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Assessing the Importance of Gender Roles in Couples' Home-Based Sexual Health Services in Malawi

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Abstract

To more effectively address individuals' and couples' sexual and reproductive health needs, innovative service delivery strategies are being explored. These strategies are logistically and ethically complicated, considering prevailing gender inequalities in many contexts. We conducted an exploratory study to assess the acceptability of couples' home-based sexual health services in Malawi. We collected qualitative data from six focus group discussions and 10 husband-wife in-depth interviews to gain a more thorough understanding of how gender norms influence acceptability of couples' sexual health services. Findings reveal that women are expected to defer to their husbands and may avoid conflict through covert contraceptive use and non-disclosure of HIV status. Many men felt that accessing sexual health services is stigmatizing, causing some to avoid services or to rely on informal information sources. Gender norms and attitudes toward existing services differentially impact men and women in this setting, influencing the perceived benefits of couples' sexual health services

Keywords

Gender roles and gender issues; HIV/Aids; contraception; community-based programs and interventions; Malawi; Africa

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Introduction

Integrated HIV voluntary counseling and testing (VCT) and family planning (FP) services are a cost-effective way to increase access to sexual and reproductive health (SRH) services and to maximize limited health care resources, especially in HIV-prevalent and lower-income settings.^{1, 2} Moreover, couple VCT/FP services may be more convenient and reach broader and more diverse groups than individually offered services.^{2, 3} Combined VCT/FP services also provide a cost-effective strategy in reducing mother-to-child transmission of HIV, and may better address the unmet need for contraception among reproductive-aged couples and individuals.^{4, 5} There are some concerns regarding the heightened demand of integrated services on providers and service delivery points; however, these concerns are perceived to be surmountable and outweighed by the benefits of combined services, prompting national and international agencies to call for stronger linkages between sexual and reproductive health and HIV/AIDS efforts and to scale up integrated VCT/FP services.^{1, 2, 6, 7}

With a greater proportion of HIV transmission occurring among young adults and within the context of marriage or stable unions, researchers and policymakers have also supported greater investment in couple-based and home-based services, such as VCT and family planning counseling.⁷⁻¹² Couple-focused family planning interventions have been shown to be more effective, with respect to contraceptive acceptance and continuation, as compared to interventions with women alone.¹³

Couples VCT (CVCT), in which both partners receive HIV testing and counseling together, has resulted in increased condom use in Zaire,¹⁴ and Rwanda, as well as greater uptake of nevirapine among HIV-positive pregnant women in Nairobi.¹⁶ Despite these benefits, studies indicate limited acceptance of CVCT, with 14–33 percent of invited couples participating.^{17, 18} With respect to home-based sexual health services, long-standing evidence exists on the benefits of home-based family planning outreach; however, there is much less evidence on home-based VCT. A recent Cochrane review of the only two existing studies indicated that home-based testing is associated with higher uptake of VCT than facility-based VCT.¹⁹ Recent findings from a longitudinal household panel study in Malawi indicated that 92 percent of respondents agreed to be tested when offered home-based VCT with a rapid blood test, and of those tested, 98 percent received their results.²⁰

Although in many settings these innovative service delivery interventions may provide advantages over the existing standard of care, they also present logistical and ethical complexities. Counseling partners together in their home may minimize barriers to seeking care, offer greater privacy, and provide a safe environment in which partners may disclose sensitive information with the assistance and support of a trained counselor. These interventions, however, may also place individuals, especially women, at greater risk of adverse outcomes if partners do not agree on participation in the intervention, or if the intervention precipitates a negative reaction upon discussion or disclosure of information within the couple dyad. Past studies on contraceptive use have shown that whereas couple-based interventions may increase individual partners' knowledge and partner communication, these interventions could inadvertently reveal secret contraceptive use, raise

suspicion of contraceptive use in front of a disapproving partner, or cause conflict or violence between spouses with disparate opinions.²¹ These concerns are particularly salient for women who, in many contexts, have less decision-making power within and outside the household and are dependent on their partners or spouses for their economic and social well-being.

Similar concerns arise for couple-focused, home-based VCT. HIV testing and status disclosure pose several risks, particularly for HIV-positive women, including loss of economic support, abandonment or divorce, physical and emotional abuse, and disruption of family relationships.²² A recent review of studies indicated that the proportion of women who chose to disclose their HIV status to their partners varied greatly (17–86 percent); of those who did disclose, the majority reported supportive reactions from partners.²³

Recent findings from a home-based VCT study in Malawi showed that though there were similar proportions of men and women who refused HIV testing (33 percent of men and 32 percent of women), reasons for refusal were different between men and women.²⁴ Couple-based health interventions have the potential to benefit both members of the couple; however, it is important also to consider any potential repercussions of the intervention for one partner in particular, given existing gender norms and roles, or ways in which the intervention could exacerbate any existing gender inequalities. In Malawi, as in other settings, the effects of gender on health outcomes need to be considered.

Background - Setting

Malawi is a landlocked country of 14.2 million people with one of the highest HIV prevalence rates in the world—11.8 percent among adults ages 15–49.²⁵ Among those tested during the 2004 Malawi Demographic and Health Survey (MDHS), HIV prevalence was found to be higher for females than for males.²⁵ The MDHS also showed that prior experience with HIV testing was limited, with 83 percent of women and men reporting that they had never been tested. In hopes of slowing the epidemic, VCT services are offered in 184 centers throughout Malawi, and opt-out HIV testing was recently integrated into women's antenatal care services.

The national total fertility rate is six children per reproductive-aged woman.²⁵ One-third of currently married and 26 percent of sexually active unmarried women report using contraception, primarily injectables; however, 28 percent of married women have an unmet need for contraception.²⁵ Government health facilities remain the primary supplier of family planning services, with the balance coming from hospitals, clinics, and non-profit organizations.

Background – Gender Norms and Inequalities in Malawi

A DHS comparative study of the status of women in 25 countries found that Malawi ranked near the bottom, at 22nd, when assessing the status of women according to a range of domains (e.g., education, employment and workload, marriage and childbirth, etc.).²⁶ The lower status and power of Malawian women relative to Malawian men have been discussed extensively elsewhere, as they affect household decision making, as well as the health and well-being of women and their families.^{27–29} Some studies indicate that Malawian women

may dominate within specific domains or find culturally appropriate ways in which to exert their autonomy and individual agency.^{30–32}

Gender-based differences shape HIV/AIDS and family planning knowledge, attitudes, and behaviors in Malawi.^{29–31,33,34} The most commonly used contraceptive methods in Malawi are female-controlled, while male vasectomy is virtually nonexistent (0.8 percent of currently married men), and only 1.8 percent of married women report current use of the condom.²⁵ Although knowledge of family planning methods is widespread among both men and women, 28 percent of women have never discussed family planning with their husbands, and 27 percent of men think that contraception is a “woman’s business” (15 percent of men in Blantyre, the area in which this study was conducted).²⁵

Similarly, gender differences have transformed the context in which HIV is known and transmitted in Malawi. Findings from the MDHS and the 2007 Malawi HIV/AIDS country report show that HIV prevalence is higher among young women than young men (13.2 percent versus 3.9 percent in ages 20–24), likely due to sexual relationships between older men and younger women; however, women are less likely to have been exposed to HIV/AIDS information as compared to men (66 percent versus 80 percent).^{25,35} Moreover, 26 percent of men report having more than one partner in the last 12 months, as compared to only 8 percent of women.

Regional studies from Malawi further indicate that sources of HIV knowledge and risk perception, as well as reports of knowledge and behavior, are likely to be different for Malawian men and women.^{30,33,34} These differences may place Malawian women, in particular, at a greater risk of HIV because of prevailing cultural and social norms that reinforce male domination in household and sexual decision making.^{36,37} As reported by Watkins (2004) from a 2001 survey, 52 percent of wives reported their husbands and their husbands’ “other partners” as their greatest risks for HIV acquisition; in contrast, only 23 percent of husbands named their wives as their greatest concern.³⁰ Similar discrepancies existed in men’s versus women’s reports of suspected infidelity. In the face of stark contrasts in sexual behavior and risk taking between men and women, women employ a variety of strategies to minimize their risk of exposure to HIV, including “discussing the dangers of HIV/AIDS with their husbands, ... publicly confronting husbands’ girlfriends, and divorcing men who do not adopt safer practices” (p. 479).³¹

Acknowledging the complex and sensitive nature of gender relations in Malawi and the possible benefits of providing couples’ home-based FP/VCT services, this study was designed as an exploratory, qualitative study to identify: 1) the feasibility and acceptability of providing couples’ home-based FP/VCT services in selected peri-urban communities near Blantyre, and 2) the specific ways in which gender roles and gender inequality could influence the acceptability and implementation of couples’ home-based FP/VCT services and to assess the potential risks and benefits for both women and men.

Methods

Site Characteristics

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

Study Design and Data Collection

The study team consisted of investigators from the University of Malawi College of Medicine (COM), the Centre for Reproductive Health (CRH), and the Johns Hopkins Bloomberg School of Public Health (JHSPH). The study design and study instruments (field guides) were translated into Chichewa, reviewed and approved by the JHSPH and COM institutional review boards. The study interviewers were three men and three women from Blantyre, several of whom had previous in-depth interviewing experience. Their training consisted of orientation on the study aims and methods, role playing, discussion of field logistics and ethical considerations, and refinement of field instruments based on mock interviews.

Prior to data collection, research staff from the COM visited the four study villages to explain the purpose and scope of the study and to obtain permission from the village chiefs to conduct the study within their villages. The research staff also contacted local health surveillance assistants (HSAs) to help in the identification and recruitment of study participants. Oral informed consent was obtained from all participants prior to the study.

A total of six focus group discussions (FGDs) (three male and three female) were conducted with community members ages 20–30 years. Each focus group consisted of eight to nine people, had a same-sex moderator and note-taker, and was conducted in a private location within the community (e.g., church or school building). The FGD field guide first elicited opinions on the proposed study (i.e., offering FP/VCT to couples in their homes), then focused on specific components of the proposed intervention, such as the acceptability of home-based services and the preferred characteristics of study staff. Focus group participants were recruited from the community, with the help of the HSAs. Each FGD was approximately 90 minutes long, was conducted in Chichewa, and was digitally recorded after obtaining permission from the participants.

In addition to the FGDs, 10 in-depth interviews (IDIs) were conducted with husband-wife pairs from each of the communities. The HSAs recruited married or in-union couples in which both partners were of reproductive age (20–40 years). The interviewers consisted of three male/female teams, with one person as interviewer and one person as note-taker. An equal number of interviews were led by male and female interviewers. The IDI interview guide consisted of questions regarding perceptions and sources of information for FP and VCT, discussions about the decision to receive FP and/or VCT, and the ways that disagreements are typically resolved. Both members of the couple were asked to respond

spontaneously to the questions; if only one partner responded, the interviewer probed the other partner. The interviewers also noted non-verbal cues and the interaction of the partners during the couple interview since the dynamics of the joint interview were also considered to be valuable data.³⁸ Each interview was conducted within the couple's home, lasted approximately one hour, and was digitally recorded after obtaining permission from both partners.

Data Analysis

Audio files were uploaded to personal computers, transcribed, and translated into English. The research team reviewed the transcripts and provided simultaneous feedback to the interviewers as the data collection progressed. The data were uploaded to NVivo 8.0 and analyzed using the constant comparative method in which similar pieces of text are compiled into codes or categories across the data, then further refined and explored both to identify the range of situations and to ensure theoretical saturation of the categories.³⁹ To further validate the findings, several investigators independently read the transcripts and provided input on the identified themes. Lastly, verbatim passages were selected from the transcripts to illustrate these themes.

Results

Study Participants

The male and female FGD participants were 20–30 years of age and predominantly farmers (Table 1). Farming is common in rural areas with 68 percent and 78 percent of rural men and women, respectively, reporting farming as their occupation in the MDHS.²⁵ In Blantyre, which is the largest city closest to the study site, 19 percent of men and 45 percent of women report being farmers.²⁵ Apart from residence and age, the characteristics of the FGD participants varied with respect to marital duration, schooling, and number of children. The majority of the female FGD participants reported using injectable contraception, a proportion higher than that of the general population. In Malawi, 35 percent of women ages 20–44 reported using a method of contraception and 37 percent of women in Blantyre District reported use.²⁵

The characteristics of the couples participating in the IDIs are listed in Table 2. As noted in the table, individuals ranged from 23 to 40 years, with an age gap between husband and wife of one to 10 years. Couples varied in their marital duration, schooling, and number and sex of children; however, most couples were currently using injectable contraception.

Influence of Gender Norms on Couple Communication and Negotiation

Participants described clearly defined gender and marital roles. The husband role consists of being “head of the household.” Wives are considered to be the “left-hand” of the man (*dzanja la manzere*), never equal but always attached. Both male and female participants talked about the dominance and presumed greater intelligence of men versus women:

It can be good as he [husband] said earlier on that men are more intelligent than women and the way I am talking can actually show that my husband is at least more intelligent than me. (wife, couple #7)

When asked about the willingness of couples to receive home-based sexual health services, many of the male participants indicated that it was their role as husbands to discuss and try to convince their wives according to their perspectives. Although discussion was mentioned frequently as a means of reaching consensus within the male focus groups, there was no mention of such discussion in the female focus groups. In the in-depth interviews, however, when asked about sexual health-related discussions, the majority of couples indicated that they had discussed childbearing, use of family planning, and, in some cases, whether to obtain HIV testing. The wife in one couple (#3) divulged during the interview that she had secretly obtained contraception without informing her husband. Only one couple (#7) said that they had never discussed HIV/AIDS.

When probed for their opinions on couples' home-based sexual health services, participants consistently said these services would provide an opportunity to discuss these issues together with a trained counselor. Study participants also indicated that such an intervention could cause some disagreement and difficulty in "blending two views into one" with the husband's preferences likely to prevail:

Interviewer: Let's say that you, a husband, wanted to talk with the health worker together with your wife, but your wife doesn't want to, what would happen?

Husband: If we are a couple, it means we are one flesh so I can talk to her about getting the information together. I can insist as a couple to have the information together.

Interviewer: How would you come to a decision about what to do?

Husband: I can try hard to talk to her, up to the extent that she can accept. If I fail to do so, I can just have the information for myself and the discussion with my wife later.

Wife: That means the husband is not thinking well. Everything in the family needs to be discussed if there are problems. I can't have the power because the head of the family is the husband.

Influence of Gender Norms on Reproductive and Health-Seeking Behavior

Family Planning—Most couples first discussed FP after the birth of one or more children. This discussion was often spurred by a particular incident, such as the death of a child in the community due to short birth spacing or seeing in-laws struggling financially because of "too many" children. As indicated in Table 2, however, nearly all the study couples had used or were currently using injectable contraception.

Whereas awareness and knowledge of contraceptive methods were quite high overall for both men and women, family planning was viewed as *ndizachizimayi*, or strictly for women. Men were more likely to voice concerns about specific methods and their side effects, as well as the reasons for male opposition to family planning (e.g., children as a symbol of wealth; may invite woman's promiscuity or infidelity). A few men, however, acknowledged the benefits of FP at the household level and at the population level.

Gender differences also existed with respect to men's and women's sources of contraceptive information. Women were more likely to discuss contraception with friends, whereas most men received information indirectly through their wives or from the radio. Within both FGDs and IDIs, participants indicated that although women are "used to going to the clinic," men rarely seek health care services. Lack of participation was sometimes attributed to men's inability to miss out on wage-earning opportunities and the perception of family planning as women's domain; however, a variety of both social and structural factors seemed either to precipitate or exacerbate men's disassociation from health activities. Men, in particular, said they were uncomfortable with the group family planning counseling that was offered at the health clinic and were too shy to ask questions about things they did not understand. Other men noted that it would be difficult for them to ask such personal questions when friends, neighbors, or perhaps even their mother-in-law could be sitting in the same room.

Given these barriers to male participation, women were often the only ones to access health information and services, including contraception, from the local health clinic. Some women shared this information with their spouses, while others did not (e.g., couple #3). Several women mentioned, however, that when they returned home to tell their husbands about what they had learned, the husbands would not listen or would not believe the information. Men reaffirmed this perception:

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

When asked about home-based couples FP (CFP) services, women in particular felt that CFP would allow both spouses to receive the information together and to ask questions in the privacy of their own home. Women felt that the involvement of men would make them more knowledgeable about and accepting of FP, in particular. Both male and female study participants noted that with home-based services, husbands and wives could agree on a mutually suitable method and help each other in remembering to use it consistently.

VCT—Gender differences also affected the uptake of VCT and HIV status disclosure. Study participants indicated that women are more likely to receive HIV testing—especially with opt-out HIV testing in antenatal care. Owing to the scarcity of men at health clinics, a man who receives VCT at the clinic is likely to be teased and presumed to be engaging in *kuyenda-yenda* (promiscuity) or to already be "sick" (HIV-positive). Given these constraints, some men would rely on their wives to test, then presume that their wives' HIV status was also their own. Men also assumed they were already HIV-positive and confirmation of their status would only cause conflict within the household:

Men in most cases are the ones who may have bad behavior...they might refuse to get tested with their wives as they don't want their wives to know that they are the

ones who brought this (HIV) and that's why the results are that way. I have evidence that most of the wives in this village really know that their husbands have girlfriends somewhere. For this reason most men might refuse to get tested with their wives so that they might not be identified that they are the ones who brought the problem. (male FGD participant)

The discussions and circumstances of the 10 study couples mirrored what was found in the FGDs. As indicated in Table 2, the couples represented a range of situations with respect to HIV testing. For one couple (#10), the wife received HIV VCT at a private clinic and, in the interview, openly chastised her “failure husband” for refusing to get tested. The three couples that reported to have never received VCT indicated a variety of reasons, including religious opposition, lack of privacy at health clinic, and no perceived need due to their “healthiness.” Of the couples in which the spouses tested separately, all of the women received VCT during antenatal care, while the husbands received testing at a hospital/clinic or with the Malawi AIDS Counseling and Resource Organization (MACRO), a local group that provides community-based and workplace VCT.⁴⁰

When participants were asked how they would feel about couples’ home-based VCT, they indicated that potential conflict or distrust could ensue if one partner wanted to take part, but the other refused. A wife’s refusal to participate in joint HIV testing despite her husband’s willingness seemed the most problematic, as it would raise suspicions of infidelity or promiscuity and would be considered a direct refutation of the husband’s wishes:

The wife cannot refuse the test. The husband can force the wife because here in Malawi, men overpower women. Men are the decision makers in the family. So since the husband has already accepted to participate, she can force herself to do it. (female FGD participant)

Participants noted several benefits of receiving couples’ home-based VCT, including convenience, privacy, and the presence of counselors to facilitate testing and disclosure; however, they also mentioned conflicts that could arise within the CVCT session and the differential risks of disclosure for sero-discordant partners. If a wife tested HIV-positive, this was grounds for divorce, but if a husband tested HIV-positive, it was more likely that the woman would stay with him:

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

Defiance of Gender Norms—As mentioned by women in both the FGDs and IDIs, covert use of contraception was a way in which women avoided their husbands’ known or suspected disapproval of contraception. Women described elaborate ways in which they could covertly access contraception:

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

Women also found ways to avert direct confrontation and discussion with their husbands regarding HIV. Since the introduction of opt-out testing for women during ANC visits, it is more likely that women will have received HIV testing than that their husbands will have received it. This disparity in the availability and the uptake of VCT meant that women were more often put in the position of deciding whether to reveal their test results. Some women indicated that they never revealed their test results to their husbands unless he also tested. As described by this woman, however, even if both partners tested, they would not necessarily disclose their results to one another:

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

Although many participants indicated that women could only request that their husbands get tested, or abide by what the husband decided, one of the female focus group participants indicated that women could avail other options, such as sleeping in another room or, if necessary, divorce. Informants also indicated that with respect to both FP and VCT, a wife has the ability to decide and act autonomously, even if the husband does not agree. In one of the male focus group discussions, participants objected to the ways in which men typically confront disagreement or their wives' reticence to participate in couple sexual health services:

What can happen is that the man is displaying power simply because he is a man, but in this case the man should not make that stand. It is not necessary to do that. It will then depend on the man being made to understand in the same way we have said the woman should be made to understand. ... He should not do things just for the sake of him being a man. That is not good. (male FGD participant)

Discussion

Given the rise in innovative sexual health service delivery methods such as home-based couples VCT and FP counseling, this exploratory study provides insights into some of the additional complexities and considerations that health researchers and program managers must consider with respect to gender. In Malawi, as in other settings, existing gender norms and gender inequalities influence the way that health interventions, especially sexual health interventions, are perceived and experienced. Moreover, any benefits or risks of such interventions are likely to be different for women than for men, and must be carefully considered, especially for interventions in which both partners are simultaneously involved.

Although other studies have investigated the socio-cultural and gender dynamics associated with uptake and acceptability of couples' SRH services, this study is unique in that partners were interviewed simultaneously. A benefit of this method is that interviewing partners together produces not only an account of what each partner says but the interaction of the couple as they create their accounts.³⁸ Despite evidence of strict gender roles and wives' deference to husbands in some domains, the couple IDIs were successful in eliciting information from both partners. Both husbands and wives participated in the discussions and talked frankly about gender norms and how they play out in their own relationships. In addition, wives' divulgence of covert contraceptive use and disparaging comments (the "failure husband") during the interviews indicates that, at least to some extent, these women felt comfortable with not only expressing their opinions but also divulging sensitive information to "outside" researchers. Given the preponderance of literature (including from the present study) indicating limited couple communication about family planning and women's limitations with respect to sexual decision making, the researchers were not certain that women would speak up during these joint interviews and, if so, to what extent. Clearly, the fact that women engaged and to a greater extent than perhaps anticipated is an important finding.

Marital and gender roles, however, can impact sexual health care seeking and communication. For males, there is both an opportunity cost and a social cost of attending clinical health services. The opportunity cost arises from forgoing wage-earning opportunities, whereas the social cost arises from the low attendance of males at health clinics and the ensuing stigmatization and presumption of negative behavior for males who do attend. For females, seeking health care and especially receiving family planning are considered to be *ndizachizimayi*, or a woman's domain. This, in turn, leads to the gendered uptake, not only of services, but also of the receipt of information during these services. As noted by several women (and some men) in this study, this differential access to information meant that women were put in the position of relaying information to their husbands after the fact, a process which was further complicated and inhibited by men's perceptions that they "could not be told anything useful by a wife."

The gendered exposure to services also affected VCT. Women are more likely to be exposed to VCT—through antenatal care, child care visits, and FP. Similar structured opportunities for men to be in regular contact with primary health services do not exist. In this vacuum, men and women are adopting behavioral strategies that reflect their respective gender roles. Women covertly seek HIV testing or hide HIV test results until their partner has tested. Men assume their wife's HIV serostatus is their own or assume they are already positive when they, in fact, may not be.^{41, 42} Although some organizations have scaled up efforts to provide workplace VCT (e.g., MACRO), the disparities between men and women are likely to widen unless similar, broad-scale testing options are available and accessible to men, or couple-based approaches are expanded.

The findings also indicate that while couples' home-based SRH interventions may provide several benefits to each partner and to the couple as a whole, they also need to be carefully planned and monitored, given the differential impacts for women versus men. These findings mirror what has been found in other studies on HIV testing and disclosure,

including others conducted in Malawi.⁴³ Particularly with respect to disobeying the husband's desire to receive joint VCT or in divulging HIV test results, the consequences appear to be more severe for women. As McCreary et al. noted in their study on HIV disclosure in Malawi, "Men respond with violence or divorce, while women ultimately forgive."⁴⁴ There is evidence that Malawian women may be increasingly likely to use divorce as a means of averting HIV risk;^{28, 30, 35} however, men "appear better equipped than women to apply strategies to limit their risk of infection" (p. 433).⁴⁵

It is important to note a few considerations in the interpretation of these findings. As in most qualitative studies, the study participants were purposively sampled for this study based on age and residence in the study sites. In addition, the participants were recruited from the local villages via HSAs; therefore, it is likely that the HSAs selected people who were known to them either through their health outreach efforts or personal relationships. These characteristics could have affected the selectivity of the sample with respect to couple and health behaviors (e.g., couple communication and contraceptive practices), as well as socio-demographic characteristics. In addition, though all the joint couple interviews elicited input from both partners and appeared to yield valid information, we do not know how interviewing the couple together would have been different from conducting separate interviews with each spouse. However, given evidence of high discordance between partners with respect to the reporting of household items, couple characteristics, and behavior, it is not evident that individual accounts would be any more reliable than couple accounts.^{34, 46} Some researchers might argue that couple accounts can provide greater validity since both partners are essentially weighing in on the joint response to interviewers.³⁸

Like other recent findings from Malawi by Angotti et al. (2009), study participants indicated numerous benefits of home-based couples' SRH provision, including convenience and enhanced privacy.²⁰ Participants noted that VCT at clinics or other locations does not provide individuals with the time or privacy to deal with the receipt of their HIV status, particularly if they are HIV-positive. Men, in particular, are stigmatized when seeking health services at the local health clinic. Despite the strict gender norms encountered in this study, a surprising finding was that nearly all the study participants said that the sex of the VCT/FP counselors did not matter, as long as they were knowledgeable, competent, and respectful. Actual interventions, however, should consider testing the effect of the sex of the counselor on VCT uptake, as another recent study from rural Malawi found that female counselors were associated with a higher odds of HIV test refusal in the home.²⁴ In addition, the two sentiments raised within one of the male FGDs sympathizing with wives' dissension from their husbands' wishes in the face of differential consequences for women indicate that there may be deviations from the ascribed male gender norms. Although these may be aberrant comments, they were raised within the context of FGDs, where more normative expressions are typically voiced. The expression of these sentiments suggests that not only were these deviations present, but the participants felt free to voice them in a group of their peers. Evidence from other studies indicates that men are also constrained by social expectations that may inhibit deviation from the prevailing social norms for men.⁴⁷

Conclusion

Unless SRH services reach men with more regularity, FP and VCT will continue to be a “gendered” process, with more women being aware of and using them. In addition, the burden of disclosure will continue to disproportionately affect women, who are often more vulnerable to adverse consequences. Couple-based interventions need to be cautiously planned and implemented. There are considerable benefits to couples being tested simultaneously, and the presence of a trained counselor can help mitigate the risks of unexpected test results or contraceptive use disclosure in this setting.

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Table 1

Characteristics of FGD participants

	Females (n = 24)	Males (n = 25)
Age range	20–30	20–30
Occupation	Farmer No employment Vendor	Farmer Driver Vendor Weaver
Marital duration	1–15 years	1–16 years
Years of education	0–9 years	1–12 years
Number of children	1–6	0–3
Use of contraception	Injection (19) No use (4) Pills (1)	Injection (13) No use (6) Condoms (4) Pills (2)

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Table 2

Characteristics of Couple IDI Participants

Couple	Age	Number of years married	Number of years of schooling	Number of children (Boys/Girls)	Current contraception	HIV testing experience
Couple 1		14		4 (4B)	Injectable	CVCT ¹
Male	37	4				
Female	35	7				
Couple 2		20		9 (4B/5G)	Injectable	IVCT – H/W ²
Male	38	3				
Female	34	0				
Couple 3		4		1 (1B)	Injectable	IVCT – H/W
Male	28	12				
Female	23	5				
Couple 4		10		2 (1B/1G)	Injectable	CVCT
Male	28	10				
Female	30	4				
Couple 5		11		3 (1B/2G)	Natural FP	N/A ³
Male	32	2				
Female	25	4				
Couple 6		15		2 (2B)	Hysterectomy	N/A
Male	38	9				
Female	39	3				
Couple 7		10		3 (2B/1G)	Injectable	N/A
Male	33	10				
Female	26	5				
Couple 8		5		2 (2G)	Injectable	IVCT – H/W IVCT – H/W
Male	33	12				
Female	25	10				
Couple 9		14		4 (unknown)	Injectable	CVCT
Male	40	0				
Female	30	0				
Couple 10		11			Injectable	IVCT - W ⁴

Couple	Age	Number of years married	Number of years of schooling	Number of children (Boys/Girls)	Current contraception	HIV testing experience
Male	30	1		4 (2B/2G)		
Female	28	2				

^a Husband and wife have together received couples' VCT (CVCT).

^b Husband and wife have each received separate and individual VCT (IVCT).

^c Neither husband nor wife has received VCT.

^d Only wife received individual VCT.