to stop childbearing if she wants to	46.2	66.7	50.0	53.8	-	50.0
(N)	**(13)**	**(3)**	**(2)**	**(26)**	**(3)**	**(2)**
Second+ wife						
Perceives has **no** power to stop childbearing if she wants to	66.7	25.0	64.3	53.8	64.7	47.4
Perceives has the power to stop childbearing if she wants to	33.3	75.0	35.7	46.2	35.3	52.6
(N)	**(6)**	**(4)**	**(14)**	**(13)**	**(17)**	**(19)**

Note: Chi-square tests were done for the following contrasts controlling for age at entry into current marriage (12-19 yrs old, 20-24 yrs old, and 25 + yrs old): monogamous vs polygynous wives, first vs second+ wives, first vs monogamous wives, second+ vs monogamous wives for each lineage system separately. The following contrasts were statistically significant: age at current marriage 12-19: patrilineal first vs second+ wives; patrilineal first vs monogamous wives.

What is most intriguing is that for the statistically significant results, the largest proportion of patrilineal first wives, (compared to their counterparts the second+ wives and the monogamous wives) who entered into the current marriage at 12-19 years of age, think they could stop child bearing whenever they wanted to. The first wives appear to have more comparative advantage in reproductive decision-making than the higher order wives and even those in monogamy.

When it comes to women's perceived power to delay births, just being in polygyny is not enough to guarantee women's acquisition of latent reproductive decision-making power. But what really matters is the wife's rank. The contrasts between the wife categories of age at current marriage, 12-19: Tumbuka (patrilineal) wives (first vs. second+ and first vs. monogamous and those with age at current marriage 25 years and above: the first vs. monogamous wives) and Chewa (matrilineal) wives (first vs. monogamous) were statistically significant[39]. This suggests that in a society that practices strong patrilineal system, comparatively, the first wives are more likely than the second+ or the monogamous wives to think they have the latent power to decide to delay births whenever they want to. The contrast between the degrees of perceived latent power between the first and second+ wives as well as between first wives and monogamous wives within a patrilineal community would mean that the first wives who enter into current marriage early would be more liberated in terms of child spacing practices than their counterparts, the second+ or the monogamous wives.

[39] The results for Tumbuka and Chewa contrasts between first and monogamous wives should be treated with caution because of the significantly very small numbers of first wives who entered into current marriage at age 25 or after.

Table 6-11: **Patrilineal versus matrilineal wives:** percent distribution of wives who perceive they have the power to make autonomous decisions to space births whenever they want to by age at entry into current marriage and wife's rank, MDIC Survey 1998

Variables	Matrilineal wives % (N=259)			Patrilineal wives % (N=273)		
	Age at entry into current marriage					
	12-19 yrs	20-24 yrs	25+ yrs	12-19yrs	20-24 yrs	25+ yrs
Wives' perceptions that they have the power to space births whenever she wants to						
Monogamous Wives						
Monogamous Wife						
Perceives has **no** power to space births whenever she wants to	60.4	45.5	50.0	32.5	35.7	28.6
Perceives has the power to space births whenever she wants to	39.6	54.5	50.0	67.5	64.3	71.4
(N)	**(154)**	**(44)**	**(18)**	**(126)**	**(42)**	**(21)**
Polygynous wives						
Polygynous wife						
Perceives has **no** power to space births whenever she wants to	52.6	14.3	56.3	21.1	40.0	34.8
Perceives has the power to space births whenever she wants to	47.4	85.7	43.8	78.9	60.0	65.2
(N)	**(19)**	**(7)**	**(16)**	**(38)**	**(20)**	**(23)**
First Wife						
Perceives has **no** power to space births whenever she wants to	53.8	-	50.0	12.0	66.7	100.0
Perceives has the power to space births whenever she wants to	46.2	100.0	50.0	88.0	33.3	-
(N)	**(13)**	**(3)**	**(2)**	**(25)**	**(3)**	**(2)**
Second+ wife						
Perceives has **no** power to space births whenever she wants to	50.0	25.0	57.1	38.5	35.3	28.6
Perceives has the power to space births whenever she wants to	50.0	75.0	42.9	61.5	64.7	71.4
(N)	**(3)**	**(4)**	**(14)**	**(13)**	**(17)**	**(21)**

Note: Chi-square tests were done for the following contrasts controlling for age at entry into current marriage (12-19 yrs old, 20-24 yrs old, and 25 + yrs old): monogamous vs polygynous wives, first vs second+ wives, first vs monogamous wives, second+ vs monogamous wives for each lineage system separately. The following contrasts were statistically significant: a) age at current marriage 12-19: patrilineal first vs second+ wives; patrilineal first vs monogamous wives and b) age at current marriage 25 and above: patrilineal/matrilineal first vs monogamous wives.

As discussed in Chapters two and five and at the beginning of the current Chapter, theoretically, the women who enter into polygynous marriages at an older age (supposedly after being divorced or widowed) are expected to be more likely to think they have the power to make autonomous fertility or contraceptive decisions than those who enter into polygynous marriages at young age. But it appears what is practically happening in the strong patrilineal society of the Tumbuka contradicts that theory. It is in fact those first wives who entered into the current polygynous marriages at a very young age (12-19 years old) who are most likely to consider themselves capable of making autonomous decisions to use any contraceptive methods without their husbands knowing.

Results displayed in Table 6.12 and significant chi-square test results for the comparison of the different categories of wives in that table suggest that the Tumbuka first wives, with age at current marriage12-19, are more likely than the second+ wives and monogamous ones with the same age at current marriage to think they can use any contraceptive method covertly. This suggests that in comparison to second+ wives and monogamous wives, first wives (who are likely to have started childbearing early) have more chances of acquiring latent reproductive decision-making power. A possible contributing factor to that acquisition of power would be the number of children they might have already given birth to.

Table 6-12: **Patrilineal versus matrilineal wives:** percent distribution of wives who perceive they have the power to make autonomous decisions to use child spacing/family planning methods covertly by age at entry into current marriage and wife's rank, MDIC Survey 1998

Variables	Matrilineal wives % (N=259)			Patrilineal wives % (N=273)		
	Age at entry into current marriage					
	12-19 yrs	20-24 yrs	25+ yrs	12-19yrs	20-24 yrs	25+ yrs
Wives' perceptions that they have the power to use any contraceptive method covertly						
Monogamous Wives						
Monogamous Wife						
Perceives has **no** power to use any contraceptive method **covertly**	63.4	63.6	50.0	37.3	33.3	19.0
Perceives has the power to use any contraceptive method **covertly**	36.6	36.4	50.0	62.7	66.7	81.0
(N)	**(153)**	**(44)**	**(18)**	**(126)**	**(42)**	**(21)**
Polygynous wives						
Polygynous wife						
Perceives has **no** power to use any contraceptive method **covertly**	78.9	14.3	56.3	12.5	40.0	39.1
Perceives has the power to use any contraceptive method **covertly**	21.1	85.7	43.8	87.5	60.0	60.9
(N)	**(19)**	**(7)**	**(16)**	**(40)**	**(20)**	**(23)**
First Wife						
Perceives has **no** power to use any contraceptive method **covertly**	84.6	-	50.0	11.1	66.7	50.0
Perceives has the power to use any contraceptive method **covertly**	15.4	100	50.0	88.9	33.3	50.0
(N)	**(13)**	**(3)**	**(2)**	**(27)**	**(3)**	**(2)**
Second+ wife						
Perceives has **no** power to use any contraceptive method **covertly**	66.7	25.0	57.1	15.4	35.3	38.1
Perceives has the power to use any contraceptive method **covertly**	33.3	75.0	42.9	84.6	64.7	61.9
(N)	**(6)**	**(4)**	**(14)**	**(13)**	**(17)**	**(21)**

Note: Chi-square tests were done for the following contrasts controlling for age at entry into current marriage (12-19 yrs old, 20-24 yrs old, and 25 + yrs old): monogamous vs polygynous wives, first vs second+ wives, first vs monogamous wives, second+ vs monogamous wives for each lineage system separately. The following contrasts were statistically significant: a) age at current marriage 20 and 24: patrilineal/matrilineal polygynous wives, matrilineal first vs monogamous wives and b) age at current marriage 12-19: patrilineal first vs second+ and first vs monogamous wives.

The first wives, having started childbearing early, must have had time to protect their social status, which is determined by the capacity to bear as many children as possible since children are considered as part of family wealth (Locoh, 1991; FAO, 1994; Caldwell, 1968). So the first wives, as was observed in a study conducted in Ghana where polygyny is also prominent, "When a woman has given her husband many children, it is good that she rests" (quoted in Pool, 1972:252). Motherhood is therefore a source of power and prestige (Pool, 1972). In Chapter five, percent distribution of the number of children ever born by wife rank suggests that pattrilineal vs polygynous first wives are likely to have six children and above. Patrilineal first wives who entered into the current marriage at very young age also reported high perceptions about their capacity to make autonomous decisions to use child spacing or family planning methods without their husbands knowing.

Patrilineal vs matrilineal wives: age at entry into marriage and women's perceptions about their power to negotiate desired reproductive outcomes

Discussions in earlier chapters showed that women's *perceptions about their capability to talk with their wives about desired family size or about using child spacing and family planning methods* are indicators of women's degree of negotiating power

Table 6-13: **Patrilineal versus matrilineal wives:** percent distribution of wives who perceive they have the power to negotiate desired family sizes with their husbands by age at entry into current marriage and wives' rank, MDIC Survey 1998

Variables	Matrilineal wives % (N=259)			Patrilineal wives % (N=273)		
	Age at entry into current marriage					
	12-19 yrs	20-24 yrs	25+ yrs	12-19yrs	20-24 yrs	25+ yrs
Wives' perceptions about their power to talk with their husbands about desired family size						
Monogamous Wives						
Monogamous Wife						
Perceives has **no** power to talk with her husband about desired family size	39.9	31.8	50.0	55.6	47.6	47.6
Perceives has the power to talk with her husband about desired family size	60.1	68.2	50.0	44.4	52.4	52.4
(N)	**(153)**	**(44)**	**(18)**	**(126)**	**(42)**	**(21)**
Polygynous wives						
Polygynous wife						
Perceives has **no** power to talk with her husband about desired family size	47.4	14.3	75.0	62.5	50.0	69.6
Perceives has the power to talk with her husband about desired family size	52.6	85.7	25.0	37.5	50.0	30.4
(N)	**(19)**	**(7)**	**(16)**	**(40)**	**(20)**	**(23)**
First Wife						
Perceives has **no** power to talk with her husband about desired family size	46.2	-	50.0	63.0	66.7	-
Perceives has the power to talk with her husband about desired family size	53.8	100.0	50.0	37.0	33.3	100.0
(N)	**(13)**	**(3)**	**(2)**	**(27)**	**(3)**	**(2)**
Second+ wife						
Perceives has **no** power to talk with her husband about desired family size	50.0	25.0	78.6	1.5	47.1	76.2
Perceives has the power to talk with her husband about desired family size	50.0	75.0	21.4	38.5	52.9	23.8
(N)	**(6)**	**(4)**	**(14)**	**(13)**	**(17)**	**(21)**

Note: Chi-square tests were done for the following contrasts controlling for age at entry into current marriage (12-19 yrs old, 20-24 yrs old, and 25 + yrs old): monogamous vs polygynous wives, first vs second + wives, first vs monogamous wives, second + vs monogamous wives for each lineage system separately. The following contrasts were statistically significant: age at current marriage 20 and 24: matrilineal polygynous wives; matrilineal first vs second+ wives and b) age at current marriage 25 and above: patrilineal/matrilineal second+ vs monogamous wives.

In Chapter four, sex and age were identified as strong predictors of negotiating power in African societies where communication between spouses and between parents and children (the young and the old) is not encouraged. Women and the young are expected to listen to and obey elders. Newly weds are also instructed to listen to and obey their husbands although these days, as elders lament, young women no longer listen to their husbands (Alam et al., 1992; Kaler, 2001; Shatz, 2002).

Tables 6.13 and 6.14 are results of cross-tabulation relating age at entry into current marriage wife's rank and women's perceptions about their power to negotiate reproductive choices. Based on earlier discussion in the chapter, *women's perceptions about their power to talk with their husbands about desired family size and about using child spacing and family planning methods* were among the strongest predictors of women's power in reproductive decision-making processes. The pattern that was depicted in the contrasts between patrilineal vs matrilineal and polygynous vs monogamous wives in general is similar to the pattern that we have in the two tables when we contrast women of different generations and wife's rank.

The contrasts of the polygynous wives' perceptions about their capability to talk with their husbands about using contraception were statistically significant for both the patrilineal and matrilineal wives. Among the matrilineal wives, those who reported age at current marriage 20-24 are likely to think they have the power to negotiate for contraception with their husbands.

Table 6-14: **Patrilineal versus matrilineal wives:** percent distribution of wives who perceive they have the power to negotiate with their husbands about using child spacing/family planning methods by age at entry into current marriage and wife's rank, MDIC Survey 1998

Variables	Matrilineal wives % (N=259)			Patrilineal wives % (N=273)		
	Age at entry into current marriage					
	12-19 yrs	20-24 yrs	25+ yrs	12-19yrs	20-24 yrs	25+ yrs
Wives' perceptions about their power to talk with their husbands about using child spacing/family planning methods						
Monogamous Wives						
Monogamous Wife						
Perceives has **no** power to talk with her husbands about using cs/fp methods	33.5	34.1	61.1	42.5	33.3	28.6
Perceives has the power to talk with her husbands about using cs/fp methods	66.5	65.9	38.9	57.5	66.7	71.4
(N)	**(155)**	**(44)**	**(18)**	**(127)**	**(42)**	**(21)**
Polygynous wives						
Polygynous wife						
Perceives has **no** power to talk with her husbands about using cs/fp methods	26.3	28.6	68.8	50.0	35.0	69.6
Perceives has the power to talk with her husbands about using cs/fp methods	73.7	71.4	31.3	50.0	65.0	30.4
(N)	**(19)**	**(7)**	**(16)**	**(39)**	**(20)**	**(23)**
First Wife						
Perceives has **no** power to talk with her husbands about using cs/fp methods	23.1	33.3	100.0	38.5	100.0	50.0
Perceives has the power to talk with her husbands about using cs/fp methods	76.9	66.7	-	61.5	-	50.0
(N)	**(13)**	**(3)**	**(2)**	**(26)**	**(3)**	**(2)**
Second+ wife						
Perceives has **no** power to talk with her husbands about using cs/fp methods	33.3	25.0	64.3	46.2	58.8	71.4
Perceives has the power to talk with her husbands about using cs/fp methods	66.7	75.0	35.7	53.8	41.2	28.6
(N)	**(6)**	**(4)**	**(14)**	**(13)**	**(17)**	**(21)**

Note: Chi-square tests were done for the following contrasts controlling for age at entry into current marriage (12-19 yrs old, 20-24 yrs old, and 25 + yrs old): monogamous vs polygynous wives, first vs second+ wives, first vs monogamous wives, second+ vs monogamous wives for each lineage system separately. The following contrasts were statistically significant: a) age at current marriage 20 and 24: matrilineal monogamous and polygynous wives; patrilineal polygynous wives; and patrilineal first vs patrilineal monogamous wives; b) age at current marriage 25 and above: patrilineal/matrilineal second+ vs patrilineal/matrilineal monogamous wives.

But those who reported age at current marriage 25 and above are less likely to think that way than those who report younger age at current marriage (Table 6.14). The latter probably have not had time to bear many children to warrant them any freedom of independent reproductive decision-making. This pattern also emerges in the contrast between categories of age at current marriage for matrilineal monogamous wives, whose results are also statistically significant.

Regarding negotiation for family size limitation, the results are statistically significant for some categories of the matrilineal wives and only one category of the patrilineal wives. Generally, when we control for type of union, the matrilineal polygynous wives who entered into this marriage at a young age of below 24 are likely to think that they could negotiate desired family size with their husbands. But those who went into the current marriage at 25+ are unlikely to think they can talk with their husbands about desired family size. When we take wife's rank into consideration, it is those matrilineal or patrilineal first wives who went into the current union at the age of 25+ who are most likely to perceive they have the power to discuss with their husband about desired family size. What these results are showing is that the matrilineal wives, what really matters for the acquisition of negotiating power is the age at entry into marriage and not the type of union.

Table 6-15: **Patrilineal versus matrilineal wives:** percent distribution of wives who have the manifest power to use any child spacing/family planning methods by age at entry into current marriage and wives' rank, MDIC Survey 1998[40]

Variables	Matrilineal wives % (N=259)			Patrilineal wives % (N=273)		
	Age at entry into current marriage					
	12-19 yrs	20-24 yrs	25+ yrs	12-19yrs	20-24 yrs	25+ yrs
Wives' acquired power to use any contraceptive method whenever she wants to						
Monogamous Wives						
Monogamous Wife						
Has **not** acquired the power to use any contraceptive method	69.7	61.4	61.1	70.1	61.9	66.7
Has acquired the power to use any contraceptive method	30.3	38.6	38.9	29.9	38.1	33.3
(N)	**(155)**	**(44)**	**(18)**	**(127)**	**(42)**	**(21)**
Polygynous wives						
Polygynous wife						
Has **not** acquired the power to use any contraceptive method	47.4	85.7	87.5	50.0	70.0	60.9
Has acquired the power to use any contraceptive method	52.6	14.3	12.5	50.0	30.0	39.1
(N)	**(19)**	**(7)**	**(16)**	**(40)**	**(20)**	**(23)**
First Wife						
Has **not** acquired the power to use any contraceptive method	53.8	100.0	50.0	51.9	100.0	50.0
Has acquired the power to use any contraceptive method	46.2	-	50.0	48.1	-	50.0
(N)	**(13)**	**(3)**	**(2)**	**(27)**	**(3)**	**(2)**
Second+ wife						
Has **not** acquired the power to use any contraceptive method	33.3	75.0	92.9	46.2	64.7	61.9
Has acquired the power to use any contraceptive method	66.7	25.0	7.1	53.8	35.3	38.1
(N)	**(6)**	**(4)**	**(14)**	**(13)**	**(17)**	**(21)**

Note: Chi-square tests were done for the following contrasts controlling for age at entry into current marriage (12-19 yrs old, 20-24 yrs old, and 25 + yrs old): monogamous vs polygynous wives; first vs second+ wives; first vs monogamous wives; and second+ vs monogamous wives for each lineage system separately. The following contrasts were statistically significant: a) all categories of age at current marriage: matrilineal polygynous wives; b) age at current marriage 25 years and above: matrilineal second+ vs monogamous wives.

[40] Due to very small numbers of women who reported to be using any contraceptive method covertly at the time of the survey, the comparison of women's degree of acquired decision-making power to use any contraceptives was restricted to reported current use of any contraceptive method.

Since it is the early entries into marriage, that are likely to feel empowered to negotiate family planning or desired family size, one could conclude that these are the women who are likely to have high fertility levels because of their early sex and childbearing debut. If these wives feel that they have the latent powers to make autonomous decisions to delay births of use contraceptives whenever they want to and that they have the manifest powers to negotiate desired family sizes and the use of family planning methods, then one would expect that they would have high levels of contraceptive use. In that way, they would have acquired the manifest power to use any contraceptive methods.

But the results in the Table 6.15 suggest that it is the comparisons that are significant are those between matrilineal polygynous wives and those between the second+ and monogamous matrilineal wives that entered into this marriage after the age of 25. Among all the polygynous wives, it is those who entered into current marriage at the teenage who are likely to have high levels of contraceptive use. Very low levels of contraception would be expected among those who entered into this marriage at 25 years or older. Similarly, the contrast between the second+ and monogamous wives suggests that *low* levels of contraception would be expected among the matrilineal polygynous wives and particularly the second+ wives who entered into the current marriage in the late twenties compared to their counterparts who are in monogamous unions.

Table 6-16: **Patrilineal wives:** Percent distribution of children ever born by age at entry into marriage by current age and wife rank

Variables	Age at entry into current marriage					
Children ever born/wife rank	Less than 20 years			20 yrs and above		
	Current age			Current age		
	<20 yrs	20-29 yrs	30+ yrs	< 20 yrs	20-29 yrs	30+ yrs
Monogamous wives						
None	37.5	0.0	0.0	0.0	21.4	0.0
1-2 children	58.3	37.5	2.6	0.0	64.3	8.6
3-5 children	0.0	60.9	17.9	0.0	14.3	48.6
6+	4.2	1.6	79.5	0.0	0.0	42.9
(N)	**(24)**	**(64)**	**(39)**	**(0)**	**(28)**	**(35)**
Polygynous wives						
None	50.0	10.0	0.0	0.0	12.5	0.0
1-2 children	50.0	40.0	3.6	0.0	25.0	3.7
3-5 children	0.0	50.0	25.0	0.0	62.5	40.7
6+	0.0	0.0	71.4	0.0	0.0	55.6
(N)	**(2)**	**(10)**	**(28)**	**(0)**	**(16)**	**(27)**
First Wife						
None	0.0	0.0	0.0	0.0	0.0	0.0
1-2 children	100.0	25.0	4.5	0.0	100.0	0.0
3-5 children	0.0	75.0	22.7	0.0	0.0	25.0
6+	0.0	0.0	72.7	0.0	0.0	75.0
(N)	(1)	(4)	(22)	(0)	(1)	(4)
Second Wife						
None	100.0	16.7	0.0	0.0	13.2	0.0
1-2 children	0.0	50.0	0.0	0.0	20.0	4.3
3-5 children	0.0	33.3	33.3	0.0	66.7	43.5
6+	0.0	0.0	66.7	0.0	0.0	52.2
(N)	**(1)**	**(6)**	**(6)**	**(0)**	**(15)**	**(23)**

Note: Chi-square tests were done for the following contrasts controlling for age at current marriage and current age: a) monogamous vs polygynous wives with age at marriage (less than 20 years) and current age (30 years and above); b) monogamous vs polygynous wives with age at marriage (20 years and above) and current age (20-29 years); c) monogamous vs polygynous wives with age at marriage (20 years and above) and current age (30 years and above); d) second+ vs monogamous wives with age at current marriage (20 years and above) and current age (20-29 years); e) second+ vs monogamous wives with age at current marriage (20 years and above) and current age (30 years and above); and f) first vs monogamous wives with age at current marriage (less than 20 years) and current age (30 years and above). Contrasts b), d), e) and f) were statistically significant.

Based on the results of the contrasts of degrees of reproductive decision-making power between polygynous and monogamous wives and between polygynous wives of different wife ranks in the matrilineal and patrilineal systems, one would conclude that generally in both systems, the first wives in polygynous unions and monogamous wives who report age at current marriage 12-19 years, are more likely to acquire latent power that enables them make independent decisions to space births

and use any contraceptive methods than those who report age at current marriage 20 years and above.

Table 6-17: **Matrilineal wives:** Percent distribution of children ever born by age at entry into marriage by current age and wife rank

Variables	Age at entry into current marriage					
Children ever born/wife rank	Less than 20 years			20 yrs and above		
	<20 yrs	Current age 20-29 yrs	30+ yrs	< 20 yrs	Current age 20-29 yrs	30+ yrs
Monogamous wives						
None	42.9	9.4	0.0	0.0	0.0	0.0
1-2 children	57.1	41.2	2.1	0.0	60.0	7.7
3-5 children	0.0	44.7	31.3	0.0	40.0	34.6
6+	0.0	4.7	66.7	0.0	0.0	57.7
(N)	**(21)**	**(85)**	**(48)**	**(0)**	**(35)**	**(26)**
Polygynous wives						
None	50.0	0.0	0.0	0.0	0.0	0.0
1-2 children	50.0	20.0	0.0	0.0	33.3	5.9
3-5 children	0.0	80.0	20.0	0.0	66.7	35.3
6+	0.0	0.0	80.0	0.0	0.0	58.8
(N)	**(4)**	**(5)**	**(10)**	**(0)**	**(6)**	**(17)**
First Wife						
None	100.0	0.0	0.0	0.0	0.0	0.0
1-2 children	0.0	0.0	0.0	0.0	50.0	0.0
3-5 children	0.0	100.0	12.5	0.0	50.0	66.7
6+	0.0	0.0	87.5	0.0	0.0	33.3
(N)	**(2)**	**(3)**	**(8)**	**(0)**	**(2)**	**(3)**
Second Wife						
None	0.0	0.0	0.0	0.0	0.0	0.0
1-2 children	100.0	50.0	0.0	0.0	25.0	7.1
3-5 children	0.0	50.0	50.0	0.0	75.0	28.6
6+	0.0	0.0	50.0	0.0	0.0	64.3
(N)	**(2)**	**(2)**	**(2)**	**(0)**	**(4)**	**(14)**

Note: Chi-square tests were done for the following contrasts controlling for age at current marriage and current age: a) monogamous vs polygynous wives with age at current marriage (less than 20 years) and current age (30 years and above); b) monogamous vs polygynous wives with age at current marriage (20 years and above) and current age (30 years and above); first vs monogamous wives with age at current marriage (20 years and above) and current age (30 years and above). None of the contrasts were statistically significant.

The results displayed in Table 6.16, which suggest that first wives in polygynous unions and monogamous wives who report age at current marriage to be less than twenty years and current age to be above 30 years are likely to have given birth to at least six children.

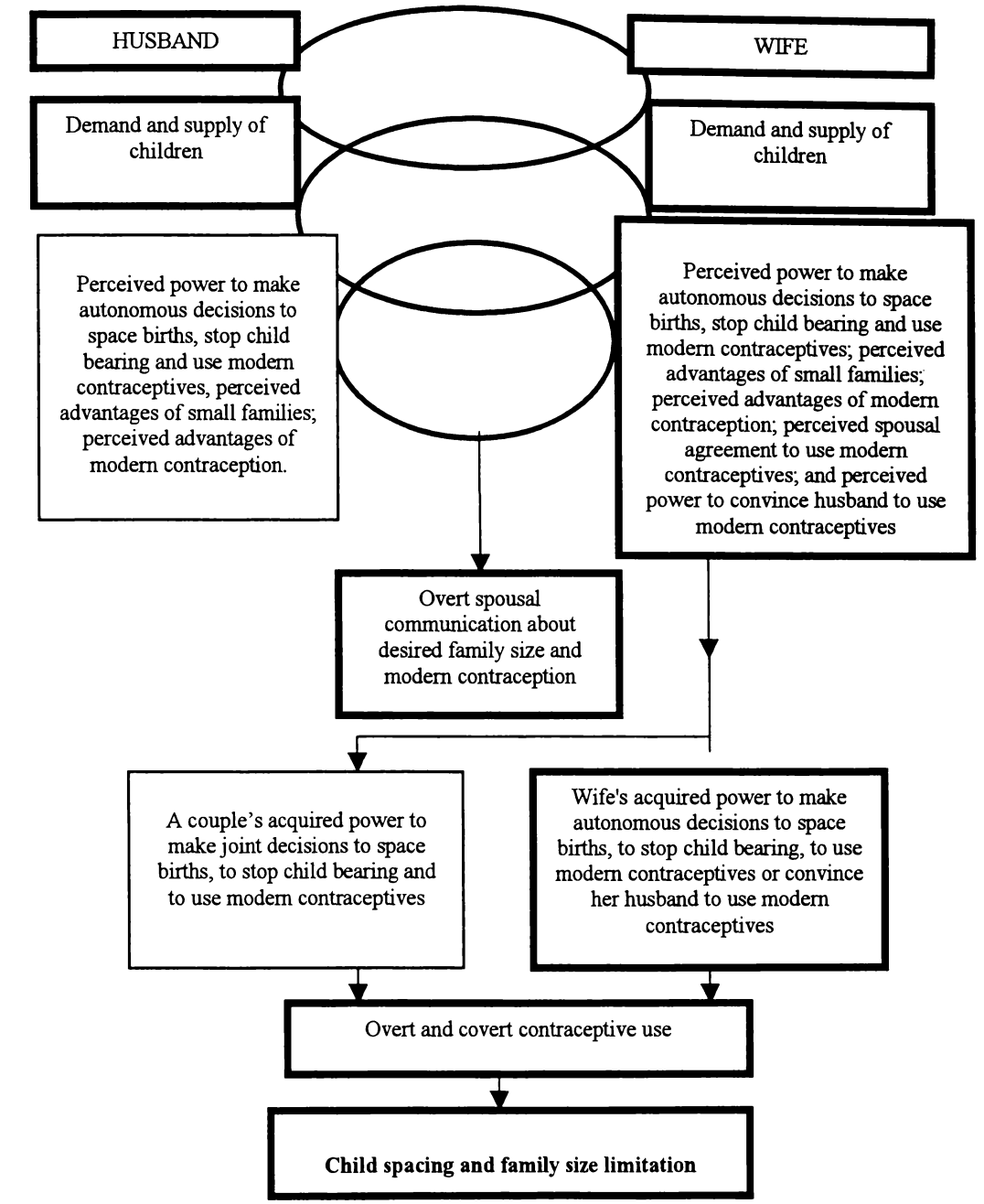
Towards a Reproductive Decision-Making Analytical Framework

In order to facilitate the analytical process, an analytical framework (Figure 6.1) will be developed. It will be assumed that individuals consider new ideas, information, their experiences and those of their friends before they make any reproductive choices and decisions. They think about issues related to the information and experiences they have had, and they seek more information about them from network groups, family planning advocacy groups and community elders. Therefore, as identified in other studies (Rutenberg and Watkins, 1997; Watkins, Rutenberge and Wilkinson, 1997; Kohler, Berhman and Watkins, 2001) social networks influence RDM and behaviours through social interactions.

One would argue that the nature of spousal interaction is an outcome of community-level social interactions. The couple is viewed as a small world within a larger world and behaving in response to the circumstances surrounding it. If a marital context were characterised by inegalitatiran ethics, one would argue that such a marital context would reduce the extent of spousal agreement about reproductive goals (Mason and Smith, 2001), which is associated with overt spousal communication (Hollerbach, 1983). In this thesis it is postulated that spousal communication that ends in an agreement is likely to lead to joint couple decision-making and those ending in disagreement are likely to lead to women's autonomous decision-making. Wives who discuss reproductive issues with their husbands and end in agreement become empowered to perceive they have the power to negotiate their reproductive desires. Those who talk to their husbands about their reproductive desires and end in

disagreement fail to recognise their power to negotiate their reproductive desires. Instead they recognise they have the power to resist husbands' disagreement by making autonomous reproductive decisions.

Figure 6-1: An Analytical Framework for Reproductive Decision-Making Processes



Source: Present author

Summary and conclusions

In summary, this chapter has taken us through the process of data coding and the methodology for data analysis that will be used in the rest of the chapters. The discussion has covered how the logistic regression analysis will force an interaction between various factors operating at all levels of aggregation in society (the macro-, meso- and micro- levels) and their impact on the outcome of RDMP. Spousal communication and women's power were identified as the foci for the analysis in this thesis.

This chapter has illustrated how themes and variables will be constructed based on issues drawn from theory and praxis. The identified themes and variables include fertility, contraception, desired family size, perceptions about reproductive decision-making power, overt and covert spousal communication, fertility and contraceptive decision-making, types of union, lineage systems, production relations, and power relations.

The discussion in this chapter has also covered how these variables will be constructed and used in the analyses. Women's perceptions of the degree of their latent power to make autonomous decisions to space births, to stop child bearing, to use modern contraceptives and women's perceptions of their manifest power to negotiate desired reproductive outcomes were identified as the as dependent variables. This chapter also identified the use of contraceptive (overt or covert) as

indicators of the outcomes of women's power to make autonomous reproductive decisions and to participate in RDMP. Current use of modern contraception was identified as an indicator of women's acquired manifest power to use family planning methods. Covert contraceptive use was identified as an indicator of women's acquired latent power to use modern contraception.

This chapter also discussed the following independent variables: *lineage, freedom to go to the market, freedom to go to the health centre, spousal communication about desired family size, spousal communication about modern contraception, spousal communication about earnings, and wife's exposure to urban lifestyle.* Control variables that were discussed include *husband's exposure to urban lifestyle, household economic status, wife's reported performance of income generating activities, wife and husband's education level, wife's current age, wife's rank, wife and husband's desired family size, infant mortality and religion.* The independent and control variables will be used as predictors of women's power to make autonomous reproductive decisions and to negotiate desired reproductive behaviours and outcomes.

Drawing from a combination of variables, the postulates and study objectives presented in Chapter one, an analytical framework for RDMP was developed. Through this framework, it is postulated that individual wives or couples make reproductive decisions in response to a combination of factors surrounding them and

in response to their own reproductive desires. The surrounding environment comprises changes within the social, cultural, economic and political contexts.

The analytical framework suggests that RDMP involve continuous responses to the forces of social interactions. Specific to this study is the process of empowerment that women undergo as they develop the capacity to participate in RDMP and influence the outcomes. This chapter suggests that using this framework, a number of indices would be identified as the measures of women's autonomy and power to influence the outcomes of RDMP. The framework suggests that combinations of multivariate and ethno methodological analyses will give a clearer understanding of the degrees of autonomy and power that wives in different lineage and marital contexts already have or might need.

A preliminary analysis of the relationship between the identified measures of women's autonomy and power to influence RDMP and their outcomes has shown that more patrilineal and polygynous wives than matrilineal and monogamous wives recognise that they have the capacity to make autonomous reproductive decisions and to negotiate desired reproductive behaviours and outcomes. Also other cross-tabulation results showed that there is a direct relationship between the acquisition of latent power and age at entry into marriage and wife's rank. The first wives with age at current marriage being 12-19 think that they have the power to make any reproductive decisions just because they have already had many children. Within the African context, many children are a source of prestige and power.

PART III: EMPIRICAL ANALYSES

CHAPTER 7

WOMEN'S PERCEPTIONS ABOUT THEIR AUTHORITY IN DECIDING TO SPACE BIRTHS OR STOP CHILD BEARING

Introduction

This chapter examines the relationship between women's empowerment and wives' perceptions about their power to make autonomous decisions to space births or to stop child bearing whenever they want. It will be argued that perceived wives' autonomy in making reproductive decisions illustrates how gender inequalities are reflected in the lack of women's participation in family decision-making processes. In order to prove this argument; this chapter first explores how different lineage systems construct gender inequalities that surface in Reproductive Decision-Making Processes (RDMP). The extent to which wives perceive that they have the power to control reproductive decisions in monogamous compared to polygynous unions will be examined.

Secondly, the analyses in this chapter will be focused on examining the probability that women's power variables will influence wives' perceptions about their power to make autonomous decisions to practice child spacing or family size limitation. This analytical focus will be based on the assumption that the force of interaction between combinations of factors determines the relative powers of men and women in RDMP.

The logistic regression analyses and ethno-methodological analyses will be used to test the hypotheses:

1) That, married women are more likely to be empowered to make autonomous decisions to space births or to stop child bearing in a lineage system that applies stronger egalitarian ethics than they are in a lineage system that applies weaker egalitarian ethics.
2) That, polygynous wives are more likely to perceive they have the power to make autonomous decisions to space births or to stop child bearing than are monogamous wives.
3) That, if wives recognise that they have the autonomy to make any family decisions, they are more likely to sense they have the power to make autonomous decisions to space births or to stop child bearing than if they do not have such autonomy.

Two dependent variables will be drawn from the sample survey questions that asked *whether wife thinks she could delay the next birth if she wanted to* and *whether wife thinks she could stop child bearing if she wanted to.* Taking into consideration the possible influence that the socio-cultural context could have on RDMP, the logistic regression analytical results for monogamous and polygynous women will be presented separately. Two models, one for monogamous women and another one for polygynous women will be run using *wives' perceptions about their power to make autonomous decisions to space births and wives' perceptions about their power to*

make autonomous decisions to stop child bearing as dependent variables. The assumptions underlying this comparative analysis is that firstly, polygynous unions are more empowering than monogamous unions because they constitute multiple power relationships (between spouses, between co-wives, between wives and affines/kins etc.) which force women to identify individual survival strategies. Secondly, it is assumed that contextual and social interaction variables have a direct influence on individual's perceptions about their position in society.

The co-variates to be used in the logistic regression analyses will be those predictors of women's power (identified in Chapter six), which will be treated as independent variables and will be drawn from women's responses. These will include *lineage, wives' perceived freedom of movement, wife-to-husband communication about family planning and earnings, and wives' exposure to urban life style.* These variables will be referred to as power variables because of their role in influencing changes in gender roles, gender structures and power relationships. In the analyses, the weak matrilineal system practised by the Chewa will be considered to be more egalitarian than the strong patrilineal system practised by the Tumbuka. The rest of the women's power variables will be considered as elements of social change that affect the nature of spousal power and communication relationships including RDMP.

Control variables will include *husband's exposure to urban lifestyle, wife and husband's schooling, wife's religion, and wife's current age, wife and husband's desired family size and infant or child mortality.* The logistic regression analyses will

be used to measure the impact of the interaction between the dependent and independent variables (which are a combination of macro-, meso- and micro- level factors). Findings from RDM ethnographic data analyses will be used to strengthen the interpretations and explanations of logistic regression analyses. Specifically selected excerpts in which respondents indicated how they reached the decision to practise child spacing or to stop child bearing and whom they think has more say between husband and wife family decision-making will be used for in-depth analyses.

This chapter is divided into two sections. The first section will be a discussion of the analytical results on the relationships between monogamous and polygynous women's perceptions about their authority in deciding to space births when they want to or stop child bearing when they want to and the selected women's empowerment factors. This discussion will be drawn from logistic regression and ethnographic data analyses. In the second section, the results will be discussed in detail. This discussion will draw from the theoretical and empirical issues that would explain the position of women in RDMP in egalitarian and non-egalitarian lineage or marriage systems.

Analytical results

Factors influencing wives' perceptions about power to make autonomous decisions to practice child spacing

Results from logistic regression analysis for monogamous women (See Table 7.1) show that patriliny is more empowering than matriliny. Patrilineal monogamous wives are 2.4 times more likely to think that they have the power to space births when they want to than are matrilineal wives. Patrilineal system has a similar influence on polygynous women's capability to perceive that they have the capacity to decide to delay the next birth whenever they want. Analytical results displayed in Table 7.1 also show that Patrilineal polygynous wives are 4.59 times as likely to think that they could delay the next birth when they want to as are the matrilineal ones. This suggests that matrilineal polygynous wives are less autonomous than are patrilineal polygynous wives in deciding to space births.

Furthermore, spousal communication about modern contraception has a positive relationship with polygynous wives' perceptions about their power in making autonomous decisions to space births. Those who reported to have once discussed with their husbands about the use of modern child spacing and family planning methods are 2.53 times as likely to think that they could space their births when they want to as those who reported no spousal communication about modern contraception.

Table 7-1 **Monogamous versus polygynous wives:** estimated odds ratios (from multivariate logistic regression) on wives' perceptions about their autonomy (Yes versus No) in *deciding to space births* by selected women's power variables, MDIC Survey 1998

Co-variates	Estimated odds ratios for monogamous wives (N= 405)	Estimated odds ratios for polygynous wives (N= 125)
Lineage		
Matrilineal	1.00	1.00
Patrilineal	2.41***	4.59**
Wife thinks it is acceptable for her to go to the market without seeking husband's permission		
No	1.00	1.00
Yes	0.99	0.88
Wife thinks it is acceptable for her to go to the health centre without seeking husband's permission		
No	1.00	1.00
Yes	1.32	2.13
Wife ever talked with husband about desired family size		
No	1.00	1.00
Yes	1.40	0.59
Wife ever talked with husband about using modern contraceptive methods		
No	1.00	1.00
Yes	1.22	2.53*
Wife informs her husband about the amount of money she earns		
No	1.00	1.00
Yes	0.00	7.14
Wife ever lived in the city for over six months since age 15		
No	1.00	1.00
Yes	1.01	2.65*

Note: *** = significant levels at one percent, ** = significant levels at five percent, * significant levels at ten percent. The following variables have been controlled for in the models and have been excluded from the table and the discussion of analysis: *husband's exposure to urban lifestyle, wife's and husband's schooling, wife's religion, wife's current age, wife's and husband's desired family size, and infant or child mortality.*

Out of the sixteen ethnographic interviews held with female Tumbuka and Chewa respondents, eight were polygynous. Of these six reported to have had a discussion about the use of modern child spacing and family planning methods with their husbands. All the six respondents indicated that they had already made independent decisions to practice child spacing but *asked for their husbands' permission* for them

to use modern child spacing and family planning methods. Others indicated that their husbands *told* them to start using modern contraceptive methods. Five out of the six respondents were living in a strongly patrilineal system. For example, a Tumbuka wife aged thirty-five years explained how she sought approval from both her late and current husband for her to use modern contraceptives:

> I asked for permission from my first husband. He accepted because I had an operation. My fear was that we could be having sex in the house and I could get pregnant yet the operation scar would not have healed properly. When such things happen, you just know that you killed yourself. So he allowed me to go for modern child spacing methods. I asked him to choose the method that he wanted. He refused to use the condom. So I just had to take the pills. .... And for me to start using the modern contraceptive method I am now using with my current husband, I had asked for his permission. My argument was that the baby was born premature. So I needed to take care of her before becoming pregnant again. I knew that staying in the same house with a man who still wants more children would lead to another pregnancy soon. He agreed and I went for an injection.
> *(Reproductive Decision-Making Project, Tumbuka older woman number four, thirty-five years old with secondary education and having four children surviving).*

In addition to individual women's autonomy and women's perceived power to negotiate their reproductive desires through spousal communication, exposure to the outside world (through migration) has a positive impact on polygynous wives' views about their authority in the timing of their births. As discussed in Chapters three and four, migration exposes individuals to new ideas and lifestyles. Experience of urban lifestyle appears to empower polygynous wives to think that they have the authority to decide to space births. Data shown in Table 7.1 suggests that polygynous wives,

who reported to have once lived in a city for over six months since the age of 15, are 2.65 times more likely to think that they have the power to space births in contrast with those who have never lived in a city.

Factors influencing wives' perceptions about their autonomy in making the decision to stop child bearing

A comparison between factors influencing monogamous wives' perceptions about their authority in deciding to space births and stop childbearing reveals that only spousal communication about desired family size has a significant relationship with monogamous wives' perceptions about their power to decide to stop child bearing whenever they want. Analytical results in Table 7.2 show that monogamous wives who reported to have discussed with their husbands about desired family size are 1.52 times more likely to perceive their authority in decision-making about family size limitation than are those who reported no spousal communication about family size desires.

Comparatively, however, a number of factors have a positive relationship with polygynous wives' perceptions about their power to make autonomous decisions to stop child bearing. Patriliny, wives' perceived freedom to go to the health centre, spousal communication about desired family size and wife's exposure to urban lifestyle appear to empower polygynous wives to think that they have the autonomy in making the decision to stop child bearing.

Table7-2 **Monogamous versus polygynous wives:** estimated odds ratios (from multivariate logistic regression) on wives' perceptions about their autonomy (Yes versus No) in *deciding to stop child bearing* selected women's power variables, MDIC Survey 1998

Co-variates	Estimated odds ratios for monogamous wives (N= 405)	Estimated odds ratios for polygynous wives (N= 125)
Lineage system		
Matrilineal	1.00	1.00
Patrilineal	0.88	3.76*
Wife thinks it is acceptable for her to go to the market without seeking husband's permission		
No	1.00	1.00
Yes	1.60	0.30
Wife thinks it is acceptable for her to go to the health centre without seeking husband's permission		
No	1.00	1.00
Yes	0.91	4.58*
Wife ever talked with husband about desired family size		
No	1.00	1.00
Yes	1.52*	2.83*
Wife ever talked with husband about using modern contraceptive methods		
No	1.00	1.00
Yes	0.69	0.91
Wife informs her husband about the amount of money she earns		
No	1.00	1.00
Yes	0.36	0.65
Wife ever lived in the city for over six months since age 15		
No	1.00	1.00
Yes	1.05	2.99**

Note: ** = significant levels at five percent, * significant levels at ten percent. The following variables have been controlled for in the models and have been excluded from the table and the discussion of analysis: *husband's exposure to urban lifestyle, wife's and husband's schooling, wife's religion, wife's current age, wife's and husband's desired family size, and infant or child mortality.*

Similar to the case of monogamous wives, the supposedly inegalitarian lineage system does empower polygynous wives to think that they can make independent decisions to stop child bearing whenever they want to. Patrilineal polygynous wives are 3.76 times more likely to perceive their power to make autonomous decisions to

limit family size than are matrilineal polygynous wives. Beyond that, perceived wives' freedom to go to the health centre also influences polygynous wives to think that they have the power to make autonomous decisions to stop child bearing whenever they want to. Those who think that it is acceptable for them to go to the health centre without seeking permission from their husbands are 4.58 times more likely to perceive their autonomy in making the decision to stop child bearing than are those who do not think so.

Furthermore, spousal interactions appear to have a positive effect on women's perceptions about their authority to make the decision to stop child bearing. Firstly, wife-to-husband communication about desired family size appears to empower polygynous wives to perceive their autonomy in deciding to limit family size. Those who reported to have had a discussion with their husbands about desired family size are 2.83 times more likely to think that they have the power to stop child bearing whenever they want to than are those who did not. This is also social interaction through migration. Exposure to urban lifestyles appears to influence polygynous wives to sense that they have a role in controlling family size. Polygynous wives who reported to have lived in a city or town for more than six months are 2.99 times more likely to perceive that they have power to make autonomous decisions to stop child bearing than are those who have never lived in a city or town that long.

Discussion

Patrilineal values and women's power to make autonomous reproductive decisions

Three major issues can be drawn from the results discussed above. Firstly, contrary to the current theoretical understanding, a strong patrilineal system empowers married women to make autonomous decisions about child spacing or family size limitation. Although traditionally, matriliny implies women exercising authority, the status of women could be high but their position could usually be weak (Caldwell and Caldwell, 1992) because as discussed in Chapter three, decision-making power was still vested in male folks. Drawing from this, one could argue that since the Chewa have a weakly lineage system, they would be more likely to have more egalitarian ethics than would be the Tumbuka. The weak matrilineal system of the Chewa would be more empowering than would be the strong patrilineal system of the Tumbuka. But the contrary appears to be the case.

While from a feminist perspective, patrilineal systems subordinate women and therefore dis-empower them from making any family decisions or from influencing any family decision-making, analytical results discussed in sections 7.2 and 7.3 show that in fact the inegalitarian system is more empowering than it is thought to be. This raises the question of whether egalitarianism really matters for women's empowerment in reproductive decision-making and ultimately family planning or fertility reduction. This hypothetical question also applies when we compare monogamous and polygynous Tumbuka women. Polygyny, which theoretically is a

function of patriliny, also appears to be an empowering context for Tumbuka women in particular. Logistic regression analysis shows that polygynous Tumbuka women are almost twice more empowered than monogamous Tumbuka women to make autonomous decisions to practice child spacing and are over three times more empowered than their monogamous counterparts to limit family size whenever they want to. This might be an indication that women's resistance to male dominance in patriliny and polygyny produce women's power to make independent reproductive decisions to meet their reproductive goals. Traditionally, Tumbuka women have always expressed their discontent with traditional norms and sanctions through the traditional cult dance *vimbuza* whereas the Chewa women also express their discontents with societal issues through the songs of the *Gule wa Mkulu* cult dance (Kamlongera *et al.,* 1992). The spread of Western religion has reduced the number of Chewa women participating in this cult dance. In this way the Chewa women must have lost their latent power. Although the *vimbuza* dance among the Tumbuka has also been affected by the spread of Western religion, Tumbuka women have retained their covert practices. Through *vimbuza* songs and dance, Tumbuka women used to and still identify a traditionally acceptable channel of expressing and communicating their concerns and covertly use the believed ancestral intervention to achieve their desired goals. In this way, Tumbuka women resist the standing traditional norms and sanctions and they in turn empower themselves. Similarly, in terms of reproductive decision-making, Tumbuka women appear to capitalise on the traditionally accepted child spacing practice and are likely to think that they can space births whenever they want to because they are likely to be supported by the patrilineal principles of

traditional contraceptive practices. Traditional contraceptive norms followed by the Tumbuka prescribe a birth interval of at least two years (Mwale, 1988; Srivastrava and M'Manga, 1992; Alam, *et al.,* 1992; Zulu, 1998). Tumbuka women would therefore feel secure to make autonomous decisions to space births because they know that the system would support them. Their husbands would also not question because they are expected to respect the traditional norms of contraception.

In patrilineal traditional societies, ownership and control of resources is not shared. The strength of patriliny lies in the triangular relationship between the patriarch, his wife and children. The wife takes a middle position (Caldwell and Caldwell, 1992). This means that Tumbuka women have no control over family resources including children. Nevertheless, the findings in this chapter reveal that patrilineal wives are more empowered to think that they could make independent reproductive decisions and implement them. The fact that patrilineal wives, particularly those in polygyny are more likely to think that they can space births or stop child bearing whenever they want to is an indication that they have the ability to make clandestine autonomous decisions. They are likely to engage in clandestine fertility regulation activities such as covert contraceptive use and abortions. For example, a female traditional healer reported that she has been clandestinely giving women traditional contraceptive methods particularly those who have trouble convincing their husbands to use any contraceptives[41].

[41] The author personally interviewed this traditional healer during the 1999 field visit. The interview was conducted because women were uncomfortable talking about covert contraceptive use. The author assumed that the elderly women who prepare traditional contraceptive methods are likely to know more about covert contraceptive use even if they would not give specific names. And indeed this traditional healer confirmed that many women do seek traditional contraceptive methods covertly. She even indicated that she also helps some women to abort.

> Women could come to me and ask me to give them oral traditional contraceptive methods covertly. They could explain to me that their husbands are insisting that they continue child bearing without resting. So, I would help them knowing that what they were doing was the right thing. It could sometimes happen that their husbands would discover that their wives had come to me to ask for medicine. The husbands would come to me asking why I gave their wives medicine. I would ask them: 'is what she took the medicine for a wrong thing?
> *(Special kinship interviews with a female traditional healer).*

Is spousal communication a process of empowerment?

Based on the analytical results discussed in earlier, it could be argued that through the process of spousal communication, women get empowered to perceive their capacity to negotiate desired reproductive behaviours and outcomes through convincing their husbands to use modern contraception. For child spacing, spousal communication about modern contraception permits polygynous wives to perceive that they have the power to make independent decisions to space births or influence their husbands to support their decision to use modern contraceptives for child spacing. Polygynous wives could be using spousal communication about modern contraception to seek spousal approval in order to secure their marriage. It is likely that polygynous wives feel insecure to implement their independent decisions to space births without informing their husbands or without seeking their approval. One could conclude that spousal communication, if ever it takes place, gives polygynous wives the capacity to sense that they would have their husbands' agreement to use modern contraception. Through spousal communication, polygynous wives seek joint couple decision-making about fertility issues.

Spousal communication about desired family size appears to be a very important indicator of women's power to participate in RDMP. As is the case with polygynous wives, women's perceptions that they have the power to space births whenever they want, appear to affect both monogamous and polygynous wives particularly those who talk to their husbands about their family size desires. Through spousal communication women either seek spousal approval or they just want to inform their husbands about their decisions or they seek their husband's support so that they might make joint couple decisions. The fact that married women, whether in polygyny or monogamy, are more likely to sense that they have the power to make autonomous decisions to stop child bearing if they have at one time discussed with their husbands about desired family sizes, suggests that spousal communication is a mechanism through which wives test their perceived autonomy and power. At the same time, they test whether or not they are likely to get support from their husbands to stop child bearing. This is an indication that decision-making about family size limitation is more of a serious issue worth couple discussion than is child spacing.

In fact, as indicated earlier, ethnographic data show that quite a good proportion of polygynous women reported that they have had discussion about family planning with their husbands. The following excerpts suggest that decision-making about family planning is slowly becoming a joint effort. It could be argued that joint decision-making is innovative and therefore reflects changes in the nature of spousal power and communication relationships, which in turn affect the nature of

reproductive decision-making processes. When asked who, between husband and wife, has more say in decision-making about family planning issues, a young Chewa wife, an old Tumbuka husband and an old Chewa husband said:

> It should be the woman because she is the one who gives birth. Even if the man suggests the number of children he wants, may be the woman's body cannot manage that. The strength of the body may have reduced. But if the man insists, the woman should try hard to convince him.
> *(Reproductive decision-making research project, Chewa young woman #3, twenty-seven years old, primary education, four children still living)*

> The man has more say because he is the head of the family. However, he is supposed to agree with the wife because in the house there are two people. So when the man says; 'we should have so many children, the wife considers the problems the man experiences in the house. We men are able to tell that a woman is happy with the idea or not. If she is not happy, we try another way. So if the woman wants more children, the man should try to convince her that stopping at six is good. If you both agree then it means that you share the powers to decide. Otherwise, if the wife and the husband do not agree, then trouble starts. One may start having extra-marital affairs.
> *(Reproductive decision-making research project Tumbuka old man #4, thirty-five years old with primary education and four children still living).*
> **Interviewer:**
> In the past, who used to have more say on the number of children a couple would have?
> **Respondent:**
> To tell the truth, it was the parents of the woman who had the power to decide on the number of children to be born in a family. This is because they are the ones who knew that "the clan is now expanding. It will grow".
> ...These days, however, the husband's relatives claim that the children are theirs. So all the wealth that a family has, they claim that it is for the children. So the husband's young brothers and sisters, or even nieces and nephews cannot claim that wealth. If they fight for the wealth, the children go to Government to

> lodge a complaint. Or else they go to the courts and open a case. So whatever wealth the family accumulates, it is for the father and the children.
> *(Kinship Special Interviews, Chewa old man).*

The above ethnographic interviews show that the locus of reproductive decision-making power has shifted from the lineage to the couple. There is consensus within the rural communities in Malawi about the need for couple discussion and agreement about reproductive issues. As the old man in special kinship interviews reported that these days, children inherit accumulated wealth of the family, wealth flows are slowly shifting from an outward flow of *children-to-parents (including lineage heads)* to an inward flow as it is less toward lineage members and more towards neo-nuclear family members. However, it is important to note that this could be in its very early stages and therefore aggregate data may not show these changes as verified by Wenreib's findings on intergenerational transfers' study (Chapter three).

Westernisation as a process of women's empowerment

Logistic regression analysis and ethnographic data are consistent with my arguments in Chapter four that Westernisation and urbanisation are likely to motivate individuals and couples to change their views about traditional norms and sanctions about child spacing and family size. Ultimately individuals change their reproductive choices, decisions and behaviours. The nature of reproductive decision-making power structure also changes as the lineage looses control and couples or individuals take such powers upon themselves. Return migration status of women has been treated as a proxy for macro-level variable of migration, Westernisation and

urbanisation. Its positive relationship with women's perceptions about their authority in deciding to space births and stop child bearing shows that women's exposure to urban lifestyle is more empowering for polygynous wives than it is for monogamous women. Based on this finding one could argue that women in polygynous unions are generally less empowered than are women in monogamous unions and would therefore require more empowerment than would monogamous women. Yet the analytical results in this chapter are paradoxical. This suggests that polygynous wives use their perceived latent powers derived from their resistance to the male dominating principles of patriliny to survive.

Firstly, polygynous wives capitalise on traditionally acceptable childcare practices such as child spacing and health centre visits. Women's perceived freedom to go to the health centre is likely to be due to the well-known available under-five clinic services. Women, particularly those in polygyny, are likely to perceive their authority in deciding to stop child bearing by clandestine contraceptive use under cover attending under-five services. Such women are likely to clandestinely limit family size under cover of child spacing, which would delay their child bearing until they reach menopause.

Secondly wives derive more power to implement their decisions from spousal communication and thirdly from their exposure to urban lifestyle. Spousal communication and exposure to urban lifestyle are channels for women's empowerment. This is because these two variables are mechanisms used to bring

about change in traditionally rigid principles of spousal communication, which restricted women from free social interaction and expression particularly in relation to reproductive matters (Alam *et al.,* 1992; Kamlongera *et al.* 1992). Women's capability to discuss reproductive issues with their husbands and their exposure to new ideas about contraception through their exposure to urban lifestyle would imply that these women are exposed to new ideas of gender equality and freedom of expression. They are able to negotiate their reproductive desires openly and not covertly as women used to do traditionally through dramatic cult dances. But it is also possible that unsuccessful couple discussions may push women into clandestine contraceptive use.

In fact the introduction of child spacing and family planning programmes in the rural areas of Malawi could be another aspect of Westernisation or urbanisation. It appears to be a challenge to the traditional spousal communication relationships and reproductive decision-making power structure. Although traditional child spacing methods still exist and continue to be used (Srivastrava and M'Manga, 1991; Kalipeni and Zulu, 1993; Zulu 1996, 1998), the introduction of modern child spacing and family planning methods are slowly replacing the traditional contraceptive practices. This suggests that rural Malawian societies are still in transition from traditional to modern contraception. Those women who discuss with their husbands about family planning and those who are return migrants are innovators and therefore agents of change in reproductive behavioural patterns in the rural areas. As indicated in Chapter four, diffusion of new ideas about reproductive behaviours such as use of

modern contraceptive methods and family size limitation is likely to be channelled through women's networks. Through these networks, individual women are likely to be empowered to perceive their power in deciding to space births or stop child bearing and reduce their uncertainties about side effects or benefits of choosing to have fewer children. As this young woman indicated in an interview:

> My friend is also using the injection. She also started with a loop like me. She had problems with it. She used to complain about abdominal pains. We both had the same problem. So we felt that it was better to go for a method that would give us less trouble, which at the same time enabled us to space our births. The problem is that people talk too much about modern contraceptives. They discourage us. In my case, I courageously decided to use them. I said to myself, 'which is better, I give birth and the baby dies or I practice family planning and my baby grows. I can then have another one later'.
> *(Reproductive Decision-Making Research Project, Chewa younger woman number one: thirty-one years old with primary education and four children still living).*

Summary and conclusions

This chapter has covered factors that empower women to perceive that they have some control over the decisions about child spacing and family size limitation. Patrilineal system, spousal communication about family planning, perceived freedom to go to the health centre and women's exposure to urban lifestyle have been identified as significant empowering factors for women either in monogamous or polygynous unions to perceive that they have the capacity to make autonomous.

Specifically, ethical values of patrilineal lineage systems positively affects monogamous as well as polygynous wives' capacity to recognise that they have the

power to make autonomous decisions to space births. Spousal communication about desired family size, however, matters for monogamous wives' empowerment to sense they have the power to make autonomous decisions to stop child bearing. But for polygynous women a few more factors matter. Combination of patriliny, freedom of movement, spousal communication and exposure to urban lifestyle is responsible for their empowerment to make independent reproductive decisions or manage to negotiate their reproductive goals with their husbands.

The discussions in this chapter suggest that lineage, particularly patriliny, has more bearing on women's capacity to influence RDMP than has matriliny. Surprisingly, the relationship between patriliny and women's perceived power in RDMP is contrary to the conventional thinking that patrilineal systems, which are believed to employ inegalitarian ethics, are dis-empowering. This is consistent with Foucault's concept of power that it exists only if there is resistance (Grosz, 1997). This means that Tumbuka women and particularly those in polygynous unions get empowered as they resist against the domineering patrilineal principles.

The situation of the polygynous women suggests that the degree of their power to influence the outcomes of RDMP increases when they have a chance to discuss desired reproductive outcomes with spouses and if they are exposed to modern ideas and lifestyles. This suggests that exposure to urban lifestyle and spousal communication about family planning multiplies the power of polygynous wives to sense that they have the capacity to influence reproductive behaviours and outcomes.

As discussed in Chapter three, women's networks are emerging as alternative channels for women's empowerment. The fact that social interactions have a positive effect, particularly on polygynous wives to make autonomous reproductive decisions is an indication that women living in lineage and marriage systems that apply inegalitarian ethics benefit from their social interactions to develop the capacity for them to exercise some control over RDMP.

Spousal communication has been identified as an empowering process for both polygynous and monogamous wives. If spousal communication is difficult, married women are less likely to negotiate desired reproductive behaviours and outcomes unless they decide to resist and make clandestine autonomous decisions to practise family planning. However, if wise do have a chance to discuss family planning with their husbands, they are likely to perceive whether or not they have the capacity to influence the outcomes of RDMP.

CHAPTER 8

WOMEN'S PERCEPTIONS ABOUT THEIR POWER TO NEGOTIATE DESIRED REPRODUCTIVE OUTCOMES

Introduction

In Chapter seven, spousal communication was identified as a process through which women get empowered to perceive their relative powers in RDMP. In this chapter, it is assumed that before spousal communication about family planning takes place, women perceive that they have their husbands' agreement to space births or limit family size through practising modern contraception. Through discussing family planning with their husbands, wives test whether their perceived husbands' agreement to use modern contraceptives is right or wrong. If perceived spousal agreement to practise modern contraception is proved right then spousal communication about family planning makes married women recognise that they have the capacity to participate in RDMP. The outcome is likely to be a joint couple decision-making. But if wives perceive that the perceived husbands' agreement to practise modern contraception is wrong, then wives discussing family planning with husbands renders wives powerless. This would lead them into autonomous decision-making to use modern contraception secretly or into not using any modern contraception at all.

As preconceived in Chapter four, the outcomes of spousal communication are either spousal agreement leading to joint couple decision-making or spousal disagreement, which produces women's autonomous decision-making or complete power relinquishment. Existing empirical evidence shows that spousal communication about family planning is non-existent or difficult in some unions because wives perceive spousal disagreement to regulate fertility using modern child spacing and family planning methods (Ezeh, 1993; Biddlecom *et al.,* 1996; McGinn *et al.,* 1997; Lassé and Becker, 1997). Based on these arguments, two indicators of women's power to negotiate their reproductive desires are identified. These are *women's perceptions that they have the capacity to convince their husbands to use family planning methods* and *women's perceptions that they are likely to have their husbands' agreement to use family planning methods*. In an attempt to measure these women's power variables, the following hypotheses will be tested:

1) That a more egalitarian lineage system is more likely to allow wives to perceive that they have the capacity to negotiate their reproductive desires than a less egalitarian one.
2) That monogamous wives are more likely to recognise they have the authority to talk to their husbands about the desired birth intervals or number of children than are polygynous wives.
3) That if wives sense that there are more advantages in having small families than in having large families, they are more likely to recognise that they have the capacity to negotiate the desired reproductive behaviours and outcomes.

4) That if wives sense that there are advantages in using modern contraceptive methods they are more likely to think that they have the capacity to negotiate the desired reproductive behaviours and outcomes than if they sense that there are disadvantages to modern contraception.
5) That spousal communication about family planning that ends in agreement is likely to make wives perceive that they have the power to negotiate their desire to practise child spacing and limit family size using modern family planning methods.

As in Chapter seven, regression analyses will be used to test most of these hypotheses. Ethnographic data analyses will provide in-depth explanation of the quantitative analytical results. But since MDIC sample survey did not ask questions related to perceptions about the advantages and disadvantages of small or large families, the two hypotheses related to these perceptions would be tested using RDM ethnographic data.

This chapter is presented in two sections comprising two parts each. The first section is a discussion of the analysis and the results. A sub-section to this is a discussion of the stages involved in the process of reproductive decision-making within the neo-nuclear family. These stages will be derived from an analysis of one selected ethnographic interview. Further examination of these stages of RDMP will be done using analytical results of two regression models for monogamous and polygynous using women's perceptions that they could have their husbands' agreement to use

modern contraceptives as the dependent variable. In the second section, the factors that influence women's perceptions about their power to change their husbands' mind about modern contraception are discussed.

The third section presents the results drawn from the analyses in section two. A sub-section to this is a synthesis of the analytical results related to spousal communication about family planning. In this synthesis, spousal communication about family planning is examined, as a mechanism through which married women develop the capacity to negotiate desired reproductive outcomes. In the final section the findings in this chapter are used to critically examine the relationship between lineage systems, marriage systems and women's power to make autonomous reproductive decisions or to convince their husbands to space or limit births using modern contraception.

Analytical results

What constitutes women's reproductive decision-making processes?

The following ethnographic account by a monogamous matrilineal wife gives an example of the process through which individual wives and couples make reproductive decisions. This account suggests that in RDMP, individual wives consider their own desires about family size as well as those of their spouses before identifying the mechanism to achieve those desires. In the process, they perceive spousal agreement to do something about their family size desires in relation to their perceptions of the comparative advantages of large and small family sizes. A Chewa

woman tells her reproductive life history in which she recounts the process through which she tried to get approval from her husband and his lineage members for her to practice child spacing.

> My husband and I were very happy to have our first child. After five months, we resumed having sex. Soon, I realised that I was pregnant again. I said: "This is serious. What do I do?" My mother in-law came and took the first child away. She took care of that child until I gave birth. After that delivery, I said, "I should not put myself to shame". I went to my mother-in-law to collect a traditional contraceptive method. When I explained to her that I wanted to avoid having close birth spacing, my mother in-law refused to help me. I came back without any contraceptive medicine. After five months, I became pregnant again. My father in-law came and took the second child away. So I felt that the three pregnancies were too close for my health. I wondered what I could do. I felt that I needed to try harder to solve this problem. I went to my husband's aunt and asked her to help me have a traditional contraceptive string[42]. She prepared one for me and put it on my waist. I used that string to space four children since then. I would keep the string on my waist until the new child started walking. After a while, I could tell that my husband wanted us to have another child. Then I would cut the string.
>
> I was really scared with the way I had started child bearing. When I had eight children, I felt that I would have more difficulties with childbearing. So I decided to start using modern child spacing and family planning methods. By then, I had heard about the injection. I asked my husband if I could start using the injection. He said: "No, you should not start this early. Let's have another child to make nine". Later, he said let's have ten, then eleven. Then I said to myself: "This will not help me. I may not live to enjoy myself with these children (She meant to say she could not live long enough to be supported by her children in future). So, I just told him that I am going to have the injection. I

[42] A traditional contraceptive string is made up of a simple string with beads traditionally worn by women around the waste. Pieces of root of a herb believed to have the power to prevent conception are put together with the beads. It is believed that when the string with beads and the contraceptive root pieces are around the waste, the contraceptive power of the root penetrates through the woman's body and she cannot conceive at anytime. She can only conceive when the string is untied or broken.

> have since had the injection three times, and then I just dried up (She could no longer conceive). So I told him that I am happy it happened that way. I said, "Let's just take care of these children now". I really felt bad. My friends had only six or seven children and yet I had more than that. I felt that mine were too many for me. That was how I stopped child bearing.
> *(Reproduction Decision-Making research project, Chewa old woman number three, Chewa wife, 39 years old with primary education and six children still living out of 11 births)*

According to this account, no overt spousal communication about family planning took place in this family until late in the woman's reproductive lifetime because the wife could perceive her husband's disapproval of contraceptive use. However, the wife perceived spousal disagreement to use any contraceptive method through her husband's covert communication. When open discussion took place, the wife did not manage to convince her husband to use family planning methods for her to stop child bearing. Neither did she get support from her mother-in-law but did get support from her husband's aunt. One would argue that this woman was also communicating her reproductive desires covertly to her husband through his relatives and her secret use of traditional contraceptive string. Her husband also communicated covertly about his desire for more children. Overt communication took place after the wife decided to stop child bearing.

Consistent with findings in Chapter seven and the above account, spousal communication about family size limitation is often overt. This means that women decide to negotiate or inform their husbands about their desire and decision to limit family size. In fact the above account shows that the wife was empowered because

she resisted her husband's disapproval and went ahead to implement her decision to stop childbearing, using the semi-permanent family planning method of injection. One could speculate that her parity, her understanding of the advantages of modern contraception and her social interaction with her women's network group empowered her to make her independent decisions to space births or stop child bearing.

This suggests that a combination of factors were responsible for this woman to make the autonomous decision to space her births using a traditional contraceptive method and finally the decision to stop child bearing using a family planning method. Firstly, this woman was concerned about her health and that of her children. This means that she perceived family health as the main advantage of practising contraception. Secondly, she also wanted to secure her marriage. This explains why she sought support or approval from her husband's relatives and later from her own husband. Thirdly, she feared losing her integrity in her women's network group if she had more children than her colleagues.

A number of issues are worth noting from the above discussion for the purpose of the analysis in this chapter. RDMP involve so many other processes and actors. Firstly an outcome of covert spousal communication, is that wives perceive the agreement of their significant others to use any contraceptive method. Covert communication is derived either directly from spousal attitude expressed non-verbally or indirectly from the traditional norms and sanctions of traditional

contraception. Secondly, a wife perceives her power in influencing the significant others (her husband's relatives or her husband) to support her desires to practise child spacing and family size limitation through successful overt communication with the significant others. Third, a combination of perceived spousal agreement and perceived power to convince significant others, particularly the husband, to use modern contraception empowers a woman to negotiate her desires to space births or stop child bearing. In the second section, the factors that influence wives' perceptions that they have the capacity to negotiate desired reproductive behaviours and outcomes are discussed in detail.

Regression analysis results displayed in Table 8.1 show that spousal communication about modern contraception has a significant relationship with women's perceptions about spousal agreement to use modern contraceptives regardless of type of union. Monogamous wives who reported to have had a discussion with their husbands about modern contraception are 5.80 times more likely to perceive spousal agreement to use modern contraceptives than are those who reported no spousal communication. To a lesser degree, polygynous wives who reported to have discussed family planning with their husbands are 3.46 times more likely to report perceived spousal agreement to use modern contraceptives than are those who did not report any couple discussion of family planning.

Table 8-1 **Monogamous versus polygynous wives:** estimated odds ratios (from multivariate logistic regression) on wives' perceptions about husbands' agreement to use modern contraceptives (Yes versus No), by selected women's power variables, MDIC Survey 1998

Co-variates	Estimated odds ratios for monogamous wives (N= 405)	Estimated odds ratios for polygynous wives (N= 125)
Lineage		
Matrilineal	1.00	1.00
Patrilineal	1.00	0.17**
Wife thinks it is acceptable for her to go to the market without seeking husband's permission		
No	1.00	1.00
Yes	0.75	0.13**
Wife thinks it is acceptable for her to go to the health centre without seeking husband's permission		
No	1.00	1.00
Yes	0.75	4.57*
Wife ever talked with husband about desired family size		
No	1.00	1.00
Yes	1.42	1.12
Wife ever talked with husband about using modern contraceptive methods		
No	1.00	1.00
Yes	5.80***	3.46**
Wife informs her husband about the amount of money she earns		
No	1.00	1.00
Yes	2.04	1.88
Wife ever lived in the city for over six months since age 15		
No	1.00	1.00
Yes	0.74	1.24

Note: *** = significant levels at one percent, ** = significant levels at five percent, * significant levels at ten percent. The following variables have been controlled for in the models and have been excluded from the table and the discussion of analysis: *husband's exposure to urban lifestyle, wife's and husband's schooling, wife's religion, wife's current age, wife's and husband's desired family size, and infant or child mortality.*

All other empowerment variables have no significant effect on monogamous wives perceptions about their husband's approval of family planning but a few do for polygynous wives. A wife's perceived freedom to go to the health centre is an

indicator that she perceives spousal agreement to use modern contraceptives. Those polygynous wives who reported that they think it is acceptable for them to go to the health centre without seeking their husbands' permission are 4.57 times more likely to perceive their husbands' agreement to use modern contraceptives than are those who did not.

On the contrary patriliny and perceived freedom to go to the market without seeking husbands' permission have a negative relationship with polygynous wives' perceptions about their husbands' agreement to use modern contraceptives. Patrilineal wives living in polygynous unions are 83 percent less likely to report they perceive spousal agreement to use modern contraceptives than are matrilineal ones living in monogamous unions. Furthermore, polygynous wives who reported that they think it is acceptable for them to go to the market without seeking their husbands' permission are 87 percent less likely to think their husbands would agree to use modern contraceptives than are those who reported otherwise.

Ethnographic data shows that almost the same proportion of wives reported having had a discussion with their husbands about modern contraception and about desired family size (See Table 8.2). Out of the 16 wives interviewed under RDM research project, ten reported to have talked with their husbands about family planning and eleven reported to have had a discussion with their husbands about desired family size. Two of the sixteen respondents neither discussed the use of modern contraceptives nor desired family size. Three had talked about using modern

contraceptives but not about desired family size. Another three reported to have only talked about desired family size but not about using modern contraceptives. Based on this pattern of reported spousal communication about family planning, one would argue that when spouses discuss about modern contraception, they are also likely to discuss issues of desired family size. This suggests that spousal communication about family planning involves a discussion of both modern contraception and family size limitation. Therefore perceived spousal agreement to use modern contraceptives must also be related to perceived spousal agreement to limit family sizes.

Table 8-2 Wives' reports relating to their conversations with their husbands about family planning, RDM Ethnographic Interviews 1998

Respondent	Question	Response	Question	Response
	Ever talked with husband about desired family size?		Ever talked with husband about using modern contraception?	
COW(1)		Yes		Yes
COW(2)	"	No	"	Yes
COW(3)	"	Yes	"	Yes
COW(5)	"	No	"	No
CYW(1)	"	Yes	"	Yes
CYW(2)	"	Yes	"	Yes
CYW(3)	"	Yes	"	No
CYW(4)	"	Yes	"	No
NOW(1)	"	Yes	"	Yes
NOW(2)	"	Yes	"	No
NOW(3)	"	No	"	No
NOW(4)	"	No	"	Yes
NYW(1)	"	Yes	"	Yes
NYW(2)	"	Yes	"	Yes
NYW(3)	"	No	"	Yes
NYW(4)	"	Yes	"	No

Note: COW = Central Old Woman, CYW = Central Young Woman, NOW = North Old Woman, NYW = North Young Woman.

What makes women recognise that they have the capacity to negotiate desired contraceptive behaviour?

The analytical results in this section appear to be contrary to the conventional wisdom. But a critical examination of these results reveals that they reflect the true logical stages that married women go through in their attempt to participate in RDMP. Spousal communication comes out as a very significant intermediate variable for women's power to participate in RDMP. As was the case with perceived spousal agreement to use modern contraception in earlier section, spousal communication is a channel through which wives confirm their perceptions that they have the capacity to convince their husbands to use modern contraception.

To begin with, based on results displayed in Table 8.3 below, lineage does influence monogamous wives to perceive that they have the capacity to convince their husbands to practise modern contraception. Monogamous patrilineal wives are 1.69 times as likely as are monogamous matrilineal wives to think that they have no power to convince their husbands to use modern contraceptive methods. Also spousal communication about modern contraception makes monogamous wives sense that they cannot change their husbands' mind about practising modern contraception. This is because they have already been told that modern contraception would not be tolerated. Thus monogamous wives who reported to have had a discussion with their husbands about modern contraception are 1.54 times more likely to recognise that they have no power to convince their husbands to use modern

contraceptive methods than are those who reported to have had no discussion about modern contraception with their husbands.

Table 8-3 **Monogamous versus polygynous wives:** estimated odds ratios (from multivariate logistic regression) on wives' perceptions that they lack the capacity to convince their husbands to use modern contraceptives

Co-variates	Estimated odds ratios for monogamous wives (N= 405)	Estimated odds ratios for polygynous wives (N= 125)
Lineage		
Matrilineal	1.00	1.00
Patrilineal	1.69**	0.67
Wife thinks it is acceptable for her to go to the market without seeking husband's permission		
No	1.00	1.00
Yes	1.28	0.46
Wife thinks it is acceptable for her to go to the health centre without seeking husband's permission		
No	1.00	1.00
Yes	1.03	3.44*
Wife ever talked with husband about desired family size		
No	1.00	1.00
Yes	1.46	0.87
Wife ever talked with husband about using modern contraceptive methods		
No	1.00	1.00
Yes	1.54*	1.01
Wife informs her husband about the amount of money she earns		
No	1.00	1.00
Yes	0.55	10.32*
Wife ever lived in the city for over six months since age 15		
No	1.00	1.00
Yes	0.88	4.09***

Note: *** = significant levels at one percent, ** = significant levels at five percent, * significant levels at ten percent. The following variables have been controlled for in the models and have been excluded from the table and the discussion of analysis: *husband's exposure to urban lifestyle, wife's and husband's schooling, wife's religion, wife's current age, wife's and husband's desired family size, and infant or child mortality.* **Special note:** The question related to the variable *wife thinks she lacks capacity to convince her husband to use modern contraception* was: "If my partner does not want to use modern child spacing methods, there is nothing I can do about it" **(Agree or Disagree)**. Those who said they agree meant that they think they do not have the capacity to convince their husbands to use modern contraception. Those who said they disagree meant that they think they do have the capacity to convince their husbands to use modern contraception.

For polygynous wives, perceived freedoms of movement, spousal communication about earnings and exposure to urban lifestyles are the most significant factors that make them think that they do not have the ability to convince their husbands about modern contraception. Data in Table 8.3 show that polygynous wives, who think that they are free to go to the health centre at will are 3.44 times more likely than are those who think that they are not free to go to the health centre whenever they want to think that they can not change their husbands' mind about practising family planning.

Furthermore, those who reported to have talked with their husbands about their earnings are 10.32 times more likely to think that they lack the power to convince their husbands to use modern contraceptives than are those who did not. Also those polygynous wives who are return migrants are 4.09 times more likely to think that they do not have the capacity to change their husbands' attitude about family planning than are those who are not return migrants.

Based on the above results, it appears that married women (in monogamous or polygynous unions) do make use of any chance that they may have to discuss with their husbands to confirm their perceptions that their husbands would agree to use modern contraception or that they have the capacity to convince their husbands to use modern contraception. In fact, one way they test their perceptions is when they capitalise on the advantages of modern contraception, the advantages of small families and the disadvantages of large families to convince their husbands to use family planning methods. Table 8.4 is a display of the RDM ethnographic data

analysis in which the relationship between the following variables is assessed: *wife-to-husband communication about modern contraception, wife-husband communication about desired family sizes, wives' perceptions about the advantages of modern contraception, wife's perceptions about the advantages of small families* and *wives' perceptions about the disadvantages of large families.*

Table 8-4 Spousal communication about family planning (Yes versus No) and wives' perceptions about the advantages of small families, the disadvantages of large families and the advantages of modern contraception, RDM Ethnographic Interviews 1998

Respondent	Discussed desired family size and perceive advantages of small families or perceive disadvantages of large families	Discussed desired family size and perceive advantages of modern contraception	Discussed modern contraception and perceive advantages of small families or perceive disadvantages of large families	Discussed modern contraception and perceive its advantages
COW(1)	Yes	-	Yes	-
COW(2)	-	-	Yes	-
COW(3)	Yes	-	Yes	-
COW(5)	-	-	-	-
CYW(1)	Yes	-	Yes	-
CYW(2)	-	-	-	-
CYW(3)	-	-	-	-
CYW(4)	-	-	-	-
NOW(1)	Yes	Yes	Yes	Yes
NOW(2)	Yes	Yes	-	-
NOW(3)	-	-	-	Yes
NOW(4)	-	-	-	-
NYW(1)	-	Yes	-	Yes
NYW(2)	Yes	-	Yes	-
NYW(3)	-	-	Yes	-
NYW(4)	Yes	-	-	-

Note: COW = Central Old Woman, CYW = Central Young Woman, NOW = North Old Woman, NYW = North Young Woman.

It appears close to the same proportion of wives, who reported to perceive advantages of small families and disadvantages of large families, reported to have discussed modern contraception and ideal family sizes with their husbands (See Table 8.4). The same proportion of wives who reported to perceive advantages of

modern contraception, reported to have talked with their husbands about modern contraception and desired family sizes.

The above results suggest that wives are likely to capitalise on their perceived advantages of small families and their perceived disadvantages of large families to initiate a discussion of reproductive issues with their husbands and in the process negotiate their reproductive desires. This is probably because wives might think that their husbands are likely to have similar perceptions and are likely to agree with them to limit family sizes with an aim to avoid facing the problems that arise from having a large family. As data in Table 8.5 show, the largest proportion of the husbands who were interviewed under RDM ethnographic research reported that they see advantages in having small families and practising modern contraception.

Table 8-5 Husbands' perceptions about the advantages of small families, the advantages of modern contraception and the disadvantages of large families, RDM Ethnographic Interviews 1998

Respondent	Perceive advantages of small families	Perceive disadvantages of large families	Perceive advantages of modern contraception
COM(1)	Yes	Yes	-
COM(2)	Yes	Yes	Yes
COM(3)	-	-	Yes
COM(4)	Yes	-	Yes
CYM(1)	-	-	Yes
CYM(3)	Yes	-	Yes
CYM(4)	Yes	-	-
CYM(6)	-	-	-
NOM(1)	Yes	-	-
NOM(2)	Yes	Yes	Yes
NOM(4)	-	Yes	-
NOM(5)	-	-	Yes
NYM(1)	Yes	-	-
NYM(2)	Yes	Yes	Yes
NYM(4)	Yes	Yes	Yes
NYM(5)	-	Yes	Yes

Note: COM = Central Old Man, CYM = Central Young Man, NOM = North Old Man, NYM = North Young Man.

However, relatively smaller proportions (only seven male respondents out of 16) reported that they felt large families were a source of family problems. They cited economic hardship, food shortage, land shortage, health problems, and children's lack of discipline as the main disadvantages of having large families. But both husbands and wives mentioned economic, land and food problems that are related to having many children. Most husbands and wives perceived economic advantages, land and food availability as the main benefits of having small families.

Discussion

Spousal communication: a process for women to develop negotiating power

The logistic regression analysis and the ethnographic data analysis are consistent with the argument that spousal communication tests perceived spousal agreement to use modern contraceptive methods. The direct link between perceived spousal agreement to practise modern contraception and perceived spousal agreement to limit family size might explain the negative relationship between patriliny, polygyny and women's probability to perceive spousal agreement to use modern contraceptives. This is because inegalitarian societies like those of the Tumbuka patrilineal people do not encourage men to discuss fertility matters with their wives. Traditionally, patrilineal wives are expected to only listen and perform their reproductive roles without questioning (FAO, 1994).

It could be argued that within the conjugal unit, patrilineal husbands are agents of the patrilineal system and matrilineal wives are agents of the matrilineal system. Polygynous patrilineal wives are less likely to perceive spousal agreement to use modern contraceptives because they know that by having many wives, their husbands want many children. The act of patrilineal husbands marrying many wives is one channel of covert communication about their desire for many children, hence the perceived husbands' disagreement to use modern contraceptives. One could speculate that this covert communication could make wives sense that they do not have the power to change their husbands' mind about child spacing or limitation of family size using family planning methods.

Ethical values of the lineage and women's perceptions that they have negotiating power

Monogamous wives: perceived power to negotiate desired reproductive behaviours and outcomes

Findings in this chapter suggest that monogamous wives sense from the ethical principles of a patrilineal system that they do not have the capacity to negotiate their reproductive desires because they are aware that they cannot change their husbands' mind about family planning. This suggests that only monogamous wives in matrilineal societies recognise they have the ability to change their husbands' attitude towards the use of family planning methods. The matrilineal monogamous wives use the ethical principles of matriliny, which assumes that reproductive decision-making

power lies in the female kin, to consider themselves having the capacity to change their husbands' mind about family planning. These findings are consistent with the two hypotheses: a) that a more egalitarian system, in this thesis, the weak matrilineal system practised by the Chewa people, is likely to permit wives to sense they have the capacity to negotiate their reproductive desires and b) that monogamous wives are more likely than polygynous wives to recognise that they have the capacity to talk to their husbands about family planning.

Ethnographic data shows that monogamous wives have a strategy, which they use to convince their husbands to sue family planning methods. Since monogamous wives are likely to discuss family planning with their husbands (Chapter six), they use perceived disadvantages of large families and perceived advantages of small families to convince their husbands to agree to use modern contraceptives. As discussed in chapter eight, husbands and wives have similar perceptions about the disadvantages of many children and advantages of fewer children. This consistency between spousal perceptions about the benefits of limiting family size is likely to empower wives to perceive their husbands' agreement to use modern contraceptives. Consistency between spousal perceptions about the benefits of limiting family size might reflect the impact of economic and environmental crises on people' values about traditional norms and sanctions regarding family sizes. Through spousal communication, it is also these perceived benefits of limiting family size that monogamous wives are likely to use to convince their husbands to agree to use modern contraception.

Polygynous wives: perceived power to negotiate desired reproductive behaviours and outcomes

Perceived autonomy in deciding to go to the health centre, spousal communication about earnings and exposure to Western ideas are the predictors of polygynous wives' perceptions that they do not have the power to change their husbands' attitude towards family planning. Instead, polygynous wives appear to make use of their already acquired autonomy to meet their reproductive desires. However, exposure to Western ideas and their economic power are likely to enhance their already acquired autonomy. Polygynous wives' perceptions that they have the freedom to go to the health centre whenever they want is an indicator of autonomous contraceptive decision-making and clandestine contraceptive use. This suggests that polygynous wives are aware that they do not have the power to convince their husbands to use modern contraception. They capitalise on their already acquired latent powers to make reproductive decisions for the survival of the members of their households. For example, the following excerpts show how polygynous wives (in patrilineal and matrilineal systems) struggle to convince their husbands to use modern contraception even those who have lived in the city or have higher education level:

> **Interviewer:**
> So when your husband did not want you to go for the contraceptive injection, what reasons did he give for that?
> **Respondent:**
> He said; "We should continue with child bearing. Otherwise, I am going to marry another woman". I said to him: "Go ahead". He did marry another woman. He had one child with that woman. Then when his mother came to visit us, she asked him: "Have you married another woman? Why?" He replied to her saying: "It is because this one is playful. She does not want to have children".

His mother said: "Are these children too few for you?" He said: "No, I just want children". Then my mother-in-law sent away the other woman. But he just brought that woman back".

(Reproductive decision-making research project; Chewa Older Women number three, 39 years old with some primary schooling and six children surviving out of more than ten births).

Interviewer:

If you let your husband have another wife, don't you fear that he will contract AIDS and affect you?

Respondent:

I told him that immediately he marries another woman that will be the end of us having sex. I would let him enter the house only to see the children. He said: "Then it's better that we just stay the way we are staying now". I said to him: "You are still young. You haven't had many children. You may want to continue with childbearing. I for one, I do not want to continue with childbearing. This is the last one. If you still want to have more children, marry another woman. .... When I say that, he responds saying: "Don't tell me that. I am a man. When I want to marry another woman, it is me who will tell you and not you telling me. Don't tell me that as if you are the man in this house". So, I tell him: "don't bother me anymore about you wanting to have anymore children".

(Reproductive Decision-Making research project, Tumbuka older women number four living in a levirate union, 35 years old with secondary education and four children surviving out of five children).

Summary and conclusions

Based on the discussion in this chapter, spousal communication about family planning empowers married women to have some relative control over RDMP. From the analyses and discussion, women's power in RDMP is an outcome of their

responses to circumstances surrounding them. Depending on the strength of spousal communication relationship, individual wives either make autonomous reproductive decisions or participate in joint couple reproductive decisions. They develop the courage to negotiate desired reproductive outcomes with their significant others (particularly spouses) when they perceive spousal agreement to practise family planning. In fact, spousal communication (overt or covert) proves perceived spousal agreement to use modern contraceptives right or wrong. It also makes married women perceive that they have the capacity to change their husbands' mind about using family planning and influencing the outcomes of RDMP.

Overt spousal communication has three possible outcomes. First, if the negotiation fails, wives are likely to relinquish their perceived power to make reproductive decisions. Secondly, if there is a disagreement, wives are likely to opt for clandestine autonomous reproductive decision-making. Third, if the discussion ends in agreement, wives are likely to participate in joint couple RDMP and therefore recognise that they have the capacity to influence the outcomes of RDMP.

These findings are consistent with the hypothesis that monogamy and a weak matrilineal system empower wives to perceive they have the capacity to negotiate their reproductive desires. They are also consistent with the other hypotheses: that wives' perceptions about the advantages of small families, wives perceptions about the disadvantages of large families and wives' perceptions about the advantages of modern contraception will empower women to negotiate desired reproductive

behaviours and outcomes through discussing these issues with their husbands. This would mean that wives capitalise on the economic crisis and issues of quality of life to convince them to appreciate the need for family planning. Monogamous wives, who, as identified in Chapter seven, are less autonomous than are polygynous wives, make use of overt spousal communication to sense whether or not they lack the power to negotiate their reproductive desires. But polygynous wives deduce from covert spousal communication that they do not have the power to change their husbands' mind about family planning.

CHAPTER 9

WOMEN'S PERCEPTIONS ABOUT THEIR POWER TO USE MODERN CONTRACEPTIVE METHODS COVERTLY

Introduction

This chapter begins with the assumption that married women's perceptions about their power to make autonomous decisions to use contraceptives whenever need arises will make them perceive their power to use modern contraceptive methods covertly. Wives' perception that they have the power to make autonomous decisions to use modern contraceptives covertly is a predictor of married women's power to make autonomous reproductive decisions. Autonomy being an indicator of acquired latent power; it is an indicator of lack of negotiating power. The analysis in this chapter will compare factors that influence perceived covert contraceptive use among monogamous and polygynous wives.

Findings discussed in Chapters six to eight show that lineage values, women's perceived autonomy, women's perceived negotiating power (through spousal communication) and Westernisation are the forces behind women's perceptions of their power to make autonomous decisions to space births or to stop child bearing or to negotiate desired contraceptive behaviours. In Chapter eight, it was argued that covert spousal communication about family planning pushes wives into making

autonomous decisions and use modern contraceptive methods clandestinely. It is also argued that overt spousal communication that ends in disagreement make some wives use modern contraception secretly.

Considering that it is unlikely for covert contraceptive users to report their actual current use (Biddlecom and Fapounda, 1996), it will be assumed that covert contraceptive users are likely to report their perceived covert contraceptive use. Factors contributing to married women's perceptions about current use of modern contraception are likely to be predictors of actual current use of modern contraceptive methods. The analysis in this chapter will be focused on wives' reported perceptions that covert contraceptive use could occur. Multivariate and bi-variate logistic regression analyses and ethnographic data will be used to test the hypotheses:

1) That, a less gender egalitarian lineage system is more likely than is a more egalitarian lineage system to influence married women to make autonomous decisions to use modern contraceptive methods without their husbands' knowledge.
2) That, polygynous wives are more likely to make autonomous decisions to use modern contraceptive methods covertly than are monogamous wives.
3) That, if couple discussion about using family planning methods ends in disagreement, wives are more likely to sense that they have the power to make autonomous decisions to use modern contraceptive methods covertly than if it ends in agreement.

4) That, if wives perceive that they have the power to make autonomous decisions to space births or to stop child bearing, they are more likely to recognise that they have the capacity to make autonomous decisions to use modern contraceptive methods without their husbands' knowledge.

In order to test these hypotheses, the following dependent variables will be used for analysis: *wives' perceptions about their power to make autonomous decisions to use modern contraceptives without their husbands' knowledge.* Two multivariate logistic regression models will be run: one for monogamous wives and the other for polygynous wives, using the independent variables (lineage, perceived freedom of movement, spousal communication about family planning and earnings and wife's exposure to urban lifestyle) and control variables (husband's exposure to urban life style, household economic status, wife's income generating status, husband's and wife's years of schooling, wife's religion, wife's current age, wife's desired family size, husband's desired family size and infant/child death) as co-variates. But the control variables will be excluded from the discussion in this chapter.

This chapter will be presented in two sections. The first section will be a discussion of the relationship between the predictors of women's power in RDMP and wives' perceptions that they have the power to make autonomous decisions to use modern contraceptives without their husbands' knowledge. That discussion will compare the likelihood that women's power variables (the independent variables) will influence

monogamous and polygynous wives to develop the capacity to make autonomous decisions to use modern contraceptives covertly.

The second section will be a critical discussion of the logistic regression analysis presented in the first section. This section will comprise three sub-sections, which will be a critical interpretation of the significant relationships between some measures of women's power in RDMP and perceived covert contraceptive use among monogamous and polygynous wives. This chapter will finally assess whether or not perceived covert modern contraception is a predictor of married women's power to make autonomous reproductive decisions.

Analytical results

Factors influencing wives' perceptions about their power to make autonomous decisions to use modern contraceptive methods covertly

Data in Table 9.1 show that patrilineal system and spousal communication have a significant and positive relationship with monogamous wives' perceptions about their power to use any contraceptive method whenever they want to. Patrilineal monogamous wives are 2.85 times more likely to think that they have the power to make autonomous decisions to use modern contraceptive methods covertly than are matrilineal monogamous wives. Comparatively, patrilineal polygynous wives are much more likely to think that way than are matrilineal monogamous wives. Patrilineal polygynous wives are 6.50 times more likely to perceive that they have

the power to use contraceptives without their husbands' knowledge than are matrilineal ones.

Table 9-1: **Monogamous versus polygynous wives:** estimated odds ratios (from multivariate logistic regression analysis) on wives' perceptions that they have the power to use modern contraceptives covertly (Yes versus No), by selected women's empowerment variables, MDIC 1998

Co-variates	Estimated odds ratios for monogamous wives (N= 405)	Estimated odds ratios for polygynous wives (N= 125)
Lineage system		
Matrilineal	1.00	1.00
Patrilineal	2.85***	6.50***
Wife thinks it is acceptable for her to go to the market without seeking husband's permission		
No	1.00	1.00
Yes	1.00	0.37
Wife thinks it is acceptable for her to go to the health centre without seeking husband's permission		
No	1.00	1.00
Yes	1.01	2.23
Wife ever talked with husband about desired family size		
No	1.00	1.00
Yes	1.96**	0.81
Wife ever talked with husband about using modern contraceptive methods		
No	1.00	1.00
Yes	1.68*	0.99
Wife informs her husband about the amount of money she earns		
No	1.00	1.00
Yes	0.00	5.49
Wife ever lived in the city for over six months since age 15		
No	1.00	1.00
Yes	1.07	2.64*

Note: *** = significant levels at one percent, ** = significant levels at five percent, * = significant levels at ten percent. The following variables have been controlled for in the models and have been excluded from the table and the discussion of analysis: *husband's exposure to urban lifestyle, wife's and husband's schooling, wife's religion, wife's current age, wife's and husband's desired family size, and infant or child mortality.*

The data in Table 9.1 also shows that wives who have once had a discussion with their husbands about desired family size and modern contraception are about twice more likely to perceive that they have the power to engage in covert contraceptive

use than are those wives who have never had any discussion with their husbands about family planning. No other factor, except wife's exposure to urban life style, is significantly related to polygynous wives' perceptions about their power in deciding to use modern contraceptives covertly. Polygynous wives who have once lived in the city are 2.64 times more likely to think that they have the power to decide to use modern contraceptive methods whenever they want to than are those who reported to have never been to the city before.

Discussion

Male dominance and women's perceived power to use modern contraception covertly

As findings in Chapters six to eight also suggest, patrilineal lineage system appears to allow married women to have some autonomy in making reproductive decisions. This is contrary to the conventional thinking that women in non-egalitarian lineage systems are likely to be subordinated. In earlier chapters, it has been found out that patrilineal wives are more likely to perceive that they have the power to make autonomous reproductive decisions than are matrilineal wives. As the analytical results in this chapter show, indeed that perceived autonomy translates into clandestine contraceptive behaviour. Whether in monogamous or polygynous unions, patrilineal wives are more likely to think that they can use modern contraceptives without their husbands' knowledge than are matrilineal wives. This suggests that ethics of the lineage affect women's views about their degree of power in RDMP.

Current use of modern contraception can be interpreted as latent power, which could be an outcome of women's resistance to male dominance.

Spousal communication and perceived power to use modern contraception covertly

The findings in this chapter are consistent with the empirical evidence discussed in Chapters seven and eight that spousal communication is a mechanism for the empowerment of married women to develop the capacity to negotiate desired reproductive behaviours and outcomes. Spousal communication was also identified as a channel through which wives can prove their perceptions about spousal agreement to use modern contraception right or wrong. In the present chapter, spousal communication is significant only for monogamous wives' perceptions about their power to use modern contraceptives whenever they want.

The discussion in Chapter six also revealed that more monogamous and matrilineal wives than polygynous and patrilineal wives discuss with their husbands about family planning. These findings show that monogamous and matrilineal systems (contrary to polygynous and patrilineal systems) are contexts that empower married women to negotiate desired reproductive outcomes through overt spousal communication. This is consistent with the findings in Chapter eight that for patrilineal and monogamous wives, couple discussion about modern contraceptives develops in them the ability to sense that they have the capacity to convince their husbands to use modern contraceptives.

Ethnographic evidence presented in Chapter eight show that covert or unsuccessful communication pushes women into thinking of engaging in covert contraceptive practices. This suggests that whether spousal communication about family planning takes place or not, married women are still likely to think of current use of modern contraceptives. Monogamous and matrilineal wives who are less autonomous than polygynous and patrilineal wives (Chapter seven) probably use their perceived negotiating power (through spousal communication) to develop the capacity to influence the outcomes of RDMP. This also explains why these less autonomous wives capitalise on perceived advantages of small family sizes, perceived disadvantages of large family sizes and perceived advantages of practising modern contraception to convince their husbands to use modern contraceptives by raising these issues with their husbands.

Negotiation, through spousal communication appears to be an empowering process for monogamous and matrilineal wives to recognise that they have the capacity to make autonomous reproductive decisions or to participate in RDMP. If the negotiation is not successful, these women may choose to engage in clandestine contraceptive use. In contrast, the next section illustrates that what really matters for polygynous and patrilineal wives is a combination of perceived autonomy to make reproductive decisions and an environment that permits them to implement their autonomous reproductive decisions.

Social change and women's perceived power to use contraceptives covertly

Apart from the lineage system, Westernisation has also been identified as a determinant of clandestine contraceptive use particularly among polygynous wives. Westernisation through exposure to urban lifestyle has a significant influence particularly on polygynous wives' views about current use of modern contraceptive methods suggesting that Westernisation is more relevant for the empowerment of polygynous wives than it is for the empowerment of monogamous wives. If one critically reviews the impact of Westernisation on polygynous wives' perceptions about their autonomy in deciding to use modern contraceptives, one would argue that modern contraception is a challenge to the balance of traditional conjugal power relations. Wives' perceived power to use modern contraceptives covertly might indicate the surfacing of traditional practice of covert contraceptive use. This suggests that modern and traditional contraceptive practices have two different types of power structures.

The transition from traditional to modern contraception, which has led to a change in the locus of contraceptive decision-making, might have exposed some hidden elements of traditional contraceptive practices. Married women have always had some autonomy in deciding to use traditional contraceptives covertly. Elderly women who controlled traditional contraceptives facilitated this autonomous contraceptive decision-making and covert contraceptive use particularly when the health of the mother was at risk (Zulu, 1996). The actual or potential current users of modern

contraceptives might expect family planning service provision to offer opportunities similar to those provided by traditional contraceptive services.

Since traditionally, Tumbuka women are famous for covert communication about their feelings towards societal issues (Kamlongera *et al.,* 1992) it is not surprising that they are the most autonomous in making reproductive decisions. As the following excerpt suggests, traditional contraceptive providers could provide covert services to some wives who have trouble convincing their husbands to use modern contraceptives. A female traditional healer (also a birth attendant) confirmed this in an interview[43].

> Women could come to me and ask me to give them oral traditional contraceptive methods covertly. They could explain to me that their husbands are insisting that they continue child bearing without resting. So, I would help these women knowing that what they were doing was the right thing. It could sometimes happen that their husbands would discover that their wives had come to me to ask for medicine. The husbands would come to me asking why I gave their wives medicine without their knowledge. I would ask them: 'is what she took the medicine for a wrong thing?
> *(Special kinship interviews with a traditional birth attendant).*

Based on these findings, married women generally think that clandestine contraceptive use may occur whether or not they perceive spousal agreement to practise modern contraception and whether or not negotiations for limiting family size or for use of modern contraceptives have occurred or have been successful. This

[43] The author personally interviewed this traditional healer during the 1999 field visit. The interview was conducted because the author noticed that most women were uncomfortable talking about covert contraceptive use. It was assumed that women who prepare traditional contraceptive methods are likely to know more about covert contraceptive use even if they would not

implies that wives' perceived power to make autonomous fertility and contraceptive decisions make them perceive their power to use modern contraceptives covertly.

Diffusion of new ideas about modern contraception, through Westernisation (as one aspect of social change) empowers polygynous wives in particular to think that they have the power to make autonomous contraceptive decisions. Westernisation leads to erosion of traditional norms and sanctions about contraception. As the older women lamented in a focus group interview that

> **All respondents:**
> These young people of today tell us that; "Those were the old days. These are modern days. These things you tell us are mere beliefs or myths."
> *(Special kinship interviews; Focus group interviews with Chewa older women)*

Perceptions relating contingencies that might lead to covert contraceptive use in Malawi

In the case of Malawi, married women's decisions to use modern or traditional family planning methods covertly may depend on many conditions. Firstly, in traditional societies, married women were not expected to express their sexual and fertility-related desires. Implicitly, they were not free to talk with their husbands about sex or contraception. Ethnographic evidence shows that they expressed their contraceptive and fertility desires through covert communication. They could use traditional contraceptives without their husbands' knowledge but could consult female relatives of their husbands. The introduction of family planning services,

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give specific names. Indeed this traditional healer confirmed that many women do seek traditional contraceptive methods covertly. She even indicated that she also helps some women to abort.

which is more public and administered by outsiders, is a challenge to the administrative structure of traditional contraception. Married women are likely to seek private and confidential family planning services because they want to have a trusted person like the trusted elderly women who used to give them traditional contraceptive services.

Secondly, in traditional societies, married women were not free to go out of the home without seeking permission from the husband or at least informing the husband (Alam *et al.*, 1992). This is probably why a wife who perceives spousal disagreement for her to go to the health centre for family planning services she will not initiate any discussion about it. She will most likely adopt covert contraceptive use. During RDM ethnographic interviews most of the women who reported that they had once used any contraceptive method secretly, indicated that they did it because they could tell (through covert communication) that their husbands would not agree to use contraceptives. As this Chewa woman mentioned in an interview:

> "I ended up having six children just because I could sense that it was the ruling in the house"
> *(Reproductive Decision-Making research project, Chewa older women number two, 41 years old with primary education and six children surviving).*

Current use of modern contraceptives is only possible if private and confidential family planning service provision is available at the same time and place where under-five clinic services are provided. The author interviewed two nurses working at two health centres located in the two research sites. These nurses indicated that since the 1994 Cairo conference, family planning was integrated with maternal child

health care and reproductive health services. The new integrated program is called Maternal and Child Health, Family Planning and Reproductive Health (MCH/FP/RH) program. Under this integrated approach, people are able to receive antenatal, under-five, reproductive-health, and family planning services at the same time and in the same place.

The author's observation of the integrated MCH/FP/RH clinic showed that privacy was limited. Except for antenatal physical examinations, counselling services and provision of injections, all other services take place in an open space. Therefore married women who make autonomous decisions to space births or stop child bearing using modern child spacing and family planning methods covertly are more likely to have logistic problems to use these services. They are likely to fear that their husbands' relatives or their co-wives (in case of polygynous wives) could see them and report them to their husbands. It could therefore be concluded that covert contraceptive use has social stigma attached to it, particularly when the contraceptive services are not private and confidential. Apart from seeking private and confidential services at the health centre, married women are also likely to seek private and confidential family planning services from CBDs. As one older Tumbuka wife explained: "It is difficult to seek contraceptive services from the CBDs because they are too young and related to us".

Another important point to note about potential covert contraceptive users is that it appears those married women who choose to use modern contraceptives covertly

would want to deal with family planning service providers who are trustworthy. This reflects the legacy of traditional contraceptive service provision whereby couples trusted community female elders who administered the provision of traditional contraceptive methods. The issue of trust is related to confidentiality. In Malawi, Government and non-governmental organisations put in place CBDs to provide family planning services in remote areas. However, potential clients are concerned with the fact about the type of people who are recruited as CBDs (STAFH, 1995), are too young or patrikin relatives.

Summary and conclusions

The discussion in this chapter shows that wives' perceived autonomy and spousal communication are the main factors that really matter for married women to perceive that they have the power to make autonomous decisions to use modern contraceptive methods whenever they want. Empirical findings have revealed that married women think of using modern contraceptives covertly even when other conditions do not favour covert contraceptive use.

Firstly, although non-egalitarian lineage or marriage systems subordinate women, patrilineal and polygynous wives resist to this subordination and make clandestine autonomous decisions to use modern contraceptives to meet their desired reproductive outcomes. Secondly, whether or not overt spousal communication about family planning takes place, wives think that they can use modern contraceptives without their husbands' knowledge. Thirdly, even if wives fail to convince their

husbands to agree to use modern family planning methods, they still think that they can use modern contraceptives whenever they want. And fourthly, whether or not there are signs of husbands' agreement to use modern contraceptives, wives still thin that they can practise covert modern contraception.

A less gender egalitarian system is theoretically not an empowering context for married women to express their reproductive desires freely or to participate in RDMP. But empirical evidence discussed in this chapter contradict the hypothesis that a matrilineal system will empower married women to make autonomous decisions to use modern contraceptives without their husbands' knowledge. The inegalitarian ethics of a patrilineal system force patrilineal wives to identify their power to make autonomous decisions to use modern contraceptives whenever they want. Apart from patriliny, polygyny has also been identified as a force that makes married women think of using modern child spacing and family planning methods clandestinely.

Patrilineal and polygynous wives appear to use the ethical values of the lineage system that support them to achieve their family size and contraceptive goals. These wives rely on the fact that child spacing is a traditional norm. This probably makes them assume that they have a role to play in RDMP. They exercise autonomy in deciding to clandestinely delay births leading to a motivation to covertly stop childbearing. These wives are aware that covert contraceptive could have a social

cost. However, they courageously proceed knowing that, if discovered, the system can support them and they should be able to get away with it.

From these findings, one can conclude that inegalitatrian systems do not necessarily render married women completely powerless. Instead they produce power as wives in those societies seek survival strategies. They identify ethical principles, which favour women's autonomy and use those principles to cover their defiance to male dominance.

Wives who cannot sense their autonomy to make decisions to use modern contraceptives capitalise on spousal communication, which could be covert or overt. Ethnographic data has shown that mostly, wives think of using modern contraceptives covertly after getting signals of disapproval from their husbands through covert communication. However, logistic regression analysis has shown that those wives who have conversations with their husbands about modern contraception do think that they can use modern contraceptives whenever they want to. This suggests that spousal communication about family planning empower monogamous wives to sense their power to practise modern contraception without their husbands' knowledge. This is because on the one hand, spousal communication about family planning confirms wives' perceptions about their husbands' agreement to use modern contraceptive methods and assures them of their support. On the other hand, it confirms the wives' perceived spousal disagreement and makes them adopt clandestine family planning activities or give up.

The findings in this chapter also confirm the hypothesis that difficult spousal communication will empower wives to make autonomous decisions to use modern contraceptives covertly. Monogamous wives who are less autonomous than polygynous wives generally feel empowered to think of using modern contraceptives covertly when they discuss family planning with their husbands. In contrast, spousal communication about family planning is not a significant factor for polygynous wives who are more autonomous than are monogamous wives. Polygynous wives do not perceive they have the power to convince their husbands to use modern contraceptives whereas monogamous wives do. This is because polygynous wives do not perceive spousal agreement to use modern child spacing and family planning methods and therefore do not recognise that they have the capacity to negotiate their desire to use those methods.

According to the findings in Chapters seven to the present one, what empowers polygynous wives to make autonomous decisions to space births, or to stop child bearing or to use modern contraceptives is exposure to urban lifestyle. Those polygynous wives who have once lived in cities or towns for sometime become Westernised and are therefore likely to acquire new ideas about contraception, freedom of choice, and freedom of expression and gender equality. These new ideas are likely to strengthen polygynous wives' perceived autonomy to make reproductive decisions. But as noted earlier, for polygynous wives to effectively implement their perceived autonomy and freedom to decide use family planning methods without

their husbands' knowledge, they would need private and confidential family planning services. In conclusion, as postulated in Chapter one, polygyny does develop in women the capacity to recognise that they have the power to make autonomous reproductive decisions, particularly when other factors allow them to exercise such powers.

PART IV TOWARDS A SYNTHESIS

CHAPTER 10

WOMEN'S EMPOWERMENT, SPOUSAL COMMUNICATION AND FAMILY PLANNING IN MALAWI

Introduction

This chapter constitutes a synthesis. It reviews the examination in earlier chapters of the relationship between on the one hand, the empowerment of women to give them the capacity to make autonomous reproductive decisions or to negotiate with their spouses over desired reproductive outcomes, and, on the other hand, modern contraceptive use. Empowerment has been seen as a process that has been analysed indirectly here by measuring differences in levels of women's reproductive decision-making power and then analysing the co-variates of these. From this perspective, power is an outcome of the process of women's empowerment.

Although the analysis has been centred on spousal power relations, methodologically, the analysis in this chapter is focused on modern contraceptive use as reported by the wives themselves and not by both spouses. This is for three main reasons.

Firstly, most of the analysis in this thesis has been focused on exploring factors that empower married women to make autonomous reproductive decisions or negotiate

their reproductive desires. A few husbands' responses have been used to measure the effect of husbands' views on their wives' perceptions about their power in Reproductive Decision-Making Processes (RDMP). Since the Malawi Diffusion and Ideational Change (MDIC) sample survey did not have questions on husbands' views about their power in deciding to space births or to stop child bearing, it has not been possible to measure the feedback effect of wives' empowerment on husbands' power in RDMP.

Secondly, there is mounting empirical evidence that there are significant gender differences in reported contraceptive use with men reporting higher contraceptive use than women. This is plausible especially because men are more likely to have other sexual partners than their wives, and they are likely to use condoms in those relationships. These differences have been observed in studies conducted in Zambia and in the Dominican Republic (Becker 1998, 1999), in Tanzania and Kenya (Ezeh, 2000) as well as in Malawi (Miller, Watkins and Zulu, 2000). Gender differences in reports about contraceptive use are likely to affect the interpretation of different patterns of contraceptive behaviour among couples or individual married women.

Thirdly, since most contraceptive methods are female-oriented, it is unlikely that husbands' reports about contraceptive use would be as reliable as women's reports themselves. This is because, as explained in Chapter five, many husbands want to control access to *modern* ideas. Husbands may thus over-report contraceptive use in order to appear to be "up with the play". However, over-reporting or under-reporting

may not also be completely ruled out of female reports that may depend to a degree on what they think researchers "want to hear" (Miller, Watkins and Zulu, 2000).

Another important aspect that will be taken into consideration in this analysis is that women often refer to traditional and modern contraceptives when they report on contraceptive use. However, there are indications that a shift from traditional to modern contraceptive use is occurring although both sets of methods are still used simultaneously[44]. In this chapter, the focus of the analysis will be on modern contraception and its relationship with women's capacity to make autonomous reproductive decisions or to negotiate the desired reproductive outcomes.

There are two main sections to this chapter. The first section is an exploration of whether or not empowerment has any direct effect on married women's current use of modern contraceptives. That section will discuss the measurement of the effects of women's perceived autonomy in RDMP and the effects of women's perceived power to negotiate reproductive outcomes on the probability of wives using family planning methods overtly. In the second section, it will be explored whether women's perceived power to make autonomous reproductive decisions has any direct effect on the probability of wives using modern contraceptives covertly. In that section, the interactive effect of women's perceived autonomy in RDMP and women's power to negotiate desired reproductive outcomes on current use of family planning methods would be measured. Finally, the third section comprises a critical examination of the

type of women's empowerment that would develop in individual married women or couples the capacity to space or limit births using modern child spacing and family planning methods. That section will be a synthesis of theoretical and policy issues identified in literature review (Chapters two to four) and the empirical findings from Chapters seven to the present one.

Logistic regression analyses and ethno-methodological data analyses will be used to examine and explain the relationship between the predictors of women's power and overt or covert modern contraception. Because of the low levels of contraceptive use recorded in the two research sites, a multivariate regression analysis will not be possible. Bi-variate regression models will be used instead. The analytical interpretation will therefore have to be taken with caution. There will be two dependent variables, which will be drawn from two MDIC survey questions: (i) whether *at the time of the survey, the wife was using any child spacing or family planning method (traditional or modern)? (ii) Whether there was a time when the wife was using modern child spacing or family planning methods but her husband did not know?* It will be assumed that current use of modern contraceptives refers to overt contraceptive use. But the possibility that current use may also refer to current use cannot be completely ruled out. It should also be noted, however, that we are dealing with very few cases of current use of modern contraceptives. This is likely to affect the outcome of the analysis.

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[44] The author learnt through informal discussions and ethnographic interviews with female respondents that traditional contraceptive methods were becoming scarce these days due to deforestation. Many of those available are ineffective because

Two logistic regression models will be run: one for monogamous wives and another one for polygynous wives using the two identified dependent variables; (i) *Wives' current use of modern contraceptives* and *(ii) Wives' ever use of modern contraceptives covertly*[45]. The following independent variables were also employed: *lineage, freedom of movement, spousal communication about using family planning methods and about earnings, and wife's exposure to an urban lifestyle.* The following control variables were included in the models but will not be shown in the tables: *husband's exposure to urban lifestyle, wife's and husband's schooling, wife's religion, wife's current age, wife's and husband's desired family size, and infant or child mortality.* The impact of these variables on reported contraceptive use is not discussed in this chapter. This is because, in the statistical model, when these variables were controlled for, the effect of variables indicating women's power on wives' probabilities of using modern contraceptive methods showed no change. Instead, it is more useful to turn to in-depth interpretation of logistic regression analysis. Ethnographic data are of particular utility when critically analysing the purposes for which married women use modern contraceptives. A distinction will be made between women's reproductive decision-making power and their reporting on modern contraceptive use for child spacing and on modern contraceptive use for family size limitation. These analyses will be used to test the following hypotheses:

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they are not the original herbs.

[45] The switch from current to ever-use should be noted. The need to employ data on ever-use is simply for pragmatic reasons. N's for current use of modern contraception, let alone current use of modern contraception, are very small.

1) That, a more gender egalitarian system will empower married women more than a less gender egalitarian system to use family planning methods without their husbands' knowledge.

2) That, if married women perceive that they have the power to negotiate with their husbands the desired reproductive outcomes, they are likely to be using family planning methods than if they do not perceive themselves to have any negotiating power.

3) That, women living in polygynous unions will be more likely to be using family planning methods covertly than will be those living in monogamous unions.

4) That, if wives consider themselves empowered to space or limit births, they will be more likely to have ever been engaged in clandestine family planning activities than if they do not consider themselves to be empowered to make such decisions.

5) That, if married women perceive that they have the autonomy to decide to use modern contraceptives whenever they want, they are more likely to be using modern contraceptives for the purposes of limiting family size than if they do not have the same perceptions.

6) That, if married women think that they have the power to negotiate desired reproductive outcomes through talking to their husbands about using family planning methods, they are more likely to be using modern contraceptives limit family size than if they do not think they have such power.

Current use of modern contraceptives and women's empowerment

The following results present some powerful but not unexpected correlations. They show that spousal communication about family planning and the perception that monogamous as well as polygynous wives have the power to make certain autonomous reproductive decisions are strong predictors of actual use of family planning methods. Also, for monogamous wives in particular, there are strong links between the perception of their own level of power in negotiating with their husbands the desired reproductive outcomes and their current use of modern contraceptive methods.

Monogamy and current use of modern contraceptives: women's empowerment

Analytical results displayed in Table 10.1 show that among the selected women's power variables, only spousal communication about using family planning methods influences monogamous wives to use modern contraceptives overtly. Those who have once had a conversation with their husbands about using family planning methods are 3.63 times more likely than are those who reported that they have never had one to use modern contraceptives overtly. Couple discussion about family planning is likely to solicit husbands' support for modern contraception leading to joint couple decision-making about using family planning methods.

Polygyny and current use of modern contraceptives: Women's Empowerment

While patriliny is not significantly related to monogamous wives' current use of modern contraceptives, it is significantly related to polygynous wives' use of modern contraceptives. Logistic regression models for polygynous wives in Table 10.1 suggest that polygynous wives living in a patrilineal society are 5.78 times as likely as polygynous wives in a matrilineal system[46] to be using modern contraceptives. As is the case for monogamous wives, however, polygynous wives who have had a discussion with their husbands about using family planning methods are 5.16 times more likely to be using modern contraceptives than are those who have never had any discussion with their husbands about family planning.

Related to spousal communication is exposure to urban lifestyle, which as discussed in Chapter nine, empowers polygynous wives to exercise their freedom of choice and expression. According to the analysis presented in Table 10.1, polygynous wives who have once lived in the city are 3.40 times as likely to be using modern contraceptives as those who have never lived in the city before. But perceived freedom of movement, particularly perceived freedom to go to the market without seeking their husbands' permission does not have a positive effect on polygynous wives' current use of modern contraceptives.

[46] It will be recalled that in the patrilineal societies, this status was universal, whereas the proportion following matrilineal presumptions was below universal in the matrilineal society.

Table 10-1 **Monogamous and polygynous wives:** estimated odd ratios (from multivariate logistic regression) on wives current use of modern contraceptives, by selected women's power variables, MDIC Survey 1998

Co-variates	Estimated odds ratios for monogamous wives (N= 405)	Estimated odds ratios for polygynous wives (N= 125)
Lineage system		
Matrilineal	1.00	1.00
Patrilineal	1.02	5.78**
Wife thinks it is acceptable for her to go to the market without seeking husband's permission		
No	1.00	1.00
Yes	1.44	0.10**
Wife thinks it is acceptable for her to go to the health centre without seeking husband's permission	1.00	1.00
No	0.85	0.81
Yes		
Wife ever talked with husband about desired family size		
No	1.00	1.00
Yes	1.44	0.41
Wife ever talked with husband about using modern contraceptive methods		
No	1.00	1.00
Yes	3.63***	5.16***
Wife informs her husband about the amount of money she earns		
No	1.00	1.00
Yes	1.00	5.73
Wife ever lived in the city for over six months since age 15		
No	1.00	1.00
Yes	0.99	3.40**

Note: *** = significant levels at one percent, ** = significant levels at five percent. The following variables have been controlled for in the models but have been excluded from the table and the discussion of analysis: *husband's exposure to urban lifestyle, wife's and husband's schooling, wife's religion, wife's current age, wife's and husband's desired family size, and infant or child mortality.*

Polygynous wives who think that they have the freedom to go to the market without their husbands' permission are 90 percent less likely to be using modern contraceptives than are those who do not think that they have the freedom to go to the market whenever they want. This is most likely because polygynous wives have less

exposure to sexual intercourse, practice long periods of postpartum abstinence and therefore have reduced frequency of sex.

Women's perceived autonomy in RDMP and modern contraception

The analysis presented in Table 10.2 below reveals that except in two cases, all indicators of women's perceived autonomy in RDMP are significantly related to current use of modern contraceptives. The two exceptions are firstly, that women's perceived autonomy in deciding to stop childbearing has no significant relationship with monogamous as well as polygynous wives' current use of family planning methods. Secondly, as expected, when wives perceive that they have the capacity to convince their husbands to use family planning methods, this is not significantly related to polygynous wives' current use of modern contraceptive methods. From these findings, one can conclude that the perceptions that wives have the power to stop child bearing or to negotiate with their husbands the desired reproductive behaviours and outcomes are not strong predictors of actual contraceptive use among polygynous wives.

Monogamy and contraceptive use: women's perceived autonomy in reproductive decision-making processes

The data in Table 10.2 present some seemingly counter-intuitive results. Women's perceived autonomy in deciding to space births and women's perceived power to negotiate desired reproductive outcomes correlate with lower probabilities that monogamous wives will use modern contraceptives. Monogamous wives who sense

that they have the power to make autonomous decisions to space births are fifty percent less likely to be currently using modern contraceptive methods than are those who do not feel that they have this capacity. Those who think that they do not have the capacity to convince their husbands to use modern contraceptives are, in fact, 43 percent less likely to record current modern contraceptive use than are those who think they do have that capacity.

In contrast to the above findings, women's perceived autonomy to use modern contraceptives covertly and women's perceived spousal agreement to use family planning methods increase the probability that monogamous wives will be using modern contraceptives. Bi-variate analytical results in Table 10.2 show that monogamous wives who feel that they have the power to use modern contraceptives without their husbands' knowledge, are 2.69 times as likely to be using modern contraceptives overtly as are those who do not feel that they have such powers.

This confirms an earlier argument (Chapter nine) that reported current use of modern contraceptives includes unreported as well as reported current use. The results of bi-variate analyses also show that monogamous wives who perceive that they have their husbands' agreement to use modern contraceptives are 1.83 times more likely to be using modern contraceptives than are those who perceive that their husbands would disagree to use modern contraceptives. In the discussion at the end of this chapter, these seemingly paradoxical findings will be examined.

Table 10-2 **Monogamous and polygynous wives:** estimated odd ratios (from bivariate logistic regression) on wives' current use of modern contraceptives, by wives' perceptions about their autonomy and negotiating power in RDMP, MDIC Survey 1998

Co-variates	Estimated odds ratios for monogamous wives (N= 405)	Estimated odds ratios for polygynous wives (N= 125)
Wife thinks she can space births whenever she wants to		
No	1.00	1.00
Yes	0.50***	2.23**
Wife thinks she can stop child bearing whenever she wants to		
No	1.00	1.00
Yes	1.12	1.31
Wife thinks she can use modern contraceptives without her husband's knowledge		
No	1.00	1.00
Yes	2.69***	1.82*
Wife thinks husband could agree to use modern contraceptives		
No	1.00	1.00
Yes	1.83***	3.08***
Wife thinks she cannot convince her husband to use modern contraceptives		
Disagree	1.00	1.00
Agree	0.57***	0.71

Note: *** = significant levels at one percent, **= significant levels at five percent, * = significant levels at ten percent.

Polygyny and modern contraceptive use: women's perceived autonomy

The situation of the polygynous wives is rather different from that of monogamous wives. The data displayed in Table 10.2 shows that polygynous wives who perceive that they have the autonomy in spacing births are 2.23 times more likely to be using modern contraceptives than are their counterparts among the monogamous wives. As is the case of monogamous wives, however, polygynous wives who perceive that they have the power to use modern contraceptives covertly and those who perceive that they have their husbands' agreement to use modern contraceptives are more likely to be using modern contraceptives than are those who perceive otherwise.

Logistic regression analysis reveals that polygynous wives who think that they have the power to use modern contraceptives covertly are almost twice as likely as are those who do not think so to report current use of modern contraceptives. Those who think that their husbands might agree with the use of modern contraceptive methods are three times as likely as are those who do not think that way to be using modern family planning methods.

Current use of modern contraceptive methods and women's empowerment

The results discussed in the present section on current use of modern contraceptive methods are similar to those for current use of modern contraceptives in this chapter. According to these results, there is a very close relationship between women's perceptions that they lack the capacity to make autonomous reproductive decisions and covert contraceptive use.

Monogamy and current use of modern contraceptives: women's empowerment

Notably, women's power variables are significant only for monogamous wives' reported current use of modern contraceptives (see Table 10.3). Two women's power variables are significantly related to monogamous wives' actual current use of modern contraceptive methods.

As would be expected, monogamous wives who think that they have the power to go to the market without their husbands' permission are 3.37 times more likely to have used modern contraceptive methods covertly than are those who do not think that

they have this degree of autonomy. But wife-to-husband communication about earnings has a negative effect on the chances of monogamous wives using modern contraceptive methods covertly.

Table 10-3 **Monogamous and polygynous wives:** estimated odds ratios (from bivariate logistic regression) on wives current use of modern contraceptives, by women's power variables, MDIC Survey 1998

Co-variates	Estimated odds ratios for monogamous wives (N= 405)	Estimated odds ratios for polygynous wives (N= 125)
Lineage system		
Matrilineal	1.00	1.00
Patrilineal	1.83	-
Wife thinks it is acceptable for her to go to the market without seeking husband's permission		
No	1.00	1.00
Yes	3.37*	0.51
Wife thinks it is acceptable for her to go to the health centre without seeking husband's permission	1.00	1.00
No	1.39	1.04
Yes		
Wife ever talked with husband about desired family size		
No	1.00	1.00
Yes	1.40	0.68
Wife ever talked with husband about using modern contraceptive methods		
No	1.00	1.00
Yes	-	2.18
Wife informs her husband about the amount of money she earns		
No	1.00	1.00
Yes	0.12*	0.23
Wife ever lived in the city for over six months since age 15		
No	1.00	1.00
Yes	0.88	1.65

Note: * = significant levels at ten percent. The following variables have been controlled for in the models and have been excluded from the table and the discussion of analysis: *husband's exposure to urban lifestyle, wife's and husband's schooling, wife's religion, wife's current age, wife's and husband's desired family size, and infant or child mortality.* – N is very small.

Monogamous wives who inform their husbands about their earnings are 88 percent less likely to use modern contraceptives without their husbands' knowledge than are those who do not discuss their incomes with their husbands. This testifies the earlier findings that levels of spousal communication are high among monogamous couples. Thus monogamous couples do have a higher likelihood to that they will discuss family planning if circumstances permit them to talk about fertility issues.

Monogamy and covert contraceptive use: women's perceived autonomy

In this section, the concern shifts from empowerment to autonomy. The analytical findings presented in Table 10.4 show that perceived autonomy in deciding to space births does influence monogamous wives' clandestine use of modern contraceptives. Those who think that they have the power to make autonomous decisions to space births are six times as likely as those who do not think that they have such powers to have ever-used family planning methods secretly. Against this, however, women's perceived autonomy in deciding to stop child bearing and women's perceived power to negotiate the desire to use modern contraceptives are negatively associated with monogamous wives engaging themselves in clandestine family planning activities. The logistic regression analytical results presented in Table 10.4 below show that monogamous wives who sense that they have autonomy in deciding to stop child bearing are 68 percent less likely to report having ever used modern contraceptives covertly than are those who do not sense such autonomy. Also monogamous wives who think that they do not have the power to convince their husbands to use modern

contraceptive methods are 70 percent less likely to be using those methods without their husbands' knowledge than are those who think they have such powers.

Polygyny and covert contraceptive use: women's perceived autonomy

In relation to perceived power to stop child bearing, the inverse occurs among polygynous wives. Their perceived autonomy in deciding to stop child bearing does have a positive effect on the probability of them using modern child spacing and family planning methods clandestinely. The data in Table 10.4 show that polygynous wives, who perceive that they have the power to stop child bearing whenever they want are 10.83 times as likely to have, at one time, used modern family planning methods secretly as those who do not perceive that they have such powers.

However, the direction of the relationship between current use and perceived lack of power to negotiate desired reproductive behaviours and outcomes is the same for polygynous and monogamous wives. But those who think that they have the capacity to convince their husbands to use modern contraceptive methods are 86 percent less likely to secretly use modern contraceptive methods than are those who do not think that they have such powers. This suggests that indeed covert use of contraception is directly related to issues of gender and power relations within the conjugal unit.

Table 10-4 **Monogamous and polygynous wives:** estimated odds ratios (from bivariate logistic regression) on wives' current use of modern contraceptives, by wives' perceptions about their autonomy and negotiating power in RDMP, MDIC Survey 1998

Co-variates	Estimated odds ratios for monogamous wives (N= 405)	Estimated odds ratios for polygynous wives (N= 125)
Wife thinks she can space births whenever she wants to		
No	1.00	1.00
Yes	6.01*	-
Wife thinks she can stop child bearing whenever she wants to		
No	1.00	1.00
Yes	0.32*	10.83**
Wife thinks husband could agree to use modern contraceptives		
No	1.00	1.00
Yes	0.76	0.85
Wife thinks she cannot convince her husband to use modern contraceptives		
Disagree	1.00	1.00
Agree	0.30*	0.14*

Note: ** = significant levels at five percent, * = significant level at ten percent. – N is very small.

Discussion

The findings in this chapter present a somewhat perplexing paradox that is contrary to some of the postulates outlined in Chapter one. They show how, for example, male dominance and inegalitarian ethics do not necessarily render married women powerless. This seems to imply that married women in a less egalitarian society and those in a more egalitarian society may both be empowered to some degree, but that, contrary to what might be expected, the former are more autonomous than the latter.

There are probably two reasons for this paradox. Firstly, at a macro-level, there may need to be a distinction made between overt behaviours derived from feelings of

empowerment in non-egalitarian unions, and covert behaviours emanating from a spirit of autonomy in defiance, as it were, of the dominance wives perceive their husbands to have. Secondly, there may also be meso-level factors operating. That is, wives living in a less gender egalitarian system (the patrilineal system) undergo the process of empowerment by the pooling of resources available within the society to develop their ability to make autonomous reproductive decisions or to negotiate desired reproductive outcomes. To state an extreme case, polygynous wives might decide among themselves, without reference to "him" to space or limit births using modern contraception.

These findings suggest that, on the one hand, in making reproductive decisions, what married women really depend on, particularly those in patrilineal societies and polygynous unions in Malawi, is not empowerment *per se*, but access to resources that will sustain the autonomy as covert power that they have already acquired. On the other hand, however, for matrilineal and monogamous wives to solicit joint reproductive decisions, they depend more on the acquisition of negotiating power and particularly the capacity to convince their husbands to agree to the use of family planning methods. Married women are therefore likely to practise modern contraception under two conditions. Either if they perceive that they have the capacity to make autonomous reproductive decisions, even when they are in gender in egalitarian marriage systems, or, if they are in a more gender egalitarian union, they feel that they have the power to convince their husbands about using modern family planning methods.

A fair proportion of wives (regardless of lineage or type of union) perceive that they have some degree of power to make autonomous decisions to space or to limit births using modern contraception (Chapter seven). But spousal communication about family planning has a significant effect only on matrilineal and monogamous wives; wives depend on discussions with their husbands, which end in agreement. In contrast, many patrilineal and polygynous wives make autonomous reproductive decisions in the absence of spousal communication. To make autonomous decisions to space or to limit births, and/or to convince their husbands to use modern family planning methods, all wives, matrilineal or monogamous, patrilineal or polygynous, must have access to some set of external resources. In the section that follows, I use the findings in this chapter to demonstrate some of the external resources to which married women (patrilineal or matrilineal, monogamous or polygynous) could have access.

These external resources are drawn, as I will show, from culturally delineated (and therefore culturally acceptable) sources in their immediate environment. Strengthening this, as will be clear from the analysis below, is the fact that the effects of such resources are more likely to be felt in relation to spacing rather than to family size limitation. Child spacing is a reproduction behaviour that is not merely accepted traditionally, but often is subject to sanctions to encourage its occurrence, and also criticism of couples that have short intervals (Alam *et al.,* 1992). As noted earlier, even the late President Hastings Kamuzu Banda, a bitter foe of family planning,

especially of family size limitation, did advocate spacing. For Banda, this involved no paradoxes or conflicts with cultural values.

Monogamy and family planning: women's power

As discussed in earlier analytical Chapters (seven to nine), monogamous wives are less autonomous in RDMP than are polygynous wives. In contrast, monogamous wives are more likely to be able to negotiate overt reproductive behaviour. This suggests that monogamous wives depend on a different form of empowerment compared to polygynous wives. For example, in Chapters seven and eight, we found out that spousal communication about family planning is the main empowerment process that monogamous wives go through. Whether or not any discussion that they have with their husbands ends in agreement, monogamous wives still have a high probability of using family planning methods, covertly or overtly. But they are more likely to use these methods overtly if spousal communication about family planning ends in consensus. This means that their greater perception, by comparison with polygynous married women, that their husbands will agree to use modern contraceptives is right. But they are likely to turn to using family planning methods covertly if discussions with their husbands about family planning end in disagreement. In this case, of course, their perception that their husbands will agree to use modern contraceptives has proven wrong. Thus, if spousal communication about family planning leads monogamous wives to think that they have the power to negotiate desired reproductive outcomes or the use of modern contraceptives. They will enhance their capacity to change their husbands' mind. If this fails, monogamous

wives then may turn to making autonomous reproductive decisions. This will be especially true in situations where spousal communication is difficult.

Monogamous wives who think that they have the power to make autonomous decisions to space births are more likely to engage in clandestine than overt family planning activities. For example, as is the case with polygynous wives, when monogamous wives recognise that it is acceptable for them to go to the market without seeking husbands' permission, they are also more likely to practise covert family planning than when they do not. Current use of modern contraceptives among monogamous wives is possible if they sense that they have some degree of autonomy only in deciding to space births.

Surprisingly, however, monogamous wives who perceive that they do not have the capacity to convince their husbands to use family planning methods are unlikely actually to use family planning methods. This suggests that perceived lack of capacity to negotiate desired reproductive behaviours and outcomes discourages monogamous wives to use modern contraceptive methods. The most empowering variables for these wives are either perceived autonomy so that they by pass negotiations with their husbands or a successful outcome of discussions about family planning with their husbands. If the discussion is successful, moreover, monogamous wives will adopt overt modern contraception. But if it is not successful and if these monogamous wives perceive autonomy in deciding to space births, they will turn to covert modern contraception.

The contrary is true for those who sense that they have autonomy in deciding to stop child bearing. They are unlikely to practise family planning clandestinely. This suggests that while monogamous wives cannot limit family size clandestinely using modern family planning methods, they can, however, practise covert family planning methods for child spacing purposes. There are two possible explanations for this curious pattern. Firstly and less likely, there could be the residential effects of policies enunciated during the Banda regime accepting spacing but opposing limitation. This policy just fitted into the traditional pattern prevalent throughout Africa long before Banda that child spacing was more acceptable than limiting. Secondly, the explanation may rest with the internal dynamics of monogamous unions. From the researcher's recent observations, it seems that many such women may fear that family limitation may make them less desirable from their husbands who see large families as a prime goal. They may feel that they are at risk of loosing their husbands (Alam *et al.*, 1992).

Polygyny and family planning: women's power

Findings discussed in this thesis suggest that polygynous wives are *contextually*[47] empowered to make autonomous reproductive decisions. But the findings in the present chapter show that despite polygynous wives being already empowered, they still need some type of resource to sustain their empowerment. These empowerment

[47] By the word *contextually*, I refer to the environment in which they live (characterised by competition between co-wives and male dominating power). This makes them become autonomous because they have to manage their single units and ensure that they and their children "survive". Secondly, as noted in Chapter three, there is often also the support of co-wives and also of female patri-kins.

forces that would support their already acquired power and autonomy to make reproductive decisions are likely to be contextual. This chapter has shown that women's power variables, which influence polygynous wives to practise family planning, include the following: one indicator of women's autonomy (*perceived autonomy in deciding to stop child bearing)* and a few predictors of women's empowerment (*patriliny, spousal communication about modern contraception and exposure to modern ideas and lifestyles*).

The patrilineal system itself appears to be one such empowering context for polygynous wives but not for monogamous wives to perceive that they have the capacity to practise family planning covertly. As discussed in Chapters seven to nine, polygynous wives capitalise on patrilineal principles that allow them to make autonomous reproductive decisions, and hence the high probability for polygynous wives to engage in current use of family planning methods. But it appears that patrilineal principles are not empowering in themselves. It is the combination of male dominance, perceived autonomy and social interactions (through urban residence or freedom of movement) on the part of polygynous wives that empower the latter to practise family planning.

As discussed earlier in this chapter, Westernisation, through past exposure to urban lifestyles empowers polygynous wives to perceive that it is possible to have the freedom of choice and expression. It would be argued that the interplay between this acquired knowledge about freedom of choice or expression, and their perceived

autonomy in deciding to stop child bearing empowers polygynous wives to communicate (mostly through covert means) to their husbands about what they think are the desired reproductive outcomes. Equally, however, data in the present chapter show that male dominance and spousal communication about using family planning methods and exposure to urban lifestyles develop in polygynous wives the capacity to practise family planning overtly. These findings suggest that polygynous wives depend on an environment that can sustain their existing capacity to make autonomous reproductive decisions and to allow them to use family planning methods covertly. But when they have open discussion about family planning with their husbands they are then likely to make them use family planning methods.

The analysis discussed in this chapter has also revealed that two contextual empowerment variables (one meso-level and one micro-level) have a negative effect on polygynous wives' power in RDMP. On the one hand, the meso-level variable (*wives' perceived freedom to go to the market*) does not seem associated with the capacity of polygynous wives to use family planning methods. This suggests that polygynous wives might use the freedom of going to the market as a cover for clandestine family planning activities. My field observations of the research sites are consistent with this finding, in that both have big markets and health centres close to each other. Although there are smaller markets near the respondents' residences, it is assumed that the correlation between freedom to go to the market and covert contraceptive use apply to where three are larger markets.

On the other hand, however, the micro-level variable (*the perception that wives have the lack of capacity to convince their husbands to use modern contraceptives)* does negatively influence polygynous wives to engage in clandestine family planning activities. From this, one can conclude that covert practise of family planning is an indirect indicator of polygynous wives' lack of power to negotiate desired reproductive outcomes. This is consistent with the theoretical understanding that wives living in systems that apply less gender egalitarian principles have no freedom of expression (Chapter three) and therefore have no negotiating power.

These findings suggest that the male dominance inherent in a patrilineal systems makes polygynous wives sense that they have some degree of autonomy in RDMP because they have to survive on their own. They perceive that they have the power to practise contraception whenever they want to since the use of contraception for child spacing is a traditionally acceptable practice. Surprisingly, however, these polygynous wives also seem to sense that they have the capacity to stop child bearing whenever they want to, a practice that is not traditionally acceptable. But the implementation of this capacity depends on the availability of a favourable environment.

It is ironical that the call by the Cairo Plan of Action for the development of public policies that permit individual women and couples the freedom to choose the timing of births and the size of their families. This is likely to favour the situation of polygynous wives (particularly those in patrilineal societies). Since the socio-cultural

environment for polygynous wives is already conducive to the development of autonomy in RDMP, such autonomy is sustainable if the policy environment is conducive to the contextual forces that are empowering. In a sense, the Malawian Cairo model of the plan may address the needs of women in the least gender egalitarian systems; the downside of this is that it may also increase the propensity for the covert practice of family planning.

Migration seems to operate through exposure to modern ideas and lifestyles (Chapter nine) to have a positive effect on family planning. In this regard, the experience of urbanisation will have been an empowering process for polygynous wives. It seems to empower polygynous wives to perceive that they have the capacity to make free reproductive choices and autonomous decisions. If polygynous wives develop negotiating power, they will overtly discuss desired reproductive behaviours and outcomes. They will not engage in covert contraceptive use. In fact as discussed in Chapter eight, some polygynous wives sense that they have gained their husbands' permission to use modern contraceptives when they have a chance to discuss family planning with their husbands. These findings suggest that in general polygynous wives do not sense that they have the capacity to negotiate desired reproductive outcomes. When they have the chance to discuss family planning issues with their husbands, they are likely to confirm their perceptions that they do not have the capacity to convince their husbands. This is particularly the case if the discussions end in disagreement, which is more likely to be the case for polygynous couples. For example, a Tumbuka polygynous wife, who lived in the city with her husband for

sometime, explained how she attempted to convince her husband to use sterilisation for her to stop child bearing:

Interviewer:
Did you discuss with your husband before starting to use the injection? How did you do it?
Respondent:
I initiated the idea.
Interviewer:
Did your husband agree with that?
Respondent:
Yes but he said, I should continue with child bearing because I am still young. So when I propose that I stop childbearing, he refuses.
Interviewer:
Did you ask him about sterilisation?
Respondent:
Yes. He said I should just use child spacing methods. May be he wants a boy. Also he may feel that if I have fewer children, I may be cheating on him. If I have many children, he thinks that I would just stay at home with the children.

Modern contraception: for spacing or limiting sizes?

RDM ethnographic data in Table 10.5 confirm the earlier statistical analyses and underline the difference between spacing and limitation. Thus out of the 16 wives interviewed, four said they had agreed with their husbands to use modern contraceptives but only for child spacing. Of the three wives who reported to using modern contraceptives covertly, only one reported to have made a unilateral decision to have sterilisation to stop child bearing. The other two were using the injection to space births. Although these results suggest that most married women who use modern family planning methods do so for child spacing purposes, it is likely that

they are aware that the injection may lead to sterilisation. They may therefore use the injection also for limitation of births. They may also use the injection to limit births because it is the most convenient method for possible limiting of births, one that does not require an operation. As it has been noted in other studies social influence, through social networks, affect contraceptive use among women (Watkins *et al.,* 1997; and Kohler *et al.,* 2001).

Moreover, the MDIC survey data show that the type of the lineage has a significant influence on wives' probability to use modern contraceptive methods, particularly for those who are using of the pill and the injection. In contrast, cross-tabulations of wives' reported current uses of modern contraceptives by type of union did not show significant differences. This might mean that types of union, as empowering variables, are significant only in deciding about the spacing and limiting of births using modern contraceptives but not in choosing the type of modern contraceptive to use. But it should be noted that access to modern family planning services differ by administrative area. In chapters two and five, we learnt that Rumphi, the resident area for patrilineal couples has easier access to modern family planning services than Mchinji the resident area for matrilineal couples. That being the case then one could conclude that patrilineal wives are also more accessible to modern family planning services that matrilineal wives.

Table 10-5 Wives' reports about their own use of modern contraceptive methods for child spacing and the limitation of family size, RDM Ethnographic Interviews 1998

Respondent	Joint decision to use modern contraceptives for child spacing	Joint decision to use modern contraceptives for family size limitation	Autonomous decision to use modern contraceptives for child spacing	Autonomous decision to use modern contraceptives for family size limitation
COW (1)	-	-	-	-
COW (2)	-	-	Yes (injection)	-
COW (3)	-	-	Yes (injection)	-
COW (5)	-	-	-	-
CYW (1)	Yes (loop)	-	-	-
CYW (2)	-	-	-	-
CYW (3)	-	-	-	-
CYW (4)	-	-	-	-
NOW (1)	-	-	-	-
NOW (2)	-	-	-	-
NOW (3)	-	-	-	-
NOW (4)	Yes (pill)	-	-	-
NYW (1)	Yes (pill)	-	-	-
NYW (2)	-	-	-	Yes (sterilisation)
NYW (3)	Yes (condoms)	-	-	-
NYW (4)	-	-	-	-

Note: COW = Central Older Women; CYW = Central Younger Women; NOW = North Older Women; NYW = North Younger Women. - No decision to use modern contraceptives was made.

Table 10.5 shows that generally, the injection is the most frequently reported modern contraceptive, with almost 11 percent of all the female respondents currently using the injection. The second most frequently reported modern contraceptive method is the pill, with seven percent of the female respondents currently using the pill. Based on MDIC sample survey reports (see Table 10.6), a comparison between the two lineage systems shows that a large proportion of patrilineal wives use the pill (about ten percent) while among the matrilineal wives, about 17 percent use the injection. This difference may be related to logistic factors such as the availability and time lapse between contraceptive intakes. Both the pill and the injection are the best-supplied modern contraceptive methods in most health centres (Support to AIDS and Family Health, 1996:26). Logistically, it takes three months before a woman needs to receive another injection whereas it takes only a month for the pill.

But the question is why patrilineal wives use the pill more than do matrilineal wives, and why matrilineal wives use the injection more than do patrilineal wives. One possible explanation is that patrilineal wives, who are mostly Tumbuka wives, have Community Based Distributors (CBDs) (Support to AIDS and Family Health, 1996) and have a health centre within the vicinity of five kilometres to their residences. In contrast, the matrilineal wives, who are mostly Chewa wives, do not have CBDs and, typically have to go to health centres quite a distance from home[48]. The other possible explanation is related to the covert practice of family planning. According to RDM ethnographic data (Table 10.6), the injection is a modern contraceptive method that is most commonly used by current users because of its convenience (Zulu, 1996).

The perceived power by wives of their degree of autonomy and the negotiating power (Chapter six), the analytical results of the relationship between women's power variables and wives' degree of acquired autonomy have shown that patrilineal wives have a high probability of using modern contraceptives covertly. Yet matrilineal wives make recourse to the injection more than do patrilineal wives. As discussed in Chapters nine and the present one, patrilineal wives (particularly those living in polygyny) are more likely be using modern contraceptives overtly than are

[48] During the field visits, the author personally found out and confirmed that the research site for the matrilineal respondents (the Chewa people) had no CBDs whereas the research site for the patrilineal respondents (the Tumbuka people) had CBDs. According to the Support to AIDS and Family Health (1996), some CBDs were trained in an area within the district of the Chewa (matrilineal respondents) (Mchinji) respondents but not within their coverage. Some of those trained in Rumphi district cover the research site of the Tumbuka (patrilineal) respondents.

matrilineal wives. This is because patrilineal wives are very secretive about their covert contraceptive use.

Table 10-6 Wives' reports about their own use of modern contraceptive methods, by the type of lineage to which they belong, MDIC Survey 1998

Reported current use	Matrilineal wives (N= 254)	Patrilineal wives (N = 278)	TOTAL (N = 532)
Wife is using the pill			
No	96.1	89.9	92.9
Yes	3.9	10.1	7.1
Wife is using the injection			
No	83.1	95.0	89.3
Yes	16.9	5.0	10.7
Wife is using the loop			
No	100.00	99.6	99.8
Yes	-	0.4	0.2
Wife is using sterilisation			
No	99.6	99.3	99.4
Yes	0.4	0.7	0.6

Note: chi^2 is significant for all values except for those for the loop and sterilisation.

But since matrilineal wives are generally less autonomous than are their counterparts (the patrilineal wives) and they are more likely to negotiate desired reproductive outcomes, they engage in overt secrecy. For example, they might seek permission from their husbands to take a child to the under-five clinic, and then they use such clinic visits to seek covert family planning services. As the following Chewa wife indicated in an interview how she used the injection for years without her husband's knowledge:

> I just told my husband that I was going to under-five clinic with the youngest baby. I would then go to the clinic and have my injection. One day, when I had the injection, I developed a sore where the injection pierced me. I just told my husband that I had a blister and that I had to go to the hospital so that I could have it removed.
> *(Reproductive Decision-Making research project, Chewa older women number two, 41 years old with primary education and six children surviving)*

Summary and conclusions

The analysis in this thesis suggests that *perceived autonomy, perceived negotiating power* are the factors permitting married women to acquire a capacity either to make autonomous reproductive decisions, or to negotiate desired reproductive outcomes including the practice of family planning. These in turn vary according to the type of lineage and the type of union to which these women belong. But these are not sufficient in themselves. Instead, to be brought into play, women must have resources at their disposal, especially those emanating from traditional sources, such as female-kin networks.

Although two-fifth of the women, who were interviewed under the MDIC sample survey, reported they perceived that they had the autonomy in making reproductive decisions, this perceived autonomy was not empowering in itself. On the one hand, monogamous wives and matrilineal wives depend, more than do polygynous and patrilineal wives, on acquiring the capacity to negotiate desired reproductive outcomes. On the other hand, however, polygynous and patrilineal wives depend,

more than do monogamous and matrilineal wives, on accessing resources that might sustain their acquired autonomy.

Findings in this thesis also suggest that, contrary to what might be expected, monogamous and matrilineal wives do not have a relatively higher degree of autonomy in RDMP, than do patrilineal and polygynous wives. At the same time, however, and in keeping with expectations, matrilineal and monogamous wives may have a relatively higher degree of power to negotiate reproductive outcomes than do polygynous and patrilineal wives. Consequently, monogamous and matrilineal wives are less likely to practise covert family planning than are polygynous and patrilineal wives. The former are more likely to talk with their husbands about family planning and perceive that they have the power to convince their husbands to use modern contraceptives than their counterparts, yet it appears they are not very likely to have successful negotiations. When they discuss family planning with their husbands and the discussion ends in agreement, do jointly make decisions with their husbands to use family planning methods mainly for child spacing. But those monogamous and matrilineal wives who fail to negotiate reproductive outcomes with their husbands either consider using clandestine modern contraception or withdraw altogether the idea of using family planning methods.

Those polygynous and patrilineal wives who are relatively autonomous do not bother to talk with their husbands about family planning because their surrounding context (of the values relating to polygynous unions and patrilineal systems) does not favour

spousal communication about reproductive-related issues. Wives who think that they have the power to make autonomous decisions to space births, to stop child bearing or to use modern contraceptives may believe that they are behaving within their expected reproductive roles. This is because they want to space births using family planning methods for the health of their children and for their own health and this with traditional practices that are acceptable within that lineage system. Furthermore, findings in this thesis show that wives capitalise on the negative effects of economic, health and land crises on the family to convince their husbands to use family planning methods for spacing or limiting births.

The analyses in the present chapter have shown that only polygynous wives are likely to engage in covert family planning to limit family size whereas monogamous wives are likely to do so only for child spacing purposes. This is because polygynous wives are more likely than are monogamous wives to perceive that they have the power to stop childbearing whenever they want. Curiously, it is patriliny, for which polygyny can perform pivotal functions that turns out to be a factor producing an empowering context for married women (in monogamy or polygyny) enabling them to sense that they have the power to make autonomous decisions to space births. The forces of male dominance (for monogamous patrilineal wives) and the forces of competition between wives (for polygynous wives) drive patrilineal wives to develop the power to resist any subordination and to perceive survival strategies. Clandestine use of family planning methods solely for child spacing is one such survival strategy used by wives who sense that they do not have autonomy in making reproductive

decisions or by those who do not recognise that they have the power to negotiate desired reproductive outcomes. Only polygynous wives, who are more likely to think that they can make autonomous reproductive decisions, engage in clandestine limitation of births.

Joint couple decisions to limit family size using modern family planning methods appear to be far from common in Malawi at this time. This is probably because levels of spousal communication are generally low (Chapter six). Not many married women feel confident that they have the power, not only to negotiate desired reproductive behaviours and outcomes but also to actually convince their husbands to practise family planning.

CHAPTER 11

CONCLUSIONS AND IMPLICATIONS FOR RESEARCH AND PUBLIC POLICY

Introduction: A review of the basic postulates

This thesis began by setting out three postulates. It argued, firstly that a more gender egalitarian lineage system is more likely than a less gender egalitarian one to increase the probability that equitable, effective and/or productive spousal communication and women's empowerment will take place. Secondly, it postulated that varying aspects of social change empowers individual married women to perceive that they have the capacity either to make autonomous reproductive decisions or to negotiate desired reproductive outcomes. Thirdly, it put forward the view that shifts in the paradigms underpinning public policies, that attempt to address issues of *fertility, gender and development* (individually or in combination), will effect changes in lineage structures, in power and communication relationships, and, in individual or group statuses.

The empirical evidence presented in this thesis strongly supports only one of the three postulates (the second one). In the case of the first and third postulates, the empirical results document a major paradox that must be reviewed in further detail. The third of these postulates is, in effect, based on what might be called the "Cairo

model". The idea behind this model was that shifts in public policy paradigm orientations would effect changes for women at the meso-level, that is, within their immediate social environments in the community and the lineage. This would then lead to changes in their lives at the micro-level. Linked to this was the idea reflected in the first postulate, and coming essentially from feminist theory, that gender egalitarian lineage or marriage systems would be the best seedbeds in which to grow the "Cairo model".

The lack of fit between the thesis' results and these two postulates raises the question of whether the two postulates were ideologically driven rather than having firm theoretical underpinnings. That lack of fit equally raises the issue that the data analysed in this thesis do not illustrate these postulates. Moreover, it also raises a related issue at least for Malawi, when policies emanating from the theoretical/ideological position central to the Cairo model were being implemented at the meso- and micro-levels, their effect may have been undermined by anti-thetical public policies coming from a different ideological position. On the one hand, there were the idealistic Cairo-based policies, which are ideologically driven from a feminist-orientation, albeit that they drew on a research base (Basu, 1997b; Grimes, 1998). Against these "policies" were posed neo-liberal policies, also ideologically driven but from a market orientation that had little place for the ideals of the Cairo model (Adepoju, 1993). The neo-liberal policies produced economic crises, at both the macro- and meso-levels. These had the effect of fragmenting and disintegrating decision-making power and dynamics of many lineages. It is at this point that the

second postulate becomes critical, for it more accurately reflects what the empirical analyses show.

The social changes underpinning postulate two seem to have taken the following form. The shift in the locus of reproductive decision-making power has, on the one hand, following the fragmentation of lineages, had the effect of enhancing the capacity of many women to make autonomous reproductive decisions, simply to assure the survival of their unit of the wider family. On the other hand, it has also increased the capacity of couples to discuss fertility-related issues and to make joint reproductive decisions.

These changes at the community, the lineage and the community-levels have also been affected by changes at the national level. The cause and effect relationship between these changes illustrate the linkages between the macro- and meso-levels, which operate as follows. The history of development in Malawi (Chapters two and three) has shown that at the macro-level, there are massive social changes (education, economic crisis, migration, environmental crisis and AIDS crisis), some of which were driven by the dominant paradigms that have underpinned public policies.

Critical among the economic policies have been Structural Adjustment Policies (SAPs) at the meso-level, as noted above, which have led to the disintegration of the lineage power and gender structure. Instead of making life affordable, SAPs have produced economic crises, which have forced individuals and couples to seek

survival strategies outside the lineage, thus discrediting the traditional locus of reproductive decision-making power. However, the analytical results in this thesis have demonstrated that kin-based networks act as a safety net for individuals, particularly women who manage households single-handed. These networks also influence individual women's autonomous decision-making processes. The autonomy, which women in less gender egalitarian unions may derive from their traditional normative context, will be enhanced by factors endogenous to that context such as female-kin networks.

In relation to the first postulate, the empirical results therefore present a perplexing paradox. They seem to contradict the theoretical notion that married women in more gender egalitarian lineage and marriage systems are more likely to be autonomous in Reproductive Decision-Making Processes (RDMP) than are those in less gender egalitarian lineage and marriage systems. At the same time, the empirical results equally support the postulate that more gender egalitarian systems will empower married women to recognise that they have the capacity to negotiate with their husbands both desired reproductive behaviours and their outcomes than would be so in a less gender egalitarian system.

The empirical analyses presented in this thesis suggest that married women's power in RDMP in Malawi is affected by dichotomous and mutually contradictory meso-level contextual factors that are correlated with (a) the power dynamics linked to *patriliny and polygyny;* and (b) the social interactions associated with *matriliny and*

monogamy. These marriage and lineage systems are subject to diametrically opposite effects on the process of women's empowerment and its outcomes. First, patrilineal and polygynous wives become autonomous as they resist to the strength of the traditional values surrounding male dominance and underpinning patrilineal and polygynous unions. Second, and in contrast, matrilineal and monogamous wives become empowered to negotiate desired reproductive outcomes, a strength drawn from an ethos of matrilineal systems that decision-making powers lie within the female kin. This is also contrary to an assumption underpinning the Cairo model that, since married women in developing countries like Malawi have low status, they lack the power to make independent reproductive choices and decisions.

There is another nuance that emerges from the data presented here. Driven by neo-liberal feminist ideologies, the Cairo conference felt that the empowerment of women was a pre-requisite to women's reproductive rights and choices. This thesis has demonstrated that a significant number of married women in Malawi feel that they can exercise their reproductive rights and choices either through autonomous reproductive decision-making or through spousal communication (Chapter six). This suggests that, at best, the Malawi model of women's power only fits partially to the Cairo women's power model derived from feminist theory. The Malawi model presents two categories of married women. First, there are those who perceive that they have some degree of autonomy and negotiating power in RDMP. These women depend on their access to resources that would enable them put their perceived reproductive rights and choices into operation. Second are those married women who

perceive that they do not have the power to make autonomous reproductive decisions or to negotiate desired reproductive outcomes, are the ones who might need empowerment *per se* as stipulated in the Cairo plan of action.

As the analytical results have suggested, all married women, patrilineal and polygynous or matrilineal and monogamous have the probability of having some degree of autonomy in RDMP. What contrasts the two groups of wives is the relative degree of autonomy that they experience. This in turn depends on the different cultural context to which they are exposed. The support of female-kin networks in autonomous reproductive decision-making applies, of course, equally to matrilineal and monogamous wives as well as to patrilineal and polygynous wives, whose capacity to resist (against male dominance) permit them to develop the capacity to make autonomous reproductive decisions or exercise their acquired negotiating power.

This conclusion is highly significant, but echoes results emerging from other recent research in Africa and Asian countries that in-depth analyses provide clearer explanations of the complex factors related to women's empowerment and RDMP (Williams *et al.*, 1997; Ezeh and Gage, 2000; Mason and Smith, 2000). The variables that are currently used to measure women's power and autonomy may not be appropriate in the context of developing countries. The field of *development-gender-fertility* may therefore require the reformulation of some of its body of theory, re-

identification of power variables, and careful in-depth analysis to investigate these issues. Finally, this conclusion also raises questions about existing policies.

Need for in-depth analyses of women's power and family planning.

This thesis has identified several variables related to socio-economic, cultural, psychosocial and socio-demographic factors, which could be used to measure women's power and autonomy in RDMP. The analytical results have shown that these variables have an indirect relationship with women's power in RDMP. Two types of women's power in RDMP are identified: *latent* and *manifest* power. *Latent* power refers to perceived autonomy in deciding to space, to stop child bearing, to use modern contraception covertly, perceived freedom of movement and perceived power to negotiate reproductive behaviours and outcomes. *Manifest* power involves negotiation and the use of contraception, especially modern contraception.

Among the socio-economic women's power variables that have been identified in this thesis is the factor of *migration,* which reflects the history of one's exposure to modern ideas and lifestyles. Other variables include perceptions about the comparative advantages of smaller and larger families, based on the community's own definition of small or large family (Chapter five) and perceptions about the advantages of modern contraception. The analyses in this thesis (both quantitative and qualitative) have shown that these socio-economic variables produce latent powers in married women, which allow them to develop and exercise manifest powers.

The socio-economic power variables depend, however, on endogenous factors, such as more gender egalitarian or less gender egalitarian lineage values, which operate within the contexts of marriage systems. The factors related to economic crisis (perceived advantages of small families and perceived disadvantages of large families) apply to all lineage and marriage systems. But exposure to modern ideas and lifestyles has a significant effect on polygynous wives only. Essentially, this fits with conventional theories of social change, which suggest that some aspects of social change will erode traditional values and these will be replaced with modern values. Indeed, anthropological and ethnographic data presented here have shown that migration and economic crisis have produced both autonomous and joint reproductive decision-making powers.

These findings are consistent with the postulates posed by some scholars that on the one hand, some aspects of social change (including education, migration, economic crises, family planning, AIDS crisis and environmental crisis) are likely to strengthen spousal relations leading to an increase in spousal communication and joint couple decision-making about family planning issues (Pool, 1972; Caldwell, 1982; Phiri, 1983; Ezeh, 1993a; Locoh 1996, 1997; Pilon and Vignikin, 1996). Thus, some aspects of social change instil in women Western ideas of gender equality and freedom of choice or expression. Increased levels of spousal communication may produce couple reproductive decision-making power that is intimacy-based. On the other hand, for some women, the acquisition of Western ideas about gender equality (through gender community training, schooling and urban residence) produces the

power to resist male dominance. As a consequence, current use of modern contraception is a manifestation of married women's capacity to exercise the intimacy-based reproductive decision-making power. Current use involves latent power to resist.

A very fundamental issue has emerged from these findings. Although some married women in Malawi may claim to have the powers to make autonomous decisions to space or stop child bearing to negotiate reproductive behaviours and outcomes and to use modern contraceptives, these perceived powers do not necessarily translate into limiting births or family sizes. There are two possible explanations to this.

First, the quantitative variables (drawn from sample survey data) that were used to measure women's power in deciding to limit family size were related to stopping child bearing, which may not necessarily refer to limiting family size. The qualitative variables (drawn from ethnographic data) were related to the consequences of having a certain number of children, whether fewer and many. This suggests that there is a need to formulate more refined questions to provide new women's reproductive decision-making power variables, which would measure women's power in deciding to limit births or family sizes.

Second, birth spacing, an outcome of both autonomous and joint couple decision-making, is a traditional practice in both patrilineal and matrilineal societies. In contrast, the idea of family size limitation does not exist in traditional contraception.

Family size limitation is a new term in the vocabulary of most Malawian communities. The general picture drawn from ethnographic data is that the introduction of modern child spacing and family planning methods has led to the diffusion of the idea of *family size limitation* in Malawian communities, particularly in the late 1990s. For 30 years (1964 to 1994), the late Banda accepted *child spacing*, which was driven by traditional family ideologies, but denounced *family planning*.

As indicated in Chapter two, the patrilineal societies in Rumphi district in the Northern part of Malawi have lower fertility compared to the matrilineal societies in Mchinji, central region, who have the highest fertility. This would suggest that the patrilineal and polygynous wives, who are more autonomous than the matrilineal and monogamous wives, have more chances of making and implementing autonomous decisions to limit births or family sizes. But the difficulty lies in the presentation of those decisions.

Women's autonomy or negotiating power in RDMP could have a stronger effect on family size limitation if significant numbers of women exercised their manifest powers to use modern contraceptive methods. The increase in the numbers of married women using modern contraception would depend on two conditions. Firstly, levels of spousal communication, especially those that ending couple agreements, must increase. In order to achieve this goal, married women will depend on resources that will empower them to convince their husbands to use family planning methods not only for spacing but also for limiting family size. Secondly,

those women who have difficulties in negotiating desired reproductive behaviours and outcomes will require empowering resources to allow them develop the capacity to make autonomous reproductive decisions and implement them.

In order to conduct a comprehensive examination of these two aspects of women's reproductive decision-making power in relation to family size limitation, in-depth analyses of the relation women's autonomy, women's negotiating power and modern contraception for limiting family sizes will be needed. Such analyses would focus on decision-making power variables (individual women or men's and couple power variables) that are related to voluntary attempts to limit family sizes. The in-depth analyses must examine the relation between women's power, men's power and couple power in RDMP and the effect of on reproductive decisions, behaviours and outcomes.

Towards evidence-based public policies

If one reviews the findings, arguments and conclusions in this thesis, it provides more elaborate analyses of spousal power relations and RDMP that will be a rich source of information on which to base public policy formulation. In terms of women's empowerment, there are three categories of married women who have been identified in this thesis: those having some degree of autonomy, those having some degree of negotiating power and those having none of these two powers. These categories of women each require different policy instruments to allow them meet their reproductive goals. These instruments must take into account endogenous

factors (those inherent in traditional lineage and marriage systems) exogenous factors (aspects of social change, public policies and laws) and the impact of these on women's power, men's power and couple power in RDMP. Those individual women and men and couples having some degree of autonomy will depend on enabling resources (ie. confidential access to family planning services) to allow them to implement this autonomy. Those having negotiating powers will depend on policy instruments that will enable them convince their spouses to use modern contraception for family size limitation. But those with no decision-making power at all will require policies that will empower them.

Appropriate public policies would have to reflect the different types of empowerment, which individuals (men and women) and couples experience in family life. To begin with, there is empowerment *per se*, which is driven by changes in exogenous factors, which either produces the sense of autonomy or decision-making between spouses, or within gender groups. This type of empowerment is supported by endogenous factors that are driven by persisting traditional family ideologies and values.

The other exogenous factor that has an empowering effect is exposure to modern ideas of gender equality, freedom of choice and expression, and laws that enhance or develop in women and/or couples the capacity to make autonomous reproductive decisions or to discuss desired reproductive behaviours or outcomes. One would speculate that if public policies reflected in-depth analyses of the degrees of power,

which men, women and couples have in RDMP, they would have accurate targets for intervention programmes. If research, legislature and public policies were to take into account cultural and socio-economic-based women's power measures, they would be more accurate in their areas of focus.

ANNEX II: FEMALE QUESTIONNAIRES FOR MDIC SAMPLE SURVEY

The Role of Informal Conversations on Fertility and AIDS Behavior in Malawi
WOMEN'S QUESTIONNAIRE

INTRODUCTION TO RESPONDENT

My name is _____. ***I am working with a research team from the University of Malawi and the University of Pennsylvania. We are doing a survey in order to learn about various health issues in your area. I'll begin with some questions about you yourself and your household. I'll then ask about conversations you've had about family planning and about AIDS. And please be as accurate as possible, since your answers will help us understand the experiences and concerns of those living in this region today. Please ask me to explain if you don't understand any of the questions that I ask. If there are any questions you don't want to answer, please let me know. Everything you tell us will be seen only by the research team and will be kept fully confidential.*** **May I begin now?** ***Thank you very much for agreeing to talk with me.***

SECTION 1: IDENTIFICATION PARTICULARS

Traditional Authority (TA) _____ |_|
Village _____ |_|_|
Headman's name _____
Head of compound _____ |_|_|
Respondent's name _____ |_|_|
Respondent's other names/nicknames _____
Respondent's father's name _____
Respondent's birthplace (District and Village) _____
Husband's name _____ Compound |_|_| Personal |_|_|
Husband's other names/nicknames _____
Husband's birthplace (District and village) _____

House material: Sunburnt bricks.....1 Fired bricks.... 2 Mud.....3 Other.....4
Roof material: Metal sheet/sisal titles.....1 Thatch.....2 Other....3

Language of interview Tumbuka...1 Yao...2 Chichewa...3 Other (Specify_____).4

Interviewer's Name _____ |_|_|
Gender of Interviewer _____ M F
Date of Interview _____ |_|_|_|_|_|_|
Time begun _____

Outcome of Interview:

First Visit:	Complete...1	Refused...2	Other (SPECIFY)_____3
Second Visit:	Complete...1	Refused...2	Other (SPECIFY)_____3
Third Visit:	Complete...1	Refused...2	Other (SPECIFY)_____3

Supervisor's initials _____
Final checker's initials _____
Data entry persons initial's _____

SECTION 1: BACKGROUND QUESTION

NO.	QUESTION	RESPONSE	SKIP
"I would like to begin by asking you a few questions about yourself."			
B1	In what year were you born?	(YEAR): _____ Don't know..... 88	->B2
B1b	IF RESPONDENT DOES NOT KNOW YEAR OF BIRTH, ESTIMATE AGE	ESTIMATED AGE: _____	
B2	Are you now married or living with a man, or are you now widowed, divorced, or no longer living together?	Currently married/living together..... 1 Separated..... 2 Divorced..... 3 Widowed..... 4 Never Married..... 5	 ->B5a ->B5a ->END
B2a	Does your husband/partner have other wives apart from yourself?	Yes..... 1 No..... 0 Don't know..... 88	
B2b	Are you the first, second.....wife?	1st Wife..... 1 2nd Wife..... 2 3rd Wife..... 3 4th+ Wife..... 4	
B4	In what year did you get married (this marriage)?	(YEAR): _____ Doesn't Know..... 88	
B5a	Did you ever go to school?	Yes..... 1 No..... 0 Don't know..... 88	 ->B6 ->B6
B5b	What is the highest level of school you went to?	Primary ..... 1 Secondary ..... 2 University ..... 3 Other..... 4 Don't know..... 88	 ->B6 ->B6
B5c	How many years of school did you complete at that level?	Years: _____ Don't know..... 88	
B6	What religion are you?	Catholic..... 1 Protestant..... 2 Revivalist..... 3 Moslem..... 4 Traditional African..... 5 Nothing..... 6 Other..... 7 b(SPECIFY_____)	

NO.	QUESTION	RESPONSE	SKIP
	B7	What tribe are you?	Yao..... 1 Chewa ..... 2 Lomwe ..... 3 Tumbuka ..... 4 Ngoni ..... 5 Sena ..... 6 Tonga ..... 7 Senga ..... 8 Other ..... 9 (SPECIFY _____) Don't know 88
B8	What languages (other than language of interview) can you speak well enough to have a conversation? DO NOT READ LIST. MORE THAN ONE ANSWER IS POSSIBLE. A Chichewa B Tumbuka C Yao D English E Ngoni F Tonga G Sena H Senga I None J Other (SPECIFY_____)	ONLY CIRCLE IF YES Yes A 1 B 1 C 1 D 1 E 1 F 1 G 1 H 1 I 1 J 1	
B9	Does your husband usually stay in this village or does he usually stay somewhere else?	Stays in village..... 1 Stays somewhere else..... 0	

NO.	QUESTION	RESPONSE	SKIP
B10	Since you became 15 years old, have you ever been to: READ LIST. MORE THAN ONE ANSWER IS POSSIBLE. A Lilongwe? About how many times? B Blantyre? About how many times? C Mzuzu? About how many times? D Zomba? About how many times? CODE "SEVERAL" AS 5 CODE "MANY" OR "LIVED THERE" AS 20	No Yes # of times A 0 1 ____ B 0 1 ____ C 0 1 ____ D 0 1 ____	
B11	Since you were aged 15, have you stayed outside this District for 6 months or more?	Yes..... 1 No..... 0 Don't know..... 88	 ->E1a ->E1a
B12	Where did you stay? DO NOT READ LIST. MORE THAN ONE ANSWER POSSIBLE. A Lilongwe B Blantyre C Mzuzu D Zomba E Other	ONLY CIRCLE IF YES Yes A 1 B 1 C 1 D 1 E 1	

SECTION 2: ECONOMIC QUESTIONS

NO.	QUESTION	RESPONSE	SKIP
E1a	*"I'm now going to ask some questions about things that your household may have, about what your household spends money on, and about the kind of work you do."*		
E1b	First I'm going to read a list of things that households might have. Could you please tell me whether your household has any of them? A Bed with mattress B Radio [If yes, is it working?] C Bicycle D Pit latrine E Paraffin glass lamp	Working No Yes No Yes A 0 1 B 0 1—> 0 1 C 0 1 D 0 1 E 0 1	
E1c	I'm going to read a list of animals. Would you please tell me about how many of these your household owns now? A Cattle B Goats C Pigs D Chickens/ ducks	WRITE NUMBER OF ANIMALS HOUSEHOLD OWNS A _____ B _____ C _____ D _____	

NO.	QUESTION	RESPONSE	SKIP
E1d	Please, tell me how many animals you yourself own. By own, I mean that you could sell them if you wanted to, without asking your wife's permission, or you can take them with you if your marriage ended. A Cattle B Goats C Pigs D Chickens/ ducks	WRITE NUMBER OF ANIMALS RESPONDENT OWNS A _____ B _____ C _____ D _____	
E2	As you know, some women take up jobs for which they are paid in cash or kind. Others sell things at the market or have a small business like brewing beer or cooking food for sale. Others might work on the family farm or in the family business. Are you currently doing any work through which you generate some income in cash or in kind?	Yes..... 1 No..... 0 Other (SPECIFY).....	–>E8a
E3	How much do you usually earn for this work? IF THE RESPONDENT IS NOT PAID IN CASH, ESTIMATE THE MONETARY VALUE OF THE PAYMENT.	_____Kwacha Don't know..... 88 Other (SPECIFY).....	
E4	Over what period of time do you earn this amount?	Per hour..... 1 Per day..... 2 Per week..... 3 Per month..... 4 Per year 5	
E5	About how much did you earn last week?	_____Kwacha Don't know..... 88 Other (SPECIFY).....	
E6	Do you share information with your husband/partner about how much you earn from this work?	Yes..... 1 No..... 0	–>E8a
E7	Do you always tell him, or only sometimes?	Always..... 1 Sometimes..... 2	
E8a	INTERVIEWER: ARE ANY OF THE FOLLOWING PEOPLE PRESENT / WITHIN EARSHOT? A Other male older than 10 B Other male younger than 10 C Other female older than 10 D Other female younger than 10	Yes No A 1 0 B 1 0 C 1 0 D 1 0	
E8b	Do you have any money set aside that you can use in any way you wish, without informing your husband/partner?	Yes..... 1 No..... 0	
E9	Do you personally participate in any kind of rotating credit or saving scheme?	Yes..... 1 No..... 0	

NO.	QUESTION	RESPONSE	SKIP
E10	About how many days last week did you eat chicken, fish or meat?	Number of days: _____	

SECTION 3: CHILDREN

NO.	QUESTION	RESPONSE	SKIP
	"Now I'd like to ask you some questions about your children. First, I'd like to know how many children you have given birth to in your whole life, including children who died and children not living with you anymore and children from other relationships."		
C1	Can you give me the total number of children you have given birth to? IF THE WOMAN IS RECENTLY MARRIED AND CHILDLESS, SKIP TO C3A IF THE WOMAN HAS BEEN MARRIED MORE THAN FIVE YEARS AND HAS NO CHILDREN, SKIP TO F1	Number of children born: _____	
C2	How many are still living?	Number of children alive: _____	
C3a	Are you currently pregnant?	Yes ..... 1 No ..... 2 Don't Know 3	 ——>C3d ——>C3d
C3b	At the time you became pregnant, did you want to become pregnant <u>then</u>, did you want to wait until <u>later</u>, or did you <u>not</u> want to become pregnant at all?	Pregnancy wanted then.....1 Pregnancy wanted later.....2 Pregnancy not wanted at all.3 Did not care .....4 Don't Know 88	
C3c	After the child in your belly is born, would you like to have another child or would you like to stop having children?	Have a(another) child ..... 1 Stop, no more./none..... 2 Says she can't get pregnant/ too old..... 3 Don't know..... 88	 ->C5 ->C5 ->C5 ->C5
C3d	Would you like to have another child or would you like to stop having children?	Have a(nother) child ..... 1 Husband deceased, left..... 2 Stop, nomore./none..... 3 Says she can't get pregnant/ too old..... 4 Don't know..... 88	 ->C5 ->C5 ->C5 ->C5

NO.	QUESTION	RESPONSE	SKIP
C4	How long would you like to wait before having this child? PROBE: IF RESPONDENT SAYS SHE JUST WANTS TO REST, ASK IF SHE WANTS TO REST MORE THAN 2 YEARS OR LESS THAN 2 YEARS	As soon as possible..... 1 Less than 2 years..... 2 More than 2 years..... 3 No preference/whenever.. 4 Don't know..... 88	
C5	If you had the choice, how many living children would you like to have in your lifetime?	Number _____ Don't know..... 88 Up to God/Non-numeric.. 99	
C6	Have you and your husband/partner ever discussed the number of children you would like to have? IF HUSBAND IS DEAD OR IF SHE IS SEPARATED, ASK ABOUT THE TIME WHEN THEY WERE LIVING TOGETHER	Yes..... 1 No..... 0	
	CHECK C1:		
C7	Have you given birth to a child in the last 5 years (since 1993)?	Yes..... 1 No..... 0 Don't know..... 88	->F1a ->F1a
C8	Now I'd like to ask you about the last child you gave birth to in the last 5 years (since 1993). When was this child born? IF RESPONDENT DOESN'T KNOW THE YEAR, ASK HOW MANY HARVESTS?	Year: _____ Don't Know Year .....88 Month: _____ Don't know Month 88	
C9	Is this child still alive?	Yes..... 1 No..... 0 Don't know..... 88	---->C11 ---->C11
C10	When did the child die?	Year: _____ Don't Know Year .....88 Month: _____ Don't know Month 88	
C11	How long did you breastfeed the child?	Months _____ Still breastfeeding..... 99 Don't know 88	
C12	How many months after the birth of this child did your menstruation begin?	Months _____ MPS not .resumed..... 99 Don't know 88	
C13	How many months after the birth of this child did you start having sex again?	Months _____ Sex not resumed..... 99 Don't know 88	->F1a
C14	After you started having sex after this birth, did you or your husband do anything to keep from getting pregnant again?	Yes..... 1 No..... 0 Don't know..... 88	->F1a

NO.	QUESTION	RESPONSE			SKIP
C15	After the birth of this child, why did you decide not to use child spacing/ family planning? DO NOT READ LIST, MORE THAN ONE ANSWER IS POSSIBLE				
	Method:		Yes	No	
	A. Side effects	A	1	0	
B.	Afraid could not give birth again	B	1	0	
A.	Not effective	C	1	0	
	Opposition				
A.	Husband/other relative opposed	D	1	0	
	Clinics				
B.	Too far away	E	1	0	
C.	Costs too much	F	1	0	
	Fertility-related				
D.	Trouble getting pregnant	G	1	0	
E.	Wants another child	H	1	0	
I.	Desires many children	I	1	0	
	Sexuality				
J.	promotes promiscuity	J	1	0	
K.	Other reason (SPECIFY_____)	K	1	0	
L.	Don't know	L	1	0	

SECTION 4: FAMILY PLANNING AND SOCIAL NETWORKS

NO.	QUESTION	RESPONSE	SKIP
F1a	*"I am now going to ask you some questions about child spacing and family planning– the various ways and methods that a couple can use to delay or avoid a pregnancy. I am interested both in the new methods that are given out by the clinics or the CBDs or health surveillance assistants and also in the traditional methods that have been used here for a long time."*		
F1b	As you know, there are now new methods for child spacing and for family planning; such as, pills, injections, the loop, and others. What are your biggest concerns about using any of these methods? DO NOT READ LIST, MORE THAN ONE ANSWER IS POSSIBLE		

	Method:		Yes	No
	A. Side effects	A	1	0
B.	Afraid could not give birth again	B	1	0
B.	Not effective	C	1	0
	Opposition			
F.	Husband/other relative opposed	D	1	0
	Clinics			
G.	Too far away	E	1	0
H.	Costs too much	F	1	0
	Fertility-related			
I.	Trouble getting pregnant	G	1	0
J.	Wants another child	H	1	0
I.	Desires many children	I	1	0
	Sexuality			
J.	promotes promiscuity	J	1	0
K.	Other reason (SPECIFY_____)	K	1	0
L.	Don't know	L	1	0

NO.	QUESTION	RESPONSE	SKIP
F2	And what about the traditional methods? I mean the string, herbs or medicines, or ejaculation/climax outside, or abstinence (have a break) or the rhythm method (periodic). What are your biggest concerns about using traditional methods? DO NOT READ LIST, MORE THAN ONE ANSWER IS POSSIBLE Method: A. Side effects B. Afraid could not give birth again C. Not effective Opposition K. Husband/other relative opposed Clinics L. Too far away M. Costs too much Fertility-related N. Trouble getting pregnant O. Wants another child I. Desires many children Sexuality J. promotes promiscuity K. Other reason (SPECIFY_____) L. Don't know	Yes No A 1 0 B 1 0 C 1 0 D 1 0 E 1 0 F 1 0 G 1 0 H 1 0 I 1 0 J 1 0 K 1 0 L 1 0	
F3	Do you think that women who use modern child spacing/family planning methods might not be able to have more children when they want?	Yes..... 1 No..... 0 Don't know..... 88	
F4	Have you and your husband/partner ever talked about using modern childspacing/ family planning? IF WOMAN IS WIDOWED OR SEPARATED, ASK THESE QUESTIONS ABOUT THE TIME BEFORE HUSBAND'S DEATH OR SEPARATION	Yes..... 1 No..... 0 Don't know..... 88	
F5	If you wanted to use modern child spacing/ family planning, do you think he would agree?	Yes..... 1 No..... 0 Don't know..... 88	

NO.	QUESTION	RESPONSE	SKIP
F6	About how many women in this village do you know who you think may have used modern methods of childspacing/family planning? Sometimes it's hard to know, but I'd like you to include your guesses.	Number: _____ Don't know..... 88	
F7	Some women use modern methods of childspacing/family planning without their husband knowing about it. Have you heard of women using modern childspacing/ family planning secretly?	Yes..... 1 No..... 0 Don't know/ no answer..... 88	 ->F9a ->F9a
F8	About how many women do you suspect, know or have heard about who have used family planning secretly? CODE "SEVERAL" AS 5, CODE "MANY" AS 20	Number: _____	
F9a	*"Now I'd like to ask you about other people that you may have talked with about family planning. Women often chat with each other about children and about ways to keep from having another birth. Now I would like to know about your chats with friends and relatives about modern methods of childspacing/family planning. Some of these people may approve of family planning, but some may not approve of it"*		
F9b	How many people have you chatted with about modern methods of childspacing/family planning? I mean people other than your husband or partner. Aganichisye mundu jwine jwakwe? Kutama apo palikuwa mawecheto ata ngawecheta kandu. 1. DO NOT INCLUDE HUSBAND; 2. IF LESS THAN FOUR ARE NAMED, PROBE:	Total number named: _____ IF NONE ARE NAMED AFTER PROBING	 ->F26a
F10	Could you please give me the names of four of these? As I said earlier, this information will be completely confidential, it's just for our research. AFTER YOU WRITE THE FOUR NAMES HERE, TURN TO THE MATRIX AT THE BACK OF THE QUESTIONNAIRE AND WRITE ALL FOUR NAMES AGAIN, IN THE SAME ORDER. THEN GO TO F11.	Name: 1. _____ 2. _____ 3. _____ 4. _____	

NO.	QUESTION	RESPONSE	SKIP	#1	#2	#3	#4
F11	Is _____ male or female?	male.....1 female.....2					

NO.	QUESTION	RESPONSE	SKIP	#1	#2	#3	#4
F12	What is your relationship to_____?	friend..... 1 Male relative: father..... 2 brother.....3 father in law..... 4 brother-in-law..... 5 other male relative.....6 Female relative mother..... 7 sister..... 8 co-wife..... 9 sister-in-law/sister-in-marriage..... 10 mother in law..... ..... 11 other female relative..... 12 Other acquaintance/ workmate.. 13 family planning CBD..... 14 nurse/doctor/health surveillance assistant..... 15 other..... 16 (SPECIFY_____)					
F13	How close is _____ to you? Is he/she an acquaintance, just a friend or a confidant?	Confidant (mzanga wenini wenini)..... ..... Just a friend (mzanga).... 2 An acquaintance (ongodzuwananaye)..... 3 Met once or twice..... 4					

NO.	QUESTION	RESPONSE	SKIP	#1	#2	#3	#4
F14	Where does _____ stay?	same household..... 1 same compound..... 2 same village..... 3 same TA..... 4 same district..... 5 Lilongwe..... 6 Blantyre..... 7 Mzuzu..... 8 Zomba..... 9 somewhere else..... 10 don't know..... 88					
F15	How much education has _____ had?	Never went to school..... 0 Some primary.....1 Finished primary..... 2 Secondary or more..... 3 Don't know..... 88					
F16	How many living children does ____ have?	NUMBER _____ Don't know..... 88					

NO.	QUESTION	RESPONSE			SKIP	#1	#2	#3	#4
F17	What is _____'s biggest concern about using modern methods of childspacing/family planning? DO NOT READ LIST, MORE THAN ONE ANSWER IS POSSIBLE		Yes	No					
	<u>Method</u>:								
	A. Side effects	A	1	0					
	B. Afraid could not give birth again	B	1	0					
	D. Not effective	C	1	0					
	<u>Opposition</u>								
	P. Husband/other relative opposed	D	1	0					
	<u>Clinics</u>								
	Q. Too far away	E	1	0					
	R. Costs too much	F	1	0					
	<u>Fertility-related</u>								
	S. Trouble getting pregnant	G	1	0					
	T. Wants another child	H	1	0					
	I. Desires many children	I	1	0					
	<u>Sexuality</u>								
	J. promotes promiscuity	J	1	0					
	K. Other reason (SPECIFY_____)	K	1	0					
	L. Don't know	L	1	0					
F18	Has _____ ever done anything to try to space births or to stop childbearing altogether?	Yes.....1 Suspects/maybe.....2 No.....0 Don't know.....88			 **->F23** **->F23**				

NO.	QUESTION	RESPONSE	SKIP	#1	#2	#3	#4
F19	Has she used a modern method, a traditional method, or both?	Modern Method .....1 Traditional method .....2 Both..... 3 Don't know 88					

NO.	QUESTION	RESPONSE	SKIP	#1	#2	#3	#4
F20	What specific method(s) has ____ used? MORE THAN ONE ANSWER IS POSSIBLE. DO NOT READ LIST. IF NO USE OF TRADITIONAL METHODS, PROBE: And what about the traditional methods that have been used here for a long time? <u>Modern methods:</u> A pill B injection C loop D sterilization E calendar/natural F condom G don't know method <u>Traditional methods:</u> H withdrawal I abstinence J string K traditional medicine L other (Specify_____) M don't know method	Yes A 1 B 1 C 1 D 1 E 1 F 1 G 1 H 1 I 1 J 1 K 1 L 1 M 1					
	CHECK F20						
	CHECK F20						
	CHECK F11						
F21	Was there ever a time that her husband did not know that she used modern methods of child spacing /family planning?	Yes..... 1 No..... 0 Don't know..... 88					
F22	Is _____still using any method of childspacing/family planning now?	Yes..... 1 No..... 0 Don't know..... 88	 **->F24** **->F24**				
F23	Is _____using a modern or traditional method of childspacing of family planning?	Modern method..... 1 Traditional method..... 2 Both..... 3 Don't know..... 88					

NO.	QUESTION	RESPONSE	SKIP	#1	#2	#3	#4
F24	Has _____ ever mentioned to you that he/she would like to stop childbearing, or do you suspect that he/she would like to stop childbearing?	Yes, he/she mentioned 1 Yes, I suspect..... 2 No..... 0 Don't know..... 88					
F25	Has _____ ever mentioned to you that he/she heard a talk about modern family planning at the clinic/hospital or on the radio, or did he/she ever tell you that a CBD/health surveillance assistant came to his/her home to give him/her information about child spacing/ family planning?	Yes..... 1 No..... 0 Don't know..... 88					

NOW RETURN TO F11 AND ASK THE QUESTIONS ABOUT THE NEXT CONVERSATION PARTNER UNTIL YOU FINISH ALL PARTNERS.

IF RESPONDENT MENTIONED LESS THAN FOUR CONVERSATION PARTNERS, PROBE:

"Is there anyone else you have talked to about family planning that you did not mention before?"

IF THERE IS, GO BACK TO F10, WRITE THE PERSON'S NAME, AND ASK THE QUESTIONS ABOUT THAT PERSON FROM F11.

IF THERE IS NO ONE ELSE SHE HAS TALKED WITH, GO TO F26a

	QUESTION	RESPONSE	SKIP
F26a	*"Now I'd like to ask you about you yourself."*		
F26b	INTERVIEWER: ARE ANY OF THE FOLLOWING PEOPLE PRESENT/ WITHIN EARSHOT? A Other male older than 10 B Other male younger than 10 C Other female older than 10 D Other female younger than 10	Yes No A 1 0 B 1 0 C 1 0 D 1 0	
F26c	Have you ever used any traditional or modern method of childspacing or family planning?	Yes..... 1 No.....0 Don't know.....88	 **->F34** **->F34**

	QUESTION	RESPONSE	SKIP
F27	What methods have you <u>ever</u> used at any time? I am interested in both traditional and modern methods. DO NOT READ LIST. MORE THAN ONE ANSWER IS POSSIBLE. IF NO USE OF TRADITIONAL METHODS, PROBE: And what about the traditional methods that have been used here for a long time? <u>Modern methods:</u> A pill B injection C loop D sterilization E calendar/natural F condom <u>Traditional methods:</u> G withdrawal H abstinence I string J traditional medicine K other (SPECIFY_____) L don't know method	Yes A 1 B 1 C 1 D 1 E 1 F 1 G 1 H 1 I 1 J 1 K 1 L 1	
	CHECK F27		
	CHECK F27		
F28	Was there ever a time when you were using modern childspacing/ family planning but your husband/partner did not know you were using it?	Yes..... 1 No.....0 Don't know.....88	 **->F31** **->F31**
F29	Did he ever find out you were using a method?	Yes..... 1 No.....0 Don't know.....88	 **->F31** **->F31**

	QUESTION	RESPONSE	SKIP
F30	What happened when he found out? MORE THAN ONE ANSWER IS POSSIBLE. DO NOT READ LIST A Asked her to leave B Left her C Talked with relatives/elders D Made her stop E Got another woman F Beat her G Quarreled with her H Decided to discuss it I Did not do anything J Other (SPECIFY_____)	Yes A 1 B 1 C 1 D 1 E 1 F 1 G 1 H 1 I 1 J 1	
F31	In what year did you first use modern methods of childspacing/ family planning?	Year: ____ Other ..... 9 (SPECIFY_____) Don't know... 88	
F32	Are you now using any method of childspacing/ family planning? I'm interested in both modern and traditional methods.	Yes..... 1 No.....0	**->F34**
F33	What method are you now using? MORE THAN ONE ANSWER IS POSSIBLE. DO NOT READ LIST IF NO USE OF TRADITIONAL METHODS, PROBE: And what about the traditional methods that have been used here for a long time? <u>Modern methods:</u> A pill B injection C loop D sterilization E calendar/natural F condom <u>Traditional methods:</u> G withdrawal H abstinence I string J traditional medicine K other (SPECIFY_____) L don't know method	Yes A 1 B 1 C 1 D 1 E 1 F 1 G 1 H 1 I 1 J 1 K 1 L 1	
F34	Have you ever heard a talk at the clinic/hospital about modern family planning?	Yes..... 1 No.....0 Don't know..... 88	

	QUESTION	RESPONSE	SKIP
F35	Have you ever heard a radio program about modern family planning?	Yes..... 1 No.....0 Don't know..... 88	
F36	Has someone like a CBD Agent or a Health Surveillance Assistant ever come to your home to give you information about health or childspacing?	Yes..... 1 No.....0 Don't know..... 88	

SECTION 6: GENDER QUESTIONS

NO.	QUESTION	RESPONSE	SKIP
	"I'd now like to ask a few questions about your attitudes to men and women."		
G1	In your opinion, is it proper for a wife to leave her husband if: READ LIST A He does not support her and the children financially? B He beats her frequently? C He is sexually unfaithful? D She thinks he might be infected with AIDS? E He does not allow her to use family planning	 No Yes Don't know A 0 1 88 B 0 1 88 C 0 1 88 D 0 1 88 E 0 1 88	
G2	Is it acceptable for you to go to the local market without informing your husband?	Yes..... 1 No.....0 Don't know..... 88	
G3	Is it acceptable for you to go to the local health center without informing your husband?	Yes..... 1 No.....0 Don't know..... 88	
	"Please tell me if you agree, disagree or have no opinion about the following statements"		
G4	If my partner does not want to use modern methods of childspacing /family planning, there is nothing I can do to change his mind.	Agree..... 1 Disagree..... 2 No opinion..... 3	

NO.	QUESTION	RESPONSE	SKIP
G5	If I decide that I want to delay the next birth, I will be able to have my way.	Agree..... 1 Disagree..... 2 No opinion..... 3	
G6	If I decide that I want no more children, I will be able to have my way.	Agree..... 1 Disagree..... 2 No opinion..... 3	
G7	Even if my husband does not want me to use family planning, if I want to I will use without his knowledge.	Agree..... 1 Disagree..... 2 No opinion..... 3	

SECTION 7: AIDS QUESTIONS

NO.	QUESTION	RESPONSE	SKIP
A1a	*"I am now going to ask you some questions about diseases. As you know, many people in Malawi today are concerned about various diseases. Please remember that all your answers are confidential. If there are any questions you are uncomfortable answering, please tell me and I'll skip them."*		
A1b	If a person gets very thin and dies, what disease do you think probably killed them?	AIDS..... 1 Kaliwondewonde/ chitega/ witchcraft..... 2 Could be either AIDS or Kaliwondewonde/ chitega/ witchcraft..... 3 TB/malaria etc..... 4 Other..... 5 (SPECIFY)_____ Don't know..... 88	
A2	I'm going to read a list of ways that women might get infected with the AIDS virus. Which of these ways are you most worried about for yourself? READ LIST. ONLY ONE ANSWER IS POSSIBLE. A. Husband B. Other partner C. Needle / injections D. Transfusions E. Other (Specify.....) F. Don't Know	Yes No A 1 0 B 1 0 C 1 0 D 1 0 E 1 0 F 1 0	
A3	How worried are you that you might catch AIDS?	Not worried at all ..... 1 Worried a little ..... 2 Worried a lot ..... 3 Don't know..... 88	
A4	Do you think it is acceptable to use a condom with a spouse to protect against AIDS?	Yes..... 1 No.....0 Don't know.....88	
A5	Can you get AIDS if you have sex with someone who looks perfectly healthy?	Yes..... 1 No.....0 Don't know.....88	

NO.	QUESTION	RESPONSE			SKIP
A6	What do you think is the best way to protect yourself from getting AIDS? DO NOT READ LIST, MORE THAN ONE ANSWER IS POSSIBLE			Yes No	
	<u>Advise Spouse</u>				
	A. Advise spouse to take care	A	1	0	
	<u>Use condoms with</u>:				
	B. <u>all</u> other partners except spouse	B	1	0	
	C. Prostitutes / bargirls	C	1	0	
	D. people from town	D	1	0	
	E. other people you think might be infected	E	1	0	
	<u>Avoid having sex with</u>:				
	F. any partners except spouse	F	1	0	
	G. prostitutes / bargirls	G	1	0	
	H. many partners	H	1	0	
	I. people from town	I	1	0	
	J. other people you think might be infected.	J	1	0	
	<u>Avoid other</u>:				
	K. transfusions/ injections/ sharing razor blades.	K	1	0	
	L. other (SPECIFY _____)	L	1	0	
	M. Nothing.	M	1	0	
	N. Don't know	N	1	0	
A7	How many people do you know who you think have died from AIDS? PEOPLE MAY NOT BE SURE, BUT ASK THEM TO JUST GUESS.	NUMBER: ____ Don't know..... 88			
A8	As you know, sometimes women in this area have sex with men who are not their husbands. Now, I'd like to ask you about your best female friend. Has she slept with anyone other than her husband in the last 12 months?	Yes..... 1 Suspects..... 2 No..... 0 Don't know..... 88			 **->A11a** **->A11a**
A9	How many men other than her husband do you think she has slept with in the last 12 months?	NUMBER: ____ Don't know..... 88			
A10	Does she sometimes or always or never use a condom when she sleeps with men other than her husband?	Always ..... 1 Sometimes ..... 2 Maybe ..... 3 Never ..... 4 Don't know 88			
A11a	*"Now I'm going to ask some questions about you yourself."*				

NO.	QUESTION	RESPONSE	SKIP
A11b	INTERVIEWER: ARE ANY OF THE FOLLOWING PEOPLE PRESENT / WITHIN EARSHOT? A Other male older than 10 B Other male younger than 10 C Other female older than 10 D Other female younger than 10	Yes No A 1 0 B 1 0 C 1 0 D 1 0	
A11c	Have you ever talked to your husband about the chances that you or he might get infected with AIDS?	Yes..... 1 No..... 0 Don't know 88	
A12	Do you suspect or know that your husband has had sexual relations with other women apart from you since you were married? IF HUSBAND HAS MORE THAN ONE WIFE, QUESTION REFERS TO WOMEN WHO ARE NOT HIS WIVES	Yes, know ..... 1 Suspect ..... 2 Can't know what he does 3 Probably not..... 4 Don't know..... 88	
A13	Have you yourself slept with anyone other than your husband in the last 12 months?	Yes..... 1 No..... 0	**→A24a**
A14a	How many men other than your husband did you sleep with in the last 12 months?	Number: _____	
A14b	Do you sometimes or always or never use a condom when you sleep with men other than your husband?	Always ..... 1 Sometimes ..... 2 Maybe ..... 3 Never ..... 4 Don't know 88	
A24a	*"Now I'd like to ask you some questions about people you've chatted with about AIDS"*		
A24b	How many people have you chatted with about AIDS? I mean people other than your husband or partner. 1. DO NOT INCLUDE HUSBAND; 2. IF LESS THAN FOUR ARE NAMED, PROBE: Can you think of anyone else? How about sitting in on a conversation, even if you yourself didn't say anything?	Total number named: _____ IF NONE ARE NAMED AFTER PROBING	**→A43**
A25	Could you please give me the names of four of these? As I said earlier, this information will be completely confidential. AFTER YOU WRITE THE FOUR NAMES HERE, TURN TO THE MATRIX AT THE BACK OF THE QUESTIONNAIRE AND WRITE ALL FOUR NAMES AGAIN, IN THE SAME ORDER. THEN GO TO A26.	Name: 5. _____ 6. _____ 7. _____ 8. _____	

NO.	QUESTION	RESPONSE			SKIP	#5	#6	#7	#8
A26	How worried is _____ about getting AIDS?	Not worried at all..... 1 Worried a little..... 2 Worried a lot..... 3 Don't know..... 88							
A27	What does ____ think is the best way to protect herself/himself from getting AIDS? DO NOT READ LIST, MORE THAN ONE ANSWER IS POSSIBLE								
	<u>Advise Spouse</u>			Yes No					
	A. Advise spouse to take care	A	1	0					
	<u>Use condoms with</u>:								
	B. <u>all</u> other partners except spouse	B	1	0					
	C. Prostitutes / bargirls	C	1	0					
	D. people from town	D	1	0					
	E. other people you think might be infected	E	1	0					
	<u>Avoid having sex with</u>:								
	F. any partners except spouse	F	1	0					
	G. prostitutes / bargirls	G	1	0					
	H. many partners	H	1	0					
	I. people from town	I	1	0					
	J. other people you think might be infected.	J	1	0					
	<u>Avoid other</u>:								
	K. transfusions/ injections/ sharing razor blades.	K	1	0					
	L. other (SPECIFY _____)	L	1	0					
	M. Nothing.	M	1	0					
	N. Don't know	N	1	0					

NO.	QUESTION	RESPONSE	SKIP	#5	#6	#7	#8
A27	What does ____ think is the best way to protect herself/himself from getting AIDS? DO NOT READ LIST. MORE THAN ONE ANSWER IS POSSIBLE.	<u>Advise spouse</u>: advise spouse to take care..... 1 advise husband not to take another wife ..... 2 <u>Use condoms with</u>: <u>all</u> other partners except spouse..... 3 prostitutes/ bar girls.....4 people from town.....5 other people you think might be infected..... 6 <u>Avoid having sex with</u>: any partners except spouse.....7 prostitutes/ bar girls.....8 many partners.....9 people from town..... 10 other people you think might be infected.....11 <u>Avoid other</u>: transfusions/ injections/ sharing razor blades..... 12 other ..... 13 (SPECIFY_____) Nothing..... 14 Don't know..... 88					
A28	Has _____ ever mentioned to you that she has heard a talk at the clinic/hospital about AIDS, or heard a radio program about AIDS?	Yes..... 1 No.....0 Don't know.....88					
A29	Is ____ one of the same people you told me you talked to about family planning? IF YES, LOOK AT THE MATRIX AT THE END AND IDENTIFY WHICH FAMILY PLANNING NETWORK PARTNER THIS IS. THEN FILL OUT THE "SAME AS" COLUMN, MAKING SURE THAT THE NAMES ARE THE SAME.	Yes..... 1 No.....0	**->A36**				
A30	Is _____ male or female?	male.....1 female.....2					

NO.	QUESTION	RESPONSE	SKIP	#5	#6	#7	#8
A31	What is your relationship to_____?	friend.....1 <u>Male relative:</u> father..... 2 brother.....3 father-in-law..... 4 brother-in-law..... 5 other male relative.....6 <u>Female relative</u> mother..... 7 sister..... 8 co-wife..... 9 sister-in-law/sister-in-marriage..... 10 mother-in-law..... ..... 11 other female relative..... 12 <u>Other</u> acquaintance/ workmate13 family planning CBD..... 14 nurse/doctor/health surveillance assistant.....15 other..... 16 (SPECIFY_____)					
A32	Where does _____ stay?	same household.....1 same compound..... 2 same village.....3 same TA.....4 same district..... 5 Lilongwe..... 6 Blantyre.....7 Mzuzu..... 8 Zomba..... 9 somewhere else..... 10 don't know..... 88					

NO.	QUESTION	RESPONSE	SKIP	#5	#6	#7	#8
A33	How close is _____ to you? Is he/she an acquaintance, just a friend or a confidant?	Confidant (mzanga weniwe ni)..... Just a friend (mzanga).... 2 An acquaintance (ongodzuwananaye)..... 3 Met once or twice..... 4					
A34	How much education has _____ had?	Never went to school..... 0 Some primary..... 1 Finished primary.....2 Secondary or more..... 3 Don't know..... 88					
A35	Has _____ ever used modern family planning?	Yes..... 1 No.....0 Don't know.....88					
A35a	Has _____ ever mentioned to you that he/she has heard a talk at the clinic or hospital, or heard a radio program about AIDS?	Yes..... 1 No.....0 Don't know.....88					
A36	Is _____ the best friend that you talked to me about earlier?	Yes..... 1 No.....0	**->A43**				
A37	Do you think _____ had other sexual partners other than his/her spouse or regular partner in the past year?	Yes..... 1 No.....0 Don't know.....88	**->A43** **->A43**				
A38	Do you think _____ sometimes or always or never use condoms with these other partners?	Always ..... 1 Sometimes .....2 Maybe ..... 3 Never .....4 Don't know 88					

NO.	QUESTION	RESPONSE	SKIP	#5	#6	#7	#8
	NOW RETURN TO A26 AND ASK THE QUESTIONS ABOUT THE NEXT CONVERSATION PARTNER UNTIL YOU FINISH ALL PARTNERS LISTED IN A25. IF RESPONDENT MENTIONED LESS THAN FOUR CONVERSATION PARTNERS, PROBE: **"Is there anyone else you have talked to about AIDS that you did not mention before?"** IF THERE IS, GO BACK TO A25, WRITE THE PERSON'S NAME, AND ASK THE QUESTIONS ABOUT THAT PERSON FROM A26. IF THERE IS NO ONE ELSE SHE HAS TALKED WITH, GO TO A43						

A43	Have you ever heard a talk at the clinic/hospital about how people can protect themselves against AIDS?	Yes..... 1 No.....0 Don't know.....88	
A44	Have you ever heard a radio program about how people can protect themselves against AIDS?	Yes..... 1 No.....0 Don't know.....88	
A45	Has someone like a Community Based Distribution agent or a Health Surveillance Assistant ever come to your home to give you information about how people can protect themselves against AIDS?	Yes..... 1 No.....0 Don't know.....88	

SECTION 8: MATRIX

	"Finally, I would like briefly ask you how well all the people you told me about know each other."
M1	Are the NAME ON ROW and NAME ON COLUMN confidants, just friends, acquaintances, or do they not know each other? Confidants ..... 1 Just friends ..... 2 Acquaintances ..... 3 Don't know each other ..... 4 D.K..... 5
	INSTRUCTIONS FOR DATA-ENTRY STAFF:

		FAMILY PLANNING				AIDS			
x	M1 ax		M1 bx	M1 cx	M1 dx	M1 ex	M1 fx	M1 gx	M1 hx
	Same as	1	2	3	4	5	6	7	8
1									
2									
3									
4									
5			DO NOT WRITE IN SHADED AREA						
6									
7									
8									

"These are the questions that I wanted to ask you. Thank you very much for talking with me today. We very much appreciate your help in our research project about family planning and about AIDS."

TIME FINISHED _____

SECTION 8: FOR INTERVIEWER

SOON AFTER THE INTERVIEW, PLEASE ANSWER THE FOLLOWING QUESTIONS

I1	HOW WELL DO YOU KNOW THE RESPONDENT'S FAMILY?	Not at all..... 1 By name only..... 2 Quite well..... 3 Very well..... 4	
I2	ARE YOU RELATED TO THE RESPONDENT?	Yes .....1 No .....2 Don't know 3	
I3	HOW WEALTHY DO YOU THINK THE RESPONDENT'S HOUSEHOLD IS IN COMPARISON WITH OTHER HOUSEHOLDS IN THE VILLAGE?	One of the poorest ..... 1 Quite poor..... 2 Average.....3 Quite wealthy .....4 One of the wealthiest..... 5 Cannot tell 6	
I4	DEGREE OF CO-OPERATION?	Bad .....1 Average .....2 Good .....3 Very good 4	
I5	DO YOU HAVE ANY OTHER COMMENTS ABOUT THE INTERVIEW? E.G DID OTHER PEOPLE INTERRUPT, ANY HESITATION OR UNWILLINGNESS TO ANSWER _____ _____ _____ _____ _____		

ANNEX III: MALE QUESTIONNAIRES FOR MDIC SAMPLE SURVEY

The Role of Informal Conversations on Fertility and AIDS Behavior in Malawi
MEN'S QUESTIONNAIRE

INTRODUCTION TO RESPONDENT

My name is _____. I am working with a research team from the University of Malawi and the University of Pennsylvania. We are doing a survey in order to learn about various health issues in your area. I will begin with some questions about you yourself and your household. I will then ask about conversations you've had about family planning and about AIDS. Please be as accurate as possible, since your answers will help us understand the experiences and concerns of those living in this region today. And, please, ask me to explain if you don't understand any of the questions that I ask. If there are any questions you don't want to answer, please let me know. Everything you tell us will be seen only by the research team and will be kept fully confidential. **May I begin now?** ***Thank you very much for agreeing to talk with me.***

SECTION 1: IDENTIFICATION PARTICULARS

Traditional Authority (TA) _____ ⌊⌋
Village _____ ⌊⌋⌊⌋
Headman's name _____
Head of compound _____ ⌊⌋⌊⌋
Respondent's name _____ ⌊⌋⌊⌋
Respondent's other names/nicknames _____
Respondent's father's name _____
Respondent's birthplace (District and Village) _____

				Wife's village of residence
Wife#1 name	_____	Compound ⌊⌋⌊⌋	Personal ⌊⌋⌊⌋	_____
Wife#2 name	_____	Compound ⌊⌋⌊⌋	Personal ⌊⌋⌊⌋	_____
Wife#3 name	_____	Compound ⌊⌋⌊⌋	Personal ⌊⌋⌊⌋	_____
Wife#4 name	_____	Compound ⌊⌋⌊⌋	Personal ⌊⌋⌊⌋	_____

House material: Sunburnt bricks.....1 Fired bricks.... 2 Mud.....3 Other.....4
Roof material: Metal sheet/sisal titles.....1 Thatch.....2 Other....3

Language of interview Tumbuka...1 Yao...2 Chichewa...3 Other (specify)_____4

Interviewer's Name _____ ⌊⌋⌊⌋
Gender of Interviewer _____ M F
Date of Interview _____ ⌊⌋⌊⌋⌊⌋⌊⌋⌊⌋⌊⌋
Time begun _____

Outcome of Interview:

First Visit:	Complete...1	Refused...2	Other (SPECIFY)_____3
Second Visit:	Complete...1	Refused...2	Other (SPECIFY)_____3
Third Visit:	Complete...1	Refused...2	Other (SPECIFY)_____3

Supervisor's initials _____
Final checker's initials _____
Data entry persons initial's _____

SECTION 1: BACKGROUND QUESTIONS

NO.	QUESTION	RESPONSE	SKIP
"I would like to begin by asking you a few questions about yourself."			
B1	In what year were you born?	(YEAR): _____ Don't know..... 88	**-->B2**
B1b	IF RESPONDENT DOES NOT KNOW YEAR OF BIRTH, ESTIMATE AGE	ESTIMATED AGE: _____	
B2	Are you now married or living with a woman, or are you now widowed, divorced, or no longer living together?	Currently married/living together..... 1 Separated..... 2 Divorced..... 3 Widowed..... 4 Never Married..... 5	 **-->B5a** **-->B5a** **-->END**
B2a	Do you have more than one wife?	Yes..... 1 No..... 0 Don't know / other 88	

B2b Please give the names and places of residence of your wive(s) or women with whom you are living?

	Name	Village/District of Residence	Village/District of Birth
Wife#1	_____ _____	_____	_____
Wife#2	_____	_____	_____
Wife#3	_____ _____	_____	_____
Wife#4	_____	_____	_____

INTERVIEWER: ALL QUESTIONS REGARDING THE WIFE OF THIS RESPONDENT REFER TO THE WIFE MARKED BELOW. WRITE NAME OF MARKED WIFE FOR REFERENCE.

B3a	Rank of wife to base interview on: IF HE HAS ONLY ONE WIFE WHO IS LESS THAN 50 YEARS OLD, ASK HIM ABOUT HER. IF HE HAS MORE THAN ONE WIFE WHO IS LESS THAN 50 YEARS OLD, ASK HIM ABOUT:			
		1st Wife		
		2nd Wife		
		3rd Wife IF NO 3RD WIFE INTERVIEW-->	1ST WIFE	
			2ND WIFE	
B3b	Name of wife to base interview on:		_____	

NO.	QUESTION	RESPONSE	SKIP
B4	When did you get married to _____ ?	Year _____ Don't know 88	
B5a	Did you ever go to school?	Yes..... 1 No..... 0 Don't know..... 88	 ->B6
B5b	What is the highest level of school you went to?	Primary ..... 1 Secondary ..... 2 University ..... 3 Other..... 4 Don't know..... 88	 ->B6 ->B6
B5c	How many years of school did you complete at that level?	Years: _____ Don't know..... 88	
B6	What religion are you?	Catholic..... 1 Protestant..... 2 Revivalist..... 3 Moslem..... 4 Traditional African..... 5 Nothing..... 6 Other..... 7 (SPECIFY_____)	
B7	What tribe are you?	Yao..... 1 Chewa ..... 2 Lomwe ..... 3 Tumbuka ..... 4 Ngoni ..... 5 Sena ..... 6 Tonga ..... 7 Senga ..... 8 Other ..... 9 (SPECIFY_____) Don't Know 88	
B8	What languages (other than language of interview) can you speak well enough to have a conversation? DO NOT READ LIST. MORE THAN ONE ANSWER IS POSSIBLE. A Chichewa B Tumbuka C Yao D English E Ngoni F Tonga G Sena H Senga I None J Other (SPECIFY_____)	ONLY CIRCLE IF YES Yes A 1 B 1 C 1 D 1 E 1 F 1 G 1 H 1 I 1 J 1	
B9	Do you usually stay in this village or do you usually stay somewhere else?	Stays in village..... 1 Stays somewhere else..... 0	-> B10

NO.	QUESTION	RESPONSE	SKIP
B9a	Where do you stay? A Lilongwe? B Blantyre? C Mzuzu? D Zomba? E With other wife in her village F Other (SPECIFY)_____	Yes 1 2 3 4 5 VILLAGE: _____ TA: _____ 6	
B10	Since you became 15 years old, have you ever been to: READ LIST. MORE THAN ONE ANSWER IS POSSIBLE. A Lilongwe? About how many times? B Blantyre? About how many times? C Mzuzu? About how many times? D Zomba? About how many times? CODE "MANY" OR "LIVED THERE" AS 20 CODE " SEVERAL" AS 5	No Yes # of times A 0 1 ____ B 0 1 ____ C 0 1 ____ D 0 1 ____	
B11	Since you were aged 15, have you stayed outside this District for 6 months or more?	Yes..... 1 No..... 0 Don't know..... 88	 → **E1a** → **E1a**
B12	Where did you stay? DO NOT READ LIST. MORE THAN ONE ANSWER POSSIBLE. A Lilongwe B Blantyre C Mzuzu D Zomba E Other	ONLY CIRCLE "YES" Yes A 1 B 1 C 1 D 1 E 1	

SECTION 2: ECONOMIC QUESTIONS

NO.	QUESTION	RESPONSE	SKIP
E1a	*"I'm now going to ask some questions about things that your household may have, about what your household spends money on, and about the kind of work you do."*		
E1b	First I'm going to read a list of things that households might have. Could you please tell me whether your household has any of them? A Bed with mattress B Radio [If Yes, Is it Working?] C Bicycle D Pit latrine E Paraffin glass lamp	Working No Yes No Yes A 0 1 B 0 1----> 0 1 C 0 1 D 0 1 E 0 1	
E1c	I'm going to read a list of animals. Would you please tell me about how many of these your household owns now? A Cattle B Goats C Pigs D Chickens/ ducks	WRITE NUMBER OF ANIMALS HOUSEHOLD OWNS A _____ B _____ C _____ D _____	
E1d	Please, tell me how many animals you yourself own. By own, I mean that you could sell them if you wanted to, without asking your wife's permission, or you can take them with you if your marriage ended. A Cattle B Goats C Pigs D Chickens/ ducks	WRITE NUMBER OF ANIMALS RESPONDENT OWNS A _____ B _____ C _____ D _____	
E2	As you know, some men take up jobs for which they are paid in cash or kind. Others sell things at the market or have a small business. Others might work on the family farm or in the family business. Are you currently doing any work through which you generate some income in cash or kind?	Yes..... 1 No..... 0 Don't Know..... .....88 Other (specify 5	**->E3a**
E3	How much do you usually earn for this work? IF THE RESPONDENT IS NOT PAID IN CASH, ESTIMATE THE MONETARY VALUE OF THE PAYMENT.	_____ Kwacha Don't know..... 88 Other (Specify) 5	

NO.	QUESTION	RESPONSE	SKIP
E4	Over what period of time do you earn this amount?	Per hour..... 1 Per day..... 2 Per week..... 3 Per month..... 4 Per year 5	
E5	About how much did you earn last week?	_____Kwacha Don't know..... 88 Other (Specify) 5	
E6	Do you share information with your wife/partner about how much you earn from this work?	Yes..... 1 No..... 0	→E8a
E7	Do you always tell her, or only sometimes?	Always..... 1 Sometimes..... 2	
E8a	INTERVIEWER: ARE ANY OF THE FOLLOWING PEOPLE PRESENT / WITHIN EARSHOT? A Other male older than 10 B Other male younger than 10 C Other female older than 10 D Other female younger than 10	Yes No A 1 0 B 1 0 C 1 0 D 1 0	
E8b	Do you have any money set aside that you can use in any way you wish, without informing her (your wife or partner)?	Yes..... 1 No..... 0	
E9	Do you personally participate in any kind of rotating credit or saving scheme?	Yes..... 1 No..... 0	
E9b	How much land do you yourself own?	_____ ACRES _____ HECTARES Don't know 88	
E10	About how many days last week did you eat chicken, fish or meat?	Number of days: _____	

SECTION 3: CHILDREN

NO.	QUESTION	RESPONSE	SKIP
	"Now I'd like to ask you some questions about your children. First, I'd like to know how many children you have had in your whole life, including children who died and children not living with you anymore and children from other relationships."		
C1	Can you give me the total number of children you have had? DO NOT INCLUDE CHILDREN WHO CAME INTO THE MARRIAGE WITH WIFE FROM ANOTHER MAN IF MAN IS CHILDLESS, SKIP TO C5	Number of children born: _____	

NO.	QUESTION	RESPONSE	SKIP
C2	How many are still living?	Number of children alive: _____	
C3a	Is your wife currently pregnant?	Yes ..... 1 No ..... 2 Don't Know 3	 ——>C3d ——>C3d
C3b	At the time she became pregnant, did you want her to become pregnant then, did you want to wait until later, or did you not want her to become pregnant again at all?	Pregnancy wanted then.....1 Pregnancy wanted later.....2 Pregnancy not wanted at all.3 Did not care .....4 Don't Know 8	
C3c	After the child you are expecting is born, would you like to have another child or would you like to stop having children?	Have another child ..... 1 Stop, nomore./none..... 2 Says she can't get pregnant/ too old..... 3 Don't know..... 88	 ->C5 ->C5 ->C5
C3d	Would you like to have another child or would you like to stop having children?	Have another child ..... 1 Wife deceased, left..... 2 Stop, no more./none..... 3 Wife can't get pregnant/ too old..... 4 Don't know..... 88	 ->C5 ->C5 ->C5 ->C5
C4	How long would you like to wait before having this child? IS RESPONDENT SAYS "JUST WANT TO REST" ASK WHETHER HE WANTS TO REST FOR LESS THAN 2 YEARS OR MORE THAN TWO YEARS	As soon as possible..... 1 Less than 2 years..... 2 More than 2 years..... 3 No preference/whenever.. 4 Don't know..... 88	
C5	If you had the choice, how many living children would you like to have in your lifetime?	Number _____ Don't know..... 88 Up to God/Non-numeric.. 99	
C6	Have you and your wife/partner ever discussed the number of children you would like to have? IF WIFE IS DEAD OR IF HE IS SEPARATED, ASK ABOUT THE TIME WHEN THEY WERE LIVING TOGETHER	Yes..... 1 No..... 0	
	CHECK C1:		
C7	**Have you had a child born in the last 5 years (since 1993)?**	**Yes..... 1** **No..... 0** **Don't know..... 88**	 **->F1a** **->F1a**
C8	**Now I'd like to ask you about the last child you had in the last 5 years (since 1993). When was this child born?** **PROBE, IF HE DOES NOT KNOW THE YEAR ASK HOW MANY HARVESTS AGO**	**Year: _____** **Don't Know Year .....88** **Month: _____** **Don't know Month 88**	

NO.	QUESTION	RESPONSE	SKIP
C9	Is this child still alive?	Yes..... 1 No..... 0 Don't know..... 88	—>C13a —>C13a
C10	When did the child die?	Year: _____ Don't Know Year .....88 Month: _____ Don't know Month 88	
C13a	How many months after the birth of this child did you start having sex again with your wife?	Months _____ Sex not resumed ..... 99 Don't know..... 88	—>F1a —>C14
C13b	Between the birth of the last child and the time when you and your wife started having sex, did you have sex with someone else? IF HE HAS NOT YET RESUMED SEX WITH HIS WIFE, THE QUESTION REFERS TO THE PERIOD BETWEEN BIRTH AND NOW. BY "SOMEONE ELSE" THE QUESTION REFERS TO WOMEN WHO ARE NOT HIS OTHER WIVES	Yes..... 1 No..... 0 Don't know..... 88	
C14	After you started having sex after the last birth, did you or your wife do anything to keep from getting pregnant again?	Yes..... 1 No..... 0 Don't know..... 88	—>F1a —>F1a

NO.	QUESTION	RESPONSE			SKIP
C15	**After the birth of your last child, why did you decide not to use childspacing/ family planning?** **DO NOT READ LIST, MORE THAN ONE ANSWER IS POSSIBLE**				
	Method:		**Yes**	**No**	
	A. Side effects	**A**	**1**	**0**	
B.	**Afraid could not give birth again**	**B**	**1**	**0**	
A.	**Not effective**	**C**	**1**	**0**	
	Opposition				
A.	**Husband/other relative opposed**	**D**	**1**	**0**	
	Clinics				
B.	**Too far away**	**E**	**1**	**0**	
C.	**Costs too much**	**F**	**1**	**0**	
	Fertility-related				
D.	**Trouble getting pregnant**	**G**	**1**	**0**	
E.	**Wants another child**	**H**	**1**	**0**	
I.	**Desires many children**	**I**	**1**	**0**	
	Sexuality				
J.	**promotes promiscuity**	**J**	**1**	**0**	
K.	**Other reason (SPECIFY_____)**	**K**	**1**	**0**	
L.	**Don't know**	**L**	**1**	**0**	

SECTION 4: FAMILY PLANNING AND SOCIAL NETWORKS

NO.	QUESTION	RESPONSE	SKIP
F1a	*"I am now going to ask you some questions about child spacing and family planning– the various ways and methods that a couple can use to delay or avoid a pregnancy. I am interested both in the new methods that are given out by the clinics or the CBDs or health surveillance assistants and also in the traditional methods that have been used here for a long time."*		
F1b	As you know, there are now new methods for child spacing and for family planning; such as, pills, injections, the loop, and others. What are your biggest concerns about using any of these methods? DO NOT READ LIST, MORE THAN ONE ANSWER IS POSSIBLE	Yes No	
	<u>Method</u>:		
	A. Side effects	A 1 0	
B.	Afraid could not give birth again	B 1 0	
B.	Not effective	C 1 0	
	<u>Opposition</u>		
F.	Husband/other relative opposed	D 1 0	
	<u>Clinics</u>		
G.	Too far away	E 1 0	
H.	Costs too much	F 1 0	
	<u>Fertility-related</u>		
I.	Trouble getting pregnant	G 1 0	
J.	Wants another child	H 1 0	
I.	Desires many children	I 1 0	
	<u>Sexuality</u>		
J.	promotes promiscuity	J 1 0	
K.	Other reason (SPECIFY_____)	K 1 0	
L.	Don't know	L 1 0	

NO.	QUESTION	RESPONSE	SKIP
F2	And what about the traditional methods? I mean the string, herbs or medicines, or ejaculation/climax outside, or abstinence (have a break) or the rhythm method (periodic). What are your biggest concerns about using traditional methods? DO NOT READ LIST, MORE THAN ONE ANSWER IS POSSIBLE Method: A. Side effects B. Afraid could not give birth again C. Not effective Opposition K. Husband/other relative opposed Clinics L. Too far away M. Costs too much Fertility-related N. Trouble getting pregnant O. Wants another child I. Desires many children Sexuality J. promotes promiscuity K. Other reason (SPECIFY_____) L. Don't know	Yes No A 1 0 B 1 0 C 1 0 D 1 0 E 1 0 F 1 0 G 1 0 H 1 0 I 1 0 J 1 0 K 1 0 L 1 0	
F3	Do you think that women who use modern child spacing/family planning methods might not be able to have more children when they want?	Yes..... 1 No..... 0 Don't know..... 88	
F4	Have you and your wife/partner ever talked about using modern childspacing/ family planning? IF WIDOWED/SEPARATED, ASK THESE QUESTIONS ABOUT THE TIME BEFORE WIFE'S DEATH/SEPARATION	Yes..... 1 No..... 0 Don't know..... 88	
F5	If you wanted to use modern childspacing/ family planning, do you think she would agree?	Yes..... 1 No..... 0 Don't know..... 88	

NO.	QUESTION	RESPONSE	SKIP
	"I've asked you about your wife. Now I'd like to ask you about other people that you may have talked with about family planning."		
F6	About how many women in this village do you know who you <u>think</u> may have used modern methods of childspacing/family planning? Sometimes it's hard to know, but I'd like you to include your guesses.	Number: _____ Don't know 88	
F7	Some women use modern methods of childspacing/family planning without their husband knowing about it. Have you heard of women using modern childspacing/ family planning secretly?	Yes..... 1 No..... 0 Don't know/ no answer..... 88	 ->**F9a** ->**F9a**
F8	About how many women do you suspect, know or have heard about who have used family planning secretly? CODE "SEVERAL" AS 5 CODE "MANY AS 20	Number: _____ Don't know 88	
F9a	*"Men often chat about children and about ways to keep from having another birth. Now I would like to know about your chats with people about modern methods of childspacing/family planning. Some of these people may approve of family planning, but some may not approve of it."*		
F9b	How many people have you chatted with about modern methods of childspacing/family planning? I mean people other than your wife or partner. 1. DO NOT INCLUDE WIFE; 2. IF LESS THAN FOUR ARE NAMED, PROBE: *"Can you think of anyone else? How about sitting in on a conversation, even if you yourself didn't say anything?"*	Total number named: _____ IF NONE ARE NAMED AFTER PROBING	->**F26a**
F10	Could you please give me the names of four of these? As I said earlier, this information will be completely confidential, it's just for our research. AFTER YOU WRITE THE FOUR NAMES HERE, TURN TO THE MATRIX AT THE BACK OF THE QUESTIONNAIRE AND WRITE ALL FOUR NAMES AGAIN, IN THE SAME ORDER. THEN GO TO F11.	Name: 1. _____ 2. _____ 3. _____ 4. _____	

NO.	QUESTION	RESPONSE	SKIP	#1	#2	#3	#4
F11	Is _____ male or female?	male.....1 female.....2					
F12	What is your relationship to_____?	friend..... 1 <u>Male relative:</u> father.....2 brother..... 3 father-in-law.....4 brother-in-law..... 5 other male relative..... 6 <u>Female relative</u> mother..... 7 sister..... 8 co-wife..... 9 sister-in-law/sister-in-marriage..... 10 mother-in-law..... ..... 11 other female relative..... 12 <u>Other</u> acquaintance/ workmate. 13 family planning CBD.....14 nurse/doctor/health surveillance assistant..... 15 other ..... 16 (SPECIFY_____)					
F13	How close is _____ to you? Is he/she an acquaintance, just a friend or a confidant?	Confidant (mzanga wenini wenini)..... ..... Just a friend (mzanga).... 2 An acquaintance (ongodzuwananaye)..... 3 Met once or twice..... 4					

NO.	QUESTION	RESPONSE	SKIP	#1	#2	#3	#4
F14	Where does _____ stay?	same household..... 1 same compound..... 2 same village..... 3 same TA..... 4 same district..... 5 Lilongwe..... 6 Blantyre..... 7 Mzuzu..... 8 Zomba..... 9 somewhere else..... 10 don't know..... 88					
F15	How much education has _____ had?	Never went to school..... 0 Some primary..... 1 Finished primary..... 2 Secondary or more..... 3 Don't know..... 88					
F16	How many living children does _____ have?	RECORD NUMBER _____ Don't know 88					

NO.	QUESTION	RESPONSE			SKIP	#1	#2	#3	#4
F17	What are_____'s biggest concerns about using modern methods of childspacing/family planning? DO NOT READ LIST, MORE THAN ONE ANSWER IS POSSIBLE								
	Method:		Yes	No					
	A. Side effects	A	1	0					
	B. Afraid could not give birth again	B	1	0					
	D. Not effective	C	1	0					
	Opposition								
	P. Husband/other relative opposed	D	1	0					
	Clinics								
	Q. Too far away	E	1	0					
	R. Costs too much	F	1	0					
	Fertility-related								
	S. Trouble getting pregnant	G	1	0					
	T. Wants another child	H	1	0					
	I. Desires many children	I	1	0					
	Sexuality								
	J. promotes promiscuity	J	1	0					
	K. Other reason (SPECIFY_____)	K	1	0					
	L. Don't know	L	1	0					
F18	Has _____ ever done anything to try to space births or to stop childbearing altogether?	Yes..... 1 Suspects/maybe..... 2 No.....0 Don't know.....88			 ->F23 ->F23				

NO.	QUESTION	RESPONSE	SKIP	#1	#2	#3	#4
F19	Has she/he used a modern method, a traditional method, or both?	Modern Method .....1 Traditional method .....2 Both.....3 Don't know.....88	->F24				

NO.	QUESTION	RESPONSE	SKIP	#1	#2	#3	#4
F20	What specific method(s) has ____ used? MORE THAN ONE ANSWER IS POSSIBLE. DO NOT READ LIST. IF NO USE OF TRADITIONAL METHODS, PROBE: And what about the traditional methods that have been used here for a long time? <u>Modern methods:</u> A pill B injection C loop D sterilization E calendar/natural F condom G don't know method <u>Traditional methods:</u> H withdrawal I abstinence J string K traditional medicine L other SPECIFY_____) M don't know method	Yes A 1 B 1 C 1 D 1 E 1 F 1 G 1 H 1 I 1 J 1 K 1 L 1 M 1					
	CHECK F20						
	CHECK F20						
	CHECK F11						
F21	Was there ever a time that her husband did not know that she used modern methods of child spacing /family planning?	Yes..... 1 No..... 0 Don't know..... 88					
F22	Is _____still using any method of childspacing/family planning now?	Yes..... 1 No..... 0 Don't know..... 88	 →**F24** →**F24**				
F23	Is _____using a modern or traditional method of childspacing of family planning?	Modern method..... 1 Traditional method..... 2 Both methods .....3 Don't know..... 88					

NO.	QUESTION	RESPONSE	SKIP	#1	#2	#3	#4
F24	Has _____ ever mentioned to you that he/she would like to stop childbearing, or do you suspect that he/she would like to stop childbearing?	Yes, he/she mentioned 1 Yes, I suspect..... 2 No..... 0 Don't know..... 88					
F25	Has _____ ever mentioned to you that he/she heard a talk about modern family planning at the clinic/hospital or on the radio, or did he/she ever tell you that a CBD/health surveillance assistant came to his/her home to give him/her information about child spacing/ family planning?	Yes..... 1 No..... 0 Don't know..... 88					

NOW RETURN TO F11 AND ASK THE QUESTIONS ABOUT THE NEXT CONVERSATION PARTNER UNTIL YOU FINISH ALL PARTNERS.

IF RESPONDENT MENTIONED LESS THAN FOUR CONVERSATION PARTNERS, PROBE:

"Is there anyone else you have talked to about family planning that you did not mention before?"

IF THERE IS, GO BACK TO F10, WRITE THE PERSON'S NAME THERE AND IN THE MATRIX AT THE END OF THE QUESTIONNAIRE, AND ASK THE QUESTIONS ABOUT THAT PERSON FROM F11.

IF THERE IS NO ONE ELSE SHE HAS TALKED WITH, GO TO F26a

NO.	QUESTION	RESPONSE	SKIP
F26a	*"Now I'd like to ask you about you yourself."*		
F26b	INTERVIEWER: ARE ANY OF THE FOLLOWING PEOPLE PRESENT / WITHIN EARSHOT? A Other male older than 10 B Other male younger than 10 C Other female older than 10 D Other female younger than 10	Yes No A 1 0 B 1 0 C 1 0 D 1 0	
F26c	Have you ever used any traditional or modern method of childspacing or family planning?	Yes..... 1 No.....0 Don't know..... 88	 **->F34** **->F34**

NO.	QUESTION	RESPONSE	SKIP
F27	What methods have you <u>ever</u> used at any time? I am interested in both traditional and modern methods. DO NOT READ LIST. SEVERAL ANSWERS ARE POSSIBLE. IF TRADITIONAL METHODS NOT MENTIONED, PROBE: And what about the traditional methods that have been used here for a long time? <u>Modern methods:</u> A pill B injection C loop D sterilization E calendar/natural F condom G don't know modern method <u>Traditional methods:</u> H withdrawal I abstinence J string K traditional medicine L other (SPECIFY_____) Mdon't know traditional method	Yes A 1 B 1 C 1 D 1 E 1 F 1 G 1 H 1 I 1 J 1 K 1 L 1 M1	
	CHECK F27		
F31	In what year did you and your wife first use modern methods of childspacing/family planning?	Year: _____ Other ..... 9 Don't know..... 88	
F32	Are you and your wife now using any method of childspacing / family planning? I'm interested in both modern and traditional methods.	Yes..... 1 No.....0 Don't know.....88	 -->F34 -->F34

NO.	QUESTION	RESPONSE	SKIP
F33	What method are you now using? MORE THAN ONE ANSWER IS POSSIBLE. DO NOT READ LIST IF NO USE OF TRADITIONAL METHODS, PROBE: And what about the traditional methods that have been used here for a long time? <u>Modern methods:</u> A pill B injection C loop D sterilization E calendar/natural F condom <u>Traditional methods:</u> G withdrawal H abstinence I string J traditional medicine K other (SPECIFY_____) L don't know method	Yes A 1 B 1 C 1 D 1 E 1 F 1 G 1 H 1 I 1 J 1 K 1 L 1	
F34	Have you ever heard a talk at the clinic/hospital about modern family planning?	Yes..... 1 No.....0 Don't know.....88	
F35	Have you ever heard a radio program about modern family planning?	Yes..... 1 No.....0 Don't know.....88	
F36	Has someone like a CBD agent or a Health Surveillance Assistant ever come to your home to give you information about health or childspacing?	Yes..... 1 No.....0 Don't know.....88	

SECTION 6: GENDER QUESTIONS

NO.	QUESTION	RESPONSE	SKIP
	"I'd now like to ask a few questions about your attitudes to men and women."		
G1	In your opinion, is it proper for a husband to leave his wife if: READ LIST A She neglects her household chores? B She is disobedient and doesn't follow his orders? C She is sexually unfaithful? D He thinks she might be infected with AIDS? E He finds out she has been using family planning without his knowledge?	No Yes Don't know A 0 1 88 B 0 1 88 C 0 1 88 D 0 1 88 E 0 1 88	

SECTION 7: AIDS QUESTIONS

NO.	QUESTION	RESPONSE	SKIP
A1a	*"I am now going to ask you some questions about diseases. As you know, many people in Malawi today are concerned about various diseases. Please remember that all your answers are confidential. If there are any questions you are uncomfortable answering, please tell me and I'll skip them."*		
A1b	If a person gets very thin and dies, what disease do you think probably killed them?	AIDS..... 1 Kaliwondewonde/ chitega/ witchcraft..... 2 Could be either AIDS or Kaliwondewonde/ chitega/ witchcraft..... 3 TB/malaria etc..... 4 Other..... 5 (SPECIFY)_____ Don't know..... 88	

NO.	QUESTION	RESPONSE	SKIP
A2	I'm going to read a list of ways that men might get infected with the AIDS virus. Which of these ways are you most worried about for yourself? READ LIST. ONLY ONE ANSWER IS POSSIBLE. A. Wife B. Other partner C. Needle / injections D. Transfusions E. Other (Specify.....) F. Don't Know	Yes No A 1 0 B 1 0 C 1 0 D 1 0 E 1 0 F 1 0	
A3	How worried are you that you might catch AIDS?	Not worried at all ..... 1 Worried a little ..... 2 Worried a lot 3	
A4	Do you think it is acceptable to use a condom with a spouse to protect yourself against AIDS?	Yes..... 1 No..... 0 Don't know.....88	
A5	Can you get AIDS if you have sex with someone who looks perfectly healthy?	Yes..... 1 No..... 0 Don't know..... 88	

NO.	QUESTION	RESPONSE			SKIP
A6	What do you think is the best way to protect yourself from getting AIDS? DO NOT READ LIST, MORE THAN ONE ANSWER IS POSSIBLE				
	<u>Advise Spouse</u>			Yes	N
	A. Advise spouse to take care	A	1	0	
	<u>Use condoms with</u>:				
	B. <u>all</u> other partners except spouse	B	1	0	
	C. Prostitutes / bargirls	C	1	0	
	D. people from town	D	1	0	
	E. other people you think might be infected	E	1	0	
	<u>Avoid having sex with</u>:				
	F. any partners except spouse	F	1	0	
	G. prostitutes / bargirls	G	1	0	
	H. many partners	H	1	0	
	I. people from town	I	1	0	
	J. other people you think might be infected.	J	1	0	
	<u>Avoid other</u>:				
	K. transfusions/ injections/ sharing razor blades.	K	1	0	
	L. other (SPECIFY _____)	L	1	0	
	M. Nothing.	M	1	0	
	N. Don't know	N	1	0	
A7	How many people do you know who you think have died from AIDS? PEOPLE MAY NOT BE SURE, BUT ASK THEM TO JUST GUESS.	NUMBER _____ Don't know 88			

NO.	QUESTION	RESPONSE	SKIP
A8	As you know, sometimes men in this area have sex with women who are not their wives. Now, I'd like to ask you about your best male friend. Has he slept with anyone other than his wife in the last 12 months?	Yes..... 1 Suspects..... 2 No..... 0 Don't know..... 88	 **->A11a** **->A11a**
A9	How many women other than his wife (wives) do you think he has slept with in the last 12 months?	NUMBER: ____ Don't know 88	
A10	Does he sometimes or always or never use a condom when he sleeps with women other than his wife (wives)?	Always ..... 1 Sometimes ..... 2 Maybe ..... 3 Never ..... 4 Don't know 88	
A11a	*"Now I'm going to ask some questions about you yourself."*		
A11b	INTERVIEWER: ARE ANY OF THE FOLLOWING PEOPLE PRESENT / WITHIN EARSHOT? A Other male older than 10 B Other male younger than 10 C Other female older than 10 D Other female younger than 10	Yes No A 1 0 B 1 0 C 1 0 D 1 0	
A11c	Have you ever talked to your wife about the chances that you or she might get infected with AIDS?	Yes..... 1 No..... 0	

NO.	QUESTION	RESPONSE	SKIP
A12	Do you suspect or know that your wife has had sexual relations with other men since you were married?	Yes, know ..... 1 Suspect ..... 2 Can't know what he does 3 Probably not..... 4 Don't know 88	
A13	Have you yourself slept with anyone other than your wife (wives) in the last 12 months?	Yes..... 1 No..... 0	-->A24a
A14a	How many women other than your wife (wives) did you sleep with in the last 12 months?	Number: _____	

ASK RESPONDENT THE FOLLOWING QUESTIONS FOR EACH OF THE LAST THREE WOMEN THAT HE HAS SLEPT WITH IN THE LAST 12 MONTHS.

IF RESPONDENT HAS SLEPT WITH ONLY ONE WOMAN, ASK A15-->A17, THEN SKIP TO A24a

IF RESPONDENT HAS SLEPT WITH TWO WOMEN, ASK A15-->A17, THEN SKIP TO A24a

A15	Tell me about the last time you had sex with someone other than your wife. Did you use a condom?	Yes..... 1 No..... 0 Don't know..... 88	
A16	Who (what sort of woman?) did you sleep with?	Bargirl ..... 1 Girlfriend ..... 2 Other ..... 3 (SPECIFY) _____	

NO.	QUESTION	RESPONSE	SKIP
A17	Where does this woman live? INTERVIEWER: "CITY" REFERS TO BLANTYRE, LILONGWE, ZOMBA, AND MZUZU	Same village ..... 1 Nearby village ..... 2 Town/trading center ..... 3 City 4	
	CHECK A14a		
A18	What about the woman before that last one? Did you use a condom the last time you slept with her?	Yes..... 1 No..... 0 Don't know..... 88	
A19	Who (what sort of woman?) was she?	Bargirl ..... 1 Girlfriend ..... 2 Other ..... 3 (SPECIFY) _____	
A20	Where does this woman live? INTERVIEWER: "CITY" REFERS TO BLANTYRE, LILONGWE, ZOMBA, AND MZUZU	Same village ..... 1 Nearby village ..... 2 Town/trading center .. 3 City 4	
	CHECK A14a		
A21	Now tell me about the woman before the second one I asked you about above? Did you use a condom the last time you slept with her?	Yes..... 1 No..... 0 Don't know..... 88	

NO.	QUESTION	RESPONSE	SKIP
A22	Who (what sort of woman?) was she?	Bargirl ..... 1 Girlfriend ..... 2 Other ..... 3 (SPECIFY) _____	
A23	Where does this woman live? INTERVIEWER: "CITY" REFERS TO BLANTYRE, LILONGWE, ZOMBA, AND MZUZU	Same village ..... 1 Nearby village ..... 2 Town/trading center .. 3 City 4	
A24a	*"Now I'd like to ask you some questions about people you've chatted with about AIDS"*		
A24b	How many people have you chatted with about AIDS? I mean people other than your wife or partner. 1. DO NOT INCLUDE WIFE; 2. IF LESS THAN FOUR ARE NAMED, PROBE: Can you think of anyone else? How about sitting in on a conversation, even if you yourself didn't say anything?	Total number named: _____ IF NONE ARE NAMED AFTER PROBING	**->A40a**
A25	Could you please give me the names of four of these? As I said earlier, this information will be completely confidential. AFTER YOU WRITE THE FOUR NAMES HERE, TURN TO THE MATRIX AT THE BACK OF THE QUESTIONNAIRE AND WRITE ALL FOUR NAMES AGAIN, IN THE SAME ORDER. THEN GO TO A26.	Name: 5. _____ 6. _____ 7. _____ 8. _____	

NO.	QUESTION	RESPONSE	SKIP	#5	#6	#7	#8

NO.	QUESTION	RESPONSE			SKIP	#5	#6	#7	#8
A26	How worried is _____ about getting AIDS?	Not worried at all..... 1 Worried a little..... 2 Worried a lot..... 3 Don't know 88							
A27	What does ____ think is the best way to protect herself/himself from getting AIDS? DO NOT READ LIST, MORE THAN ONE ANSWER IS POSSIBLE			Yes No					
	<u>Advise Spouse</u> A. Advise spouse to take care	A	1	0					
	<u>Use condoms with</u>:								
	B. <u>all</u> other partners except spouse	B	1	0					
	C. Prostitutes / bargirls	C	1	0					
	D. people from town	D	1	0					
	E. other people you think might be infected	E	1	0					
	<u>Avoid having sex with</u>:								
	F. any partners except spouse	F	1	0					
	G. prostitutes / bargirls	G	1	0					
	H. many partners	H	1	0					
	I. people from town	I	1	0					
	J. other people you think might be infected.	J	1	0					
	<u>Avoid other</u>:								
	K. transfusions/ injections/ sharing razor blades.	K	1	0					
	L. other (SPECIFY _____)	L	1	0					
	M. Nothing.	M	1	0					
	N. Don't know	N	1	0					
A28	Has _____ ever mentioned to you that she has heard a talk at the clinic/hospital about AIDS, or heard a radio program about AIDS?	Yes..... 1 No.....0 Don't know.....88							

NO.	QUESTION	RESPONSE	SKIP	#5	#6	#7	#8
A29	Is ____ one of the same people you told me you talked to about family planning? IF YES, LOOK AT THE MATRIX AT THE END AND IDENTIFY WHICH FAMILY PLANNING NETWORK PARTNER THIS IS. THEN FILL OUT THE "SAME AS" COLUMN, MAKING SURE THAT THE NAMES ARE THE SAME.	Yes..... 1 No.....0	**-->A35a**				
A30	Is _____ male or female?	male.....1 female..... 2					
A31	What is your relationship to_____?	friend..... 1 <u>Male relative:</u> father..... 2 brother.....3 father-in-law..... 4 brother-in-law..... 5 other male relative.....6 <u>Female relative</u> mother..... 7 sister..... 8 co-wife..... 9 sister-in-law/sister-in-marriage..... 10 mother-in-law..... ..... 11 other female relative..... 12 <u>Other</u> acquaintance/ workmate 13 family planning CBD..... 14 nurse/doctor/health surveillance assistant.....15 other ..... 16 (SPECIFY) _____					
A32	Where does _____ stay?	same household.....1 same compound..... 2 same village..... 3 same TA.....4 same district..... 5 Lilongwe..... 6 Blantyre.....7 Mzuzu..... 8 Zomba..... 9 somewhere else..... 10 don't know..... 88					

NO.	QUESTION	RESPONSE	SKIP	#5	#6	#7	#8
	How close is _____ to you? Is he/she an acquaintance, just a friend or a confidant?	Confidant (mzanga wenini wenini)..... Just a friend (mzanga).... 2 An acquaintance (ongodzuwananaye)..... 3 Met once or twice..... 4					
A34	How much education has _____ had?	Never went to school..... 0 Some primary..... 1 Finished primary..... 2 Secondary or more..... 3 Don't know..... 88					
A35	Has _____ ever used modern family planning?	Yes..... 1 No.....0 Don't know.....88					
A35a	Has _____ ever mentioned to you that he/she has heard a talk at the clinic or hospital, or heard a radio program about AIDS?	Yes..... 1 No.....0 Don't know.....88					
A36	Is _____ the best friend that you talked to me about earlier?	Yes..... 1 No.....0	**->A40a**				
A37	Do you think _____ had other sexual partners other than his/her spouse or regular partner in the past year?	Yes..... 1 No.....0 Don't know.....88	**->A40a** **->A40a**				
A38	Do you think _____ sometimes or always or never uses condoms with these other partners?	Always ..... 1 Sometimes .... 2 Maybe .....3 Never ..... 4 Don't know 88					

NOW RETURN TO A26 AND ASK THE QUESTIONS ABOUT THE NEXT CONVERSATION PARTNER UNTIL YOU FINISH ALL PARTNERS LISTED IN A25.

IF RESPONDENT MENTIONED LESS THAN FOUR CONVERSATION PARTNERS, PROBE:
"Is there anyone else you have talked to about AIDS that you did not mention before?"

IF THERE IS, GO BACK TO A25, WRITE THE PERSON'S NAME, AND ASK THE QUESTIONS ABOUT THAT PERSON FROM A26.

IF THERE IS NO ONE ELSE HE HAS TALKED WITH, GO TO A40a

A40a	If you met an interesting and beautiful bargirl who was interested in having sex with you, would you have sex with her?	Yes..... 1 No.....0 Don't Know 88	**—>A41a** **—>A41a**
A40b	Would you: READ LIST A Use a condom the first time? B Only use a condom until you established a relationship with her? C Use a condom all the time?	Yes No A 1 0 B 1 0 C 1 0	
A41a	If you met an interesting and beautiful woman from within or around your village who was interested in having an affair with you, would you have sex with her?	Yes..... 1 No.....0 Don't Know 88	**—>A42a** **—>A42a**
A41b	Would you: READ LIST A Use a condom the first time? B Only use a condom until you established a relationship with her? C Use a condom all the time?	Yes No A 1 0 B 1 0 C 1 0	

A42a	If you met an interesting and beautiful woman from a town or the city who was interested in having an affair with you, would you have sex with her?	Yes..... 1 No.....0 Don't Know 88	 —>A43 —>A43
A42b	Would you: READ LIST A Use a condom the first time? B Only use a condom until you established a relationship with her? C Use a condom all the time?	Yes No A 1 0 B 1 0 C 1 0	
A43	Have you ever heard a talk at the clinic/hospital about how people can protect themselves against AIDS?	Yes..... 1 No..... 0 Don't know.....88	
A44	Have you ever heard a radio program about how people can protect themselves against AIDS?	Yes..... 1 No..... 0 Don't know..... 88	
A45	Has someone like a CBD agent or a Health Surveillance Assistant ever come to your home to give you information about how people can protect themselves against AIDS?	Yes..... 1 No..... 0 Don't know..... 88	

SECTION 8: MATRIX

	"Finally, I would like briefly ask you how well all the people you told me about know each other."
M1	Are the NAME ON ROW and NAME ON COLUMN confidants, just friends, acquaintances, or do they not know each other? Confidants ..... 1 Just friends ..... 2 Acquaintances ..... 3 Don't know each other ..... 4 D.K..... 5
	INSTRUCTIONS FOR DATA-ENTRY STAFF:

		FAMILY PLANNING				FAMILY PLANNING			
x	M1 ax		M1 bx	M1 cx	M1 dx	M1 ex	M1 fx	M1 gx	M1 hx
	Same as	1	2	3	4	5	6	7	8
1									
2									
3									
4									
5			DO NOT WRITE IN SHADED AREA						
6									
7									
8									

"These are the questions that I wanted to ask you. Thank you very much for talking with me today. We very much appreciate your help in our research project about family planning and about AIDS."

TIME FINISHED _____

SECTION 8: FOR INTERVIEWER

SOON AFTER THE INTERVIEW, PLEASE ANSWER THE FOLLOWING QUESTIONS

I1	HOW WELL DO YOU KNOW THE RESPONDENT'S FAMILY?	Not at all..... 1 By name only..... 2 Quite well..... 3 Very well..... 4	
I2	ARE YOU RELATED TO THE RESPONDENT?	Yes .....1 No .....2 Don't know 3	
I3	HOW WEALTHY DO YOU THINK THE RESPONDENT'S HOUSEHOLD IS IN COMPARISON WITH OTHER HOUSEHOLDS IN THE VILLAGE?	One of the poorest ..... 1 Quite poor..... 2 Average.....3 Quite wealthy .....4 One of the wealthiest..... 5 Cannot tell 6	
I4	DEGREE OF CO-OPERATION?	Bad .....1 Average .....2 Good .....3 Very good 4	
I5	DO YOU HAVE ANY OTHER COMMENTS ABOUT THE INTERVIEW? E.G DID OTHER PEOPLE INTERRUPT, ANY HESITATION OR UNWILLINGNESS TO ANSWER _____ _____ _____ _____ _____		

ANNEX IV: INTERVIEW GUIDELINES FOR REPRODUCTIVE DECISION-MAKING ETHNOGRAPHIC RESEARCH PROJECT, 1998

Family size

- Can you tell me your childbearing history, when you started? How you started? How many children you have had? What was happening until today? (Probe as much as possible). This question should lead you to the following questions.
- Can you tell me any conversation you had with your husband about how many children you would like to have? (Probe: Who started the conversation? What happened after that?)
- Can you tell me any conversation you had with any of your relatives about family size? (Probe for parents from both husband's and wife's side). Also probe: How did it start? What happened after that?
- Can you tell me what your friends say about family size
- What family size do people refer to when they say 'this family is large' or 'this family is small?'
- Can you tell me what people say about families that they consider as large in your community? What do they say are the advantages and the disadvantages of a large family?
- Can you tell me what people say about small families? What do they say are the advantages and the disadvantages of having a small family?
- Can you tell me what your church people say about family size. What do they say are the advantages and disadvantages of a large family? What do they say are the advantages and disadvantages of a small family?

Family planning

- (If spacing) How did you start child spacing? (Probe: Who started it?).
- (If not spacing) Can you tell me any conversations you had with your husband or wife about child spacing?
- Can you tell me any conversation you had with your husband about child spacing and family planning methods? (Probe: Who started the conversation? What happened after that?)
- Can you tell me what your relatives say about using child spacing and family planning methods? (Probe for parents from both husband's and wife's side). Also probe: How did it start? What happened after that?
- Can you tell me what your friends say about using child spacing and family planning methods? What do they say are the advantages of using modern child spacing and family planning methods or traditional contraceptive methods? What do they say are the disadvantages?
- Can you tell me what your church people say about using child spacing and family planning methods? What do they say are the advantages or disadvantages about using modern or traditional contraceptive methods?

Reproductive health

- What health problem is common in your area? (Probe for AIDS/STDS)
- Do married men have extra-marital affairs? (If they do, probe: What do their wives do about it?)
- Do married women have extra-marital affairs? (If they do, probe: What do their husbands do about it?)
- Is AIDS a problem in your area? What do people think about AIDS, family size and modern contraceptive use?
- Is abortion an issue in your area? Do married women also abort? Why?

Kinship Special Interview Questions

- Can you tell me how marriages used to be organised in the past, starting with the choice of who to marry. (Probe: Where would the couple reside after marriage? What is happening today? What differences are there between marriage procedures of the past and of today?)
- Can you tell me how decisions were made about using any contraception? (Probe: Who used to be involved in deciding whether or not a woman could use contraception? What is happening these days? Why?)

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