That's your way, this is ours: Yao women's perspectives on sexual and reproductive health knowledges, rituals and traditions in a rural community of Balaka, Malawi

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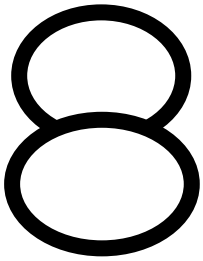
'If we don't tell our stories, hailstones will continue to fall on our heads' (Abena P.A. Busia, 2010).

Preface - a short note on the title.

This thesis is my original work and the research project, of which this thesis is a part, received research ethics approval from the University of Essex Ethics Committee and the National Committee on Research in the Social Sciences and Humanities (Malawi), Project Name, Title No. Ethics ETH1920-1750: Miss Lucia Collen, on 20/01/2021 and Ref no. NCST/RTT/2/6 on 10/03/2021respectively.

The thesis title, although appearing binary, points to three important issues derived from the research findings, which showed that people's perspectives and positions, as well as my own were never black nor white or fixed, but rather a two-way interaction between variables as represented by the combined circle below.



Firstly, the title reflects the rural women's perspectives and behaviours towards Western knowledge and medicine versus indigenous knowledge and traditional medicine. Their respect and utilisation of the two knowledges and practices appeared to be interactive and at times, their behaviours appeared to favour traditional ways, despite being exposed to Western ways.

Secondly, the title reflects the tension between older and younger women's views towards modernity versus indigenous ways. Although, both the older generation and younger generation, appeared to revere their rituals and traditions, in practice the younger generation opted for modified rituals and traditions.

Further, my position and perspectives in this thesis reflects my research's motivations, agenda and ideologies that have changed over the period of the study. I came to the University Essex trained in western public health without understanding alternative ways of knowing, thinking and speaking, such as the indigenous knowledge system, its practices and knowledges. This could be due to my socialization into the western culture and educational systems imposed on the global south, which considered other knowledge systems to be primitive and not scientific. However, through reading various articles on indigenous knowledge and the African history, culture, and the African people from that of the colonisers and the colonised, my perspectives changed, and I started to value indigenous knowledge systems and practices.

As such my position and role in this study was fluid. I was neither an insider nor an outsider, as I was not just a researcher, but a nurse/midwife, community/public health nurse employed as lecturer at the university of Malawi, now Kamuzu University of Health Sciences.

The title thus reflects the ambivalence of both my own views and those of the study population whose positions and roles were fluid, fluctuating from being experts in their community to being novices in other settings. This fluidity is apparent in the younger generation becoming more critical and less compliant towards rituals and traditions than the older generation, seemingly *'saying that's your way, this is ours'*.

The framework for this thesis is thus built around two different world views emphasizing alternative ways of knowing, thinking, and living in addition to Western perspectives, demonstrating the coexistence of the two knowledge systems and practices.

Abstract

Background

Young people continue to experience negative sexual and reproductive health (SRH) outcomes, despite the availability of government funded SRH services. The literature suggests that communication about sex is helpful in encouraging good decision making and positive sexual behaviours, among youth, when the message is appropriate and comprehensive. While the importance of this interaction is globally recognised, in the promotion of healthy sexual behaviours, very little is known about intergenerational SRH communication in developing countries such as Malawi, notably in rural areas, where access to health facilities and mass media is very limited and young people rely on extended family members for SRH information.

Aim

This Ethnographic and Participatory Action Research aimed to: (a) explore the views of rural women (young women, mothers and grandmothers) and influencing factors on SRH communication practices, (b) consider the broader historical, economic, and socio-political contexts that shape the intergenerational SRH communication experiences, (c) assist the rural women to act in solving SRH problems and issues among themselves.

Methods

Adopting a participatory ethnographic approach, a total of 27 participants were recruited comprising of 10 young women aged 18 - 24 years, 4 mothers, 4 grandmothers, 2 key informants, 4 traditional and 3 religious SRH counsellors. Data were collected through face-to-face interviews, focus group discussions, participant observation in SRH rituals for young

women and field notes. A comparative data analysis and an inductive Thematic approach by Braun and Clarke (2006) was used to analyse the data and triangulate the shared narratives.

Results

Five overarching themes were identified: learning about SRH issues; the role of rituals and ceremonies; gender and power dynamics; impact of colonisation; tension between older and younger generations.

The findings showed the flexibility of personal constructions of SRH communication practices, the meanings attached to initiation ceremonies mainly the puberty rite, and how the transition from childhood to adulthood leads young women to new and or (re) negotiated social identities in the context of their sexual and reproductive lives. Intergenerational perspectives on SRH communication practices emerged consistently throughout the thesis and thus provided evidence of the pollination of views and experiences across the generations. The initial findings led to the development of a culturally congruent health improvement intervention, focusing on menstrual cycle, contraceptives and SRH rights, which aimed to empower the women on SRH matters, and give them a voice in traditional community practices.

Conclusion and Recommendations

The thesis concludes that the socio-cultural contexts of the three generations of the rural women in the study, and my unique position of being from the area and trained in western biomedicine, afforded me insight into how the women drew on both traditional and biomedical understandings of SRH, with the balance changing a little with each generation, occasionally leading to tension between younger and older women.

It recommends that future intergenerational SRH communication research, undertaken in the rural communities, is rooted in nuanced socio-cultural perspectives of SRH communication practices that can inform policy and practice. The study further recommends the recognition and valuing of the existing cultural structures, rituals and associations to reach young women with a holistic view of sexual matters and programmes.

Dedication

This thesis is dedicated to my late dad Pedro Remigio Collen Onions for believing in me to pursue this dream. How I wish, you had lived long enough to witness this achievement. You are my source of inspiration. When in doubt, I always turn to you, and remember that day, at the Great Hall, of the University of Malawi.

And to

My late aunt Rozina Matthews, my role model, for your love for education. You taught me to work hard for the things that I aspire to achieve. Had you lived, this would have made you proud.

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This research study involved many people, and without their support and guidance, I would not have achieved my goal. To my supervisors Professor Gill Green and Dr. Lindsey Nicholls thank you for the support you rendered to me, starting from the project proposal which had to change several times, to ethics clearance, data collection, final report writing and thesis submission. I would like to thank you for your advice, critical guidance, comments and encouraging me to soldier on with this work. You made Colchester become a home away from home. I will always be indebted to you for the rest of my life.

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To all the women who took part in this study, I feel grateful to have experienced your culture and the welcome I received during my entire field work. Many of you, went out of your way to give up your free time and resources in support of the study and showed me hospitality. I acknowledge my responsibility to you co-researchers to disseminate the findings of the study so that your voices and the potential use of the project can be considered.

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I am also grateful to my mom Alfonsina, my brothers and sisters (Collen, Fanny, Alice, Evaristo, Maxwell, Dennis and Mercy) my nieces and nephews (Shareeka, Shabir, Owen, Shameema, Shahadat and Adolf) and the entire Onions family for your support in many ways.

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Acronyms and Abbreviations

AIDS	Acquired immunodeficiency syndrome
ARC	Action for the Rights of Children
CAQDAS	Computer-aided qualitative data analysis software
CHAM	Christian Health Association of Malawi
CINAHL	Allied Health Literature
DC	District Commissioner
DFID	Department for International Development
DHMT	District Health Office Management Team
DHO	District Health Office
EHP	Essential Health Package
EPAR	Ethnographic and Participatory Action Research
FGD	Focus Group Discussions
HIV	Human immunodeficiency virus
HPV	Human papilloma virus
HSA	Health Surveillance Assistants
IPV	Intimate partner violence
LMICs	Low- and medium-income countries
MHRC	Malawi Human Rights Commission
MoH	Ministry of Health
NYCoM	National Youth Council of Malawi
PAR	Participatory Action Research
PN	Participants narratives
PLHIV	People living with HIV/AIDS

PO	Personal observation
PSI-Malawi	Population Services International – Malawi
PHC	Primary Health Care
RHU	Reproductive Health Unit
RMNCH	Reproductive, Maternal, Neonatal and Child Health
SADC	Southern African Development Community
SDGs	Sustainable Development Goals
SRH	Sexual and reproductive health
SRHR	Sexual Reproductive Health Rights
STIs	Sexually transmitted infections
T/A	Traditional Authority
UK	United Kingdom
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WHO	World Health Organisation
YFHS	Youth Friendly Health Services

Chapter 1 Introduction and background to the study

1.0. Introduction to the Chapter

This chapter provides the background and justification for this research study. Intergenerational approaches to understanding sexual and reproductive health (SRH) communication assume that familial scripts manifest, and shape recurrent accounts passed down to the next generation (Field-Springer et al., 2019). These familial scripts shape positive and negative perceptions of girls and women that inform cultural understandings of women's roles, customs and sexual behaviours. The World Health Organisation (WHO) (2015) acknowledges that communication about sex could be instrumental in encouraging sexual responsibility and positive sexual behaviours among youths, when the message is appropriately and comprehensively delivered. As such, these interactions are vital because parents and families transmit sexual values, beliefs, traditions, information and gender expectations to their children to promote positive sexual behaviours, which protect young people from engaging in risky sexual practices (Manu et al., 2015; Dessie et al., 2015).

Of particular interest in this research is the interaction of Western ways/ bio-medical knowledge and indigenous ways of SRH learning and knowing. When seen through the Western lens of bio-medical knowledge, indigenous knowledge is often considered at best unscientific and at worst harmful, predisposing young people to negative SRH outcomes. Due to the influence of colonisation, political history and religion western medicine tends to be seen as more legitimate than indigenous knowledge (Mignolo & Walsh, 2018). For example, the attitudes of early missionaries towards African healing were generally derisive and dismissive, with aspirations to create a healthy Christian society where missionary medicine would be central (Hokkanen, 2007). However, despite these negative effects, traditional

medicine remains a highly prevalent form of healthcare behaviour in sub – Saharan Africa as observed by Moshabela et al. (2017) in a study of people living with HIV/AIDS (PLHIV). The study which sought to establish the manifestation of medical pluralism among PLHIV, found that mixing of bio-medical healthcare providers and treatment with traditional and faith-based options fuelled tensions driven by fear of drug-to-drug interactions and mistrust between providers operating in different health-worlds.

In this study, however I was keen to explore how these two knowledges can co-exist, in the belief that indigenous knowledge can contribute and that many low- and medium-income countries (LMICs) continue to rely on both knowledges. As Owusu-Ansah and Mji (2013) note, you cannot separate an indigenous person from his rituals and traditions. Also noted by Ribera (2007) that in Africa, as elsewhere, medical pluralism is the rule rather than the exception, and that people tend to use the various medical traditions to which they have access in ways that may be exclusive, sequential or complementary.

Therefore, for this reason any study focusing on medical traditions in themselves, as if their histories, development and qualities were independent of interactions with other therapeutic resources, is essentially incomplete (Ribera, 2007). Consequently, it was important to develop an understanding on when, why and for what kinds of SRH issues/ problems women choose either traditional medicine or bio-medical services; when, why and for which problems/ issues they do not use them; and when, why and for what kinds of problems they have recourse to both.

While the importance of this interaction is globally recognised in the promotion of healthy sexual behaviours, very little is known about intergenerational SRH communication in

LMICs such as Malawi, especially in the rural communities, where access to health facilities and social media is very limited and young people rely on extended family members for SRH information, rituals and traditions. Hence, I embarked on this ethnographic participatory action research (EPAR) to gain an understanding of the experience and influencing factors on communication of SRH issues from the perspectives of three generations (young women, mothers and grandmothers) in a rural community of Balaka, Malawi. Further to this, to understand their SRH seeking behaviours and what determined their choices for using either traditional medicine or bio-medical sciences of both, while considering the broader historical, economic and socio-political contexts that shape the intergenerational SRH communication experiences in a rural community of Balaka, Malawi and to assist the community to act in solving SRH problems and issues among themselves.

1.1. Background to the study

Over the past decade there have been huge strides in the understanding of the socio-cultural, economic and structural factors that influence different aspects of SRH among adolescents (WHO, 2015; WHO, 2008; O'Connor, 2018). It is widely recognised that health risks arising from inadequate knowledge, unsafe sexual practices and sexuality-related human rights abuses such as sexual coercion together contribute to the global burden of disease, for example unwanted pregnancies, unsafe abortions, STIs including HIV/AIDS (WHO, 2015; WHO, 2008; Munthali et al. 2004; Munthali & Zulu, 2007; Munthali et al., 2018). This thesis focuses on how young people acquire SRH knowledge and their healthcare seeking behaviours.

The United Nations Population Fund (UNFPA) (2013) defines an adolescent as a person aged 10 - 19 years and youth as those between 15-24 years, and when the two terminologies are combined, they are known as young people (Reavley & Sawyer, 2017). By contrast, the *African Youth Charter* (2006) and Malawi's *National Youth Policy* (Government of Malawi, 2013) define youth as individuals aged 15 - 35 and 10 - 35 years, respectively (Wigle at al., 2020). The focus in this thesis was those aged 16 – 24 and the term young people was preferred because it is more inclusive and internationally recognised. However, when reporting on studies that have used terminologies such as adolescents and youth, the terms are maintained and used interchangeably with the term young people. Borges and Nakamura (2009) describe adolescence as a period of great relevance for SRH, as it is the phase when sexual practices and sexual initiation is emphasised. Munthali et al. (2004) add that many adolescents adopt risky sexual behaviours without having adequate or correct information on how to protect themselves from the adverse consequences of these behaviours.

Globally, young people (10 -24 years) represent 42% of the world's population with 50% living in Africa (World Bank, 2017). Just like any age group, young people have a right to acquire knowledge on their health, including SRH (Quaye, 2013; WHO, 2015). However, they continue to experience more negative SRH outcomes than older people (WHO, 2008; Simmonds et al., 2021; Chimwaza-Manda et al., 2021). Globally, 40% of the unplanned pregnancies occur among the 15 –24 age group (WHO, 2008), 40% of unsafe abortions are performed by young women aged 15 - 24 years (Department for International Development (DFID), 2004) and 60% of the new HIV infections also occur in this age group (Dehne & Riedner, 2005).

Likewise, in sub-Saharan Africa, Malawi inclusive, literature shows that over 50% of young women are married by 18 years (World Bank, 2014; Stuart, 2011). A cultured education: Malawi as an example for protecting rights of the girl child in the face of cultural barriers, have experienced early pregnancies, sexually transmitted infections (STIs), HIV/AIDS and childbirth complications (UNICEF, 2001). Chandra-Mouli et al. (2013) provide the reasons for these negative SRH outcomes as being lack of adequate and accurate knowledge about sexual matters as well as a power imbalance in sexual relations between women and men. Chandra-Mouli et al. add that biological vulnerability of girls, poverty and cultural practices can lead to woman experiencing sexual trauma and ill-health. Adolescents are vulnerable to STIs and HIV infection as adolescence is a time of experimentation with sex, and it is the period when sexuality and sexual behaviour is shaped (Simmonds et al., 2021; Chimwaza-Manda et al., 2021; Quaye, 2013; Dehne & Riedner, 2005).

To overcome these challenges WHO (2015) recommends the following strategies: accessible, comprehensive SRH information, addressing social cultural and economic barriers, as well as improving access to comprehensive SRH services. A study conducted by Lenciauskiene and Zaborskis (2008) in 10 European countries, revealed easy communication between young people and their parents on SRH issues, especially with mothers. This contrasts with findings from studies conducted in sub-Saharan Africa, in which some female adolescents expressed concern about contracting STIs and other SRH-related problems owing to inadequate access to information and inability to communicate with parents about SRH matters (Quaye, 2013). Studies in Tanzania by Wamoyi et al. (2010), Ghana by Manu et al (2015) and Quaye (2013), Ethiopia by Dessie et al. (2015) and in South Africa by Mpondo et al. (2018) and Simmonds et al. (2021) found that SRH communication is a taboo topic in many cultures and that parents are not comfortable talking about sexual issues with their children. When they talked,

messages were limited to a warning against pregnancy (Mpondo et al., 2018; Wamoyi et al., 2010).

Similarly, studies conducted in Malawi by Wittenberg et al. (2007) Limaye et al. (2012) found that it is not culturally appropriate for parents to talk to their children about sexual matters. However, Wittenberg et al. (2007) observed that young females preferred to receive information on HIV/AIDS and pregnancy prevention from their parents, grandmother and relatives as they are perceived to be trustworthy, due to their life experiences and willingness to talk. Traditionally, teaching of young people on sexual matters in sub- Saharan Africa, has been the role of extended family members, such as aunts, uncles and grandparents (Wamoyi et al., 2010; Wittenberg et al., 2007). In some cultures, it is believed that keeping adolescents, especially females, ignorant about sexual issues ensures their virginity. In such cultures parents consider it an obligation to keep sexual information from their girls until they are prepared for marriage (Quaye, 2013). However, the Yao women in Malawi use initiation ceremonies at different developmental stages of a girl - child to educate her on SRH matters (Munthali et al., 2018; Munthali & Zulu, 2007).

The mass media has also been identified as a source of information when it comes to communicating sexual risk behaviours and SRH (National Statistics Office (NSO), 2016). The government in Malawi uses radios and televisions to share information on SRH but with only 33.6% of households owning a radio, 51.7% having a mobile phone and 11.8 % a television, this poses a challenge to those who do not have these gadgets, especially those in the rural community. As the NSO (2016) reports these figures could be much lower for those in the rural areas. A qualitative study in Malawi by Chimwaza-Manda et al. (2021 p.1) in Machinga and Zomba districts, bordering Balaka district showed that adolescents can learn

about sexual matters from other sources than the family, and in this case the 'DREAMS' Go Girl club participation was used.

Further, the Malawi Government through the Ministry of Health (MoH) is implementing a Youth Friendly Health Services (YFHS) in some of its health facilities to meet the diverse SRH needs of young people (10 -24 years) (MoH, 2007). Specially trained young health workers in YFHS provide these services after school hours and weekends. As such, young people are free to access SRH information and services whenever needed. However, being primarily donor funded, this has led to inequitable distribution of services and fragmented implementation (Wigle et al. 2020), with these services being concentrated in cities and big towns and are less accessible to young people from rural communities, who have to incur transport costs and uncomfortable journeys (due to poor road infrastructure and unreliable vehicles) to access them. As a result of challenges in accessing these sources of SRH information, young people in the rural areas of Malawi mainly rely on sources of information such as mothers, grandmothers, friends, religious and traditional counsellors locally known as *Anankungwi*, as well as through initiation ceremonies, rituals and traditions.

1.2. Problem statement and significance of the study

In Malawi, adolescents constitute 24% of the total population and require a wide range of Sexual Reproductive Health Rights (SRHR) services such as treatment for unwanted pregnancies and STIs including HIV and AIDS (WHO, 2018; MoH, 2022; Munthali et al., 2004). Approximately, 30.8% of adolescents begin childbearing with a high number of complications. For instance, the Mid-term review of the Malawi Health Sector Strategic Plan II (HSSP II) by MoH (2022) showed that complications from pregnancy and childbirth are

among the leading causes of death among girls aged 15-19, constituting 20% of maternal mortality in Malawi, with 14% of pregnancies in this age group ending in abortion. Besides, neonates born to very young mothers are at a greater risk of morbidity and mortality (MoH, 2022). The dangers associated with SRH problems make informing and educating young people on risky and positive sexual behaviours issues of urgency as communicating SRH has been found to be a key factor for the reduction of major sexual health problems globally (Simmonds et al., 2021; Quaye, 2013; WHO, 2015; Holman, 2014).

WHO (2008) argues that SRH is fundamental to the health of men, women and children, and this is reflected in the Sustainable Development Goals (SDGs) specifically goal 3 of ensuring healthy lives and promoting the wellbeing for all at all ages particularly target 1 and 7 (WHO, 2015; WHO, 2008). Target 1 aims to reduce the global maternal mortality ratio to less than 70 per 100,000 live births by 2030 (MoH, 2022) and target 7 aims to achieve universal access to SRH care services.

Malawi has made significant progress in improving the health of its population. Average life expectancy has increased by 10 years from 2009 - 2019 for both men (from 51 - 61) and women (from 57 - 67) and is now higher than the average life expectancy on the African continent (62 years) (MoH, 2022; World Bank, 2022). This is attributed mainly to the improvements in adult and childhood health, due to the robust implementation of HIV maternal and child health life-saving interventions (MoH, 2022). For example, the provision of free Essential Health Package (EHP) at all levels of care so as to increase equitable access to health care services. Some of the interventions included in the EHP are: Reproductive, Maternal, Neonatal and Child Health (RMNCH) HIV/AIDS and community health. Generally, Malawi's universal health coverage (UHC) has improved rising from 25% in the

year 2000 to 50% in 2019 reflecting a strengthening of health system organisation (MoH, 2022).

The goal for RMNCH was to meet modern contraceptive prevalence rate (mCPR) of 60% by 2020 for all women of reproductive age. Significant progress has been made in increasing the mCPR in all women from 38.1% in 2012 to 48.3% in 2019 with married women at 78.4% (MoH, 2022). However, many adolescents continue to lack access to contraception (Ibid.). A systematic review by Munthali et al. (2004) of SRH studies conducted in Malawi found that barriers to the use of family planning services among the youth include social and cultural factors, such as ignorance of the existence of the services, poor quality services such as negative attitudes of family planning providers toward young people, fear of parents and guardians, misconceptions, rumours and fear of side effects, for example, contraceptive use before having a child can cause impotence or infertility. In regard to HIV/AIDS, Malawi has made sustained progress in managing HIV/AIDS. The overall burden of HIV/AIDS has decreased with declining prevalence and incidence of HIV among adults aged 15-49 from 9.1% and 3.42% in 2017 to 8.1% and 2.16% in 2020 respectively (MoH, 2022).

While there is substantial amount of research literature on the SRH of young people in Malawi, only few studies have focused on the Yao culture, rituals and traditions. For instance, a qualitative study by Banda and Kunkeyani (2015) in Balaka, Zomba, Machinga and Mangochi, looked at the relationship between initiations rites, rituals and traditions, and HIV/AIDS. However, the study was not specific to the rural Yao people, as it was conducted within the townships with residents from various tribes. A recent study by Munthali et al. (2018) conducted among the Yao people looked at how initiation ceremonies in Machinga district (which neighbours Balaka) have evolved over the last 30 years and how they have

impacted on youth SRH behaviours. Although it was specific to the Yao people, the study was conducted by a male researcher not indigenous to this tribe and from a Western perspective. Previous studies of SRH among the Yao people have used qualitative approaches but not an ethnographic and participatory action approach, and this is the gap which this study intended to address. My belief is that the gender of the researcher and the primary positioning in the research would affect what is seen and understood about SRH communication practices.

In the light of the high levels of STIs, HIV/AIDS, unintended pregnancies and unsafe abortions among young people in Malawi and WHO's recommendations (2015) that sex education and communication be studied, I undertook an ethnographic and participatory research project which aimed to (a) explore the views of rural women (young women, mothers and grandmothers) and influencing factors on SRH communication practices, (b) consider the broader historical, economic and socio-political contexts that shape the intergenerational SRH communication experiences, (c) assist the rural women to act in solving SRH problems and issues among themselves. As such, this thesis focused on how young people acquire and interpret SRH knowledge, rituals and traditions. As older females form an important part of this education, the thesis explored intergenerational experiences and perspectives of rural women. While being guided by the following initial objectives and questions, and due to its participatory and exploratory design and process, the study aims and objectives began to evolve alongside the knowledge gained during the field work.

1.2.1 Study objectives.

- To explore females' practices, attitudes and communication about SRH from the perspective of three generations.

- To identify factors which facilitate or inhibit intergenerational SRH communication in the community.

- To explore how SRH knowledge and communication may influence young peoples' sexual behaviours.

- To explore how patriarchy, the legacy of colonialism and modernity has shaped and influenced the traditional gender roles of women on the social context of SRH issues.

- To examine the relationship between indigenous and bio-medical knowledges in order to develop a culturally- appropriate intervention.

1.2.2 Research questions.

- How do girls, mothers, grandmothers and traditional/religious counsellors describe their experiences, beliefs and perceptions on girls' sex education which takes place in this community?

- What are the factors which facilitate or inhibit intergenerational SRH communication in this community?

- How does SRH knowledge and communication influence young peoples' sexual behaviours.

- How do girls, mothers, grandmothers and traditional/religious counsellors view the relationship between SRH communication practices, rituals and traditions and young peoples' sexual behaviours?

- How have gender roles and SRH learning been impacted by patriarchy, colonialism and modernity?

- How do Western and traditional knowledges interact and how can this be used to develop an intervention to support rural women's empowerment to meet the identified unmet SRH needs of their young women?

1.3. Positioning the researcher

This section outlines why the researcher thought and felt it was important to research intergenerational SRH communication within one indigenous group in a rural community of Balaka, Malawi. A considerable amount of what is shared in this section of the thesis is grounded on personal and work experience, thus the researcher's voice in this section will be reflected in the first person as opposed to the third person where possible. Further accounts of the researcher's personal stances, and how these shaped the study are described comprehensively in subsequent sections and chapters. As Malterud (2001) suggests, the researchers' personal and professional experience will affect what they choose to investigate, the perspective of investigation, methods used, interpretation of findings and communication of conclusions. Therefore, as Malterud (2001) proposes, I brought a collection of experiences, values and perspectives that have shaped the study, and as such I have been an active player embedded in the study itself. It is, therefore, relevant that I declare my stance here and examine how my experiences and beliefs played a role in this research.

My personal and professional experiences have been the motivation for this research study and the methodology employed. I was born to a Zambian mother, Bemba by tribe and a Malawian father who was of mixed race. His father was a white man from United Kingdom and his mother a Black Malawian woman from the Yao tribe. I spent my early childhood in Zambia, before moving to Balaka, Malawi, which I now call home. Despite this, I have remained in close contact with my maternal relatives and visit them periodically. However, this thesis centred on my experience of living and growing up with my paternal relatives and my affiliation to the Catholic church in a rural community of Balaka, Malawi. My grandmother was a well-respected woman in our community by virtue of being married to a white man and she was a traditional initiation counsellor, locally known as ‘’Anankungwi’’. Every year, during summer holidays with her friends and relatives, she used to conduct initiation ceremonies for other girls in the village, at different stages of their lives, but not for her direct granddaughters.

I never had any conversation with my grandmother on SRH issues, and I never found out why she didn’t include me in a ceremony. Equally, my mother never talked to me about SRH issues even though she was a religious SRH counsellor. As such I never received any personalised SRH education while growing up, and the only information I had was from the church, by our Parish Priest who taught us during one of the Catechism classes that ‘’our bodies are God’s temple, and we should not mess it with boys’’. Therefore, my main sources of SRH information, were from friends, textbooks and later on my training as a nurse and midwife. During my primary and secondary school days the subject ‘’life skills’’ was not in the curriculum. Such that while in my eighth grade, I remember crying a lot after I had found a love letter in one of my notebooks, which had been put by one of my male friends. The whole class knew about it and laughed at me, including our male teacher who jokingly told

the boy to stop sending these letters to babies like me. My female classmates also joined in the laughing, asking me to go for an initiation ceremony. This led me into paying a girl in our village to learn more about these initiation ceremonies.

I remained ignorant on matters of sexual health, such that I was shocked upon seeing a sanitary bin full of soiled pads on my first day of arrival at a girls boarding secondary school. In my mind I was convinced that someone was bleeding a lot and needed to be taken to the hospital for medical attention. To my dismay, when I reported the issue to the dormitory mother, everybody just started laughing and teasing me and she simply said, never open sanitary bins again and do not attend the burning ceremony of soiled pads, as the task was for big girls only. The chapter was closed without addressing my concerns.

But this was not 'closed' for me, and I asked one of my friends from another dormitory, who told me where the blood was coming from and that nobody was dying. Needless to say, when my menstrual period came, I was ill prepared to handle the situation. I was unaware that the pads had to be changed frequently and that it would be a monthly activity. As such, I kept on soiling myself and at the same time being embarrassed to ask for help, because it meant admitting that, I was still naïve, and in many ways this experience of shame meant that I would not wish for someone to experience what I went through.

The experience increased my curiosity to learn more about SRH issues and to understand why neither my mother, nor my grandmother could talk about it to me despite their knowledge of SRH rituals and traditions. I was left wondering if it was done out of respect or fear of my grandfather, who might have considered it to be a 'primitive' practice. As for my mother, to this day, she appears to be uncomfortable with this topic, so l did not want to be

seen to be intruding. Yet, despite this silence of my body and its innate sexuality, she instilled in me the importance of humility and kindness. It is only through this research that I have come to realise that these values are important components of my well-being. I was fortunate to grow up in a caring family within a community - orientated environment.

My values and interests were also influenced by my father, aunt and cousins. They all instilled in me the spirit of hard work, the importance of compassion and going after one's dreams. My cousin always told me, ‘’you are too smart to sell cassava by the roadside.’’ My father taught me that everyone deserves respect and that we should strive to enact and promote equity and equality especially for the less privileged. My aunt instilled in me the love for education, by going back to college twice after her initial training in Nursing and Midwifery. I have emulated her resilience and dedication, going back to University three times after my undergraduate qualification.

One thing I remember very clearly was the unspoken norms to which I was expected by my family to conform, such as not marrying at an early age, not having children until I had established a career and I had wedded in church. Looking back, I recognise that in my family talking about SRH issues was a taboo topic, not to be spoken about outside the confinement of the church and the initiation ceremonies. This culture of silence on communication of SRH issues was the trigger for my interest in studies on SRH for young women. At times in this study, I have talked to traditional counsellors like my grandmother, and they filled the void in me, which she had left. Having conversations with them and attending the initiation ceremonies felt like my desire to learn more about SRH issues, and its associated rituals and traditions had been fulfilled.

The advent of HIV was also a significant period in my life. I was 15 years old when I learnt about the death of a former Miss Malawi as a result of AIDS. Years later, I lost a cousin to AIDS. He was a musician and people blamed him for being careless with his life, that's why he contracted the deadly disease. He was given a drink *''mchape''* [a herbal concoction which a certain man known as Chisupe, claimed to cure to AIDS] three times with no improvement. Seeing him emaciated and struggling to swallow water in his last days was very hard for me. I kept on wondering how he might have been feeling, hearing the unpleasant comments. I remember thinking HIV was something to be afraid of, but also felt a sense of sadness and anger at the unjust comments about my cousin who was judged based on his illness.

It wasn't until in 2001 when I won my first scholarship for my Bachelor of Science degree in Community Health Nursing at the University of Malawi, that I had the opportunity to do some research into HIV and AIDS. As a requirement for the degree, I had to undertake a research project, and I decided to conduct qualitative research on the experiences of people living with HIV/AIDS in the communities surrounding Mponela Trading Centre. I was struck by the shame and stigma, but also the resilience of the people I met. Finally, my interest in marginalised populations, led me to work and live in rural areas for almost 11 years, which gave me insight into the influence of culture on people's sexual and reproductive lives and eventually led to this study.

In 2012, I won a scholarship for my Master of Science degree in Public Health at Glasgow Caledonian University, and I chose to carry out another qualitative study among young women on factors which influenced their SRH care-seeking behaviours in Glasgow. The study findings demonstrated that family support with SRH information and caring attitudes

were critical to avert negative SRH outcomes among young women. But what struck me most was the issue of family support as a preferred strategy despite the availability of technology and social media. This is what led to the present study, as I wanted to explore on what this support entailed for the rural women of Mbatamila village in Balaka, Malawi.

My previous work role had created educational material on SRH for rural women in a rural community in the central region of Malawi. In this community I initiated and coordinated a community radio project on safe motherhood among young people with the assistance of Malawi Broadcasting Cooperation (MBC) under the Development Broadcasting unit. During this project, I was struck by the poor SRH care seeking behaviours even though the community was only 5 kilometres and 2 kms away from a Dowa District Hospital and Dzaleka Heath Centre respectively. I had been generally happy with the intangible benefits the project had achieved, which included some of our discussions being aired on the National Radio, MBC Radio One thereby, giving them a voice to be heard.

However, radio or mass media communication have limitations in terms of sharing SRH information as there is no interaction and some skills are better taught through demonstrations. I felt greater understanding of SRH issues was necessary as personal perspectives and experiences, may not have been adequately explained or captured. For instance, what does SRH really mean to young people? What are their sources of SRH information? What influences a person's access and utilisation of SRH services and what is needed to promote it? These were all unanswered questions that I wanted to explore further.

In all I have 22 years of work experience in the fields of nursing, midwifery, community/public health and sexual and reproductive health, as well as a lifetime of personal

experience as a Malawian woman. After graduating with a Diploma in Nursing and a University Certificate in Midwifery from the University of Malawi, I went on to work in the field of adult health, mental health, HIV and AIDS, SRH, maternal and child health in research, programme management, capacity building and policy development for government, NGOs and academic institutions. My work in these different settings has shown me how much the structural, social and cultural environment influences our views, behaviours and emotions. It has given me an insight into the cultures and the cultural differences and similarities in these different regions. It is this local and embodied knowledge (clinical expertise and experience) that I bring to this study. My own values and perspectives which I have discussed here are apparent throughout this research and are further reflected on in Chapter 5 and 8.

1.4. Synopsis of the Thesis

Chapter 1: Introduction

In this first chapter I have introduced the study, set out its aims, objectives and research questions, and demonstrated the significance of the research. I have also established my own stance as the researcher through reflecting on my personal and professional experiences and their relevance to the study.

Chapter 2: Literature review and contextual background to the study

This chapter reviews literature available on experiences and influencing factors on SRH communication practices and its relationship to adolescents and young people' sexual behaviours. Then it goes on to explore what is known on parent - child communication of SRH issues with an emphasis on Southern Africa countries because of contextual similarities

in cultural and religious practices. It also outlines the context of the study by providing an overview of Malawi history, contrasting local developments and trends against Malawi's political landscape. It further situates SRH issues in the broader context of colonisation, cultural dispossession, and the legacy of the single and multiparty system of government.

Chapter 3: Theoretical framework

This chapter provides the theoretical frameworks for the study. The theories that guide this study include Bronfenbrenner's socio-ecological model and Freire's conscientization model, as well as writings on Decoloniality and African feminism. Bronfenbrenner's socio-ecological systems model is used to locate young women's sexual and reproductive lives within the interactions between various socio-cultural factors present in the ecological environment. Paulo Freire's philosophy of conscientization focuses on community-based identification of both problems and solutions as well as action, since it is essential in the process of changing the reality and empowering the community, as highlighted in chapter 6. Decoloniality and African feminism focus on appreciating and restoring the ways of knowing, living and doing which existed before colonisation and modernity and is rooted within the realities of African worldviews.

In addition to being used as a theoretical lens in this study, African feminism also formed the basis for the methodology as outlined below. The perspective offers a foundation for non-hierarchical personal sharing of power, ideas and experiences. To ensure that it is achieved in this study, I used subjective methods of data collection (unstructured interviews, FGDs and participant observations). These methods allowed participants to air out their views freely without the researcher dominating participants and I learning from them as well. This aided to alleviate hierarchical relations between me as the researcher and the participants, thus,

prioritising the voice of the participants. Further, African feminism informed the hybrid approach of this study which respects the two knowledge systems of Western medicine and the traditional ways.

Chapter 4: Methodology and methods

This chapter provides a detailed presentation of and justification for the qualitative EPAR approach adopted. Processes related to sampling, research methods, data collection and analysis, reliability, validity and ethical considerations are explained. A total of 27 participants were consulted, starting with 20 face-face interviews, comprising of 10 young women aged 18 - 24 years, 4 mothers, 4 grandmothers and also 2 key informants, who were included to provide more insights on traditional medicine. I also conducted two focus group discussions (FGDs), one with 4 traditional SRH counsellors and the other with 3 religious SRH counsellors. I carried out participant observations of two initiation ceremonies, starting with the puberty rite *(ndakula)* then the initiation ceremony conducted for a young woman with her first pregnancy *(litiwo)*. Insights from all these interactions contributed to the evolving nature of the study.

Chapter 5: Findings from the field

The chapter discusses the preliminary findings which informed the intervention and my reflection as an insider/ outsider researcher and the impact it had on the research process.

Chapter 6: Partnership in Action: Health improvement intervention

This chapter discusses how the preliminary findings were used to develop an intervention designed to enhance SRH communication practices. It also highlights the steps which were followed.

Step 1: Giving feedback to the traditional counsellors and young women and assisting them to identify issues contributing to teen pregnancies and coming up with possible solutions.

Step 2: Putting into action the identified solutions – I conducted capacity building trainings whilst using locally available resources.

Step 3: Terminating the partnership and providing them with a reference manual and notebook for registering teen pregnancies, for monitoring and evaluation.

Chapter 7 Analysis of findings

This chapter provides a thorough and rich account of the rural women's perspectives on SRH communication practices based on rigorous and systematic analysis of the data. Relevant quotations from participants' narratives are used to address the research questions. The key themes generated include: learning about SRH issues; the role of rituals and ceremonies; gender and power dynamics; the impact of colonisation and tension between older and younger generations. These are described, analysed and interlinked to give an in-depth understanding of the nature of factors that enhances or inhibit positive sexual and reproductive health behaviours among young women.

Chapter 8: Discussion

This chapter consolidates the key findings emanating from the data and discusses these in the light of the extant global and local literature. The discussion also locates the findings within the socio-cultural context, which is underpinned by the social constructivism perspective, Paulo Freire's philosophy of conscientization, and the lens of decoloniality and African feminism.

Chapter 9: Conclusion and recommendations

The final chapter summarises the answers to the research questions. I then reflect on my role as the researcher in this research along three domains: personal, theoretical and methodological. Incorporated into the concluding thoughts, are insights and recommendations for clinical practice, policy and future research.

Chapter 2 Literature review

2.0. Introduction to the Chapter

This chapter reviews the related works in the area of communication on sexual and reproductive health. It begins with background information about Malawi and the Yao tribe specifically to illustrate the socio-economic and cultural context of young women's sexual behaviour. The second part of the chapter reports the findings of a focussed literature review summarising the findings of theoretical and empirical literature related to the purpose and aims of the study.

2.1. The Context of young people's sexual behaviour in Malawi

2.1.1. Country profile

Malawi is a small, landlocked country in Southeast Africa sharing boundaries with Mozambique, Zambia and Tanzania. It has a surface area of 118,484 Km2 of which 94,276 Km2 is land mass. Administratively, it is divided into three regions, north, central and south, and has 28 districts with six districts in the Northern region, nine districts in the Central, and 13 districts in the Southern region. The districts are sub-divided into Traditional Authorities (T/As) presided over by Chiefs. Each Traditional Authority is made up of villages (the smallest administrative units) presided over by village headmen/ women (see figure 2.1). Its capital city, Lilongwe, is at the centre of the country (see Figure 2.2). Mbatamila village in Balaka district is the site of the proposed study and it is in the southern region of the country (NSO, 2019) (See figure 2.3).

The district is about 200 kilometres from Lilongwe (capital city) and 115 from Blantyre (the commercial city). The district has a total population of 438,937 and covers an area of 2,193

km2 - representing 2.4% of the total land area of Malawi, with 209,274 being males whereas 229,105 are females (NSO, 2018). In terms of age distribution, 205,421persons are above 18 years (NSO, 2018). Only one in 16 women and 1 in 11 men have completed secondary education in Balaka district. One out of 8 women and men is unemployed, and the rest rely on subsistence farming, where basic tools such as a hoe are used, and labour is mostly provided by women and children. However, most families do not harvest enough maize, which is the staple food for Malawians, due to unfavourable climate and lack of fertiliser.

Balaka has poor SRH indicators. For instance, NSO & ICF (2017) reports that early childbearing among teenagers is more common in rural than in urban areas 31 versus 21 percent. In terms of regions, the North and the South were at 32 percent each respectively, compared to Central region which is at 25 percent with cultural practices fuelling the increase (National Youth Council of Malawi (NYCoM), 2009). In addition, the Southern region has HIV prevalence rate of 14.5%, which is twice as high as that in the Northern and Central regions (NSO, 2011). This could also be due to its geographical location, as the whole region is surrounded by Mozambique and trucks and trains from Niassa province must pass through the southern part of Malawi. Furthermore, people can move between the countries freely by just crossing the road without the need for a passport.

Malawi has a sub-tropical climate, which is relatively dry and strongly seasonal. The wet season stretches from November to April, with low-lying areas being prone to floods, posing a risk to agriculture, food security, health, housing and the economy. A cool, dry winter season is evident from May to August with mean temperatures falling between 4 and 10 degrees Celsius. Frost may occur in isolated areas in June and July. A hot, dry season lasts from September to October with average temperatures varying between 25 and 37 degrees

Celsius (Department of Climate Change and Meteorological Services, 2020). This was important in this project, mainly for planning and scheduling of fieldwork. For example, because of the high temperature during the fieldwork period (April – September), most of the interviews, focus group discussions and other research activities, were conducted in the afternoon, under a tree when it was a bit cooler, and the women were resting after working in their fields in preparation for the planting (rainy) season.

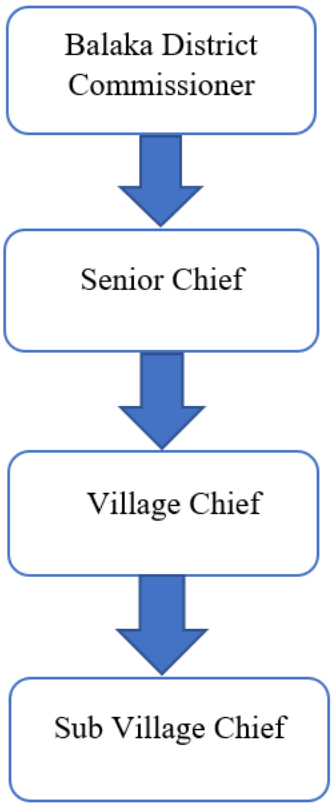


Figure 2.1 An organogram showing the hierarchy of authority in Balaka district.

Figure 2.2 Map of Malawi showing the three Regions, Towns, Districts and neighbouring Countries
Source: [republic-malawi-administrativ-political-map-flag-122600876.jpg (498×900) (dreamstime.com)]

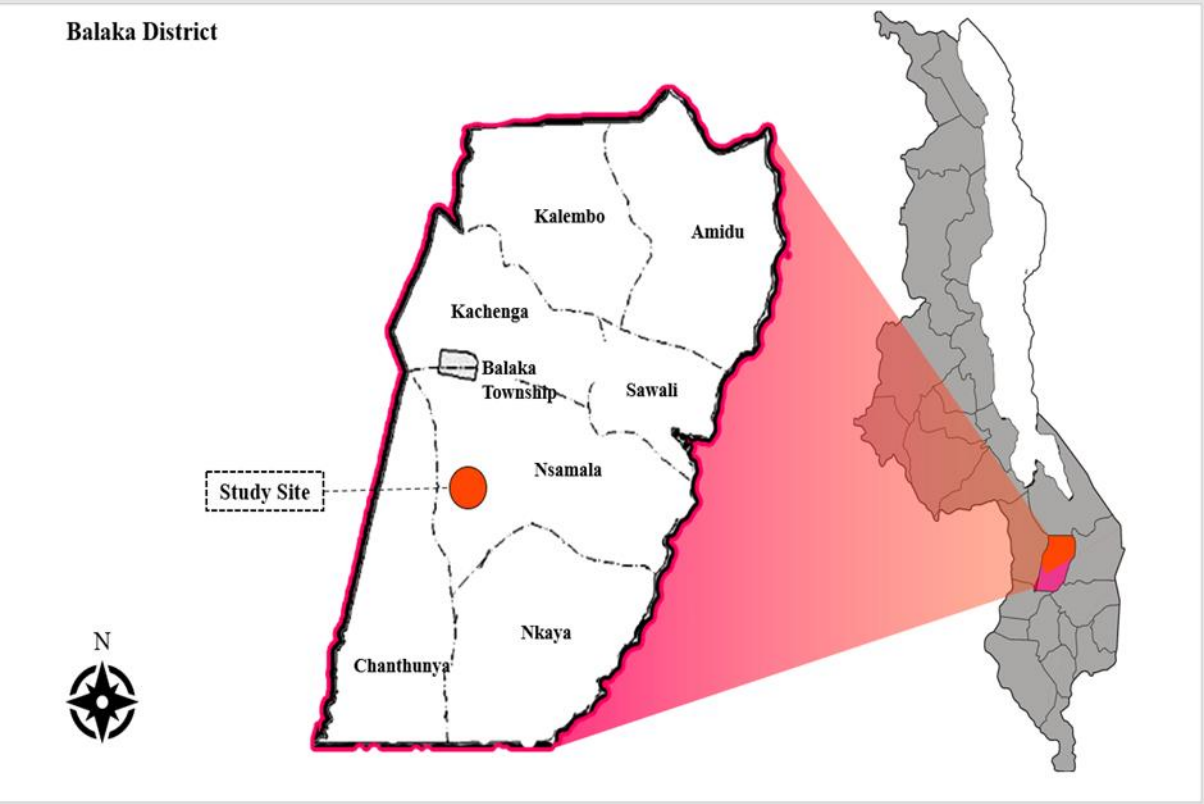


Figure 2.3 Map of Balaka district showing Balaka Township and Traditional Authorities and study site – Mbatamila village

2.1.2 Population dynamics

Malawi has a population of 17,563,749 and 84% live in rural areas (NSO, 2019). The population is expected to double by 2038 with 5 million of them being young people between 10 and 24 years (NSO, 2019; World Bank, 2019). At an average annual growth rate of 2.69% per annum, the population is estimated to grow to 23.1 million in 2030 (MoH, 2022). Unlike many of the Western countries (e.g., USA, UK and Canada), Malawi has a young population with 64% of the total population under the age of 15, 18% under the age of 5, and only 3% above 65 years. (NSO, 2019; MoH, 2022). It is predicted that Malawi will experience an average annual urban population growth rate of 4.2% from 2013 - 2030, which is expected to exert pressure on urban health care delivery system (The Malawi Labour Force Survey, 2013; MoH, 2022).

The country's economy is predominantly based on rain-fed agriculture, forestry and fishing contributing to 23.2% of GDP in 2021 (MoH, 2001). The health sector contributed 5.4% of GDP and 3.4% of annual growth of the economy in the same year (MoH, 2001; MoH, 2022). Informal employment is higher than formal employment, estimated at 89% and 11% respectively (The Malawi Labour Force Survey, 2013; MoH, 2022). The country's economy is heavily dependent on foreign development aid – for instance donor funding represented 58.6% of total health expenditures (THE) between 2015/16-2017/18 and the share declining to 55% in 2018/19 (MoH, 2019; MoH, 2022).

Poverty and inequality remain high, and the national poverty rate has slightly risen from 50.7% in 2010 to 51.5% in 2016 (World Bank, 2019). Malawi's economy is dependent on rain-fed agriculture, which is prone to climate change adversities (Ngwende et al., 2010). Despite decades of implementing poverty alleviation programmes, Malawians are characterised by poverty, vulnerability and low social progress (Ibid.). According to the Malawi Poverty Reduction Strategy Paper (2002): (Madsen et al., 2021), limited access to land, low education, poor health status, limited off-farm employment and lack of access to credit are main causes of poverty (Country, I.M.F., 2003).

2.1.3. Ethnic composition

The Malawi people are originally from the Bantu origin, and they have lots of different ethnic groups. These include Chewa, Nyanja, Yao, Tumbuka, Lomwe, Sena, Tonga, Ngoni and Nkhonde, Asians and Europeans, and their distribution is shown in Fig 2.4 below .

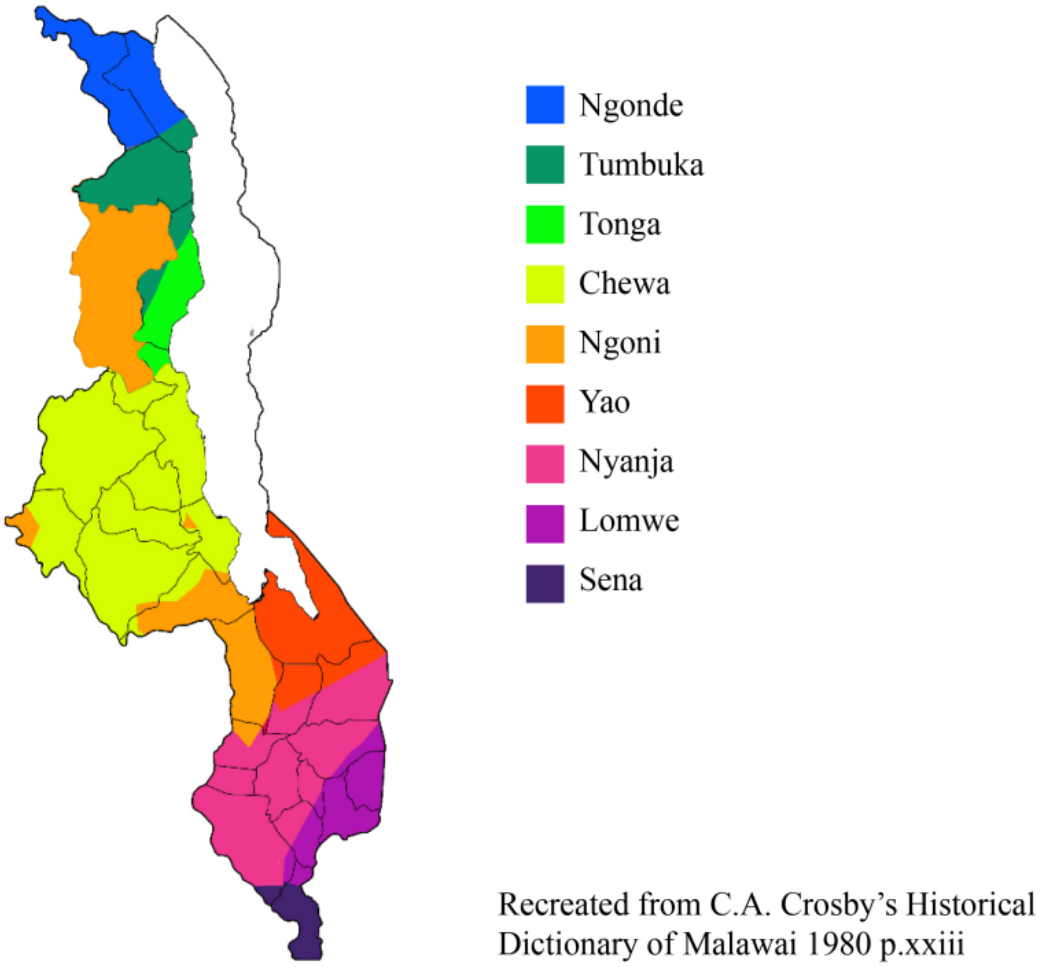


Figure 2.4 Map of Malawi showing the distribution major ethnic groups
Source: https://www.zum.de/whkmla/histatlas/southafrica/haxmalawi.html

The 2018 Population and Housing Census show that 6.0 million people (35.1%) are Chewas, 3.3 million people (18.9 %) are Lomwes; 2.3 million people (13.1%) are Yaos. Whereas 1.8 million people (12.0%) are Ngonis and 1.6 million people, (9.4 %) are Tumbukas, Senas 612,500, (3.5%) Tongas 315,000 (1.8%) and others 1,085,000 (6.2%) (NSO, 2018) (See figure 2.5).

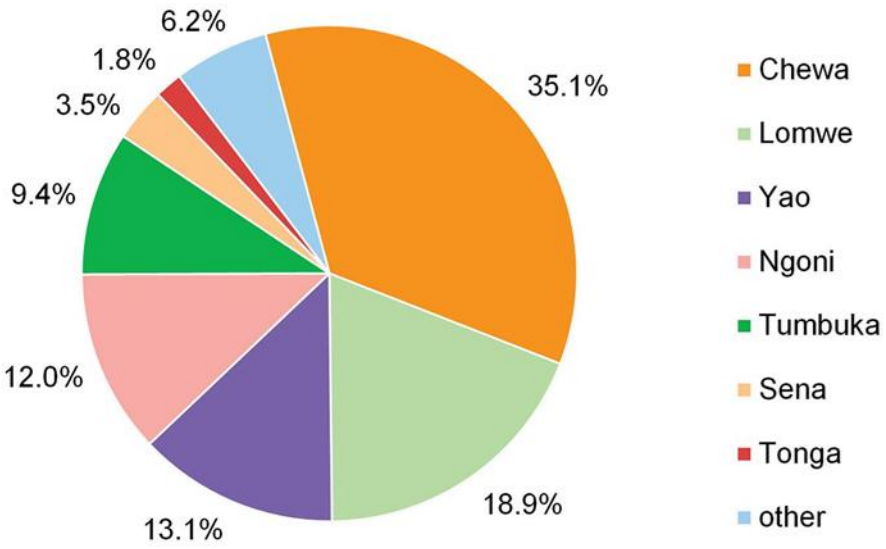


Figure 2.5 Pie chart illustrating the composition of major tribes in Malawi (2015-16)
Source: https://www.britannica.com/place/Malawi/People

Despite the diversity in ethnicity, Malawians live in harmony with many intermarriages taking place in all the three regions. However, the northern region is a patrilineal society, with the central and the south being matrilineal societies with exceptional of the Sena people. English is the official language of business, higher education and government and is widely spoken in towns and cities. Chichewa is the national language and is mainly spoken throughout the country especially in the rural areas, although, other ethnic languages are used. Malawi is home to a variety of cultural practices with some being specific to certain ethnic groups while others cut across the country. Each tribe has its own culture in terms of dress, dance and language (Juwayeyi, 2020). However, a number of changes have taken place in the nature and structure of each tribe's culture and its manifestation due to the influence of the missionaries, colonialism, the interaction with surrounding cultures and languages, Western education, the politics of nation building, and national language and cultural policies (Mtenje & Soko, 1998).

2.1.4. Education

In Malawi, education is at four levels: pre-school, primary, secondary and tertiary (The Ministry of Development Planning and Cooperation (MoDPC), 2010; Sichone, 2019). The 2015-2016 Malawi Demographic and Health Survey found that 86% of females and 92% of males aged 6 and over have ever attended school (NSO & ICF, 2017). While 67% of women had some primary education only 5% had completed primary education. Similarly, among men, 65% had some primary education, and 6% had completed the primary education (Ibid.). The NSO &1CF add, only 5% of females and 9% of males have completed secondary school or gone beyond secondary school. Fourteen percent of females and 8% of males have never attended school the NSO & ICF (2017) claims. This was important information for how and where information on sexual health can be delivered and understood. The project was designed to include women and girls who had few literacy skills and who learnt about sexual health through traditional practices and word of mouth information.

It was important also to note that the median number of years of schooling for both men and women is higher in urban areas than in rural areas with 6.7 years versus 2.7 years among women and 7.6 versus 3.4 years among men (Ibid.). This is even lower in Southern rural areas where the study took place. Primary schools offer courses in science, Social studies and Life skills education, as an introduction to issues related to sexual and reproductive health, including preventing pregnancy, HIV infection and other STIs. The majority of primary schools are under-resourced, creating an extremely challenging environment for teaching and learning. In some schools lessons are offered under a tree, a situation that impedes the delivery of sexual and reproductive health courses (The Ministry of Finance, Economic Planning and Development (MoFEPD), 2020; Sichone, 2019; Munthali et al., 2004).

In Malawi, adolescents in rural areas face more challenges as compared to their counterparts in urban areas. For example, over-age enrolment is high in rural than in urban areas. Half of the Standard 1 enrolment is over eight years of age, and therefore they receive the life skills education course later in adolescence (Ravishankar et al., 2016; Munthali et al., 2004). The percentage of household populations with no education is higher in rural areas than urban areas (16% versus 5% for females and 3% versus 9% for males) (NSO, 2019). In addition, there are often long distances to school and lack of adequate sanitation facilities are common in the rural areas, which have an impact on girls' attendance rates, particularly when the girls have attained puberty, which results in absenteeism, mainly when they are menstruating (Miiro et al. 2018). Literacy (those who can read and write) is higher among men (83%) than women (72%) but with significant strides to narrow down the gender disparities in education (NSO, 2018; MoH, 2022).

2.1.5. A brief history of Colonisation, influence of religion and Malawi Independence

European involvement in Malawi began in the years between 1875 and 1876 with the arrival of the Scottish church missionary, Dr. David Livingstone in the late 1850s. It was his reports which alerted other British missionaries and later British administrators to colonise the country (Banda, 2019). The first British envoy was stationed in the country in 1883. By 1891, a series of treaties that had been negotiated with indigenous leaders and this led to a formal declaration of Malawi as a British protectorate in 1893 (Melvin, 2009). In 1953 it became the Federation of Northern Rhodesia (Zambia) and Southern Rhodesia (Zimbabwe) and Nyasaland (Malawi). However, the natives were unhappy with the loss of political and economic power, and this contributed to rise of wide-ranging insurgencies or rebellions

against the British rule (Banda, 2019). This was mainly due to the colonial policies of land alienation; high rates of taxation; and the elements of forced labour.

Malawians gained independence in 1964 and Dr. Hastings Kamuzu Banda became the first president. After the constitutional amendment in 1970, Dr. Banda became the life president in 1971 (Lambert, 2019). He continued to rule Malawi until 1993, and in 1994 there was a referendum and people chose a multiparty system of government (Semu, 2002), and Bakili Muluzi become the first democratically elected president (Lambert, 2019). During Dr. Banda's rule all opposition was crushed and administratively all structures were centralized (Ibid.).

Although, stability was noticeable, it was done at the expense of individual freedoms (Ngwende et al., 2010). Freedom of expression, speech and assembly were systematically removed under the ultra-observance of the ruling party's four corner stones of loyalty, obedience, unity and discipline (Ibid). The autocratic government used violence and repression to reinforce loyalty, obedience, unity and discipline, and to prevent any form of self-organisation. There were many unlawful detentions, and this led to public outcry and the Western countries suspended aid due to the autocratic leadership style (Ibid.). The Catholic church also commented on the ills of the one-party system of government, such as increasing inequality between the rich and the poor, lack of respect for human rights and justice by the state, through its famous pastoral letter, titled "Living our faith" (Chinguwo, 2019). This led to the arrest of seven Catholic Bishops and deportation of an Irish Priest who was suspected of being the mastermind of the letter. Then university students took to the streets in support of the Catholic Bishops. International organisations also condemned the arrest of the bishops (Ibid.).

He continued to rule Malawi until 1993, when he was forced to hold a referendum. People opted for multiparty system of government ending Kamuzu Banda's 30-year-old rule (Semu, 2002). The first multiparty elections took place in 1994 and Bakili Muluzi won the elections becoming the first democratically elected president (Lambert, 2019). In keeping with the new constitution, which recognised human rights, the president freed all political prisoners and closed three prisons where torture used to take place. Thus, the study participants (grandmothers, mothers, young women, traditional and religious counsellors) grew up during the three systems of government.

Christianity was first introduced to Malawi (then Nyasaland) by the Jesuit missionaries (Catholics) from Portugal who visited the territory near Lake Nyasa in the seventeenth century and the word *'Nyasa'* means Lake in Yao language. David Livingstone a Presbyterian and other missionaries came in the late 1800's. However, their influence is still present today, with 85% of the population being Christians, 13.8 % Muslims and only 1.2 % who follow traditional indigenous religions. According to the 2018 Population and Housing Census, the Catholic and Presbyterian churches are dominant (NSO, 2018). My adoption of the extended periods of time, drawing conclusions from historical trends and patterns complements the medium and short-term events. It also helps to show the relevance of a historical inquiry in explaining the processes and challenges that societies go through, many of which have answers or antecedents set in the past, sometimes over decades or hundreds of years. For instance, the influence of colonisation and early Christianity is still felt today.

With the coming of Christianity to sub-Saharan Africa, people's indigenous way of life has changed. A study by Hokkanen (2007 p. 737) in the northern part of Malawi revealed how the Livingstonia mission had impacted on the tribes' cultural practices by approving a

proposal of its Moderator that a committee should be formed to discuss the 'use and practice of charms and superstitions by the early Christians'. As Hawley (2013) writes in some areas Christianity challenged African's way of life claiming that the worshipping of the ancestors was primitive. Contrary to the missionaries' claim that, their main concern was to protect the indigenous people's interests, many came to Africa to advance the interests and culture of their colonial masters and saw little of value in African culture (Mokhoathi, 2017) with some African practices being demonised as pagan (Manala, 2013). Manala highlights that because of the church's pervasive influence on family practices, it led to a serious identity crisis for many Africans.

2.1.6. Culture, traditions, and gender roles

Christianity impacted on gender relations and women's leadership roles (Miles, 2009). Missionaries encouraged a model of the family in which women's roles were to be a financially dependent housekeeping wife and mother, whereas men were to be the 'bread winners'. As a result of this socialisation women could not take part in leadership roles (Ibid.). This was in direct contrast to the pre-colonial era where women were revered as custodians of traditional values and beliefs. For instance, in Malawi, among the Chewa culture, women were the ones who are entrusted with the responsibility of choosing a chief/ king.

Traditionally, the women elders were given the responsibility for teaching young boys and girls about cultural assumptions, expectations, roles and practices regarding sexual behaviour (Limaye et al., 2013). Grandparents and traditional healers have been involved too in sex education and behaviour, passing information down orally to younger generations (Ibid.). In

addition, the women elders were tasked with passing on traditions related to general development, care and wellbeing of women and children, as well as advice regarding sex and sexuality orally to the younger generations (Limaye et al., 2013). Young girls and women are encouraged to seek sexual advice from these elders (Ibid.). Sex education and advice were and are given during initiation rites, through songs, dances and performing rituals.

Even though the specifics of the rituals vary from place to place, the process is somewhat similar; upon her first menses, a girl informs either her aunt or grandmother and then she is taken away for the entire period of her menstrual period to be counselled. While there she is informed about community-held attitudes and beliefs in relation to sexuality and appropriate sexual behaviour for transitioning to adulthood (Limaye et al., 2013). Initiation rites are performed at different stages of the girl's life, one before puberty, at puberty and the last with first pregnancy. During pregnancy she is taught about labour and delivery, which includes signs of labour, what to do when she goes into labour and how to care for the baby and herself.

Whilst these initiation ceremonies are meant to groom young people to be responsible sexual beings, Munthali et al. (2004) observed that, sometimes they could achieve the opposite, with young boys and girls engaging into premature sexual relationships as they may feel that the initiation ceremonies mark their transition to adulthood. This is contrary to the church and cultural expectations which value virginity and condemn premarital childbearing. Munthali et al. state that the traditional socialisation process also reinforced the dominance of men and boys and the subordination of women in sexual relationships, thus weakening women's autonomy to negotiate for sexual health rights (2004). The traditional socialisation system's role in adolescent sexuality and reproductive health is changing and likely declining because

of the increased influence of religion, education, exposure to media and other sources of information on SRH issues.

In modern times (21st century), women are still respected, such that in sub-Saharan Africa, including Malawi, women are considered the custodians of traditional norms and values. For instance, as part of the initiation rites of girls and boys, grandparents and aunts provide guidance on how to prevent unintended pregnancies and sexually transmitted infections (STIs) including HIV/AIDS (Wamoyi et al., 2010a; Limaye et al., 2015). However, their roles and responsibility have changed slightly through being asked to abandon some of the rituals, deemed to be incongruent with church doctrines, and for the counselling on sexual matters to take place at the church premises to ensure conformity to church doctrines. For example, the Catholic Church in Balaka invites girls after puberty to the church for counselling by a group of women who have been trained by the church. In this way the church prescribes what is taught to the girls at puberty and prior to their wedding (Kaufa & Buleya, 2015). This was seen as undermining the indigenous knowledge systems.

It is argued that a society without a culture is like a tree without roots and Malawi is governed by a culture whose values, beliefs and customs have a powerful influence on people's collectiveness and social life (Malawi Human Rights Commission (MHRC), 2006). Thompson (2017) defines culture as the norms, values, customs, traditions, habits, skills, knowledge and beliefs, as well as the general way of life of a group or society. However, some cultural practices could be obstacles to development and the fulfilment of human rights in general, especially for women and a girl child. For instance, the practice of *'kupimbila'* which is practiced in the northern part of Malawi (Karonga and Chitipa districts) and by which girls as young as 9 years are given in marriage to wealthy old men as payment for their

parents' debts (MHRC, 2006; Banda & Kunkeyani, 2015). Another example among the Chewa ethnic group is the practice of *'fisi'* in which a male adult is asked to have sexual intercourse with newly initiated girls to prepare them for married life (MHRC, 2006). Moreover, no protection (e.g. condoms) are used during *fisi* thereby predisposing these girls to teenage pregnancies, STIs, HIV/AIDS, emotional and psychological trauma as well as childbirth complications (UNICEF, 2001). For parents in sub-Saharan Africa, Malawi inclusive, these traditions could have been used for economic gain, as the bride's family receive cattle from the groom, or the groom's family, as the bride price for their daughter and in the case of *'kupimbila'* it's a debt relief (MHRC, 2006; UNICEF, 2001).

Whilst male literacy rates are higher than females, the 2015-16 Malawi Demographic and Health Survey has demonstrated increased women empowerment over time by various attributes. For instance, the percentage of women involved in decisions about their health care increased from 55% in 2010 to 68% in 2015-16 and women's involvement in decisions about major household purchases increased from 30% - 55% over the same period (NSO & ICF, 2017; MoH, 2022). Women's empowerment in making decisions about their future health was important in this project, suggesting that the new knowledge and skills acquired from the project would be taken into consideration on issues related to sexual and reproductive health. However, these cultural practices infringe on the girls' rights to education and economic empowerment, as they are forced to drop out of school, and in case of divorce or death of the older men they married, these girls are trapped in the poverty cycle (MHRC, 2006; UNICEF, 2001). With the influence of Western education, religion and modernity some of these cultural practices are being re-patterned and others are being abandoned. However, they remain very common in the rural areas, and where this study was conducted.

At an international level, Malawi is a signatory to the major international human rights treaties such as the Convention on the Elimination of all forms of Discrimination against Women and the Convention on the Rights of the Child (Ngwende et al., 2010). Within the continent of Africa, Malawi has ratified the Africa Charter on Human and Peoples' Rights and the Southern African Development Community (SADC) Gender and Development Protocol, which among other things strives to enhance the empowerment of women and eliminate discrimination (Ngwende et al., 2010). The SADC Gender and Development Protocol also strives to achieve gender equality and equity through the development and implementation of gender responsive legislation, policies, programmes and projects at sub-regional level (Ibid.). At the national level, Malawi has incorporated economic, social and cultural rights, as the right to development within its Constitution (Article 30.2) (Malawi Government, 1994). Furthermore, the Constitution affirms the State's obligation to eliminate social injustices and inequality and to "justify its policies in agreement with this responsibility" (Article 30.3) (Ngwende et al., 2010; Malawi Government, 1994).

In 1994, the Malawi government sanctioned a "National Plan of Action in the Field of Human Rights" which led to the establishment of the Malawi's Human Rights Commission through the 1998 Act of Parliament (Ngwende et al., 2010). However, a qualitative study by the MHRC (2006), Banda and Kunkeyani (2015) revealed that some of the cultural practices impact negatively on the enjoyment of human rights in general and the rights of woman and a girl child as is the case with *'kupimbila'* and *'fisi'* and *'mbirika'* (a cultural practice in the northern part of Malawi involving replacement of a deceased wife, which contributes to teenage pregnancies (NYCoM, 2009) which only apply to young women.

An overview of these cultural practices seem to have given privileges for males to be sexually active, to take control of sexual relationships and to be less responsible in preventing negative SRH outcomes, whereas girls and women are made to be subordinates, thus promoting gender inequality (MHRC, 2006; Munthali et al., 2004). Another cultural practice which also has an impact on SRH of young people is *'chokolo'* which means wife inheritance (MHRC, 2006; Banda & Kunkeyani, 2015) and it's practiced in the northern region among the Ngonis. The widow is made to marry her husband's brother, with an understanding that he looks after his brother's wife and children, regardless of whether the woman is economically independent, or not, or in agreement or not (MHRC, 2006).

The widowed women who are educated and economically independent can find a way of escaping from such cultural practices although, it can be challenging to convince the elders of the clan for her to be excused from the cultural practice. An example of this comes from my recent experience of this practice; a friend of mine's mother was a university lecturer and when his father died, his mother was forced to get married to his uncle, a younger brother to his father. Another traditional practice, in the southern part of Malawi common among the Senas, is called *'kupita kufa'* whereby a woman is made to have sex with another man a week after her husband's death, to put the husband's spirit at rest (MHRC, 2006; Banda & Kunkeyani, 2015). Condoms are not allowed, as the spirits may not be pleased. This ritual does not apply to the man if his wife dies. These particular cultural and sexual practices illustrate the rooted gender roles and power imbalance in these communities.

There are some cultural practices that protect women's rights, for instance *'chikamwini'* (a practice whereby a man takes residence at the woman's home) among the matriarchal societies (south and central Malawi) and in case of divorce, the woman gets the property and

the children. However, at household level, women's roles are confined to home and childcare care, with no control over household income, which could be attributed to the socio-historical context of sex and relationship education, which emphasises the traditional gender roles of men and women (Semu, 2002; Anderson, 2009). In sub-Saharan Africa, men are considered to be the breadwinners of the family and women as home keepers, who spend most of the time looking after the children and households (Sah, 2017; Anderson, 2009; Semu, 2002). This trend is changing, as women are also seeking both formal and informal employment. However culturally and religiously the man remains a breadwinner. Even though both men and women may be involved in maize and vegetables planting and harvesting if none of them has no formal or informal employment.

2.1.7. The Yao tribe

The research participants are of the Yao tribe, who migrated to Malawi from the area between Lujenda and Luchelingo rivers, in northern Mozambique in the 1830s and 1840s (Phiri, 1984; Northrup, 1986; Elie, 2019; Mbalaka, 2016). The Yao are predominantly Muslim people and are spread over three countries, southern end of Lake Malawi, northern Mozambique, Ruvuma and Mtwara region of Tanzania (Phiri, 1984; Elie, 2019; Mbalaka, 2016). They have a strong cultural identity, which transcends the national borders (Elie, 2019). The Yao people rich in culture, tradition and music, speak a Bantu language known as Chiyao (Northrup, 1986; Elie, 2019; Mbalaka, 2016). They also speak the official languages of the countries they inhabit, e.g., Swahili in Tanzania, Chichewa and Chitumbuka in Malawi. They are predominantly subsistence farmers, fishermen and active traders, only very few of them possess livestock of any sort with the exception of a few goats or chickens (Northrup, 1986).

The word "Yao" simply means those who come from the hills (Northrup, 1986; Elie, 2019). The Yao came to Malawi in small groups and established chieftaincies. The research participants are under the authority of Nsamala who came from the Machinga group. According to Elie (2019) there is no central authority or institution of kingship in the Yao society, and that for two centuries political organisation has been structured around a series of chiefs and subordinate village headmen. In the colonial and postcolonial eras, the appointment of chiefs and headmen usually had to be ratified by the central government. However, the chief exercised considerable ritual powers in connection with the rain-prayers, which took place both before and after the rains (Alpers, 1969).

Houses are generally build along a road or a path, and nearly all the villages have a mosque. Houses are usually built of poles and wet soil and are rectangular in shape. Most houses are thatched, while mosques may have an iron roof and a variety of architectural ornaments. Village dwellings tend to be clustered into little groups surrounded by fruit trees—mango, papaya, and banana—with gardens of maize, cassava, rice, or sugarcane farther afield (Elie, 2019). Many villagers who live near lake Malawi depend on fishing to supplement their diets and incomes. Those who have gardens and fields close to the lake are able to grow rice as well as maize and cassava, but very few people grow enough of the staple crops to feed themselves for the whole year and have to purchase extra grain. In the colonial era the Yao men were favoured as soldiers, servants, cooks and tailors. They are well known throughout southern Africa as tireless travellers in search of work in the mines or in industry or commerce. Those who live by the lake are accomplished canoe builders and fishermen. They are skilled at weaving mats used for drying fish, making earthenware pots and sewing (Elie, 2019). Women are responsible for the maintenance and running of the household, such as fetching water and wood, cleaning and cooking (Ibid.).

The Yao people are a matrilineal society and when a man marries, he leaves his village to live in his wife's village (Mbalaka, 2016). Marriage is generally matrilocal and is transacted without the exchange of significant bride-wealth or a large dowry. Divorce is common and is not difficult to accomplish (Elie, 2019; Mbalaka, 2016). Property and titles usually pass from men to their sisters' sons or in some instances from older to younger brothers (Elie, 2019). Like other Africans the Yaos have a deep-rooted religious sense of the existence of God the Creator and that of a spiritual world. To them, religion is just not a set of beliefs but a way of life, the basis of culture, identity and ''moral values'' (Mbalaka, 2016; Olausson, 2001p.70). Thus, ancestors continue to be venerated and the name of the founding ancestress of a lineage is remembered and referred to by a term meaning *"the trunk of a tree"* (Olausson, 2001; Elie, 2019 p.14). The Yao are often distinguished from other groups in the region by their conversion to Islam. However, this did not occur until the end of the nineteenth century, and there is still a considerable residue of pre-Islamic beliefs and practices among many Yao.

Traditionally the Yao people believe in the forces of good and evil which can be manipulated through prayers and sacrifice as well as in the efficacy of talismans and charms to ward off evil (Olausson, 2001). They also believe in witches and spirits and like the Lomwe people, believe in spirit possession and that sometimes the ancestral spirits possess a person as punishment or as a means of warning the community of immediate catastrophes for their disobedience. The spirit possession is locally known as *mutu waukulu, majini*. It was also necessary to carry special charms to protect themselves when going on a caravan [a journey] (Alpers, 1969).

There has been a significant influence of Sufism on the practice of Islam among the Yao, and there appears to be a large degree of convergence between traditional Yao and Sufi practices.

The Islam of the Yao is regarded as flexible and tolerant of local beliefs and customs. Yao Muslims have several categories of religious leadership. The most senior leaders are referred to as sheikhs and are often members of a Sufi order. There are also teachers and lower-order Muslim practitioners called *mwalimu* (from the Swahili word for teacher). There are ritual specialists known as *amichila* who are appointed by a chief to officiate at initiation rituals for boys.

Islam and the rites of passage: Unlike the other tribes, the majority of the Yao people converted to Islam (Mbalaka, 2016), and it is credited for not interfering with the traditional beliefs and customs of the people wherever it to spread to. If anything, it simply modified, or made slight changes while preserving the vital indigenous elements of the customs (Msiska, 1995). For instance, the initiations ceremonies for boys, girls and young women have for many years incorporated elements of Islamic practice and symbolism and were not disapproved of by even very devout Muslims until the emergence of reformist movements toward the end of the twentieth century. Most of the significant Muslim festivals are observed by the Yao, and the performance of *dhikr* (or *sikiri*, as the Yao refer to it) is often a feature of ceremonies (Elie, 2019). This central ritual of Sufi Muslims around the world has become the core of Muslim practice in the region, and it remains the key component of Islamic ritual for many of the Yao (Ibid.). However, much of the indigenous knowledge has been preserved and the initiation rites have been Islamised rather than replaced (Stannus and Davey, 1913). The rituals for girls (*nsondo, ndakula and litiwo)* conducted in Mbatamila village (study area) are discussed in full as part of the study findings in Chapter 4. Here I provide, some details on the boys' initiation ceremony – *jando* to provide some insights on the Yao rituals and traditions.

The Jando ceremony: The word *Jando* has two meanings. The first one means, male circumcision and it signifies the transition of Yao boys into adulthood (Msiska, 1995; Banda & Kunkeyani, 2015). The second one refers to a place where circumcised boys stay during their convalescent period and is also called *''ndagala''*. The boys stayed at the *ndagala* for not less than three months. This was done to give time for the circumcision wounds to heal properly and for the initiates to receive *jando* instruction. These days the ceremony takes place during the summer holiday, due to government and mission education policies (Msiska, 1995; Banda & Kunkeyani, 2015).

Each boy in the company of *nkamusi,* or " guardian," an elder brother, an uncle or a friend who volunteers for the service, would meet at the *bwalo* (an open space), where all ceremonies and dances took place, of the chief's village. In the evening, they would all leave the village for the place in the bush called *ndagala,* under the leadership of *Angaliba* and his vice called *Chitonombe* accompanied by the operating medicine-man, *m'michira* and their guardians (Stannus & Davey, 1913). During their stay at *ndagala* the *wali* (initiates) were housed in long grass sheds.

The mothers of the *wali,* who bring food each day, called from a distance "*Alombwe*, then they came to collect the food. Throughout this period rigorous discipline was maintained; the day commenced with bathing and the *wali* were woken up before sunrise. Time was also spent in receiving instruction in the arts, such as the making of baskets, mats and traps as well as being taught native custom appropriate to married life, relations, fellows and an exacting code of etiquette to be observed to their elders. They were also advised not to have sex with a woman in her monthly periods or when she has just given birth or aborted (MHRC, 2006).

Ndagala was also associated with total secrecy and should any of the *wali* die, no one was informed until the end of the ceremonies.

Health: Illnesses in Yao culture are believed to originate through physical reasons, curses or by breaking cultural taboos. In such situations where illness is believed to come from the latter two sources (folk illnesses), government health centres will rarely be consulted. Some folk illnesses known to the Yao include *undubidwa* (an illness affecting breastfeeding children due to jealousy from a sibling) and various *"ndaka"* illnesses that stem from contact that is made between those who are not sexually active with those who are (cold and hot) (Elie, 2019).

The Yao are famous as healers. Most villagers have a large body of knowledge of local medicinal herbs and healers travel far and wide to gather potent plants and ingredients. There are practitioners who make use of the Islamic scriptures in various ways for divination or healing. They believe that they will join their ancestors after death. Many also believe that they will be raised and judged on the last day as prescribed by Islamic doctrine. There seems to be little sense of contradiction between these two notions of the afterlife, which are held simultaneously by most Yao Muslims.

2.2. Sexual and reproductive health in Malawi.

This section presents information about the country's health status so as to provide the context under which the health sector responds to SRH issues mainly among young people, and the challenges the young people encounter as they seek SRH information and services.

2.2.1. Sexual and reproductive health challenges

Young people in Malawi experience some challenges in accessing youth-friendly health services. These barriers include long distances to health facilities, long waiting and inconvenient opening times, poor attitudes of health workers towards youth, lack of privacy and confidentiality, and lack of participation in developmental programmes (Stakeholder, 2015: Muheriwa Matemba, 2021). Many young people are not empowered to make appropriate decisions over their sexuality due to poor education, limited access to information and resources, culture and low socioeconomic status (Muheriwa Matemba, 2021). Also, gender-based sexual violence, common among younger teens contributes significantly to school drop-out rates, leaving them vulnerable to child marriage, early childbearing, HIV infection and other STIs that threaten their mental health and development (Munthali et al., 2006; Malawi Ministry of Health, 2015; Muheriwa Matemba, 2021).

2.2.2. SRH care delivery systems

The Malawi government offers health care at three levels: primary, secondary and tertiary. At the primary level health care is offered in rural hospitals, health centres, health posts, outreach clinics and via community health initiatives. The second level of health care services supports the activities at the primary level and this level of care is offered in district hospitals and hospitals under the Christian Health Association of Malawi (CHAM). The tertiary level of care offers specialized health care services in Central hospitals, found in the main cities of Malawi (Mzuzu, Lilongwe, Zomba and Blantyre). The Ministry of Health (MoH) coordinates all health initiatives, including SRH services through the Reproductive Health Unit (RHU) whose aim is to provide accessible, affordable, convenient and comprehensive SRH services to all women, men and the youth to enable them attain their SRH goals (Jimmy-Gama, 2009).

Adolescent SRH services are offered in clinics or under school health programmes by Community Health Nurses. The Government recognises that improving SRH services of young people is key to the economic development of the country. As such SRH services are provided free of charge in all government facilities with the intention of reducing negative SRH outcomes among young people. However, due to the shortage of nursing staff in most hospitals these services are not available particularly in rural areas (Roberts et al., 2016). The country continues to face many SRH challenges, such as high maternal morbidity and mortality rate plus high fertility rate. One of the contributing factors to the high fertility rate in Malawi is reported to be early marriages and limited use of modern family planning methods (NYCoM, 2009). The NYCoM reports that about 50% of girls in Malawi are married before the age of 18 and over 35% of all pregnancies are teenage pregnancies.

Likewise, maternal mortality rate is currently at 574/100,000 live births (NSO, 2016), with abortion accounting for 9.6% of all maternal deaths in Malawi (MoH, 2022). This means that adolescent girls are at a higher risk of childbirth complications and an increased number of children which also puts them at increased risk of maternal death (NYCoM, 2009). Malawi has restrictive abortion laws, resulting in many women and young women seeking unsafe means of terminating a pregnancy, thereby contributing to high maternal mortality rate (Levandowski et al., 2012). A qualitative study in Malawi by Levandowski et al. with 485 participants drawn from different political and social structures demonstrates that stigma also leads women to access unsafe abortion as it is perceived to be more secretive, as such it allows her to maintain confidentiality around the experience. For rural women like the ones in this in study, due to the close-knit culture, the stigma could be more pronounced.

2.2.3. Medical pluralism in Malawi.

Several healthcare approaches have been used in many in low- and medium-income countries (LMICs) to promote young people' SRH (WHO 1978; WHO 2006; Jimmy-Gama 2009) including those based on traditional indigenous approaches, Western bio-medical approaches and empowerment-based health promotion strategies. Traditional health care approaches in LMICs date back to the pre-colonial era (Jimmy-Gama, 2009). It has been an important element for SRH delivery to young people and of its use is widespread in African countries (Zachariah et al., 2002; Campbell & MacPhail 2002; Sebit et al., 2000). In some African countries, up to 70% of the general population use traditional medicine (Joint United Nations Programme on HIV/AIDS (UNAIDS) 2002b; Zachariah et al., 2002; Jimmy-Gama, 2009). As Jimmy-Gama suggests people in LMICs use traditional health system as a primary source of health care, and in some cases, they will use Western health care if the traditional care is perceived to be ineffective. Abdullahi (2011), Setswe (1999) and Richter (2003) suggests that this is because in indigenous African communities, traditional doctors are known for treating patients holistically, whereas Western medicine concentrates on patient's diseases.

James et al. (2018) observed that use of traditional medicine was more common among individuals with a lower socio-economic status, unemployed and unskilled. Setswe (1999) and Gyasi et al. (2011) also observe that the traditional healers live within the communities, which reduces transport costs and that their fees are flexible, thereby making the services user friendly to people of lower socio-economic status. A survey by Oyebode et al. (2016) in China, Ghana and India found that income level, education and geography were associated with use of traditional medicine, with the poorer, less educated and rural participants relying more on traditional medicine as opposed to those urban dwellers, with higher income and

educated. A systematic review by James et al. (2018) found that there is a relatively high use of traditional medicine, either alone or in combination with Western conventional medicine, among the general population for conditions such as malaria, diarrhoea and eye disease, and also typhoid fever and broken bones, HIV/AIDS and mental illness (Gyasi et al., 2011). The systematic review also revealed that traditional medicine is used to treat SRH conditions such as STIs, to induce abortion and during childbirth (Ibid.).

Setswe (1999) claims that, people continue to seek treatment from traditional medicine despite free services being available at government health facilities. This could be due to the value people attach to traditional medicine. As Roberts et al. (2017) claim an individual's culture shapes who they are, how they see the world, think and act. Perhaps, this could also apply to the middle class educated elite who seek help from traditional healers. For instance, a friend of mine who is a nurse/midwife sought help from a traditional birth attendant/ healer with positive results after multiple miscarriages and failed attempts with Shirodkar sutures. Traditional health care includes a range of treatments including administration of herbs, praying to their ancestors or simply giving advice and health education. Despite their diversity, Abdullahi (2011) and the Science Museum (2019) highlighted that African traditional medicine has common characteristics which are different from those of bio-medicine. As such spiritual and physical aspects of the body are equally significant to health, and causes of illness include spirit-world intervention, or family or community conflict (Mokgobi, 2014).

A study by Harries et al. (2002) in Malawi revealed that traditional healers learnt their trade through the medium of a spirit and others were taught by parents or relatives. With colonisation, indigenous knowledge was labelled as primitive and lacking scientific basis

(Tuhiwai-Smith, 2012). As such, people were forced to stop certain practices and abandon certain beliefs to embrace Christianity. Mokgobi (2014) observes that contrary to the intentions of colonial authorities, the forced conversion and Westernisation, Africans did not completely abandon the traditional African health care system and African religious beliefs. Instead, they continued to practice both concurrently, utilising the services of both traditional and Western health care systems (Mokgobi, 2014; Moshabela et al., 2017; Ribera, 2007).

However, this was not recognised by early missionaries who wanted Western medicine to be central among the African Christians as observed by Hokkanen (2007) in a micro-level case study which analysed issues of health, healing and medicine among the early Presbyterian Church in the Northern Malawi. The study revealed that missionary attitudes towards African healing were generally dismissive. However, it was observed that topics of illness and health were open to contestation and that in both theory and practice, the African Christian elite negotiated an acceptance of medical pluralism among the Presbyterian Christian communities of Northern Malawi. At times there was tension between the two ways of healing illnesses and diseases, as observed by Hokkanen's study where an African Christian elite was suspended from the church for using traditional herbs.

Concurrent use of both approaches can also contribute to treatment delays. For example, in a multi-country exploratory qualitative study in seven eastern and southern African countries: Uganda, Kenya, Tanzania, Malawi, Zimbabwe and South Africa, among people living with HIV/AIDS (PLHIV), medical pluralism among PLHIV was observed to contribute to bottlenecks along the HIV care cascade (Moshabela et al., 2017). The mixing of bio-medical healthcare providers and treatment with traditional and faith-based options fuelled tensions

driven by fear of drug-to-drug interactions and mistrust between providers operating in different health-worlds.

The literature on medical pluralism suggest that there is need to adopt culturally sensitive approaches, interventions and policies appropriate to the context of Malawi, while minimising potential harm and consequences of combining traditional and bio-medical approaches for SRH issues (Moshabela et al., 2017; Ribera, 2007). Medical pluralism, as Di Giacomo argues, is the rule rather than the exception, and exploring the intersections and interactions between different healing traditions and representations of illness requires researchers to examine the cultural logic that links elements in a complex process of health-seeking, rather than to dismiss traditional healing as an obstacle to effective medical care (Ribera, 2007). This was the guiding principle for this study, particularly as rural people in Malawi rely more on traditional medicine than Western medicine for their health needs, if compared to those in the urban areas. Thus, it provides evidence about the importance of traditional medicine in SRH in Malawi and noting the key role that traditional rituals play in girl's learning about SRH.

2.3. A focused review of the literature on SRH communication during adolescence

This section presents a focused review of literature related to how young women learn about SRH issues and factors that shape young people's sexual and reproductive lives, as well as their perspectives on SRH communication practices, rituals and traditions. It draws mainly upon articles from sub-Saharan African countries and other LMIC countries, as they appeared to be more relevant to the study's context although literature from other parts of world were

included where appropriate. The chapter concludes by discussing the influence of intergenerational SRH communication on young women's decision making and sexual behaviours.

2.3.1. Search Strategy

A search was conducted on Cumulative Index to Nursing and Allied Health Literature (CINAHL), PubMed/ MEDLINE, EBSCO, PsycINFO, Science Direct online databases. These databases were chosen because they cover health care interventions studies. Other databases such as SCOPUS, JSTOR and Google scholar were also included as they cover a wide range of topics. The search included both primary and secondary studies published in English language. Other inclusion and exclusion criteria were based on the time frame of studies and ages of the study population. Relevant world-wide articles with abstracts from 2000 – 2023 were selected to keep the search manageable and ensure that the studies were conducted relatively recently. Although, journals and articles from sub-Saharan Africa and LMICs were preferred as they appeared to be more relevant to the study's context. The literature was critically appraised to identify their limitations and strengths.

The SPICE framework was utilised in the search strategy, making it easier for the researcher to locate and obtain relevant studies (Hewitt-Taylor, 2017). Snowballing was also utilised by reference list tracking and handsearching related articles and journals. According to Gerrish and Lacey (2010) the SPICE framework which stands for setting, perspective, interest, comparison and evaluation assists the researcher to remain focussed during the literature search. Gerrish and Lacey (2010) also advocate for the use of Boolean operators "OR" and ''AND" to enhance the search (see figure 2.1). For statistical data, guidelines and policies I

relied on WHO, UNICEF, UNFPA and World Bank websites as well as local websites and publications such as the NSO, MoH, NYCoM and MDHS. Recommendations of reports and articles received from academics and fellow researchers / peers were also followed up.

Setting	**Perspective (key terms)**	**Interest (Key words)**	**Comparison**	**Evaluation**
Rural community based SRH services AND	Adolescents OR Adolescence OR Childhood OR Teenager OR young people OR young adult/s OR young person OR Youth/ parents/ SRH counsellors AND	SRH communication/ counselling/ practices/ rituals/ traditions/ initiation rites OR Sex education OR Sexual health OR Reproductive health OR Sexual issues OR Sexual matter OR Contraceptive use OR	None	Experiences of young people/ parents/ SRH counsellors OR Behaviour OR Perceptions OR Attitudes OR Access OR Utilisation AND

		Abortion OR Pregnancy OR STIs AND HIV/AIDS AND		

Table 2.1 SPICE Framework with key terms and words for search strategy

2.3.2. The importance of SRH communication during adolescence

Adolescence and sexual health

WHO (2002) defines SRH as ‘’a state of physical, mental and social well-being in relation to sexuality. It requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasure and safe sexual experiences, free of coercion, discrimination and violence’’ (Holman, 2014 p. 8). Dehne and Riedner (2005) describe adolescence as a critical period in which human beings, among other things, become aware of their sexuality. The emergence of sexuality during adolescence poses major challenges for young people, especially adjusting to bodily changes, learning to deal with sexual desires, confronting sexual attitudes and values, as well as experimenting with sexual behaviours (Raffaelli & Crockett, 2003; Mkumbo, 2008; Greydanus & Omar, 2014). A major challenge for parents at this time is the promotion of SRH to their children.

Even though sexuality is a normal and healthy part of adolescent development (Dehne & Riedner, 2005; Mkumbo, 2008), sexual risk taking, and permissive sexual attitudes are a major concern for parents, school leaders and health care professionals. Sexual risk taking is generally defined as early sexual debut, unprotected sexual intercourse, having multiple sexual partners, or engaging in sexual behaviour under the influence of alcohol or drugs (Downing-Matibag & Geisinger, 2009; Guilamo-Romos et al., 2008). A permissive sexual attitude is often described as being more tolerant towards premarital sex, casual sex and multiple partners (Schmitt & Jonason, 2015; Holman, 2014). Decreasing the number of teenage pregnancies and STIs and increasing the number of young women, who remain sexually abstinent are major health goals for many parents, school leaders and health professionals (MoH, 2022).

Previous researchers have argued that sexual attitudes often guide individuals' sexual behaviours, evaluations of sexual expressions, activities and relationships (Guerra et al., 2012; Holman, 2014). Because the present study is interested in young women - many who may not be in an intimate relationship it is important to assess both sexual behaviour and attitudes towards sexual behaviour to best capture young women experiences and perspectives surrounding sex. The need to address young women's SRH is further emphasized by the recent national demographic health survey in Malawi which although showed improvement in early childbearing among adolescent girls 15-19 years old (from 35% in 1992 to 26% in 2010) still remained very high at 44% among the lowest wealth quantile in 2015-16 (NSO & ICF, 2017). Early initiation of sexual activity also makes up one-third of new HIV infections among youth ages 15-17, of which 70% are girls and nearly 14% of other STIs among adolescent girls aged 15-19 (UNAIDS, 2016; NSO & ICF, 2017).

Despite the decline in the adolescent birth rate for women aged 15-19 years in the past ten years, there is still approximately at 173,000/1000 live births in Balaka, which is higher than the whole southern region at 162,000/ 1000 and the national level of 143, 000/1000 (NSO & ICF, 2017). Balaka's adolescent pregnancy rate remains one of the highest in the country (Ibid.) and early childbearing (Percentage of women aged 20-24 years who had at least one live birth before age 18) was at 37.0% higher than national level which is at 31.1% (Ibid.). It was also noted that about 38.1% percent of the women in Balaka were not using any contraceptive method (Ibid.). The risk does not end with pregnancy. Among adolescents who are sexually active in the Southern region 14.5 % of them have HIV infection, which is twice as high as that in the Northern and Central regions (Ibid.). A recent study by Jimu et al. (2023) using the 2015/16 MDHS to investigate the prevalence and the determinants of male and female condom use for the prevention of STIs and unplanned pregnancies among the youth (15- 24 years) in Malawi, found that 27.1 % of the youth did not use condoms in their last sexual intercourse. Jimu et al. continued to call for the need to scale up programmes and policies that target the youth to practice safer sex, which would assist in addressing the challenges of STIs, including HIV and preventing unplanned pregnancies.

Young people, compared to other age groups who are sexually active, have the highest rate of STIs including HIV infection (Dehne & Riedner, 2005). A study by Mandiwa et al. (2021) involving 10, 422 young people (15-24) found that comprehensive HIV/AIDS knowledge among adolescent girls and young women was low. Around 28% of the participants were not aware that consistent condom use can reduce the risk of HIV and 25% of the participants believed that mosquitoes could transmit HIV (Ibid.). Thus, the present study seeks to increase understanding of these health concerns from young women, mothers, grandmothers and SRH

counsellors' perspective and identify effective strategies to reduce sexual risk during adolescence.

Research has also found an association between psychological factors (e.g., self-esteem, emotional distress) and risky sexual behaviour and permissive sexual attitudes. In a cross-sectional survey of 361 adolescents in nine secondary schools in Nigeria, Enejoh et al. (2016) found that adolescents with low self-esteem were 1.7 times more likely to be sexually active compared to adolescents with high self-esteem. In short, adolescents and young women are at high risk for teen pregnancy, STIs and psychological stress associated with risky sexual behaviour, therefore, sexual health and interventions to raise adolescents' self-esteem is an important concern in Malawi. Based on these physical and psychological concerns, parents, teachers and health professionals need more communication strategies to promote information about sexual relationships, emotional health and well-being to reduce adolescents and young people's permissive sexual attitudes and sexual risk taking. In order to develop enhanced communication interventions, the following section reviews the research on adolescents and young people's current sources of information about SRH with a particular focus on parents.

Adolescence and sources of SRH Knowledge

Adolescents and young women discern information, values and societal norms about sexual attitudes and behaviours from multiple sources, including religious institutions, media, schools, peers and family (Holman, 2014; Mkumbo, 2008; Quaye, 2013; Manu et al., 2015; Dessie et al., 2015; Wittenberg et al., 2007; Heisler, 2005; Miller, 1998). Much of the research has found that the family environment, particularly parent-adolescent

communication, is a foundation of an adolescent's sexual socialisation and education and can positively influence adolescents' SRH outcomes including less risky behaviour in adolescence (Guilamo – Ramos et al., 2012; Wamoyi et al., 2010; Wittenberg et al., 2007; Warren & Warren, 2015).

Research has found that adolescents who talked with their parents were less likely to be influenced by other sources (Raffaelli & Crockett, 2003; Manu et al., 2015; Wamoyi et al., 2010). Whereas poor parent-child relationship could enhance susceptibility to peer influences and deviant friends as well as deviant behaviours with their associated negative SRH outcomes (Bingenheimer et al., 2015). Though parents often act as gatekeepers to children's information outside the family and parent-child communication is the focus of the current study, exposure to non-family sources increase greatly during adolescence and it is significant to review the main non-family sources as they interact with and relate to parents' role in adolescents' sexual socialisation.

The following section briefly reviews non-family sources including religious, media, educational and peer influences. Doing so enables the argument for positioning parents as the primary socialising agents for adolescents and young women's knowledge, rituals and traditions about sex. Ultimately, parents work in conjunction with, or sometimes in spite of these "outside" sources, which is central to the other goal of this study, to develop interventions that help parents play a positive role in their adolescents' sexual development.

***Religious influences*.** Many religious organisations in Malawi encourage adolescents to refrain from premarital sex and masturbation. Research suggests that some aspects of adolescents' religion (e.g., attending church, the importance of faith) correlate with more

conservative sexual attitudes, later sexual debut and lower number of sexual partners (Hull et al., 2011; Sah, 2017). A quantitative study in Nigeria by Somefun (2019) on sexual behaviour among 2,399 male and female youth aged 16–24 years found that, there was a positive relationship between religiosity and youth sexual abstinence. The youth talked explicitly about how their sexual attitudes and behaviours were directly related to their religious beliefs to abstain from sex until marriage.

In a study that examined adolescents' different sources of sexual knowledge, results showed that adolescents who used religious leaders (i.e., ministers or priests) as their main source of information about sex were more likely to view sex as risky and dangerous (Rostosky et al., 2004). Although religion or religious leaders may play a role in adolescents' sexual socialisation, parents often pass down religious values to their children. Park and Ecklund (2007) examined the link between religious families and communication about sexual intercourse. The study found that parents commonly used church attendance, youth groups, and/or Bible studies as ways to passively socialise their child's attitudes or values rather than through direct communication. Findings also showed that devoutly religious parents are much less likely to talk about sexual intercourse or birth control and primarily relied instead on broader religious sexual values (e.g., abstinence) (Kaufa & Buleya, 2015; Perianes & Ndaferankhande, 2020). Adolescents in the same study also reported these broader ideologies as unhelpful in understanding sexual risk-taking or sexual health. Overall, few adolescents described religious leaders or religion as a primary source of information, but parents seemed to use religious values as a foundation to talk about sexual relationships and information; thus, parents likely remain at the heart of religious influence.

Media influences. In addition to religious influences, much of adolescents' sexual knowledge comes from sexual images, sexual behaviour and sex talk shown in the media. The UN Programme on HIV/AIDS (UNAIDS) (1999) claims that mass media is the most valued source of information on SRH issues among young people in LMICs (Quaye, 2013). Brown et al. (2009) argue that traditional media (television, radio, movies) as well as new digital media (the internet, social networking sites such as Facebook), play an important role in adolescents' sexuality and sexual behaviours (Bleakley et al., 2011).

Similarly, Ward and Friedman (2006) found that greater exposure and greater involvement with sexually explicit television during adolescence were related to permissive sexual attitudes, higher expectations of sexual activities of friends and more sexual experiences (Falaye et al., 2017). The results demonstrated that the more frequently adolescents viewed prime-time television programmes (e.g., straight talk) and music videos with sexual content the more likely they were to view casual sex as a normal part of dating relationships (Ward & Friedman, 2006; Bleakley et al., 2011). Holman (2014) however, found that parents often monitor what media adolescents have access to; when adolescents were exposed to sexual images from the media, parents often used these moments to talk to their children about relationships or sex. Thus, although influential, mediated information about sex is sometimes also filtered through parental communication.

Educational influences. Adolescents also receive basic sexual knowledge from school-based sex education programmes. The main goal of these school-based sex education programmes in Malawi is to increase abstinence among adolescents, delay the initiation of first sexual intercourse, reduce number of sexual partners, and/or increase condom or other forms of birth control use (Muheriwa Matemba, 2021; Holman, 2014). Most studies suggest that current

school-based sex education programmes have little effect on adolescents' views of sex and sexual behaviours (DiCenso et al., 2002; Wight et al., 2002). A study by Bleakley et al. (2009) which examined how sources of sexual information are related with adolescents' attitudes and beliefs, found that sexual education provided by teachers had no statistically significant relationship with adolescents' beliefs about sex (Bleakley & Bleakley, 2018). A study by Kirby and Laris (2009) found that curriculum-based sex education and STI/HIV programmes were moderately associated with decreasing adolescents' risky sexual behaviours (e.g., unprotected sex).

Shtarkshall et al. (2007) claim that if schools and parents could share the responsibility and work together to teach about sexual behaviours and values, adolescents would receive more consistent messages about sex throughout adolescence. This, however, may be not work as parents may not talk to their children about sex and SRH because they assume their children will receive that information in school. This could be problematic especially as the current education policy in Malawi allows comprehensive sexual education to be taught at 15 years of age by which time when many adolescents are already sexually active (Muheriwa Matemba, 2021: Holman, 2014). Educators may thus have missed the opportunity to delay sexual debut or encourage safe sex practices (Holman, 2014).

Peer influences. Even though many adolescents receive school-based education, adolescents commonly seek more detailed information or stories about sex from their peers (Heisler, 2005; Holman, 2014). African American and Caucasian adolescents in an online survey on the sources of SRH information reported receiving more sexual information from their friends compared to other sources (media, religion, parents) (Bleakley et al., 2009; Heisler, 2005), and peer influence is known to be a major contributor to risky behaviour (Raffaelli &

Crockett, 2003; Holman, 2014). For example, Bachanas et al. (2002) found that those African American girls who reported engaging in high rates of risky sexual behaviours said that, their peers also engaged in risky sexual behaviours. Similarly, a research study by Rwenge (2000) among young people in Cameroon found that the influence of schoolmates or friends was one of the most important determinant for first sexual intercourse for the majority of them.

Adolescence may be a time when an individual is more vulnerable to peer influence, as adolescents want to "fit in" and be accepted by their friends and classmates. For instance, peers have been shown to play a role in adolescents' sexual decision-making about timing of first sexual experiences (Babalola, 2004) and romantic development during adolescence (Connolly et al., 2000). When adolescents use friends as their main source of sexual information and believe that the majority of their peers were having sex and they themselves are more likely to engage in sexual behaviours too (Babalola, 2004). In addition, communication research on casual sex by Holman and Sillars (2012) found that the frequency of communication about risky sexual behaviour with peers increased the likelihood a person would engage in those potential risky behaviours. It would seem that communication with peers could normalise sexual risk-taking.

Even though peers exert much influence, a research study in the USA by Whitaker and Miller (2000) found that African American and Hispanic adolescents who talk to their parents about sex are less likely to be influenced by peers or the media (Bleakley et al., 2009). Whitaker and Miller (2000) for example, found that peer influence on the decision to engage in unprotected sexual intercourse was more influential for adolescents who had not discussed sex or condom use with parents. As demonstrated throughout the above discussion, although sexual socialisation and education of adolescents and young people does take place outside

the family, the majority of the research on sexual communication has found that parents play a critical role in how "outside" socialisation impacts adolescents' sexual attitudes and behaviours (Raffaelli & Crockett, 2003; Park and Ecklund, 2007; Shtarkshall et al., 2007; Whitmaker & Miller, 2000). Therefore, the next section highlights the research on parental influence on sexual socialisation during adolescence.

Parental influences. Over three decades of research have established that parents can greatly increase adolescents' knowledge of sex-related topics and reduce the likelihood that adolescents will engage in risky sexual behaviour (Guilamo-Ramos et al., 2012; Park & Ecklund, 2007; Shtarkshall et al., 2007; Whitmaker & Miller, 2000; Raffaelli & Crockett, 2003). In particular, parent-child closeness, frequency of conversation about sex and parent-adolescent sex differences have emerged consistently as factors important to understanding the link between parent socialisation and child attitudes and behaviours towards sex. Yet, the existing research about this communication looks almost exclusively at parents' perceptions or emerging adults' perceptions. Thus, the current understanding of adolescent sexual risk and how parents communicate may be limited to adults' reports. Recent parent-adolescent dyadic studies have found parents and adolescents have somewhat different perceptions (e.g., Jerman & Constantine, 2010), and an adult-centric focus may be inadequate for identifying the full range of elements associated with effective parent-child sex talk. Unlike previous research, the current study examines the young women's, mothers' and grandmothers' point of view. This will help emphasize what characteristics of the parent-child relationship and communication adolescents' perceive as helpful in their own sexual development.

In the following section, parent-adolescent communication frequency, closeness and biological sex differences are reviewed as important elements between parent socialisation

and adolescent attitudes and behaviours towards sex. Frequency of parent-child SRH communication is the most common variable used to study parental impact on adolescents' sexual attitudes and behaviours (Afifi et al., 2008; Sah, 2017; Bastien et al., 2011). For example, the more parents discuss topics, such as sex, pregnancy, STIs, HIV/AIDS and birth control with their adolescents, the less likely adolescents will be to engage in risky sexual behaviour and the more likely they will be to delay their first sexual interaction (e.g., Guilamo-Ramos, et al., 2011; Stephenson et al., 2014). Although frequency seems to play a positive role in reducing adolescent risky behaviours, there is some evidence that the opposite can also occur (e.g., DiIorio et al., 2003; Whitaker & Miller, 2000) and that parents' talking about sex has been linked to increased rates of sex by adolescents (Manning et al., 2005), particularly if adolescents model their parents' casual attitudes and behaviours about sex and sexuality (Dittus et al., 1999).

A study by Martino (2008) found that repetition of sexual discussion is associated with adolescents being more open and feeling closer with their parents, which in turn relates to less risk -taking. This finding may suggest that a one-time conversation about sex is unlikely to be as effective as parents who engage in repeated conversations about sex-related topics. Having a once only "sex talk", which some parents feel is their duty and they want to "get it over with" may not be sufficient for adolescents and young people to understand sex and sexuality. Most research has shown greater frequency of parent-adolescent communication about SRH is positively related to adolescents' relationship and communication satisfaction with parents and negatively related to sexual risk (Padilla-Walker et al., 2023; Huebner & Howell, 2003).

Despite the value of examining the direct link between parent-child communication frequency and adolescent risk behaviours, the current study also considers how peer communication might interact with parental communication in the process of socialisation about SRH issues (Holman, 2014). As adolescents and young women are exposed to "outside sources" and negotiate sexual decisions, it is significant to know how this interacts with parental communication. As previously mentioned, adolescents and young women commonly report receiving more SRH information from their peers compared to all other sources, including parents (Bleakley et al., 2009; Heisler, 2005). Peer communication has also been found to normalise risk associated with drinking, smoking and sexual behaviour (Holman, 2014). These findings suggest that adolescents who report frequent conversations about sex-related topics with their peers would also report more risky attitudes and behaviours about sex. However, research shows that when adolescents report talking with both parents and peers about sex-related topics, parental communication moderates the relationship between peer communication and attitudes and behaviours surrounding risk (Whitaker & Miller, 2000).

Previous research shows that frequency of communication is an important feature of parental communication in minimising adolescents and young peoples' sexual risk-taking. However, the previous research on communication frequency about sex-related topics has yet to establish a uniform or consistent effect on adolescents and young people's sexual risk that hold across parent or adolescent reports (Miller et al., 2011). As a result, the current study attempts to look specifically at young women's perspectives towards SRH communication processes and cultural practices from mothers, grandmothers, SRH counsellors and the traditional coming of age rituals which still play a key role in SRH learning.

In addition to frequency, research demonstrates the importance of parent and adolescent relational closeness on adolescents and young women's SRH. Relational closeness with parents is considered to be one of the most stable predictors of adolescents' future sexual attitudes and behaviours (Afifi et al., 2008; Miller, 2002). Parent-adolescent relational closeness and satisfaction are associated positively with adolescents delaying their sexual debut, engaging in less frequent sex and having fewer sexual partners (e.g., Afifi et al., 2008; Inazu & Fox, 2003; Miller, 2002). A similar observation was made by Guilamo-Ramos et al. (2011) for both sexes among the Latino and Black youth. A systematic review of the family's role in adolescent sexual behaviour by Miller (2002) found that "the most consistent finding across studies of family processes or relationships is that parent-child connectedness (parental support, closeness and warmth) is related to lower adolescents' pregnancy risk, primarily through delaying and reducing adolescents' sexual intercourse" (p. 25).

Closer parent-adolescent relationships are also more likely to be characterised by higher quality and more frequent conversations. For instance, studies by Martino et al. (2008), Feldman and Rosenthal (2000) have shown that parent-adolescent communication about sex-related topics is easier when the relationship is built on open and recurring communication. Again, much of the research on closeness has been from the parent's or adult's perspective. However, parents and adults may assess closeness differently as compared to adolescents and young women, particularly given the growing independence and distancing that characterises the parent-child relationship in adolescence (Miller, 2002; Steinberg, 2001).

Previous research has also identified a link between parent-child sex differences and adolescents' sex-related communication, attitudes and behaviours. To date, most parent-based research has focused on the role of mothers in socialising adolescents' sexual attitudes and

behaviours (Guilamo-Ramos et al., 2012). Mothers tend to volunteer more for empirical studies than fathers so findings on paternal communication factors and involvement appear to be limited. Taking this into consideration, the evidence is unmistakable that, for the most part, mothers communicate with adolescents about sex more than fathers (e.g., Fox & Inazu, 1980; Guilamo-Ramos et al., 2012). When extended to other family members, it is usually grandmothers who take this role. This is very much the case in Malawi and is one of the reasons for including them is this study.

Afifi and Guerrero (1998) found children report less avoidance with mothers as compared to fathers on topics of romantic or sexual relationships. Adolescents perceive they can be more open in communication with their mothers than with fathers (Afifi & Guerrero, 1998; Laursen & Collins, 2009; Golish & Caughlin, 2002). Laursen and Collins (2009) also argued that there may be more open communication about SRH issues with mothers than fathers due to mothers being perceived as more approachable on relational topics, whereas fathers are viewed as a source solely for general information or material support. The emphasis on mothers may also be because mothers are commonly viewed as the parent primarily responsible for providing information on sexual education and relationships within the family context (Sah, 2017; Manu et al., 2015; Dessie et al., 2015). Consequently, in many families, mothers take on the role of educators and are more likely than fathers to communicate with adolescents about SRH matters (Guilamo-Ramos et al., 2012; Afifi & Guerrero, 1998), thereby potentially increasing the challenges that mothers face in parent-child communication about sex.

Research has found other gender differences as well. For example, daughters in comparison to sons, are more likely to be the recipient of conversations about SRH issues (Coffelt, 2010;

Jerman & Constantine, 2010; Wilson et al., 2010). Coffelt (2010) argues, that despite mothers and daughters feeling some tension in discussing SRH matters, the mother-daughter dyad seems to more frequently discuss sex and sexual information than any other family combination. A study by Guilamo-Ramos et al. (2008) on mother-daughter dyads, found that mothers were more likely to engage in conversations about sex with their adolescents when they felt knowledgeable in answering questions, not embarrassed, felt comfortable and confident, and that they were being a responsible parent.

While there is more empirical evidence on the role of maternal communication on parent-child relationships than paternal communication, the few available studies have shown that though communication between fathers and children may be scarce and uncomfortable, these conversations do impact children's decisions about sex (Kirkman et al., 2002; Wilson et al, 2010). In a synthesis of research on father-child communication about sex, Wright (2009) found that fathers communicated about sex more with sons than daughters. However, when fathers do talk about sex with their daughters, they usually discuss resisting sexual pressure from partners and the development of sexual values, which are commonly based on religion or the fathers' moral values. In a review of research, Guilamo-Ramos et al. (2012) found that the frequency of father-adolescent communication positively predicted consistency of condom use and negatively predicted risky sexual behaviour. Additionally, paternal disapproval of adolescent sexual behaviour was related to reducing and delaying adolescent sexual debut. Generally, the few studies on father-child communication have found that fathers can reduce the likelihood that their children will engage in risky sexual behaviour (Kirkman et al., 2002; Wilson et al., 2010).

Though, less is known about adolescents' reports of which parent is more likely to talk to them about sex-related topics, Holman (2014) suggests that understanding the adolescents' perspective may contribute to the current literature and develop interventions to help mothers and fathers competently talk to their children about sex. While this could be true in the Western world, it is unlikely to be effective if implemented in LMICs like Malawi. This is because culturally it is considered to be a taboo for parents to talk to their children on SRH topics (Dessie et al., 2015; Mpondo et al., 2018; Simmonds et al., 2021), and for a father to talk to her daughter on SRH issues, is even unthinkable. Rather, they rely on extended families, notably grandmothers and SRH counsellors, rituals and traditions as highlighted in chapter 1 (Wamoyi et al., 2010; Wittenberg et al., 2007). The SRH counsellors are either traditional or religious, depending on the family's culture and religious belief.

As shown in the section above, communication frequency, parent-child closeness and sex differences have been well established as factors linked to adolescents' sexual risk. While these factors are well-established in the literature, more research is needed to understand how parent-adolescent communication plays a role in adolescents and young people's sexual risk-taking and permissive sexual attitudes. Furthermore, it is not directly applicable to adolescents in Malawi as communication between parents and adolescents is a taboo topic (Wittenberg et al., 2007; Limaye et al., 2012).

In Malawi, rather than parents, young people also learn about SRH issues from grandmothers, SRH counsellors and through rituals and traditions (Mpondo et al., 2018; Wamoyi et al., 2010; Wittenberg et al., 2007; Munthali et al., 2018; Schroeder et al., 2022; Munthali & Zulu, 2007). This is shown in a recent review of research, Schroeder et al. (2022) relating to adolescent rites of passage and initiation ceremonies in East and Southern Africa (ESA), with

a focus on Eswatini, Malawi, South Africa and Zambia which assessed the impact of these rites on youth in these countries. The research found that different cultures have maintained a range of customs and practices to prepare young people for their roles and responsibilities as adults. This includes indigenous knowledge which tends to come either before or alongside being exposed to Western knowledge system through Western medicine.

In sub-Saharan Africa, Malawi inclusive, a child is nurtured by a community in many aspects of life, including SRH matters. Thus, this study about SRH communication explored the role played by the extended family (grandmothers) and the community (SRH counsellors, rituals and traditions) in shaping young people's sexual behaviours and their perspectives. A study by Wittenberg et al. (2007) on protecting the next generation on negative SRH outcomes in Malawi and Babalola et al. (2005) in Ivory Coast observed that young females prefer to receive information on HIV/AIDS and pregnancy prevention from their parents, in reality few have this privilege.

2.4. Conclusion

This literature review began by providing the contextual background of the study with a focus on Malawi's political history, religion and culture, as well as how SRH issues have been impacted by the same. The studies reviewed show how families, peers and other structures beyond their control can influence the development of healthy or risky sexual behaviours among adolescents and young women. This review has also shown the need for enhanced SRH learning for girls and how communication is protective, even though talking about sex within the family is a taboo. Much of the literature about sex communication is written from a Western perspective and the findings are not always relevant to the Malawian context. The focus on the literature is upon the role of the media, peers, schools and parents in teaching

adolescents about SRH issues, but in Malawi, particularly in rural areas, traditional rituals and SRH counsellors also play a key part.

It is also evident from this literature review that limited efforts have been made to explore the specific elements of the traditional rituals and counselling which may have contributed to the development of healthy or risky sexual behaviours among adolescents and young women. The empirical and systematic reviews show that traditional rituals and counselling which influence the development of sexual behaviours, have predominantly been reported from a general perspective. Interventions and programmes aimed to promote healthy sexual behaviours have followed the same concept, utilising radios and television to reach out to adolescents, which have not fully addressed the concerns and needs of the rural population. Further, the methodologies used to study the culture and the tribal people/ women have not been inclusive and after the research they have been left without recognising their assets and limitations.

Therefore, this review has shown a clear gap in our knowledge on the influence of traditional rituals on SRH issues among the rural women like the Yaos in Malawi. Previous studies among the Yao people used qualitative approaches and were mostly conducted by a male researcher not indigenous to this tribe and often written from a Western perspective (Munthali et al., 2018; Munthali & Zulu, 2007; Munthali et al., 2004). Thereby warranting an alternative approach of ethnographic and participatory action research and perspective, and specifically targeting three generations, as well as considering the gender and positionality of the researcher on the study topic.

Chapter 3 Conceptual framework

3.0. Introduction to the Chapter

The development of the unique conceptual framework for the study is discussed in this chapter. The research joins emerging scholarly works that use intergenerational perspectives for example, among grandmothers, mothers and daughters to understand personal and group comprehensions of SRH knowledges, rituals and traditions in a non-Western context. Multiple theories and models which are aptly suited to explain the factors that influence SRH communication practices, decision making, and sexual behaviours were considered. The selection of theoretical models had to acknowledge the significance of the personal life course, on-going changes in society, the impact that context has on an individual's thought and action and be applicable to the situation of rural women living in a non-Western background, such as Malawi.

The following theories and models were adopted for this study: the Life course perspective (Khan, 2019); Paulo Freire's philosophy of conscientisation (Emancipatory theory) (Genuis et al., 2015; Rugut & Osman, 2013); writings on Decoloniality; and African feminism (Mignolo & Walsh, 2018; Mukoni, 2015). However, the overall study was guided by Bronfenbrenner's ecological model (1979) as a conceptual framework. McLeroy et al. (1988) postulate that Social ecological models emphasize multiple levels of influence, and the notion that behaviours both shape and are shaped by the social environment. Thus, the Social ecological models aid the understanding of factors which affect decision making and behaviours, as well as providing guidance in developing successful community health programmes.

3.1. The Life course perspective/ Life course theory

This approach was developed in the 1960s for analysing people's lives within structural, social and cultural contexts, and it focuses on the connection between individuals and the historical and socio-economic context in which these individuals' lives unfold (Hutchison, 2019; Hutchison, 2010; Elder Jr, 1987: Khan, 2019; Owens et al., 2001). It encompasses ideas and observations from an array of disciplines, such as history, sociology, demography, developmental psychology, biology, public health and economics (Hutchison, 2019; Elder, 1987; Hser et al., 2007). As a concept, the Life course perspective is defined as "a sequence of socially defined events and roles that the individual enacts over time" (Owens et al., 2001 p. 1051; Meisler, 2012). However, these events and roles do not necessarily proceed in a certain sequence, but instead constitute the sum total of the person's actual experiences (Owens et al., 2001; Khan, 2019).

In this theory a family is perceived as a micro social group within a macro social context, a "collection of individuals with shared history who interact within ever-changing social contexts across ever increasing time and space" (Owens et al., 2001 p. 1051; Meisler, 2012). Aging and developmental change, therefore, are continuous processes that are experienced throughout an individual's life. As such, the Life course reflects the intersection of social and historical factors with personal life story and development within which the study of family life and social change can ensue. Further, Owens et al. (2001) claim that this perspective has also been and continues to be synthesized with other theories or fields of study, such as family development, gerontology and Bronfenbrenner's ecological perspective, which is the guiding theory for this study. Therefore, the Life course approach appeared to be a suitable

analytical tool for analysing the impact of intergenerational SRH communication practices on young women's decision making and sexual behaviours.

Hutchison (2019) claims that the Life course theory is useful and widely applied, and that the Life course perspective is favoured in studies which aim to explain the impact of historical and social changes on human behaviours. For instance, Khan (2019) used the Life course perspective to analyse how South African Muslim mothers and daughters of Indian descent interpreted and understood ageing. The study participants in Khan's (2019) study were of different ages and backgrounds. With the mothers being of the Apartheid era and the daughters of the 'Rainbow nation' (a multi-racial or multi-cultural country, used especially of South Africa in the post-apartheid era). Therefore, since this study involved understanding SRH communication from the perspectives of three generations, who had lived during the colonial era, autocratic and democratic system of government, this theory appeared suitable.

3.2. Paulo Freire's philosophy of conscientization

The study proposed the use of the Freirean conscientization theory as the empowerment framework for the action, which was planned as part of this study, to effectively address the issues that predispose young women to negative SRH outcomes. Roberts (2016) argues that, although the Freirean perspective does not ignore the significance of the individual, it recognises that human beings are social beings from the moment they are born. According to Freire the social nature of our existence as human beings, is evident in everything we do, that is, in the way we think, feel and act as we make our way in the world (Roberts, 2016). Roberts adds that our activities and ideas are always shaped, but not determined by our experiences as social beings, and that it is not a case of being 'more individual than social'

(2016, p.65) but of being both individual and social. Therefore, considering that sexual matters are both individual and social in nature, this theory resonated well with the objectives of this study, thereby warranting its consideration.

Further, Freire's emancipatory theory was perceived to be useful, as it provides the basis which would enable the rural women to become critically conscious about the relationship of sex education practices and young women's decision making and sexual behaviours. Freire's conscientization approach prepares people to transform their social worlds by challenging the social and political factors which disempower them and to enable them to control these factors (Findsen, 2007; Ollis, 2015). This involves identifying problems/ issues and solutions and calling for social action to empower themselves. The concepts and principles of Freire's philosophy of conscientization were successfully applied in Guinea Bissau and Tanzania in an adult education context and in New Zealand among the Maori, the indigenous people of New Zealand (Findsen, 2007). It thus, seemed likely that, if these emancipatory principles were applied in the sex education of the rural women in this study, they would work well too.

Arguably, Paulo Freire's conscientization philosophy, which prepares the oppressed to identify and ultimately challenge the social and political structures that oppress them could be viewed as promoting decoloniality and African feminism. This is because, in all these ideologies, the fight for social justice, which was weakened or lost, with colonialism and Western education system and culture is evident. For example, Findsen (2007) claims that the idea of adult education as a tool for social justice has become numbed, if not lost, in the advent of lifelong learning across Western countries, which was also promoted in LMICs. This promoted 'individualism and vocationalism' as opposed to communalism and

commonality, which are the tenets of social justice (Findsen, 2007 pp.545; Hickling-Hudson, 2014).

A similar observation was made by Hickling-Hudson (2014) in her work with the Aboriginal children and adults/parents in Alice Springs, Australia on the Honey Ant Reader project. In the project, the Aboriginal children and the adults in their community, learned to read in their local language and the Australian Standard English, using booklets and audio CDs for each book, with Elders reading the books, created from Indigenous stories told by community Elders, containing local customs and traditions. The positive outcome of the project was that, not only did the children and the adults learn how to read in the indigenous languages and culture, aboriginal English, the children felt comfortable being in school because of the strong presence of their languages and culture.

This is because, the Honey Ant Readers project utilised a vocabulary based on the everyday life experiences and cultural context of the school and its community, which enhanced their understanding as they could relate well to the material, which were delivered through the concepts surrounding them and the stories which were familiar to them. I selected this example because it exemplifies Freirean principles of conscientization which emphasises on co-learning and co-development of learning materials, as means of achieving culturally authentic Indigenous educational progress in Australian society. Therefore, going through this example, it appears that Freire's conscientization could be useful in this study to confront the issues which have negatively impacted young women's sexual and reproductive lives by encouraging the creation of knowledge for progressive social change, rather than teaching them pre-conceived knowledge, which may not be applicable to their situation. As such, it was important that Decoloniality and African feminism be considered in this study in

addition to Freire's philosophy of conscientization, as they all lean towards communalism and commonality to confront social injustices, as well as encouraging co-production of knowledge, rather than producing knowledge for others (Naylor et al., 2018; Findsen, 2007; Hickling-Hudson, 2014).

3.3. Decoloniality

Decoloniality is a concept which originated from the Bandung Conference of 1955 in West Java, Indonesia, with a representation of 29 countries from Africa and Asia (Mignolo, 2013). Its main aim was to find a common ground and vision for the future of the LMICs that was neither capitalism nor communism, but decolonisation (Mignolo, 2013; Naylor et al. 2018). While the LMICs achieved political and economic independence, colonialism nevertheless continued through the previous acceptance of Western religion, language and the education system (Mignolo, 2013; Mignolo & Walsh, 2018). This prompted the Colombian sociologist, Orlando Fals Borda and a group of Caribbean economists and sociologists to call for decolonisation in thinking (Mignolo, 2013). As such, there was a need to create categories of thought that were not derived from European political theory and economy. This subsequently led to the emergence of Decolonial theory, which emphasises thinking and 'doing decolonially', thereby reconstructing ways of thinking, speaking and living which existed before the colonial enterprise and invasion (Mendoza, 2020; Mignolo & Walsh, 2018; Naylor et al. 2018).

Therefore, since this study is about promoting indigenous knowledge system and practices, it was important that this theory was given consideration. This is because Western research paradigms, such as positivism as well as individualist roots, have shaped the way research

and knowledge are conducted and perceived, superseding culturally relevant indigenous worldviews, learning and language (Stevens-Uninsky et al., 2023). As a result, the research participants have been framed as numbers in studies, designed by those operating within a dominant culture rather than individuals with unique perspectives and experiences. For example, funding for global health which primarily originates in high-income countries (HICs), have shaped research priorities and established the measures and indicators of success without the involvement of the research participants, who are mostly form LMICs (Stevens-Uninsky et al., 2023).

This approach to research has not only undermined indigenous knowledge but has also resulted in the use of evaluation and research tools that may not be culturally appropriate and may not collect accurate and valid responses (Stevens-Uninsky et al., 2023). Hence, the need for decolonising methodologies, which centres research, methodology and practice within indigenous communities rather than rooting research in colonised institutions and epistemologies (Tuhiwai-Smith, 2012; Stevens-Uninsky et al., 2023). As such authors like Tuhiwai-Smith (2012) and Stevens-Uninsky et al. (2023) emphasise the need to allow the indigenous communities and their ways of knowing to lead research and to ensure that their voices are central to the research process.

Research that is not rooted in decolonisation can and often will, result in the continued oppression of indigenous communities (Stevens-Uninsky et al., 2023). It can result in researchers and implementors entering communities and taking what they want, leaving behind little to no positive change and othering that community as a source of information rather than centring them in the work (Stevens-Uninsky et al., 2023) under the assumption of project modernity/ coloniality (Mignolo, 2007). Mignolo demonstrates that while modernity

is presented as a rhetoric of salvation, it hides coloniality which is the logic of oppression and exploitation (2007). Modernity, capitalism and coloniality are all aspects of the same concept of control of economy and authority, of gender and sexuality of knowledge and subjectivity (Mignolo, 2007). To appreciate how tangled up the rhetoric of modernity and logic of coloniality are with each other, Mignolo (2007) provides an example on how Monsanto, a leading provider of agricultural products and solutions deploys a logic of control that labels indigenous alternatives as traditional and anti-modern. Stevens-Uninsky et al. (2023) add that colonialism and its institutions have historically oppressed women, by removing the capacity for choice and agency in family planning. They claim that, colonial powers have a history of the oversexualisation of indigenous women (Aniekwu, 2006), gynaecological experimentation, forced sterilization (Clarke, 2021), population control (Kaufman, 2000), all of which are echoed in an ongoing culture of medical experimentation in previously colonised nations (Stevens-Uninsky et al., 2023).

This history of oppression has ramifications at present in the form of perceptions around access to SRH services, reliability of institutions, discrimination in service delivery and desire to access SRH services. Therefore, reproductive justice and freedom of choice are critical areas of focus for decolonisation research (Stevens-Uninsky et al., 2023). However, the theory of Decoloniality has some limitations, such as sidelining the position of other intersectional considerations, e.g. genders / women (Naylor et al. 2018). Hence, the consideration of African feminism as one of the conceptual frameworks for the study.

3.4. African feminism

African feminism recognises the multi-layered reality of African women's experiences (Biwa, 2021). As such it acknowledges that African women operate from a place of intersectionality where race, class, gender and age are interrelated (Biwa, 2021). In that way, African feminism is distinct from Western and Black feminisms. It advocates for the political, economic and social freedoms of African women while recognising the diversity of experiences, struggles and resistance to different forms of patriarchal oppression and domination in formally colonised and historically marginalised societies (Biwa, 2021). African feminism is informed by African women's stance, their need to challenge patriarchal oppression, and their desire for equality in the form of 'complementarity' rather than 'conflict' between men and women, as well as their understanding of the connectedness of men and women within the African culture, without the 'rejection' of African culture (Mukoni, 2015; Biwa, 2021 p. 51).

African feminism is founded on the African principle of 'communalism and holism' where the community is bigger than an individual and sees it as a struggle to liberate all African people including men (Mukoni, 2015 pp. 79). As such men are recognised as partners, contrary to Western feminism, where men are sometimes seen as foes (Mukoni, 2015).
As the study is about rural women and their indigenous ways of sharing SRH information, African feminism was also adopted to be one of the foundation roots for the study within the realities of African worldviews. Feminism in Africa is a struggle against Western power, as well as the legacy of Western culture within the African continent. African feminism upholds the notion that women's lack of power in Africa is caused by the intrusion of foreign systems

with different gender orientation and new models of power organisation (Mukoni, 2015; Semu, 2002).

Although, gender hierarchy existed in traditional Africa, it became more pronounced during the colonial rule. Thus, an African woman's power struggles are caused by patriarchy on one hand and on the other by the impact of colonisation. Further, considering that men have also been impacted by colonisation and that of the spirit of *Ubuntu,* there is need to negotiate with men to confront the injustice of the Western culture imposed on them. Biwa (2021) used African feminism to analyse the discourses of gender equality, inclusion and empowerment among Namibian women in the mining sector. The findings revealed that women saw themselves as activists and not as victims, hard workers, negotiators, and men as needed partners and collaborators, which are reflective of the key principles of African feminisms: holism, collectivity, situationality and negotiation (Biwa, 2021).

Mignolo (2013) and Naylor et al. (2018) advocate for the decolonisation of knowledge and production of transformative knowledge, and therefore Decoloniality theory and African feminism were considered to resonate well with the goals of my study, which sought to understand how Western power, education, culture, modernity and urbanisation might have influenced adolescents' sexual behaviours and decision making, and if there was a link with the intergenerational SRH communication processes. Furthermore, African feminism fitted well with my aim to explore the impact of colonialism and appreciate the alternative ways of knowing, living and doing.

3.5. The Socio-ecological Systems Model

Young people's sexual lives are characterised by individualised lifestyles and relationships, which are shaped by various structural factors such as societal norms, culture, religion, peers, family relationships and sex education. Therefore, the Socio-ecological Systems Framework (Bronfenbrenner, 1979) is an appropriate framework for this study as it incorporates factors influencing young people's SRH from the individual to micro and macro levels. The Socio-ecological systems theory upholds the notion that learning occurs within a series of interactions between persons, processes, contexts and time (Bronfenbrenner, 1979; Vaccaro & Kimball, 2019). The Socio-ecological Systems Model identified five systems which interact with one another: Individual, Microsystem, Mesosystem, Exosystem and Macrosystem (Bronfenbrenner, 1979) (see Figure 3.1). It is within these systems, that young people's SRH learning, and development occurs, although each person is unique and responds differently to these factors (Bronfenbrenner, 1994; Vaccaro & Kimball, 2019).

Bronfenbrenner's five systems are often depicted as a series of concentric circles with the individual at the centre followed by the microsystem, mesosystem, exosystem and macrosystem to illustrate how factors at one level influence factors at another level. As such, this model allows researchers to understand the range of factors which put people at risk for negative health outcomes. Therefore, to prevent negative SRH outcomes among young women, it is necessary to act across the multiple levels of the model at the same time. Even though, Bronfenbrenner's Socio-ecological model (1977, 1979, 1995, 2009) has evolved, its foundation lies on the understanding that behaviour has multiple levels of influences, which includes intrapersonal (biological, psychological), interpersonal (social, cultural), organisational, community, physical environment and policy (Sallis et al., 2015).

This model recognises the complexity of the socio-cultural world in which young people are born, live and grow (Sah, 2017). Thus, young people's social, sexual and reproductive lives are influenced by the interactions of the various socio-cultural factors present within the ecological environment (Ezenwaka et al., 2020). For instance, Bronfenbrenner's socio-ecological systems theory could be used to understand the positive and risky SRH behaviours of young people and how the behaviours could be sustained for a period, because of the complex interactions among multiple spheres (see figure 3.1).

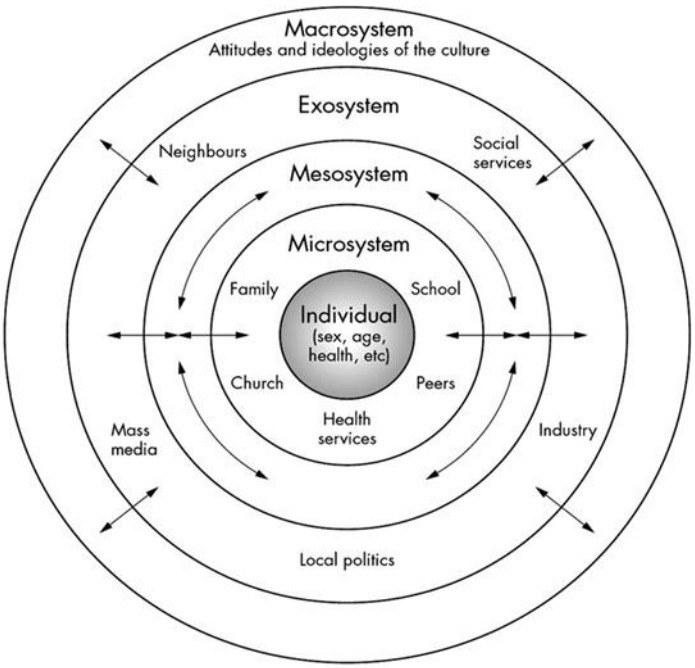


Figure 3.1 Socio-ecological Systems Model, Adapted from a PhD thesis by O'Connor (2018, p. 46). Tiko Bulabula: Understanding and measuring adolescent sexual and reproductive well-being in Fiji Islands[e-]. UNSW Sydney.

Individual Factors

The first level of influence identifies biological and personal history factors that increase the likelihood of a behaviour (McLeroy et al., 1988). These factors include demographic

characteristics such as age, gender, racial/ethnic identity, as well as economic status, financial resources, values, goals, expectations, knowledge and attitudes (McLeroy et al., 1988).

Relationships and primary groups (Microsystem)

The second level examines close relationships that may contribute to an individual's experience. It encompasses the person's closest social networks and support systems, such as peers, partners and family. McLeroy et al. (1988) view relationships with family members, friends and neighbours as important sources of influence in the health-related behaviours of individuals. For instance, boyfriends/ husbands are important influences in the decision to engage in a sexual behaviour or not. McLeroy et al. (1988) claim that people do not form their attitudes in direct response to their attributes, which in themselves have no underlying influences. Rather, they acquire norms, as they do with other pieces of information through their ties in social networks. Therefore, not only is normatively guided behaviour constrained by the structure of networks, but the inculcation of these norms is differentially reproduced through these networks.

Community Factors (Exosytems)

The third level of this Socio-ecological model explores, the settings, such as places where one lives, learns, plays and in which social relationships occur (McLeroy et al., 1988; Ezenwaka et al., 2020). At this level, the Socio-ecological model is concerned about mediating structures within the community which help create an environment in which a behaviour is encouraged or inhibited. Thus, it seeks to identify social and cultural norms that support or hinder a particular type of behaviour such as sexual behaviours. The Socio-ecological model at this level, also takes into consideration organisational structures and processes that can

have substantial influence on the health and health related behaviours of an individual (McLeroy et al., 1988).

With many young people spending most of their times in organisational settings such as religious, primary and secondary schools, it is clear that organisational structures and processes can have substantial influence on the health and health related behaviours of individuals. Organisations like religious institutions provide important social resources and are transmitters of social norms and values, mainly through individual work groups and socialisation into organisational cultures (McLeroy et al., 1988). Therefore, organisations could have positive as well as negative influence on the health and behaviours of their members as they provide the opportunity to build social support for behavioural changes, particularly if the new behaviour is a group norm.

Societal level (Macrosystems)

The fourth level looks at the broader societal factors such as history, health, economic, educational and social policies that help to maintain economic or social inequalities between groups in a society. These could relate to local level, national, and global laws and policies, which allocate resources to establish and maintain a coalition connecting individuals and the larger social environment to create healthy and acceptable behaviours (McLeroy et al., 1988). Other policies include those that restrict behaviour such as tobacco use in public spaces and alcohol sales and consumption to those under 18 (Muheriwa Matemba, 2021; McLeroy et al., 1988). At this level the Socio-ecological model aims to identify policies that affect the social determinants of health, as well as social and cultural norms that support or hinder a particular type of behaviour. For example, the Covid -19 pandemic, led to a policy which restricted movement.

3.6. Critiquing the Socio-ecological Systems framework

While the concept of Social-ecological systems remains relevant, because of the central insights concerning the dynamic coupling between humans and the environment, and its multidisciplinary approaches to solve real world problems, there is need to clarify advantages and restrictions of utilising such a concept and propose a reformulation that supports engagement with wider traditions of research in the social sciences (Stojanovic, 2016). Even though various articles have provided conceptual guidance, there are no general methods, guidelines or procedures for applying this model. As such, the model continues to be a useful tool and it can be applied in any setting, because of its adaptable framework (Partelow, 2018). It is the same principle, which I followed in this study. Despite the framework being developed primarily to apply to Western societies, the main variables of the model - social and environment are universal, hence making it applicable anywhere even in a non-Western context like a rural community of Malawi.

Further, while the evolution of the framework is supported by a long history of empirical research, critiques have viewed it more as a general tool to diagnose the sustainability of Social-ecological systems and less as a theoretical framework to advance collective action theory (Partelow, 2018). However, considering that the main purpose of a participatory action is a collective diagnosis of assets and problems/ issues and collective action in solving the identified problems/ issues, the model was perceived to be suitable for my study. McGinnis and Ostrom (2014) have likened this diagnostic approach metaphorically to medical practitioners who diagnose patients with a standardized checklist of key components and interactions in the human body to find the appropriate treatments and to allow easy comparability between patients.

Equally, this concept of diagnosis could be applied to a community setting if a list of key variables and interactive processes can be identified (Ostrom & Cox, 2010). For example, in a systematic review of peer-reviewed literature by Partelow (2018) the Socio-ecological model was applied to a wide variety of empirical contexts, with a focus on community-based systems. It found that the framework can be used as a tool for different types of research and can also be used as a conceptual tool to reframe, restructure or integrate existing data for new analysis (Ibid.). In general, the framework is used a useful conceptual tool but is less applied empirically due to a lack of methodological knowledge or guidance on how to do so (Partelow, 2018). Furthermore, because of its adaptable framework, the model is extensively cited and associated with other concepts in the broader Socio-ecological systems discourse, and thus was suited to integrate it with the Life course perspective model, Paulo Freire's Conscientization theory, Decoloniality and African Feminism.

3.7. Application of the Model for this research

The below Socio-ecological systems model (Figure 3.2) recognises that behaviour is the product of multiple factors, and that, it is developed through the interaction of biological, psychological and socio- environmental factors (individual, microsystem, exosystem and macrosystems) (Georgiadis & Kringelbach, 2012; Robinson, 2008; Thyer & Myers, 1998). This is clearly relevant to sexual behaviours, as it is this interaction which predisposes a young person/ woman to the development of risky or healthy sexual behaviours, as observed by Bastien et al. (2011). Parents, children, their immediate and distant environment tend to complement each other in perpetrating both healthy and risky sexual behaviours (Georgiadis & Kringelbach, 2012; Kar et al., 2015; Muheriwa Matemba, 2021). An ecological approach

focuses on the progressive mutual adaptation of individuals in their environment and can thus help to understand the complexity of adolescent sexual behaviours.

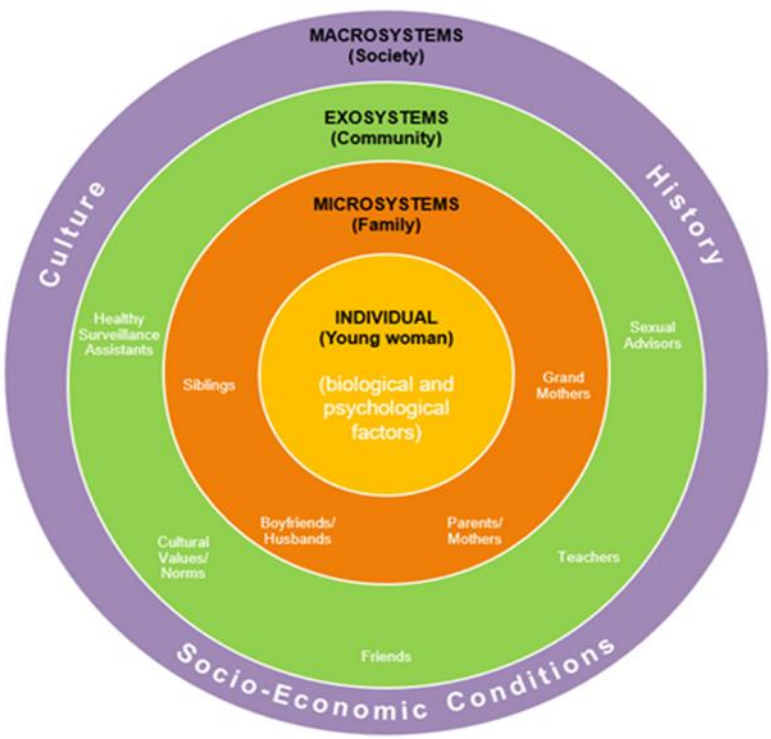


Figure 3.2 Socio-ecological Systems Framework, as applied to rural women's perspectives on SRH knowledges, rituals and traditions study (O'Connor, 2018).

Figure 3.2 shows the interactive set of systems nested within each other and sees the interdependent interaction of systems as important in shaping the context in which an individual directly experiences social reality (Bronfenbrenner, 1979). The model places an individual at the centre, with the capacity to act independently and to make his/her own free choices – and diversity. The model is also informed by an understanding that one's identity is fluid and is greatly influenced by the immediate (e.g., family, peers) and broader (e.g., culture, history) context. For example, when a girl has attained puberty, at an individual level, she may feel that she is an adult, whereas at societal level, she may not be recognised as such, until she goes through the rituals and traditions.

A systematic review by Bastien et al. (2011) found that an adolescent's sexual decision making, and behaviour are influenced by many factors, and this could be at individual, peer, family, community and societal levels. In the individual life path, there are certain life events, and turning points that occur, that have a life-long or periodic impact on the individual. According to Mortimer and Shanahan (2007) who adopted a Life course theoretical perspective, how people think about the social world around them may depend as much on what was happening in the world at the time they were growing up as it does on what is happening in the present. Reference to this as a "generational" phenomenon maybe derived from the assumption that historically based influences shaped the development of all or most people growing up at a particular time and that there is nearly always a shared cultural identity that sets them apart from the parental generation (Mortimer & Shanahan, 2007 p. 24).

The Life course perspective model posits that time related events lay the foundation for current and later views, and behaviour on and towards SRH issues. These events have meanings attached to them which is crucial for gaining insight as to how a person sees their sexual and reproductive life and to their sexual and reproductive behaviours and decision making. Of interest is the emergent difference or similarities in intergenerational perspectives on SRH communication practices, rituals and traditions amongst the rural women. The outer layer of the model illustrates the social, economic and political transformation taking place in LMICs. Not only have these factors changed the conditions in which people live but they have also impacted on young people's sexual behaviours and decision making.

For example, Jackson (2012) claims that modernisation has been associated with negative impacts on gender equality, which involves complex and contradictory processes of change impacting on SRH issues. Munthali et al. (2004) writes that traditional structures and values

which shape young people into adults are changing due to factors such as education, religion and urbanisation. As a result, this seems to have created a vacuum in young people's socialisation, mainly on sexuality issues, because the traditional structures are weakening, and the emerging ones are not necessarily meeting the socialisation needs of young people. It also can create tension with the elders, sexual advisors/ counsellors and parents who rely more heavily on their indigenous knowledges, rituals and traditions.

This intergenerational effect is well-illustrated by Bennett (2018)'s study in the Netherlands and United Kingdom (UK). Bennet (2018) sought to understand how Dutch parents teach their children about puberty, relationships and reproduction. She found that Dutch parents were more open on sex education and their approach centred on the positive side of sexual matters in contrast to the English parents who were less open and more focused on potentially negative outcomes. She attributed this to better SRH education and the greater number of resources which parents and children in the Netherlands were exposed to, such as websites which were specifically dedicated for sex education for children aged 0-12 years and older, in addition to books. Bennet (2018) revealed that the Dutch parents also reported that their parents were not as open as them, due to their grandparents' lack of sexuality education, thus resonating more with the experiences of the English cohort, on what appeared to be a generational effect (Ibid.). Regular interaction between the children and parents about SRH and the resources, allowed for interpretation and modification of the experience and behaviour hence contributing to evolving views on sexual matters.

The model shows that the socio-economic situation of the society plays an important role in promoting both healthy and risky sexual behaviours. This was also noted by Wittenberg et al. (2007) in a survey conducted in Burkina Faso, Ghana, Malawi and Uganda. Wittenberg et al.

(2007) used the national survey data to investigate the relationship between poverty-measured by wealth quintiles-and sexual behaviour of 19,500 young people aged 12-19. The results revealed that poorer girls were more likely to initiate sex at an earlier age than those girls from wealthier families (Wittenberg et al., 2007). Additionally, the study found that wealthier boys were more likely to use condoms at the last sexual encounter than poorer boys. This contrasts with findings from other studies in high-income countries, which found that higher family income was associated with an increase in risky sexual behaviours, such as an increase in number of sexual partners as well as an increase in frequency of sexual intercourse.

This finding is supported by Turner et al. (1998)'s study, which used data from the U.S. 1998 National Survey of Adolescent Males and the 1988 census, to examine the effects of neighbourhood, family and individual characteristics on teenage males' premarital sexual and contraceptive behaviours. The findings revealed that young men who earned more, had higher numbers of sexual partners and engaged in sex more frequently and were more likely to have made someone pregnant than those whose income was low. Thus, it would seem that wealth could be both a protective and a risky factor in sexual behaviours. The Western and African contexts may explain these contradictory findings. For example, in Malawi, poorer girls may have more pressure to enter into early marriage, hence predisposing them to earlier sexual relations or they may have less education and therefore be less knowledgeable about potentially negative outcomes.

Further, the model illustrates that behaviour can also be influenced by community factors, such as cultural practices, rituals and traditions. The impact of these factors could be understood from the African feminism and Decoloniality concept. Rural women/ people have

used culture and societal norms to shape young people's attitudes, views and behaviours towards SRH issues, to appreciate themselves, their culture and to reaffirm their status in the society (McNamara-Barry et al., 2010). This is because sexual activity and its associated behaviours are socially constructed and different societies tend to mould sexual desires for different social or cultural purposes (Mkumbo, 2008; Raffaelli & Crockett, 2003). Thus, sexual behaviours are embedded in social structures and contexts, which dictate what constitutes acceptable or unacceptable sexual behaviours, from which young people look for clues as to what is acceptable, as well as from their wider social networks and health services (Boislard et al., 2016; Shoveller et al. 2004; Yakubu & Salisu, 2018).

In Malawi researchers like Skinner et al. (2013) and MHRC (2006) have demonstrated a consistent linkage between cultural norms and young people's susceptibility to risky sexual behaviours. This is supported by Boislard et al.'s (2016) literature review, which revealed that youth raised in collectivist cultures are more susceptible to social influences in the development and shaping of their sexuality and sexual decision-making, than those from individualistic cultures. This is because the society prescribes expected norms and behaviours, with which young people are expected to comply. For example, in Malawi, in the case of *kupimbila* among the people of Chitipa and Karonga, which determines whom you marry and when.

At the exosystem level, the model shows that Health Surveillance Assistants (HSAs) and teachers, who represent institutions or organisations like health facilities and schools, also play a significant role in the sexual socialisation of young women. The presence or absence of institutions or organisations and how services are organised have an impact on young women's sexual behaviours. Access to resources such as health facilities, education and

recreation facilities are critical for young women's SRH. Availability, accessibility and organisation of SRH services facilitate the development of healthy sexual behaviours in young women. Thus, it is important to consider these factors when talking about sexual matters with young people, as they may enhance or deter young women from experiencing positive sexual behaviours (Jimmy-Gama, 2009). For example, in my study setting, the girls often drop out of school and that their instructions mainly come from appointed SRH counsellors within the village and or religious organisations.

Chandra-Mouli et al. (2013) claim that young women who experience greater barriers to accessing contraceptives are more likely to have a greater unmet need for contraceptives. A review of literature from sub-Saharan Africa and one from South-East Asia by Chandra-Mouli et al. (2013) found that health workers in many places refuse to provide contraceptive information and services to unmarried adolescents because to do so, would be seen as approving premarital sexual activity. In some cases, the way the services are offered may not be user friendly to young people. For example, providing family planning services to both mothers and young women at the same time may be challenging for young women who do not wish to utilise the same SRH services as their parents as it would mean showing them that, they are not conforming to the societal norms (Welch, 2010).

Welch (2010) adds that, the strategies used in health facilities to deliver SRH services may not be culturally congruent with the societal norms. For example, at one of the health facilities in the central part of Malawi it is written on the entrance door STIs, and HIV/AIDS clinic and people queue for hours to be seen. As a result of this, some may fail to access the services, even though in need of them because of the stigma associated with these conditions. Welch (2010) also claims that most development initiatives have a higher chance of success

if significant people in the communities are actively involved from the outset and are given the opportunity to act as advocates for change at the grass-roots level, and to use their cultural foundation to form plans that are more appropriate. This resonate well with Paulo Freire's philosophy of conscientization which centres on emancipatory principles of the marginalised population, as well as the Decoloniality concept which promotes non-Western perspectives and alternative knowledge systems.

The model also shows that children learn about the world through the interactions they have with their parents, family and close friends (Armbruster, 2019). As they grow older, they are likely to develop their attitudes and beliefs about sex within their family and with their closest social circle-peers. Parents, children and their immediate environment tend to complement each other in perpetrating both healthy and risky sexual behaviours as discussed in detail in the previous chapter. For example, family poverty has been associated with risky sexual behaviours among young people in sub-Saharan Africa. Wamoyi et al. (2010b) demonstrated this in a qualitative study, conducted in Tanzania on young women's motivations to exchange sex for gifts or money. Multiple issues were revealed, for some young women, it was due to poverty, while others were looking for beauty products or to accumulate business capital. Wamoyi et al. (2010b) also found that others engaged into transactional (paid) sex, due to peer pressure and to conform to the norms of the group of having adequate money, which could be transcribed as the cohort effect, if the Life course perspective was employed.

At the centre of the Socio-ecological systems model, there is a person with individual characteristics, such as biological and psychological factors, which can increase the likelihood of engaging in risky or healthy sexual behaviours. Biological factors (age, gender)

remain fundamental to human sexual experience (Baams et al., 2015). A systematic review by Pringle et al. (2017) examined the physiological influences of adolescent sexual behaviour and its associated psychosocial factors. They found that females appeared to be more influenced by psychosocial aspects, including the influence of peers, than males, and that males may be more inclined to engage in unprotected sex with a greater number of partners. This could be because men hold more positive attitudes about sex in uncommitted relationships, unlike women (Peter & Valkenburg, 2008). However, the final decision rests on the individual person as observed by Mpondo et al. (2018)'s study in South Africa on parent – child SRH communication where young women reported that it was up to an individual to decide when it was time to have sex or not, and the advice they got from home did not matter much, thereby supporting the individual's cognitive influence in developing sexual behaviours.

Pringle et al. (2017) also suggest that the stage of readiness to receive information may differ according to gender and physiological maturity and that early onset of puberty was associated with earlier sexual activity, especially in girls. This contrast is evident in Malawi in which initiation ceremonies used by SRH counsellors to educate girls on SRH issues are only for girls who have attained puberty compared to schools where sex education is given according to the grade an individual is in, and not according to their physical development (Limaye et al., 2012). Conducting sex education after puberty is likely to be more effective, as the girl could relate the advice to her personal experience.

3.8. Conclusion

This chapter has described the conceptual framework which affected my world view towards understanding factors which influence young women's sexual decision making and behaviours. These factors occur at primary, secondary and tertiary levels. This chapter explained why models like the Life course perspective, Freire's philosophy of conscientization, Decoloniality and African feminism were drawn upon for my study and the choice of Bronfenbrenner's ecological model to examine the interrelationships between individual and structural factors at multiple levels of intersections, to understand the sexual lives and relationships of young women, which contribute toward their SRH. The discussion of intersectionality sought to understand and explain the experiences of young women at the interconnections of two or more structural factors. With the aid of examples and previous research the model further illustrates interconnections of individual, familial and extrafamilial factors which affect the sexual lives of young women at multiple levels within the wider sociocultural context of the society. The chapter also described how the model was applied to explore adolescent risk and protective practices at the individual, microsystem, mesosystem and macrosystems.

Chapter 4 Study methodology and methods.

4.0. Introduction to the Chapter

This chapter provides a detailed presentation of and justification for the qualitative Ethnographic and Participatory Action Research (EPAR) adopted, as well as the social constructivist approach which underpinned this research. This is followed by a detailed description of the research process including: a short description of the study setting; how the sample was identified and recruited; data collection procedure and data analysis techniques used. Ethical considerations and reflexivity or the researcher's position with respect to this research process are also discussed.

4.1. Adopting an EPAR approach

The research employed a qualitative approach with inductive generation of ideas to provide in-depth and rich explanations of individual's views and experiences (Ritchie et al., 2013; Merriam, 2002; Patton, 2002; Strauss & Corbin, 1998). Data collection took place in real world settings and people were interviewed with open-ended questions, under conditions that were comfortable and familiar to them (Ritchie et al, 2013; Merriam, 2002; Patton, 2002). With qualitative research, the main emphasis is put on providing explanations and meanings to individual's responses and experiences (Merriam, 2002) and giving a voice to participants' voices rather than imposing a story or perspective on them.

This study used EPAR to answer the research questions. Young women's sexuality has been construed to be a social creation and for it to be well understood, there is need for an exploration on how it is influenced by local socio-cultural norms and values ((Ezenwaka et al. 2020; Sah, 2017). Ethnographic studies assume that those being studied can construct the

meaning of a situation, through discussions or interactions with other people and that meanings are socially or historically negotiated (Creswell, 2014; Cunlife, 2008; Martínez Pérez et al., 2015). A strength of ethnography is that it gives researchers the opportunity to gather empirical insights into social practices normally 'hidden' from the public eye, which is achieved through active participation of the researcher in this world (Reeves et al., 2015; Gill, 2008).

Ethnography has also been used successfully by medical anthropologists in research studies mainly those focussing on health improvement, public health, nursing and global health (Rashid et al., 2015). Further, it allows the researcher to tap into the communal hearts and minds of those being researched to obtain data in its purest form, from the source and through the actions and words of those individuals (Glen, 2014). Furthermore, it is suitable for areas where there is a paucity of evidence or if a new perspective is required, or when there is a need to lift up the voice of marginalised participants (Strauss & Corbin, 1998; Creswell, 2014; Su, 2018; Ritchie et al., 2013).

To achieve all the study goals, I also included a participatory action research (PAR) design. According to MacDonald (2012) the goal of all action research is to impart social change, with a specific action or actions. Its philosophy is embodied in the "the concept that people have a right to determine their own development and recognises the need for local people to participate meaningfully in the process of analysing their own problems/ solutions, over which they have power and control, consequently leading to sustainable development" (MacDonald, 2012 p. 36; Whitehead, 2006). As such MacDonald (2012) defines PAR as a philosophical approach to research which recognises the need for persons being studied to

participate in all phases of the research process, from the design, execution and dissemination of the study findings of any research that affects them.

The primary aim of PAR is to unearth problems or strengths that can be used to better develop an organisation or service (Danley & Ellison, 1999). It was expected that girls, their mothers and grandmothers would start to question and reflect on the relationship between the initiation ceremonies and the development of risky sexual behaviours. The development of critical awareness through conscientization would assist them to identify both problems and solutions as well as an action, and in the process change their reality. This PAR fits in well with Freire's conscientization (as highlighted in chapter 3 - the conceptual framework). This transformative research paradigm aims at improving the reality of the people the research is about (Wilson, 2001).

Dickson (1997) adds that to achieve social change, researchers must take a critical and political stand on knowledge production and central to the research process, is to identify and address local issues/ problems in ways which link them to larger structural concerns. In this way the research contributes to the empowerment of the research participants and the redistribution of societal power. Bergold and Thomas (2012) also add that participatory techniques are employed to assist researchers and participants to understand complex issues in an inclusive and participatory way.

4.1.1. Why adopt an EPAR design.

EPAR was the preferred design for this study, because it gave the researcher the opportunity to directly engage members of the rural community in Balaka with a focus on increased

social justice on issues which contribute to negative SRH outcomes among young women (Mertens, 2010). This approach differs from other qualitative designs in many ways because its purpose is to guide the research process and action, as well as to link the research back to new initiatives, through the development and planning of new activities (Tacchi, 2015; Tacchi et al., 2009). Further, EPAR is perceived as a liberating process for stakeholders in low-income areas, the setting for this study (Danley & Ellison, 1999). This made it an ideal design for marginalised population, in this case young women of a rural community of Balaka district, who are subjected to cultural practices which do not always promote their rights and health. The other strength of EPAR, lies in its cyclical process of research, reflection and action as MacDonald (2012); Danley and Ellison (1999) suggest.

Bath (2009) observes that when the ethnographic approach is combined with action research, it builds upon the notions of immersion, long term engagement and understanding of local contexts holistically. Hence, Tacchi (2015); Bath (2009) claim that EPAR method is primarily designed to help projects develop and adapt to local situations and cultures and with this understanding, it is a form of developmental evaluation (Rashid et al., 2015; Patton, 2010). Therefore, EPAR fitted well with the study aim which is to understand the local context of intergenerational SRH communication practices, rituals and traditions with a purpose of developing and initiating SRH interventions to avert negative SRH outcomes.

4.2. Adopting a social constructivist lens

4.2.1. Social Constructionism

This study adopts a Social Constructionism (SC) perspective, which is an epistemological approach to acquiring knowledge, which provides a lens through which a phenomena can be

viewed and socially constructed (Gergen 1985). From a social constructionist view, there are multiple realities as reality and knowledge are socially constructed and different societies will create their unique realities (Martinez Perez et al., 2015; Wilson, 2001; Eberle, 1992). This paradigm assumes a transactional epistemology in which the researcher interacts with those being studied (Martinez Perez et al., 2015; Kivunja & Kuyini, 2017; Taber, 2012; Andrews, 2012) to make meanings from their experiences. It assumes that those being studied can construct the meaning of a situation, through discussions or interactions with other people and that meanings are socially or historically negotiated (Creswell, 2014; Reeves et al., 2015; Andrews, 2012). Social Constructivism stresses and maintains the social nature of knowledge, and the belief that knowledge is the result of social interaction and language use, as such, it is shared, rather than an individual experience (Berger & Luckmann 2023; Prawat & Floden, 1994).

Furthermore, Social constructivists believe that truths originate from people collectively searching for it, in the process of dialogic interaction (Nesari, 2015; Martinez Perez et al., 2015). They are not concerned with uncovering the "truth" about "reality" and the validity of the knowledge generated rather, they are concerned with seeking explanations, meanings and gaining a deeper understanding of how people make sense of the world in which they live and how any body of knowledge becomes socially acceptable (Berger & Luckmann, 2023). Sexuality has been described as a social construct and as such, the meanings attached to it are strongly reflective of societal and cultural values present within different cultural groupings (Galbin, 2015; Galbin, 2014; Godia, 2012). This study assumed that the sexual behaviour of young women is created and enhanced through existing social processes and institutions and that, through social interaction, young women learn the social norms, cultural values and

beliefs, and ultimately exhibit behaviour that conforms to these beliefs and practices (Galbin, 2015; Galbin, 2014).

Critics have argued that social constructionism assigns a passive role to the individual's psychology, creativity and personal values while putting more emphasis on socialisation, language and values within given social settings or groupings (Burr & Dick, 2017; Bury 1986; DeLamater & Hyde, 1998). It is also argued that since social relations show great variability across different societies, theories derived using a social constructionist approach often reflect lived experiences of the persons under study and may not be reflective of views that can be generalised (Turnbull, 2002; Gergen, 2015). Nevertheless, social constructionism provides an avenue of gaining an understanding of how people place meanings on their everyday experiences and interaction with other members of the society (Cunliffe, 2008).

A social constructionist approach has been used in other research such as understanding human sexuality and discourses around sex (DeLamater & Hyde, 1998; Foucault, 1978), the creation and change of sexual meanings within social groupings (Villaneuva, 1997; Faulkner, 2003) and exploring the role of metaphors in understanding sexual violence (Vernon, 1998; Pseekos & Lyddon, 2009; Ramos, 2000). Through narratives of HIV positive persons, the social constructionism approach has been applied to make ''sense" of what ''safe sex" means within the Kenyan social and cultural context and the implications for policy formulation (Nzioka, 1996) as well as how HIV/AIDS is understood, responded to and treated in South Africa (Goldstein et al., 2003).

In South Africa, Shefer et al. (2002) applied the social constructionist approach to understand perceptions of STI, sexual behaviour and health seeking behaviour for STIs among

community members (Shefer et al., 2002; Goldstein et al., 2003). The social construction approach has also been applied in Malawi to make sense on the conceptualisation of sexual violence, the transaction of sex within the local economy and fish industry, and the construction of sex and sexuality as this influences cultural practices and women's vulnerability to HIV transmission and health care seeking behaviours (Kathewera-Banda et al., 2005).

4.2.2. Why a Social Constructionism approach

In this study, social construction is used as a tool to help tease out and gain a deeper understanding of the social and cultural factors that have an influence on young women's decision making and sexual behaviours. It helped to understand local meanings placed on SRH issues and therefore enabled one to explain how, within a local context, SRH communication approaches, rituals and traditions operate. It also helped to identify the meaning placed on events, actions and occurrences that are likely to have a direct effect on SRH behaviours and decision making. By taking a social constructionism stance in this research, the different contradictions, tensions and meanings placed on accounts obtained during interviews, FGDs and participant observations can be better understood. It is important to note that people's experiences are never "raw" but are entrenched in the social web of interpretation and re-interpretation (Godia, 2012 p. 100).

Social constructionism therefore helped one in taking a critical view on how SRH communication practices, rituals and traditions are organised, the meaning SRH communication practices, rituals and traditions have to young women, mothers, grandmothers and SRH counsellors, the language and labelling placed on the SRH communication

practices, rituals and traditions, and how the stated factors may either facilitate or hinder healthy sexual behaviours and decision making. It is only after we understand the social meaning placed on the SRH problems of young people, that we can understand how SRH communication practices can be improved.

4.3. The study area

The study took place in Mbatamila village under T/A Nsamala in Balaka district, Southern region of Malawi, (see Figure 2.2) which is the poorest region in the country (Tawfik &Watkins, 2007). The district has several tribes, but the main ones are the Yaos, Lomwes and Ngonis. They live in harmony with many inter-tribal marriages taking place. This study focused on the Yao women of Mbatamila village, their culture and cultural practices, religious beliefs and source of income (see chapter 2, section 2.1.7). Both Men and women in Balaka District are poor, Mbatamila men and women inclusive.

Balaka is a predominantly matrilineal and matrilocal society and family leadership roles pass down through the female's family and upon marriage, a husband moves to his wife's village (Mbalaka, 2016), where he remains somewhat as an outsider (Tawfik &Watkins, 2007). Divorce rates are high, and polygamy among men is common although women are not allowed to have more than one husband (Mbalaka, 2016). Balaka is also one of the districts in the Southern region of Malawi with the highest documented rates of HIV infection (NSO, 2011) teenage pregnancy and risky sexual behaviour, including early sexual initiation (NSO, 2011). According to the 2010 MDHS, 26% of young women aged 15–19 have already begun childbearing: 20% are mothers and an additional 6% are pregnant with their first child (NSO, 2011). In addition, young motherhood is more common in Balaka than the other districts. For

instance, according to NSO & ICF (2017) adolescent birth rate or age-specific fertility rate for women aged 15-19 years is at 173/1000 live births higher than the whole southern region which is at 162 and at national level which is at 143.

Likewise, early childbearing (Percentage of women aged 20-24 years who had at least one live birth before age 18) is at 37.0% higher than national level which is at and 31.1% (NSO & ICF, 2017). It was also noted that 38.1% percent of the women of reproductive age in Balaka were not using any contraceptive method (NSO & ICF, 2017). Another reason for selecting this region is that it is where I am from, and I am more comfortable in the languages commonly spoken. As I mentioned in chapter 1, I wanted to return to the community of my childhood and understand the issues for myself and to see, as a public health nurse, if the study could positively impact on the lives of these rural women.

4.4. Research design overview.

This study was conducted in seven steps as shown in Figure 4.1.

Step 1. Literature review. This drew upon the national and international literature to understand the SRH problems of young people. The review examined the contributing factors to these problems as well as the effectiveness of SRH interventions that have been implemented in LMICs, especially in sub-Saharan Africa. The review examined the SRH interventions that have been implemented in Malawi at family, community and at national level. The literature review also examined the conceptual models which are essential in understanding young people's sexual behaviours and decision making, as well as in the implementation of a health improvement intervention.

Step 2: Community entry and accessing research participants. This stage included introductions to the village, meetings with the HSA, senior chief and village chief, for their buy in and advise about how to recruit research participants.

Step 3. Data collection. This included three data collection methods: in-depth interviews; focus group discussions (FGDs); participant observations and field notes which were used to uncover and explore diverse SRH knowledges, rituals and traditions. Using the three methods was useful as it complemented the data enabling a degree of triangulation, as there were some variations and correlations on what the participants said and did which added depth to the generation of ideas and understanding of participants' views, perceptions, experiences, values, beliefs and expectations about a phenomenon (Patton, 2002; Lopez & Whitehead, 2013). Charmaz (2014) emphasises that combining observations and conversations is a powerful data collection strategy as it provides multiple views of each incident for a researcher to think about.

FGDs and in-depth interviews provide a good social context for gaining a deeper understanding and putting meaning to young women's sexual health experiences and perspectives (Lopez & Whitehead, 2013). They also provide an opportunity for issues to be explored in detail, as the interviewer has the chance and time to ask questions and seek clarification of issues raised (Lopez & Whitehead, 2013).

Step 4. Preliminary analysis and diagnosis. The third stage of the research involved using findings from the participant observations, to identify factors which might have contributed to the negative SRH outcomes among young women to inform an intervention.

Step 5. Feedback meetings. This stage of the research involved feeding preliminary findings back to the community, targeting key individuals (the village chief) and groups (traditional counsellors and young women) to obtain their opinions and views about the issues/ problems and for possible solutions in order to develop an intervention.

Step 6. Development of the health improvement intervention. This involved conducting training to young women and traditional counsellors to improve their understanding on SRH issues and in future those of the women and girls in this community, with the aim of reducing negative SRH outcomes.

Step 7. In-depth interpretive thematic analysis. This was conducted after field work when I returned to the UK. I used the step-by-step analysis by Braun and Clarke (2006).

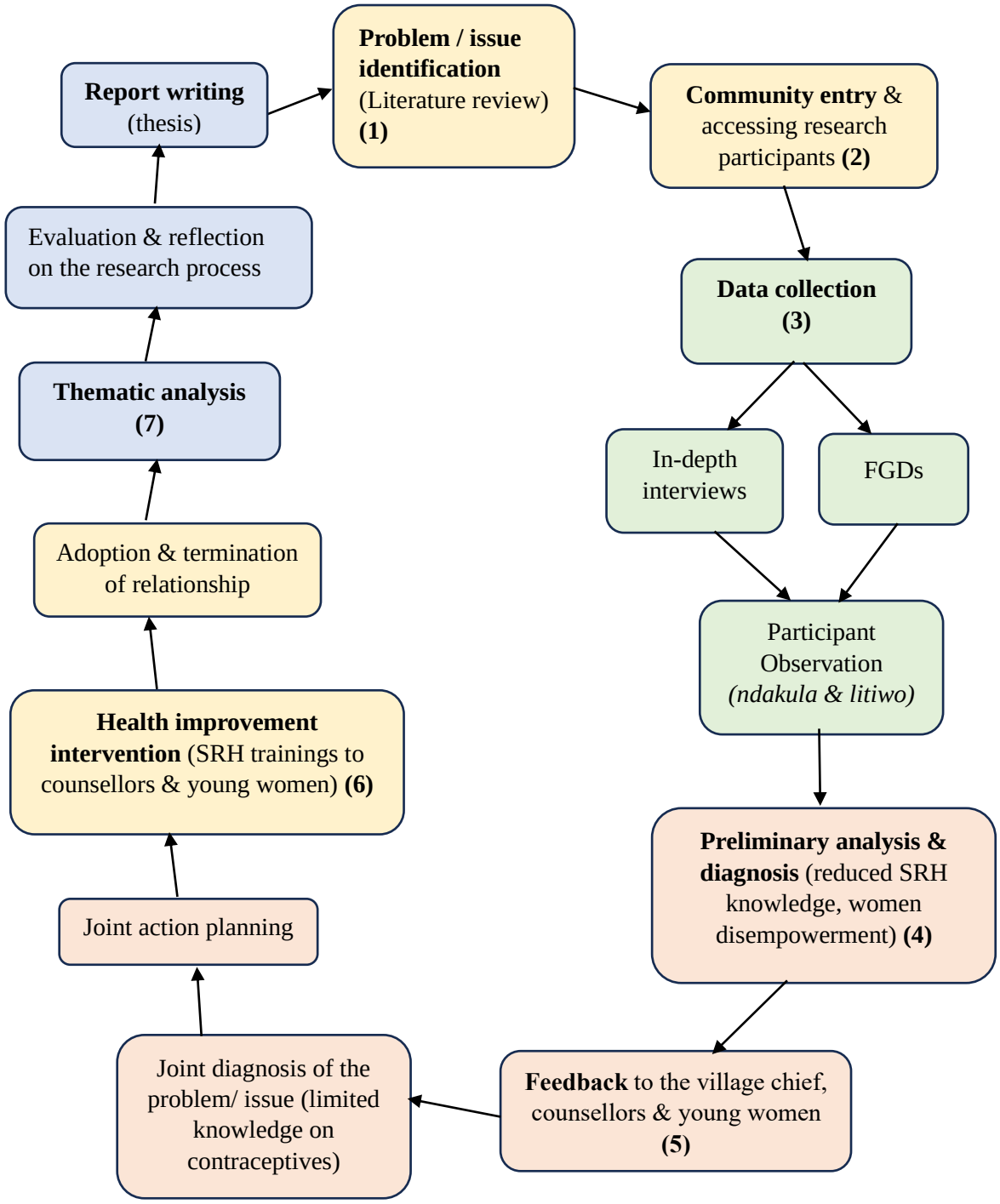


Figure 4.1 A diagram showing the development of the research

4.5. Sampling methods

Non-probability sampling techniques were used in the selection of the study setting and participants, including purposive sampling and snowball sampling.

Purposive sampling: The major sampling approach used in the study was purposive – that is, information-rich participants, who were able to provide an in-depth understanding of the area under study were selected (Moser & Korstjens, 2018; Patton, 2002). This is the most common approach to qualitative sampling whereby, the sampling units are not chosen in a random manner, but on the basis of some of their characteristics. The researcher's practical knowledge of the study area, information available in the literature and from the study itself was strategically used by the researcher to select information rich participants. Use of purposive sampling strategy enabled the inclusion of participants who represented the groups I was most interested in (young women, mothers and grandmothers) as well as some participants with specific expertise (SRH counsellors and key informants).

Snowball sampling: This involves identifying participants for inclusion in the sample by referral from other research participants (Moser & Korstjens, 2018; Chepuka, 2013; Lopez & Whitehead, 2013). This type of sampling is particularly useful where the sample is representative of marginalised or stigmatised individuals, as well as where the researcher is interested in finding and recruiting 'hidden populations', who are not easily accessible to researchers through other sampling strategies (Lopez & Whitehead, 2013 p. 125). In this study snowball sampling was used to identify other young women and key informants to be interviewed in the study area.

4.6. Data collection methods and tools

4.6.1. Data collection methods

This section describes the methods used for data collection. The rationale for choosing them is also highlighted, as well as how and where they were used.

4.6.2. Multi - methods used: interviews; focus groups and observation of rituals.

My primary data collection tool was individual interviews with 3 generations (grandmothers, mothers and young women) using a semi structured interview guide. Whilst most interviews were with young women, to understand inter-generational SRH communication more I also included some interviews with their mothers and grandmothers. The individual interviews were supplemented with FGDs, first with traditional and then religious counsellors as they are seen to play an important role in educating young women on SRH issues, as well as key informants because of their expertise in traditional medicine/ herbs which are paramount during rituals and ceremonies, as well as for SRH and wellbeing. The key informants were added later when I realised their role in contributing to the health care delivery system and to this research, by providing insights into the factors which influenced the rural women's healthcare seeking behaviours, particularly when deciding whether to use the Western medicine or traditional medicine, when confronted with an SRH issue/ problem. They key informants were identified through a young woman I interviewed, who was learning to be a herbalist. The young woman appeared to respect the traditional medicine and ways of life, so when I demonstrated interest on the topic, she referred me to her mother and grandmother who were both herbalists (the key informants).

Given the sensitivity of the topic under discussion, it was critical to ensure that the questions were non-judgemental, thereby encouraging a natural and responsive interaction between myself and the participants, in order to bring out a new understanding as the conversations were constructed and re-constructed (Khan, 2019). As such, I paid attention to interesting aspects in the interviews and FGDs and probed further. As data collection progressed, this provided me with knowledge about SRH communication practices, as well as consistent and inconsistent views and experiences on SRH issues. Thus, by the end of data collection I had a general view of patterns and associations to advance an argument (Creswell, 2014; Khan, 2019).

In-depth interviews

In-depth interviews were conducted to uncover young women and adult females' experiences and perspectives on SRH communication practices. An interview guide was used to ensure all topics were covered during the interview although, the 'two - way conversation' remained unstructured (Appendices 6A & 7A). The open-endedness of the questions allowed the conversation to unfold as determined by the participants, who were given the freedom to respond in a manner they were most comfortable with (Lopez & Whitehead, 2013). Because the in-depth interviews focused on the individual personal perspective and understanding, they enabled me to gather personal opinions, history and experiences when discussing the sensitive issue of SRH (Wigle et al., 2020; Minhat, 2015; Power, 2002).

The interviews were audio recorded and were conducted at a convenient time and place for the participants. Each interview lasted between 45 - 90 minutes. The interview guide was driven by the study objectives, questions and literature review. I frequently had to switch to the local dialect (Chiyao) mainly when I was interviewing the grandmothers and some

mothers because they were not very comfortable with the local national language (Chichewa). A total of 20 in-depth interviews were conducted with 10 young women, 4 mothers, 4 grandmothers and 2 key informants.

Focus group discussions

A focus group can be defined as a group of individuals selected and assembled by researchers to discuss and comment upon, from personal experience, the topic that is the subject of the research (Stokes & Bergin, 2006 p. 4). It is usually homogenous comprising of 6 – 12 members and the discussion can last between 1-2 hrs, under the guidance of a moderator (Minhat, 2015; Sagoe, 2012). FGDs have the capacity to bring out a multiplicity of views (Krystallis et al., 2007) areas of consensus and voices of dissent and thus provide an opportunity for collection of data on social norms (Smith et al. 2002) and the discussion of issues mostly considered to be a taboo within a society (Wigle et al., 2020; Reisner et al., 2018).

Further, FGDs have gained significance in sexual health studies and have been found to be of great value in exploring discourses involving sexual health in Malawi by Mkandawire-Valhmu and Stevens (2010), Wigle et al. (2020), Mutea et al. (2020), assessing knowledge, attitudes and practices with regards to SRH services such as contraception (Namukonda et al., 2021; Moyo & Rusinga, 2017), adolescent childbearing (Barker & Rich, 1992; Beyeza-Kashesya et al., 2010) and parent-child communication on sexuality in South Africa (Mpondo et al., 2018; Wilson et al., 2010). FGDs have also received recognition in feminist research as a critical method of inquiry with marginalised groups (Wilkinson, 1999).

In this study, FGDs were conducted among traditional counsellors and religious counsellors, with the aim of understanding their perceptions of and experiences with regards to SRH issues. I conducted the FGDs, and I was a moderator and a note taker. I was responsible for guiding the discussion, which began by welcoming the participants, leading the introductions and obtaining consent for participation and audio-recording. I also followed up the discussion with appropriate probes for depth and clarification of issues, as well as taking notes, noting down non-verbal responses and ensuring that the audio-recoding was on-going. Each FGD consisted of 3 - 4 participants, was audio recorded, so that I could remain focused on my facilitation role (Moule & Goodman, 2009) and lasted for over 120 minutes.

Although I had planned to recruit 6 – 8 participants for each group, neither of the two groups had the preferred number, as one member in each group had fallen ill on the day we met. I suggested conducting a one-to-one interview as a backup, as I had indicated in my study protocol, but they all refused insisting that they meet with me as a team. They also refused my second option, which was to postpone the FGD until the other members felt better, saying it's not in their hands to decide, as ill-health and good health comes from God. Considering that this is an EPAR project I opted to respect their wishes. An interview guide (Appendix 8A) was also used and the FGDs were conducted at a convenient time and place for the participants.

Participant observation

Bernard (1994) defines participant observation as the process of establishing rapport within a community and learning to act in such a way as to blend into the community so that its members will act naturally, then removing oneself from the setting or community to immerse oneself in the data to understand what is going on and be able to write about it (Kawulich,

2012; Kawulich, 2005). In this study I employed Bernard's definition because it resonated well with the tenets of EPAR. Further, the observations were used to triangulate the data, that is, to verify the findings derived from the in-depth interviews and FGDs.

The observation guide (Appendix 9) was mainly used before and after the observation, due to the nature of the initiation ceremonies and being a participant observer. However, this was in line with Charmaz 's (2014) recommendation that novice researchers should develop observation guides to help them think through and observe the kind of events which can assist them to achieve their study objectives. Notes were taken during the observations with some pictures and expounded at the end of the observations. Pictures were taken for contextual purposes and consent was sought from the participants.

This enabled me to have a broader view of the issue under investigation (Burns & Grove, 2011). Observations enabled me to collect first-hand information on the realities of the interaction as participants act and engage in a conversation at the same time (Kawulich, 2005). Throughout the observations, I was able to observe, listen, reflect and reconfirm the findings with the participants at an opportune time (Wehbe-Alamah & McFarland, 2015). I constantly asked myself, 'what is happening here'? which assisted me to reflect on what I was seeing and hearing during the initiation ceremonies observed (Charmaz, 2014).
I was a participant observer, for 3 days, for two of the three girls' initiation rites, namely *ndakula* (puberty rite) and *litiwo* (a rite for a girl with first pregnancy). These initiations were conducted by the traditional counsellors, with the participation of girls, mothers and grandmothers who had gone through the process themselves as described in the next chapter. However, I was unable to observe *msondo* the first initiation rite for a girl child, which is performed before menarche, when the girl is around 7 - 10 years. This is because it was

conducted while school was in progress, and I did not want to be considered as being insensitive to the girl child education.

However, general observation of participants was an ongoing activity from the time I entered this community to the farewell day. The observations were significant in this study as they helped to expose the context of intergenerational SRH communication practices. While in-depth interviews and FGDs assisted me to gain insight on how intergenerational SRH communication practices are conducted in this community, it was the observation that unearthed some of the problems/ issues of the rituals and traditions which could be linked to risky sexual behaviours and negative SRH outcomes. This is what informed the health improvement intervention, described in chapter 6.

Field notes

Field notes were taken throughout the fieldwork, and during the observations, in depth interviews and FGDs to comprehensively describe the key issues of the interactions, which transcripts could not capture such as the atmosphere of the interviews, FGDs and participants' emotions and reactions (Kawulich, 2005; Deggs & Hernandez, 2018; Phillippi & Lauderdale, 2018). In addition, a research journal was kept, documenting the researcher's thoughts, ideas and reflections on emerging understanding of the data and the researcher's supervision questions throughout the research (Phillippi & Lauderdale, 2018; Deggs & Hernandez, 2018). These two additional tools supported accuracy and enhanced triangulation to facilitate rigour and trustworthiness (Yin, 2010). The processes were guided by the following questions: ''what is the context of this issue''? ''who are the actors''? ''what are they doing''? ''what do they mean and why did they do that''?

4.7. Selection and recruitment of participants

4.7.1. Community entry and accessing the research participants.

Although the community entry was less daunting because of my rural upbringing and my work as a Community/ Public health nurse, as advised by previous ethnographers like Sangasubana (2011), I gained access to the community through the HSA - Mrs Chinkhaka. She was instrumental in assisting me in meeting gate keepers, the Traditional Authority (T/A) [Senior chief] and the Village chief. The Village chief reports to the Senior chief, who reports to the District Commissioner, who gave verbal approval to access the research participants (see Figure 2.1 in chapter 2 for the organogram). The senior chief pledged his full support for the project and asked the HSA to give me all the support which I may require, and he said that if there were any problems, I should not hesitate to contact him.

The Village chief was supportive too, even suggesting that I commence data collection immediately. This is because community leaders have many roles on adolescents HIV and SRH, which includes advisory, regulating and restricting cultural practices, encouragement and handling sexual abuse complaints (Chimatiro et al., 2020). My last visit to the village had been 30 years ago, and many things had changed, including the route to the village, because the river had shifted its course, rendering the old track impassable. In many ways this new route became a metaphor for the approach to the research and my relationship with the community.

After the ethical approvals from the University of Essex Research and Ethics Committee and the National Committee on Research in the Social Sciences and Humanities in Malawi (see Appendices 10 &11) and before proceeding with fieldwork, I had to seek permission from the

District Commissioner (DC) and the District Health Officer (DHO) who had different requirements, than I had anticipated (Appendix 12). For instance, at the DHO I had planned to brief the District Health Office Management Team (DHMT) for endorsement and to work with the HSA. However, I was referred to the Research Director, who informed me that I had to give a presentation to the research team. While presenting to the research team at the DHO I met other researchers, such as those from Population Services International - Malawi (PSI-Malawi, who provided more insight into my research project through their comments and questions.

4.7.2. Identification and recruitment of research participants

There were few difficulties experienced in identifying and recruiting participants, and most of the interviews were conducted in the afternoon, when women were relaxing. There were no pre-requisites on who was to be interviewed first. Often the first person to be interviewed was based on who was willing and had consented to be interviewed or who was available at the time I had arrived, to conduct the interviews. As such, the process was flexible to accommodate either the grandmother, mother or the granddaughter, only bearing in mind the numbers that were anticipated for the project to have value. The interviews adopted an informal conversational tone to foster connection, consequently allowing for a natural flow of information.

Although, it was clearly spelled out during the recruitment phase the purpose of the research and the anonymity issue, some participants queried the reason for the research, while others were looking for reassurances, that the chat would not be aired on the radio stations in Malawi. Another issue worth noting was related to the conflicted role and ethical dilemma I

faced during a FGD with the religious SRH counsellors, who had suggested that I should have my labia elongated as a prerequisite to the participant observation of their counselling sessions of *ndakula* [popularly known *chinamwali cha atsikana* in the Catholic church]. This suggestion might have risen because I had never attended an initiation ceremony when living in the village as a young girl, as such they were not sure I would accept their ways. However, the issue was never explored further, because the ceremony was postposed to the following year due to the Covid19 pandemic, and by then my fieldwork had ended. It is also important to note that none of the research participants became upset during the interviews, including the young women who went through the initiation ceremonies I attended.

Three categories of participants (young women, mother/grandmothers and SRH counsellors) were included in this study and a fourth category (key informants) was added to provide more insights on traditional medicine. To recruit the sample initially, I worked closely with the gate keepers, the village chief, the HSA and the community, to ensure that their expertise and networks were engaged in the process of selecting the research participants.

- Young women
- Mothers and grandmothers
- SRH counsellors
- Key informants

4.7.3. Selection of young women

The selection criteria for young women included any young woman married or unmarried who was 16 years and above, but not more than 24 years and was willing to participate in the study. (This is, because at 16 years many girls have attained puberty and are sexually active). Young women were excluded from the study if they were outside this age range or if they

self-reported to be on mental health treatment. Parental consent was meant to be obtained for the young women who were 16 or 17 years old. However, all the participants were 18 and above. Through the HSA, who was instrumental in making the introductions, this process identified 10 young women who then took part in the interviews.

4.7.4. Selection of mothers and grandmothers

Inclusion criteria for mothers were anyone above 24 years and was willing to participate in the study. Those below 25 years or who self-reported to be on mental health treatment were excluded from the study. For grandmothers, any female adult who had a granddaughter (s) and was willing to participate in the study was included other than those who self-reported to be on mental health treatment. This process identified 4 mothers and 4 grandmothers who took part in the interviews.

4.7.5. Selection of SRH counsellors

Two methods were used in the selection of SRH counsellors: Purposive sampling and snow balling. Women/ elderly women who were either traditional or religious SRH counsellors were approached for inclusion. This process identified 4 traditional SRH counsellors and 3 Catholic SRH counsellors, despite this village being a predominantly Muslim community. This is because I was only made aware after I had been granted access approval by the village chief that unlike in Christianity, there are no religious SRH counsellors in Islam.

4.8. Ethical Considerations

4.8.1. Research Ethics Committee Approval

Ethical approval was obtained from both the University of Essex Research and Ethics Committee and the National Committee on Research in the Social Sciences and Humanities in Malawi.

4.8.2. Travel and access Approval.

I also had to seek travel approval from the University Registrar in addition to the ethical approvals and these were particularly complicated due to the Covid 19 pandemic travel restrictions and regulations, which delayed the whole process of fieldwork. A number of approvals were obtained in Malawi at different levels before embarking on fieldwork. At the District level I obtained approval from the District Commissioner and the District Health Office. At the community level with the assistance of the local HSA, I obtained approvals from the T/A (Senior chief) and the Village chief, who gave verbal approval to access the research participants.

4.8.3. Consent for the in-depth interviews, FDGs and Observations

Before the individual interviews and the FGDs were conducted, informed consent was obtained from each research participant, who signed, or thumb printed a consent form as an indication of agreement to participate in the study. All the consent forms were translated into the local language and all the explanations and requests were made in the local language too, as none of the participants were conversant with English. With regards to the participant observation, verbal consent was obtained from the traditional SRH counsellors to signify acceptance to participate in the two initiation ceremonies (*ndakula* and *litiwo*). This was done

after an explanation had been given to the participants about the purpose of the study and the importance of their views on the SRH communication practices, rituals and traditions.

Participants were also given information sheets which had details about the purpose of the study. Permission was sought from the participants to have the interviews and discussions audio recorded. Participants were assured of privacy and confidentiality and that the data collected would only be accessible to me and my supervisors. Participants were informed of their right to refuse to participate in the study and that they were free to withdraw from the discussion at any time. Participants were informed that they might not benefit from the study directly, but the results of the study would be helpful in enhancing healthy sexual behaviours among young women in future.

4.9. Data management and analysis

Qualitative data analysis is described as a continuous process that begins at the initial phase of data collection and aims at bringing meaning to the topic under study (Rabiee, 2004; Godia, 2012). Due to the large quantities of data collected in qualitative research, it is essential to have the data collection and analysis taking place concurrently so that subsequent interviews and discussions build onto the previous ones (Rabiee, 2004). Analysis of qualitative data is therefore an inductive process that is highly iterative, time consuming and largely driven by the researcher (Steers, 2012). I was able to transcribe and conduct the very preliminary analysis of the data as I collected it thereby, enabling me to carry out the research inductively. It gave me the opportunity to probe more effectively in subsequent interviews and have sufficient familiarity with the interview data to generate some initial findings to use to develop an intervention.

A thematic framework approach by Braun and Clarke (2006) was used to analyse collected data. This was based on Maguire and Delahunt's (2017) suggestion, that this approach is fit for use in participatory action research, as it does not only organise and describe a data set but goes further to include interpretation of various aspects of the research topic. The analytical process was systematic and followed the six key steps of Braun and Clarke (2006). (See figure 4.2).

Figure 4.2 A picture showing a summary of the analytical process

4.9.1. Phase 1: Familiarisation with the data.

Transcription of the audio recordings and notes

Transcription of the data collected in this study was done by me (the researcher). For young women whose interviews were conducted in Chichewa, the verbatim transcriptions were done directly in English. For mothers, grandmothers, key informants and counsellors whose interviews and discussion were conducted in Chichewa and Chiyao the verbatim transcription were also done directly into English. Even though, the initial plan was to have the recordings, first transcribed in Chichewa and then translated into English, it became apparent that the process would take too long. I translated and transcribed the recordings into English, which was necessary as my supervisors were conversant in English language and not in the local dialects. It also enabled familiarisation or immersion in the data very soon after it was collected. Reading the transcripts line by line was done to generate an initial list of ideas, about what is in the data, and what is interesting about them.

Checking and validation of the transcripts.

In order to ensure accuracy and consistency of the transcripts, the checking and validation of all the transcripts was done by me (the researcher) as I am conversant with the two local languages (Chichewa & Chiyao) and English. Transcript checking was done so as to ensure their accuracy and conformity with what was said by the participants. Some of the participants were asked to listen to the recorded interview to ensure accuracy of the information and I also shared the transcripts with my supervisors. Member checking was done with those participants who had shown interest to hear what they had just shared. There was also a rigorous activity that involved listening to the recordings and at the same time,

reading the transcripts to ensure accuracy in language translation and making amendments where necessary.

Checking and validation of the transcripts was used as a way of familiarising with the data (first step in Thematic analysis by Braun & Clarke, 2006) and initial identification of common thematic areas (Stenfors et al., 2020; Braun & Clarke, 2006). To ensure accuracy of the transcripts, three of the transcripts, two for young women, one for traditional counsellors were randomly selected and reviewed by my supervisors who cross-checked them for accuracy (Creswell, 2014; Stenfors et al., 2020). Apart from the typing errors the transcripts were found to be accurate and of good quality.

4.9.2. Phase 2: generating initial codes.

This phase involves the production of codes from the data. Codes identify a feature of the data (semantic content or latent) that appears interesting to the analyst, and refer to "the most basic segment, or element, of the raw data or information that can be assessed in a meaningful way regarding the phenomenon" (Boyatzis, 1998). Strauss and Corbin (1998) summarise this process by simply defining coding as a process, which involves the researcher asking questions about, making comparisons to derive concepts that emerge from the data.

Development of the thematic framework

Following familiarisation with the data, a thematic framework for each set of transcripts, by each category of participant (young women, mothers, grandmothers and counsellors), was developed. This was guided by the research questions, objectives of the study and the major themes and concepts that emerged from each set of transcripts (Braun & Clarke, 2006) or

rather the repeating ideas that came from the raw data (Spencer & Ritchie, 2012). All the data were explored inductively to generate initial thematic categories (Gibbs, 2007; Furber, 2010). This stage led to the development of an initial coding framework which was subsequently used for coding or indexing. The transcripts for each category of participants were read one by one while noting on the right-hand margin of the transcript the initial themes generated from each section of the data. Once all the transcripts were read, the emergent themes recorded on the margin of the transcripts were then sorted and merged together to construct the initial thematic framework.

In developing the thematic framework, the following questions were asked while reviewing the raw data and using a social constructionism orientation.

> *What is the meaning of what the participant is expressing in this section of the data?*
>
> *Is this expression similar to what has been said earlier?*

Particular attention was paid to the frequency with which emerging issues were mentioned among the different participants, differences or similarities in views across the participants and specific examples of personal experiences given by the participants (Lopez & Whitehead, 2013). Identification of similar thematic areas across the study groups helped increase the trustworthiness of the data (Stenfors et al., 2020). The data analysis process also involved identifying majority views, minority views and also conflicting arguments. During this phase I asked myself questions, made comparisons about the data and I ended up with a lengthy list of different codes, identified across each data set while at the same time noting the tensions and inconsistencies among the codes.

4.9.3. Phase 3: searching for themes.

When all data had been coded, I sorted out all the different codes into potential themes and organised all the relevant coded data extracts within the identified themes. A table was used to demonstrate the relationship of emerging themes and between different levels of themes (Braun & Clarke, 2006). (See Appendix 13). The sorting of the identified themes involved listing all the themes identified and re-grouping them into main themes and sub-themes or sub-categories (Furber, 2010).

Categorising and coding of the data using thematic framework.

Computer-aided qualitative data analysis software (CAQDAS) QSR NVivo was used for data organisation and management. Unlike sticky notes, NVivo has enormous flexibility with respect to data handling and manipulation, as it is retrievable, easily organised and gives the researcher the liberty to either create, delete, alter or merge at any stage of the coding process (Wong, 2008). QSR NVivo allows for easy coding of the text on to the different themes, sub-themes or categories and allows for multiple coding of text to help in the identification of links and associations within the data.

4.9.4. Phase 4: reviewing themes.

This phase involves two levels of reviewing and refining the themes. The first one involved reviewing the themes at the level of the coded data extracts and this was done by reading all the collated extracts for each theme and considering whether they appeared to form a coherent pattern or not. If a coherent pattern was formed, then I would go to next level. If not, then there was need to find out if the theme itself was problematic, or whether some of the data extracts within it simply did not fit there – in which case, I would rework the theme,

creating a new theme, finding a home for those extracts that did not currently work in an already-existing theme, or discarding them from the analysis (Braun & Clarke, 2006). Once I was satisfied that the themes adequately captured the contours of the coded data – only then I would go to the next level. In the second level, I considered the validity of individual themes in relation to the data set.

4.9.5. Phase 5: defining and naming themes.

Once I was satisfied with the thematic map of the data I had compiled, I conducted a detailed analysis for each individual theme, to identify the story that each theme tells, and how it fits into the broader overall story, and in relation to the research question or questions. This was achieved by identifying the essence of what each theme was about as well as in determining what aspect of the data each theme captured. After doing this I organised them into a coherent and internally consistent account, with accompanying verbatim quotes. (See figure 4.3).

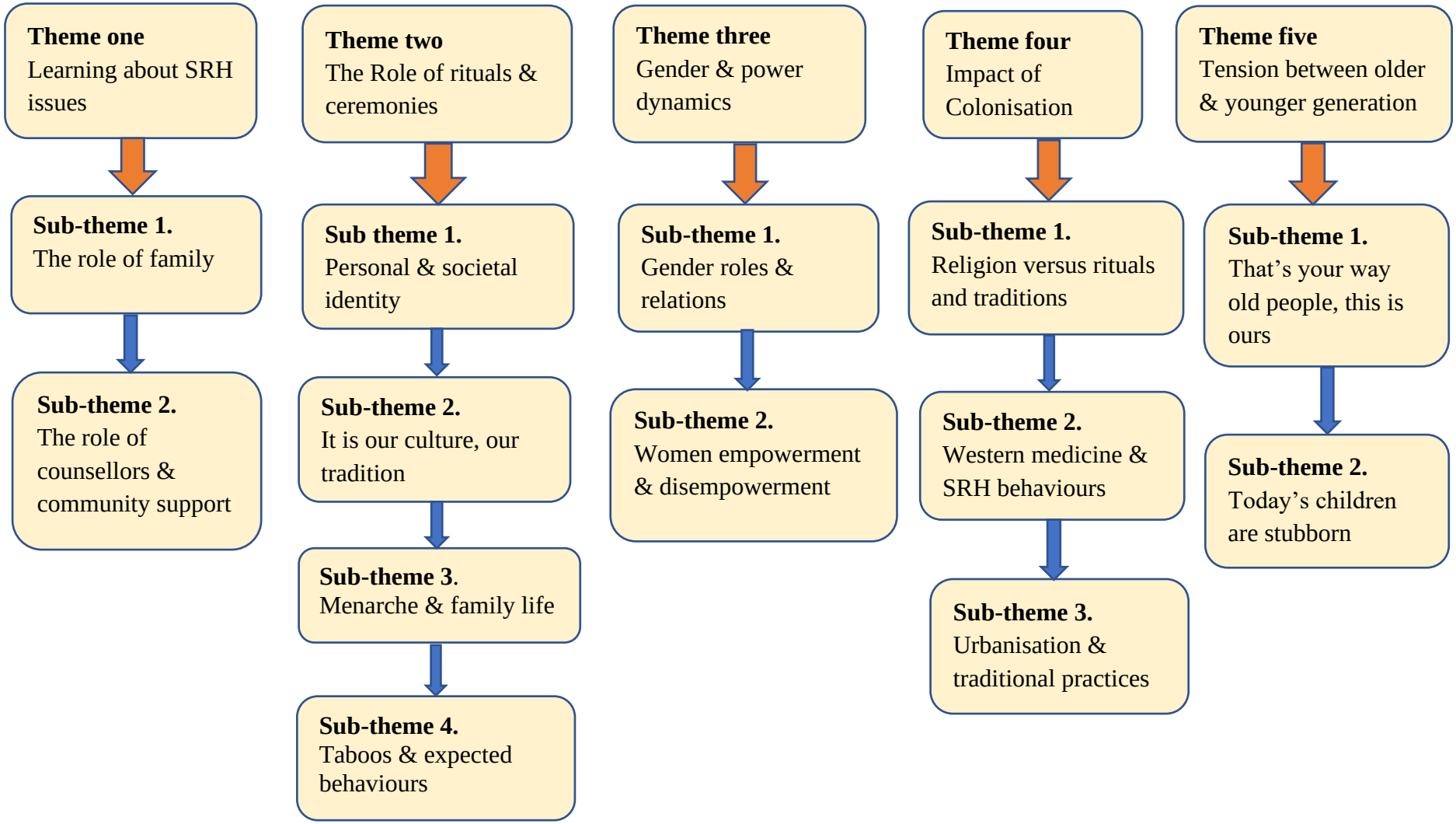


Figure 4.3 A diagram showing overall themes and sub-themes for the three generations, counsellors and key informants

4.9.6. Phase 6: producing the report.

Braun and Clarke (2006) recommend, that the analysis provides a concise, coherent, logical, non - repetitive and interesting account of the story the data tell – within and across themes. As such the analysis of data included a detailed description of all the interviews, FGDs verbatims its context, and the themes within the data set, followed by the thematic analysis across the data set. Analytical categories having been identified were used to form the final themes which were used in summarising and presenting the results. Concurrent examination of findings from in-depth interviews, FGDs, observations and different participants was used to identify points of convergence and departure (Lincoln & Guba, 1985). The identification of the original data source was maintained in the analytical process for easier reference and data retrieval.

4.10. Judging trustworthiness of the data

Trustworthiness is a term used in qualitative research to establish whether data collected during the research process is credible, transferable, dependable and confirmable (Lincoln & Guba, 1985). Trustworthiness of the data collected in this study was met through triangulation of three aspects of data collection: having different participants, using three different methods of data collection, using a researcher who had experience to conduct interviews and moderate group discussions, and was conversant with the local dialects (Patton, 1999). Member checking was also another method that was used for assessing the trustworthiness of the research findings (Lincoln & Guba, 1985). Member checking was done through feedback meetings and follow up meetings after the participant observations (Lincoln & Guba, 1985). In these feedback meetings, I presented the key research findings while allowing for feedback from the participants. The aim of the feedback meetings was to

establish whether the interpretation of the research findings was reflective of the views expressed by young women and the counsellors. It was also to countercheck whether the concerns young women had raised about SRH issues, agreed with the views of the counsellors. I also shared some of the interviews with my supervisors and we compared the themes that we each identified to ensure that my interpretation of the findings reflected the data (Pastor-Montero et al., 2012).

4.11. Positionality in the research process

It is well acknowledged that since the researcher is an instrument in qualitative research it is important to know the values, beliefs, knowledge and experiences the researcher brings into the research process and how this may positively or negatively affect the research process (Patton, 1999). This is also known as reflexivity and has been shown to enhance the understanding of the area under study (Rachamose, 2022; Martínez Pérez et al., 2015). My positionality was explained in chapter 1, and I have tried to illustrate when describing the research method how my personal familiarity with the experience of participants impacted on all phases of the research process, including the recruitment of participants, data collection either through interviews and/or observations, analysis, and as will become apparent in subsequent chapters, the interpretation of the data. I reflect on this at length in the following chapter. It is though worth mentioning here the tools I employed to aid reflexivity. This included the use of a logbook to provide a clear audit trail of reflexive accounts of both data collection and the analysis processes, including the impact of the researcher's presence, position and perspective on the research process as highlighted in chapter 5, 6 and 9 (Palaganas et al., 2017). Further, to avoid potential bias, I constantly consulted the participants each time we had an activity. When in doubt, I would consult my supervisors or

the HSA depending on the issue at hand and also to conform to the expected norms. I also kept a notebook, where I could list the objectives and tasks for that day, to help me focus on the activity at hand. Although I was accustomed to the expected cultural norms since I had lived and worked in rural areas, I was sensitive to their needs and expectations, and this assisted me to earn their trust.

4.12. Conclusion

This chapter has described in detail the methodological approach used during the research process. This study took a social constructionism approach and I pursued EPAR to gain an in-depth understanding of rural women's perspectives and experiences on SRH communication practices, rituals and traditions, lived experiences, the local meanings placed on them and how they influence their sexual behaviours and decision making. This study assumed that the sexual behaviour of young people is shaped and enhanced through social processes and institutions and that through social interaction, young people learn social norms and cultural values and ultimately exhibit behaviours that conforms to these beliefs and practices.

As such, I developed a research design that enabled me to gather data, using multiple methods, to answer the research question and locate individual experience within the social context. Young women, mothers, grandmothers, key informants and counsellors were recruited as participants and data was collected via face-to-face interviews, FGDs, participant observations and field notes. This chapter has also explained how data was collected and analysed.

Chapter 5 Findings from the field

5.0. Introduction to the Chapter

This chapter discusses the early findings from the field. I provide details of the participants and the initiation ceremonies I attended when gathering data, which are central in guiding the young ones on sexual matters and their social responsibilities. Further, the chapter ends with a reflection on my status as insider/outsider researcher and the impact that this had on the data collection processes.

5.1. Socio-demographic characteristics of the participants

The socio-demographic characteristics of the study participants are presented in Table 5.1. Figure 5.2 shows the interviewees' kin relationships and which interviewees formed familial inter-generational dyads or triads.

Table 5.1 Participants' demographics

ID number	Pseudonyms	Relation	Age	Education	Marital status	Religion	Source of income
1	Edina	Grandmother	70	Adult literacy	Divorced	Moslem	Subsistence farming
2	Hawa	Grandmother	+70	Did not go to school	Married	Moslem	Subsistence farming
3	Esitere	Grandmother	+70	Did not go to school	Widowed	Moslem	Subsistence farming
4	Dunia	Grandmother	+80	Did not go to school	Widowed	Moslem	Subsistence farming
5	Atuweni	Mother	48	Standard 1	Divorced	Moslem	Casual work/ farming
6	Esime	Mother	50	Standard 1	Married	Moslem	Subsistence farming
7	Hadija	Mother	46	Standard 8	Married	Moslem	Subsistence farming
8	Sumini	Mother	48	Did not go to school	Widowed	Moslem	Casual work, farming & selling fruits
9	Linesi	Young woman	21	Standard 7	Married	Moslem	Subsistence farming
10	Daina	Young woman	21	Standard 4	Married	Moslem	Casual work/ farming

11	Amina	Young woman	24	Form 1	Divorced	Moslem	Sells vegetables/ farming
12	Aida	Young woman	18	Standard 6	Single	Moslem	Casual work/ farming
13	Atupele	Young woman	19	Standard 7	Married	Moslem	Stays home
14	Awetu	Young woman	20	Standard 7	Married	Moslem	Stays home
15	Alinane	Young woman	23	Standard 6	Divorced	Moslem	Sells homemade snacks
11	Elube	Young woman	21	Form 4	Divorced	Catholic	Casual work
17	Mana	Young woman	23	Standard 4	Married	Moslem	Subsistence farming
18	Zione	Young woman	24	Standard 8	Divorced	Moslem	Casual work/farming
19	Alima	Key informant	65	Did not go to school	Married	Moslem	Subsistence farming/ herbalist
20	Lute	Key informant	+80	Did not go to school	Widowed	Moslem	Subsistence farming/ herbalist
21	Ananyoni	Team leader-Traditional counsellor	74	Did not go to school	Married	African church	Subsistence farming
22	Abiti	Counsellor	30	Standard 8	Married	African church	Subsistence farming
23	Anagama	Counsellor	72	Did not go to school	Married	Church of Christ	Subsistence farming
24	Andechele	Counsellor	70	Did not go to school	Divorced	Moslem	Subsistence farming

25	Idesi	Team leader-Religious counsellor	63	Standard 8	Married	Catholic	Subsistence farming
26	Consolata	Counsellor	75	Did not go to school	Widowed	Catholic	Subsistence farming
27	Eva	Counsellor	73	Did not go to school	Widowed	Catholic	Subsistence farming

Key:

First triad

Second triad

Third triad

First dyad

Second dyad

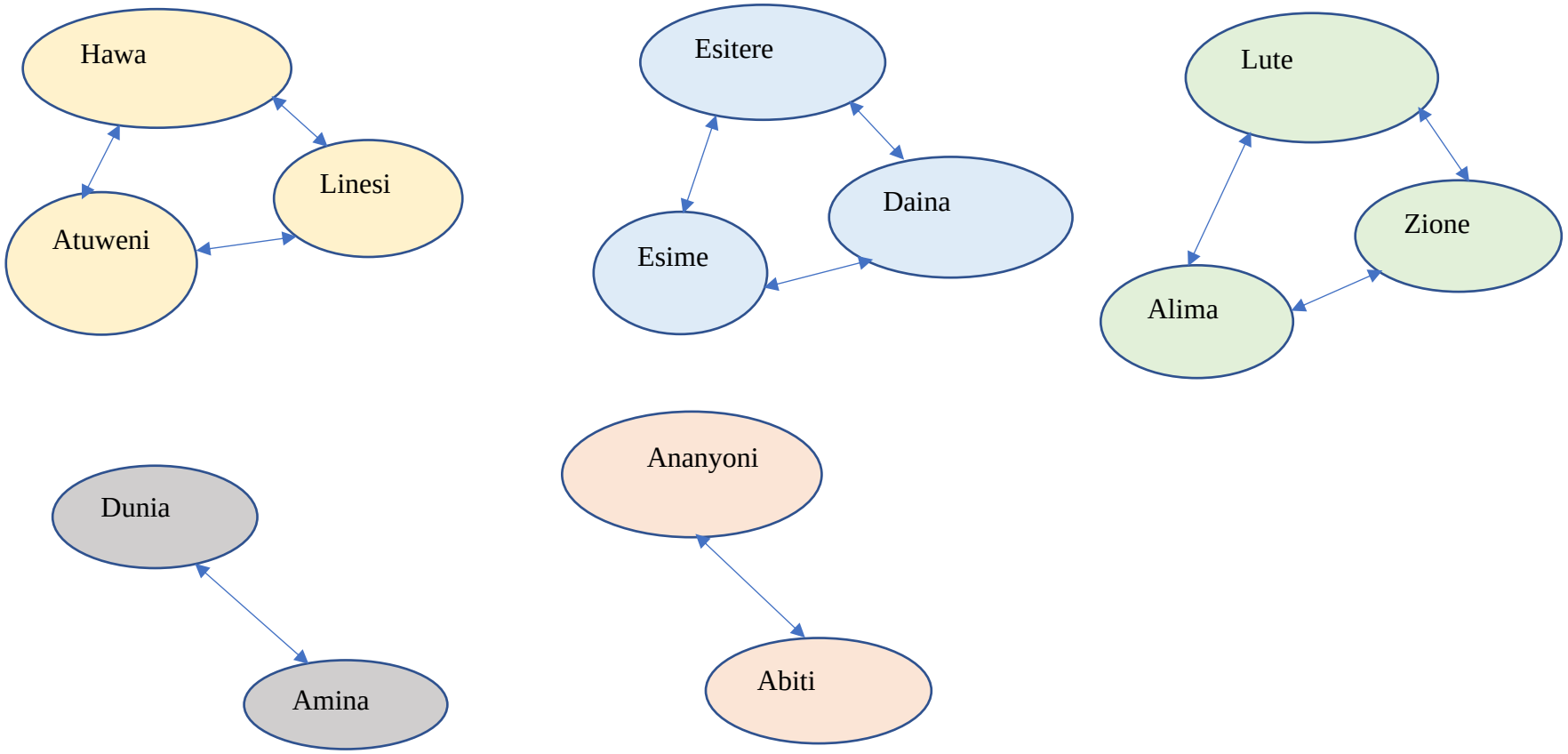


Figure 5.2 A diagram illustrating the triad and dyad relationships of research participants

A total of 20 semi-structured in-depth interviews were conducted. This included three triads of grandmother, daughter and granddaughter and a dyad of a grandmother and granddaughter and another one of a mother and daughter, key informants inclusive. Six young women, two mothers and one grandmother who were part of neither a dyad nor a triad were also interviewed (see Figure 5.2). Two FDGs, one with traditional counsellors and another with religious SRH counsellors were conducted. In addition, I attended a ceremony for two young women who had attained puberty *(ndakula)* and another for a young woman with her first pregnancy *(litiwo)*.

The participants thus consisted of three generations; the first generation comprised of four grandmothers between the ages of 70 - 80 with most of them being in their seventies. Only one of them was married, two were widowed and one was divorced. Six of the traditional and religious counsellors were between 63 and 75 years, and the seventh one was 30 years old, with four of them married, one divorced and three widowed. Of the two key informants, the daughter was 65 years and married, while her mother was over 80 and widowed. The age range for those in the second generation (their daughters) was 48 - 65 with most of them being in their forties. For the mothers, two were married, one divorced and one was widowed. The marital status of the women in the first and second generation were viewed to be significant because of the roles they play in guiding the young women on their transition from childhood to adulthood, including their reproductive lives.

For the third generation (young women), their ages ranged from 18 – 24, with the mean being 21 years. Five of the 10 young women were married, four divorced and one was single. Seven of them were mothers at 17, two by 19 and one by 14, and she was married at 13. Marital status was paramount, in establishing the roles and impact of SRH rituals and

ceremonies in young women's sexual and reproductive lives, which could be reflective of the matrilineal society of this community. Marriage is generally matrilocal and is transacted without the exchange of significant bride-price or a large dowry (Elie, 2019; Mbalaka, 2016). The bride price in this community was K5,000.00 (£5). Divorce is common and not complicated to accomplish, equally it is not difficult to get married.

The women had low incomes, relying on subsistence farming and casual work. In terms of education, none of the three generations completed secondary school. None of the four grandmothers attended formal school although one attended adult literacy classes. Only one of the four mothers could read and write. Two of the young women attempted secondary education, one dropping out in form 1 and the other in form 4, while the rest dropped out in primary school. There were few who could not read and write, mainly those who dropped out in junior primary classes. This gap in education was significant in the latent development and implementation of a health improvement intervention, as well as in designing the SRH reference booklet (highlighted in chapter 6). However, the study does not singularly purport educational achievement as an explanatory factor in the perception and understanding of SRH issues among the three generations. Rather it holds the socialised experiences and meaning of marriage and pregnancy as a contributory factor to the holistic and personal constructions of SRH issues and behaviour.

5.2. Participant observation of initiation rites for young women

Among the Yaos a girl child is expected to undergo three initiation rites in her lifetime, *msondo*, *ndakula* and *litiwo*. Special SRH instructors locally known as *'anakanga* or *anankungwi'* conduct these ceremonies and each girl has a mentor (Msiska, 1995; Personal observation (PO), 2021; Participants narratives (PN), 2021). Other women present also give

instructions but no men or uninitiated women (refers to those who have not gone through the process themselves) are allowed to take part in the ceremonies, with the exception of *litiwo,* where all mothers are welcome. The ceremonies are performed at different times, depending on the developmental age of the girl child, for instance *msondo* is performed before menarche, when the girl is around 7 - 10 years and *ndakula* after menarche. The girls seemed to be comfortable with taking part in the ceremonies, as it is something they had been expecting for some time. As such they were physically, emotionally and psychologically prepared. They had a mentor (someone, they are close to) at their side, throughout the ceremony to provide any support, they might need. The ceremonies are conducted upon parents or guardians' requests, who provide the necessary finances and material resources that might be required.

I was not able to observe *msondo,* but I describe it briefly here (based on findings from the literature and the interviews) in order to provide background context for the rituals I did observe. During *msondo,* a group of girls are secluded at a grandmother's or an aunt's house, usually with a fence for a period of 3 – 4 weeks, depending on the parents or guardians' preferences and availability of resources like food (PN, 2021). The instruction includes: the general traditional etiquette of the Yaos; respect for parents and elders, for peers, others and the community at large (Msiska, 1995; Mbalaka, 2016). Labia elongation commonly known as 'elevens' is also a central theme, such that if their elongated labia are not long enough, they are encouraged to start pulling, so that they are of the right size (about 2 centimetres) before menarche (PN, 2021). Castor oil mixed with herbs is provided to aid the pulling. The ceremony is conducted any time after harvesting and Ramadan but, before schools are open (PN, 2021). This time is deemed suitable, as the last day is marked by a festivity in the form of eating, drinking and dancing (Msiska, 1995; Mbalaka, 2016).

After the ceremony is over, the girl is thought to be a new person and is given a new name symbolising her new identity and is forbidden to play and interact with those who have not been to *mzondo*. A prefix *'Abiti'* is added to her father's name and that becomes her name onwards, for instance *Abiti Saidi*, and no one is allowed to call her by her childhood name. If caught using the old name by the elders, you can be fined, as it is deemed to be disrespectful (Msiska, 1995; Mbalaka, 2016). The last day at the camp is a day of celebrations and feasting. The girls in their new clothes are welcomed back to the community with ululation, drumming and dances. The girls are showered with money and gifts, alongside the mentors and the counsellors.

I was able to observe two ceremonies; *ndakula,* which aims to prepare the girls for married life and all that goes with adulthood in general (Msiska, 1995) and the duration varies from 1 -7 days, depending on the parents or guardians' preferences and availability of resources like food (PN, 2021). However, main content, rituals and traditions do not vary. While *litiwo* is about preparing a young woman expecting her first child on issues related to pregnancy, labour and delivery as well as motherhood. In both ceremonies I was asked to lead on a song and a dance, and these were the songs I had learnt during the FGD with the traditional counsellors. The counsellors had taught me the common songs and dances performed at the ceremonies prior to the day, so that the people would think I had been to the initiation rites before, so I would be accepted without doubt. I was always paired with the young counsellor and was able to blend in. During the participant observations any formal data collection tools were put aside, so as not to appear intruding. Observing rituals added to the depth of the data I collected. With large gatherings, people are less conscious, and this was the case with the two initiation ceremonies I observed. These revealed valuable information which otherwise, I might have missed. It was not possible to obtain an informed individual consent during the

participant observation of the two initiation rites, as observed by Gray (2014), who suggested that it is impractical to negotiate with every research participant in a public setting.

5.2.1. *Ndakula* initiation rite

I was a participant observer for a *ndakula* ceremony, which is celebrated after menarche to assist the girl to appreciate herself as a woman and prepare her for future roles as a mother and a wife. At this ceremony, two girls who are first cousins were advised on SRH issues by four counsellors. They lived about 30 kms away from the village and they just came home for this ceremony. One used to go to school, while the other one worked as a housemaid. The ceremony lasted for about 2 days, and it was conducted in three sessions, starting at the girls' grandmother's house, then the river and riverbank and ending up at home. The word *ndakula* literally means I am a grown up. Like *mzondo*, *ndakula* is celebrated after harvesting and the Ramadan period. A day prior to the ceremony, family and friends gathered at the girls' grandmother's house to prepare two drums of *thobwa* (a traditional drink, which is a mixture of maize porridge, germinated millet flour and sugar) a must during celebrations (see figure 5.3).

Figure 5.3 The left photo is depicting a drum, clay pot and firewood to be used for preparing a traditional drink for *ndakula*. The right photo is showing the traditional drink (*thobwa*) ready for consumption

The ceremony started at a place where the household waste is burnt, with one of the counsellors bringing two pieces of a broken calabash and adding a drop of water on each plus something that looked like ash. The paste was then applied to the girls' breasts, arms, wrists, ankles and feet. Then the empty pieces of the calabash were put on the ground and the girls were asked to break them with their right foot and there was jubilation and ululation. The ritual was meant to protect them from any harm, by making them invisible to people with ill thoughts as well as witches and wizards. The girls covered in wrappers were taken to the yard, where a big crowd of women had formed a three-layered circle, and the girls were put in the inner circle. Singing and dancing was followed by demonstrations as the two girls were taught tips to employ to please their future husbands in bed, including sex moves. Two women demonstrated sex moves, and one woman did the same with each of the two girls and

there was ululation and clapping of hands from the crowd. The dancing and singing continued throughout the night.

The next day, early morning we all left for the river for another notable ritual which involved putting maize flour into the mouth, some in the hands, making a tight fist and diving into the water, while making sure the maize flour did not get wet, getting out of the water, and throwing the maize flour into the air. If the maize flour did not get wet, the girl received praise and if it got wet, it meant she had failed the ritual, and her mentor would be asked to assist. If she failed, then her relation had to assist, and if she failed too, then she had to pay a fine. One of the girls failed the ritual, including her mentor and the girl's aunt and they were asked to pay a fine which they did. The ritual is important because it confers on you the cultural identity and if you are asked and you mention his ritual, you are allowed to attend any *ndakula* ceremony, as it showed you have gone through the process.

Then we proceeded to the riverbank for final rituals, advice, singing and dances. Emphasis was put on menstrual hygiene, its associated secrecy and taboos. Over and over, a great deal of time was spent on tutoring the two girls on how dangerous menstrual blood is, and to be cautious, so that men are not exposed to it, as it could lead to illnesses or death, and they could be in trouble with the man's family. One of the counsellors drew three lines on one of the girl's thighs, using red brick dust, charcoal dust and maize flour. The red brick dust symbolised menstrual blood, charcoal dust the brown discharge towards the end of the menstrual period and maize flour the vaginal discharge. Each girl was asked to describe what she saw when she attained puberty by pointing at the lines and when they pointed at the red line, there was ululation and clapping of hands.

Through a play by the counsellors, the girls were advised to never sleep with a man while menstruating because his testis could swell up and he could become weak, instead they should wait until they see the white discharge. Instructions also included behaviour in the presence of men, mainly male in-laws, and using another sketch the counsellors advised the two girls not to be too close to them, as they could take advantage and make advances on them, and if that happens, they should report this to their sisters. During the ceremony, handling of menstruation was included, and the girls were instructed, to make sure that, no one sees their sanitary pads, including their husbands, as some could have sinister motives. To uphold the secrecy, they were given two sets of beads, white and red, to be used to inform their husbands about the occurrence or end of the menstrual period, by hanging them on the wall or simply putting them on the sleeping mat. Sexual advice also included abstinence until a marriage suitor was found to avoid unplanned pregnancies and STIs including HIV/AIDS.

Once married, submissiveness is paramount, and the two girls were encouraged never to say no to sex with their husband, unless menstruating or unwell, so that their husbands do not go looking for sex outside marriage. They were also reminded on how to behave in the bedroom, and that they must sleep without anything on their bodies, in case their husbands are interested in them, they should not struggle. Another demonstration about sex moves was conducted by the counsellors, with one dressing and behaving like a man. The girls were also reminded about how to wear a traditional sanitary pad, which looks like a costume worn by Sumo wrestlers. They were then, prompted about the significance of the elongated labia (elevens), saying every house needs a fence, equally the vagina needs elevens for protection. Using the index finger the counsellor demonstrated to the girls the appropriate length for the elevens. The other advice was specific to the girls' behaviour, as it was observed that they were not assisting their aging great aunt with household chores, like drawing water and

fetching firewood. They were reprimanded, and asked to apologise to their great aunt, and there was jubilation and ululation at the riverbank after the apology.

Figure 5.4 A photo depicting a counsellor at the river bank, reprimanding two initiates who are going through the *ndakula* initiation rite, while other counsellors, a mentor and other women are observing.

Advice on general conduct towards others in the community was given too, and the girls were instructed never to rub shoulders with the elders and if walking on the road, or in a queue always give way. Towards the end there was singing and dancing which I took part in. Then we had *thobwa* and lunch at the riverbank.

Figure 5.5 A photo showing the researcher and an apprentice counsellor celebrating, marking the end of rituals and traditions at the riverbank of the *ndakula* ceremony, with other counsellors and women observing.

After a thorough bath in the river and wearing their new clothes, the two initiates and their mentors were welcomed back to the community with ululation, drumming and dances. The celebration and feast attracted men, women, girls, boys and children from all walks of life, including local politicians and it was no longer a women's affair. The village chief was in attendance too and she was delighted to know that I had gone through the initiation rite and suggested that I attend *litiwo* too, which is celebrated when a young woman is expecting her first child. Attendees were treated to goat meat, duck and chicken, served with nsima or rice. I was told that *ndakula* ceremony is more highly regarded than a wedding ceremony among the Yao people, evidenced by the multitude of people who had come to witness the ceremony.

In contrast to *ndakula*, a wedding is only witnessed by a handful of people, with two people visiting the chief for marriage endorsement. However, during *ndakula* a girl celebrates the passage from childhood to adulthood and is prepared for her future roles as a woman and a wife. In addition to nice food and *thobwa* the girls were showered with money and gifts, equally their mentors and the counsellors. This was a rewarding experience for them, and those who had come to witness the ceremony were also rewarded with free entertainment and food, which for some would have been very welcome, considering the economic situation of the community.

Towards the end of the ceremony, when the formal advice and rituals were over, and it was time for the celebrations and feasting, the initiates appeared to show a sense of contentment associated with fulfilling the cultural expectations and asserting their cultural identity. Another positive impact about the ceremony was that it provided a space for discussing freely sex issues which are commonly considered to be taboo topics, not only for the counsellors, but for the women in general. During the ceremony, it was evident that the counsellors were highly respected, and that, they had the expertise on conferring the girls with the social responsibilities on SRH issues. However, I felt that they had limited knowledge on the biological aspect of SRH issues and that some of the messages were contradictory and confusing to someone trying to navigate through the adolescent period. As a result, the girls were left to speculate, without a holistic understanding of their sexuality and their bodies as women in the society.

For instance, teaching the girls about sex moves and at the same time telling them to wait until they found a marriage suitor. How would they know, this is a marriage suitor or not? The girls could also be tempted to experiment to perfect their skills before getting married, so

as to satisfy their future husbands, which could lead to early sexual debut, teen pregnancy and teen marriage and putting them at risk of contracting STIs, including HIV/AIDS. I also observed that most adolescent marriages in the community, followed teenage pregnancies. Further, the advice that, it was safe to sleep with a man anytime when not menstruating, with no reference to ovulation, could be misleading.

5.2.2. *Litiwo* initiation rite

During the data gathering period I attended a *litiwo* ceremony for a young woman aged 17, who was about 36 weeks pregnant. As usual the ceremony gathered women who had undergone that rite to help instruct and mentor the young woman although the main tasks were left to the counsellors. One of the traditional counsellors who was very active during *ndakula* ceremony, also took a central role during this ceremony. Women who have given birth but not gone through the rite were also welcome as they were perceived to have gone through the experience, and culturally they were considered to be adults. I was allowed to observe on the understanding that I am a mother.

Like *ndakula* women had prepared *thobwa* for the ceremony and as usual the ceremony was conducted at a house with a good fence for privacy and large enough for a big crowd of women. In addition to *thobwa,* there was a drum of water for cleaning up after the oil ritual. Unlike *ndakula* this ceremony is a half day event, to give the pregnant woman enough time for resting. Through songs, drama and dances the young woman was instructed on birth preparedness, signs of labour, labour and delivery. On birth preparedness, she was given a nappy bag and two wrappers for herself and the baby.

Figure 5.6. A photo showing a pregnant girl wearing her new given wrapper and her mentor being bathed in cooking oil during a *litiwo* ceremony. The photo also shows a counsellor and another woman sharing some oil for the girls head, while other women are watching.

She was advised on childcare, postnatal care, abstinence and its associated taboos. This included not having sexual relations for 6 months following the birth, to ensure that all the products of conception were out, so as not to injure her husband. Three plays were conducted, one depicting a well-behaved pregnant woman, following instructions from the midwife throughout the three stages of labour and going home with a live baby. In the sketch, three elderly women, working in unison demonstrated childbirth, one acting like a pregnant woman, the other as a guardian and providing psychological care to the girl, while the third one took the role of the midwife conducting the delivery. They went to great lengths providing details on signs of established labour and second stage of labour and expected behaviour during labour and delivery, such that it felt like I was in a midwifery class, and at the same time giving me the opportunity to reflect on the positive experience I had encountered while practicing as a midwife in a rural hospital. The rural women seemed to be

well conversant with the expected behaviours during childbirth, and they were very cooperative, leading to positive outcomes in most cases, which could be attributed to the advice received during this cultural practice.

The second sketch depicted a stubborn young woman who would not follow advice and instructions from the midwife and kept on closing her legs and in the process suffocating the baby, and eventually going home with a still birth. The last sketch was about a pregnant girl, who ran away from the labour ward naked, in the process embarrassing her parents and husband who were seated outside the maternity ward. She was strongly warned against such odd behaviour because everyone at home, would be expecting a live baby, and if she behaves on the contrary like the second and third one, that would be the end of her marriage. She would be considered unsuitable for a wife and a mother, and no one would be interested in her. Later on, I was told that this was meant to discourage undesirable behaviour during labour and delivery.

At the peak of the celebration, the pregnant girl, her mentor and someone from her husband's side removed their blouses, exposing the chest and abdomen, only covering their waist downwards. Then there were soaked with cooking oil from the head downwards, and after some advice and songs, they were assisted with cleaning up. It was a daunting task to remove the oil, which symbolises how difficult labour and delivery is. At the end the girl was wrapped up in one of the new wrappers. The celebration continued with the invited women putting money on the girls' head, while giving her advice on what was expected of her in the labour ward and at the same enjoying the traditional drink *'thobwa'*. During this ceremony my role was minimal, I only participated in the common singing and dancing, like the rest of the women attending the ceremony.

However, general observation of the participants was an ongoing activity from the time I entered this community to the farewell day. The observations were significant in this study as they helped to expose the context of intergenerational SRH communication practices. While in-depth interviews and FGDs assisted me to gain an insight on how intergenerational SRH communication practices are conducted in this community, it was the observation that unearthed some of the problems/ issues of the rituals and traditions which could be linked to risky sexual behaviours and negative SRH outcomes, such as high teenage pregnancies and STIs among young women. This is what informed the health improvement intervention discussed in chapter 6.

5.3. Reflexive Considerations and the Fieldwork experience

Reflexivity is seen as the process of a continual internal dialogue and critical self-evaluation of the researcher's positionality as well as active acknowledgement and explicit recognition that his/ her position might influence the research process and outcome (Khan, 2019; Berger, 2015; Day, 2012). Reflexivity is also thought of as a measure of quality in qualitative research; where it becomes vital to understand how the course and conclusion of the research are impacted by the characteristics and experiences of the researcher (Khan, 2019; Berger, 2015; Palaganas et al., 2017).

In this inquiry several reflexive actions were inherent to the research. Being reflexive allowed opportunities to "monitor the tension'' between the involvement of the researcher as a co-constructor of the account with participants and the detachment intended to enhance the credibility of the findings (Khan, 2019 p. 85; Creswell, 2014). Therefore, in the interest of ensuring rigour, I undertook a high degree of reflexivity in terms of self-reflection of bias and preconceptions in all the stages of the research process (Khan, 2019).

At the onset, I was sensitive to possible bias relating to my pre-understandings which may hinder the appreciation of the traditions, religion and worldview expressed by the research participants. Pre-understandings based on already acquired knowledge are unconsciously drawn into situations of expected new understandings, hence shaping what we seek to understand and constantly remoulding pre-understandings for all involved (Khan, 2019). Such that, by the end of the research encounter, both of us (the research participants and I) were inevitably affected by the repositioning of our pre-understandings. I was deliberately conscious on several issues relating to my positionality and my role during the inquiry, which was neither an insider nor outsider, but as someone who was situated on the border. Equally my role shifted from a learner during data collection to a facilitator during the development and implementation of the health improvement intervention.

Despite living away for many years, I strongly felt that I belonged to this community, in a very personal way, as my grandmother came from this village and I had knowledge of the local dialect, thus making me an insider. However, I realised that this was not the case at the initial contact with the community, through various comments about my skin colour, which is a lighter tone and therefore different from theirs. While the children were heard chanting *azungu azungu* literal translation being ‘’white people white people’’ and the young people passing comments like *‘’mother, the white lady is speaking our language Yao’’*. [in our language when prefix – a- is put in front of a noun, it means either respect or plural]. In my case it meant respect since I was alone. I felt like an outsider as I was bounded by my positionality as a middle class, educated women with mixed background.

Although considerable, these reflexive positions are not unique to this study and have been reported in other academic reports (Finlay, 2002; Khan, 2019). In view of the participants

being largely unknown or having no prior familiarity to me, this positioning became more apparent and entwined as interviews, discussions and observations progressed. Consequently, I factored these issues into my reflexive stance throughout my fieldwork and the reporting process. A few examples are shared below to illustrate the effects my diverse positions in relation to the world and the women I studied. It is evident that my positionality and role created a scenario of simultaneously being an "onlooker" and a "member of the group studied" (Khan, 2019 p.86; Berger, 2015).

This 'insider' role was advantageous during data collection and analysis. Initially, it facilitated community entry and access to the group studied, who were receptive and cooperative in being involved in research on their traditions and practices associated with SRH issues. The participants expressed confidence in my capability as a female scholar whose origin, they are aware of *"to tell the world the truth about we [Yao people] and our traditions''.* Despite being unfamiliar personally to them, this confidence led to increased comfort and trust between the participants and myself. Nevertheless, I was mindful of the effects of my positionality which was neither an insider nor an outsider.

A further benefit is drawn on 'shared understanding' related to the use of local dialect for the Yao people. It aided the depth of data collected, as I was able to extract a nuanced comprehension and probe more efficiently, which could have been easily missed by those who do not understand the language. The research participants constantly switched between the two languages (Chichewa the national language and Chiyao the local dialect). Therefore, being conversant in both languages, I did not need clarification or interpretation, which might have unsettled the flow of the interview and thereby impacted on the overall quality of the responses, considering that the topic under study is perceived to be sensitive.

On the other hand, my knowledge of the local dialect but not their traditions and rituals were a wonder to many participants, such that at times it affected the flow of the interview as they were interested in my family roots. This was evident during the FGD with the religious counsellors, where time was spent on the logistics of how to present me to the other counsellors, since I was not from that community, and they requested if I could get my labia elongated in time for the counselling session. It later transpired that one of the religious counsellors had worked with my mother in some of counselling sessions, such that she had noted my name during the introduction. As such, I felt conflicted as to how much information should I disclose, when, how and to whom (Berger, 2015; Khan, 2019). The quality of the collected data might have been affected by my previous family membership of the community, but not significantly because the queries, usually came towards the end of the conversation, where the participants were given the opportunity to share what they had in mind through a question or a comment.

Although uncomfortable at the beginning I gradually became accustomed to answering some personal questions, whilst being careful to minimise the impact of such information on the researcher-participant dynamic. Despite constantly striving to separate my experiences from those of the participants the gap narrowed resulting in the disclosure of profoundly personal experiences (Berger, 2015). Nevertheless, it was advantageous for me, as an outsider, as evident by a narrative of this grandmother ‘’I have not told you everything here because you didn’t go through the process’’. After the disclosure, she says *‘’let me now tell you truth about mzondo’’.* Therefore, that stated, the relationship between the participants, and I still upheld professional respect and the results were not manipulated by the negotiated closing in of the research space.

In some situations, my outsider position might have led to socially desirable responses or impression management behaviours among some participants, as was a case with one of the young women. When asked if she had been to *mzondo,* she responded by saying *''No, I didn't go to mzondo, in our family we don't practice mzondo due to our religious beliefs, because according to the Islamic teaching mzondo is not allowed, but ndakula*''. A few days later, I interviewed her mother, who had this to say ''*for me all my children have gone to mzondo, all of them''.* This highlights the complexities associated with face-to-face interviews. To lessen the bias associated with social desirability, I requested honest responses and reassured them that no one will know what they said as there are no names in the recordings and that, they will only be shared with my teachers.

The last consideration I made on power dynamics was about my age and education in relation to interviewing the grandmothers, and a discussion with the traditional and religious counsellors, with no formal education. It has been suggested by some researchers that those senior academics should conduct research with older persons to avert power imbalance and potential conflict, notably in intergenerational research (Khan, 2019). As with dynamics linked to language and dress, I was mindful of my vocabulary, mode of dress and the way I carried myself. I always wore a head gear, long dress, or wrapper to conform to the expected cultural and religious norms, as well as using culturally acceptable vocabulary.

I was also mindful when engaging with the grandmothers, who frequently expressed that their command of the national language was not good. It was evident during the interviews that, if I was not conversant with the local dialect, I would have had difficulties in engaging them into meaningful conversations. One had this to say *''Thank you but I have difficulties in speaking the Ngoni language, how are we going to chat very well''.* To which, I responded

''Don't worry grandmother, I understand the Yao language very well and I also speak. So, you can be speaking to me in Yao, no problem''. To be certain of a meaningful conversation, I asked her *'' Is it okay if I mix with the Ngoni language?* She answered, *''Yes, I understand the Ngoni language, but I don't speak very well''.*

Further considerations were made in relation to my perspective of the initiation ceremonies which had changed. Having been a participant observer of the initiation, enabled me to view the ceremony differently from my previous perspective, which came from my nursing and midwifery training and work experience. However, this could have been different if I had gone through it when I was naïve, which could be the case for these girls who are not well exposed to other SRH information from social media, radios, tv and the internet. Back home my intention to attend *ndakula*, was like God had finally answered my mother's prayer. Her little stubborn girl has come back to her senses, and she was enthusiastic informing everyone who came home; however, it was short lived. On my return, she asked excitedly about how it was, and I simply told her there was nothing special I found at *ndakula,* and I saw her face dropping. I am sure I reminded her of the last time I had refused to go with her to the religious SRH counselling retreat. I regretted telling her my views about the initiation rite because she seemed to be hurt, but I was also being sincere to myself.

This conversation highlights some of the painful exchanges that occur when traditions change as young people embrace different knowledge. For example, a study by Pernthaler (2022) which aimed to explore how research on SRH could be conducted from a feminist decolonial perspective among 14 women who had migrated from remote rural communities to the city of Sucre, Bolivia. The study revealed the existence of tension on traditional gender roles between the women and their mother in-laws as they had embraced contemporary gender

roles, such as seeking formal employment, contrary to their traditional roles of being a stay home mother and wife.

5.4. Conclusion

This chapter has illustrated the process utilised in gaining community entry and accessing research participants and my reflection on the fieldwork. It has also provided an insight on the meaning behind the rituals and practices of initiation ceremonies and their impact on sexual and reproductive lives of young women. The data gathered for this study are presented in chapter 7, while the next chapter begins by detailing the feedback meetings I conducted, then goes to provide details about the health improvement intervention trainings and evaluation.

Chapter 6 Partnership in action: Health improvement intervention

6.0. Introduction to the Chapter

This chapter discusses how the preliminary findings were used to develop an intervention designed to enhance SRH communication practices. I provide details about the health improvement intervention and the steps which I followed. In an ideal situation, the health improvement intervention would have been the last activity of a PAR. However, due to the logistics of studying in UK and carrying out fieldwork in Malawi, the intervention was conducted while research work was in progress. As such, a description of the intervention belongs to this chapter, as it follows findings from the field.

6.1. Step 1. Presenting to the community the problems/issues and assets identified.

The goal at this phase was to share the preliminary findings with the traditional counsellors and young women and assist them to identify issues contributing to teen pregnancies and come up with possible solutions. Assets found included the existence of traditional SRH counsellors and a well-coordinated practice of socialising young women and girls on sexual matters and other expected behaviours, at different stages of their life, each with its own dictates at family, community, and societal levels. Unlike grandmothers, SRH counsellors use initiation rites to socialise girls and young women into their future roles as women, wives and mothers. However, the sexual information young women were being given was occasionally incorrect, mainly with regards to the reproductive cycle, and this might have contributed to the teen pregnancies in the community. In addition, to some extent, a power imbalance in sexual relations between women and men, was observed and thus reinforced during the sex

education, which might have indirectly increased the vulnerability of the young women to unplanned pregnancies.

The study further revealed the availability of other sources of SRH information through government initiatives such as schools, health facilities and the allocation of a local community health worker commonly known as a Health Surveillance Assistant (HSA). However, their impact in terms of averting negative SRH appeared to be minimal, as young women mostly utilised the health facilities for antenatal care, labour, delivery and post-natal services, i.e. after they became pregnant. The study also demonstrated that, despite the availability of these modern facilities and Western medicines, the rural women in this community have not abandoned their indigenous ways of thinking, knowing, being, doing, and living and it was this philosophy which seemed to guide the initiation ceremonies and their SRH decision making and behaviours.

Furthermore, the study revealed that, all the three generations relied on both the traditional and Western medicine, utilising the one which seemed to be more advantageous at that particular point in time, as well as the perceived origin of the disease/illness. The younger generation appeared to lean more towards the Western medicine and modernity than the older generation, who seemed to value more the traditional medicine and indigenous knowledge with its rituals and traditions, in the process creating tension between the two groups. While the older generations were concerned about the future of their histories, identities and beliefs, the younger ones appeared less concerned. However, realising that both knowledge systems were valuable in their own ways and to bridge this generation gap and to respond to the issues/ problems identified during the provisional analysis, I initiated a health improvement intervention. The initiative brought the two groups (the younger and older) together as

highlighted in the next section, while taking into consideration the tenets of PAR and Paulo Freire's philosophy of conscientization.

6.2. Step 2: Putting into action the identified solutions.

This step involved addressing some of the problems identified during the dialogue and research since PAR was built on the premise of connecting research with action (Willis & Edwards, 2014; Baskerville, 1999). The goal of PAR at this phase was to link practice and ideas in the area of human development (Reason & Bradbury, 2008). To regenerate the participants' thinking and action, I initiated and conducted several feedback meetings, where both the traditional counsellors and the young women expressed the need for assistance, and this led to several training sessions as highlighted in the subsequent sections.

6.2.1. Feedback meetings with the traditional counsellors

I met the two groups separately, starting with the traditional counsellors and each time inviting the HSA as she would be instrumental in the implementation and evaluation of the health improvement intervention. I started both meetings by acknowledging their hospitality, and support for the project. Then each group was asked to do a mini evaluation of the counselling process, the content, the aims of the rituals and practices, and the benefits to the girls. The traditional counsellors responded by saying that it was their tradition, and the main purpose of the puberty rite was to assist the girls to celebrate their transition from childhood to adulthood.

This was followed by the presentation of the findings, which showed that there was adequate knowledge on the social aspects of SRH issues among mothers and grandmothers, as well as

traditional and religious counsellors. However, there was limited knowledge on the biological aspects of some SRH issues, which might have resulted in the girls' lack understanding of the natural functions of their bodies. Further, the findings revealed a power imbalance on sexual relations between women and men – women were taught to please men at all costs – e.g., you should never refuse your husband and you must allow him to do whatever he wants. Thus girls/ women's sexual rights were not given the same attention as those of men.

These issues were presented in a way designed not to offend the traditional counsellors. The focus was on the high number of teenage pregnancies and asking them about the contributing factors (which they attributed to the stubbornness of today's girls), rather than talking about their limited knowledge about the reproductive cycle (another contributing factor). Highlighting limitations to their knowledge would have been considered to be culturally disrespectful, because elders are not allowed to be seen as having made a mistake. Instead, I guided them to reflect on the relationship of the initiation ceremonies and the teenage pregnancies so as to raise their critical awareness through conscientization and helping them to identify the problems/ issues which were contributing to teenage pregnancies as well as solutions (Rugut & Osman, 2013). At first their responses demonstrated that they were unable to see the link between the initiation rites, and the teen pregnancies or risky behaviours in general, stating that the girls were fairly guided during the initiation ceremonies. This might be due to the cultural understanding that elders do not blunder and doing so might have appeared like admitting, they had erred.

Nevertheless, when the question was rephrased depicting the issue as a general problem and how it could be solved, the team leader was quick to suggest that they should encourage the girls to go for contraceptives. My affirmative reaction to this practice opened the

opportunity for the counsellors to acknowledge the issues in a safe environment. An example of this from the literature describes how during a home visit of a white, non-Hispanic to a Hispanic family for health education examination to a client with gout but also with a history of hypertension and diabetes, the nurse found that the client had applied raw bacon on the big toe. The nurse was respectful and non-judgemental of the practice, and only inquired about the practice, which opened the chance for further conversation (Turkson-Ocran et al., 2020).

In my study, by opening up the conversation, the traditional counsellors agreed, saying that traditional contraceptives were no longer effective these days, adding that, some of them became pregnant while the strings (traditional contraceptives) were on their waists. Thus, they indirectly accepted and acknowledged the existence of the problem and identified solutions to the problem, as well as challenges associated with changing that reality. This was in line with Paulo Freire's philosophy of conscientization and the study objectives. This was evident when they asked how they could share information on contraceptives, without upsetting the girls' parents, to which I assured them that together we would find a way of solving the problems, which are tenets of PAR (Glen, 2014; MacDonald, 2012; Tacchi, 2015; Tacchi et al., 2009). The reflective and action learning meeting followed the four principles of reflect, plan, act and observe by Kemmis and McTaggart (1988) (Willis & Edwards, 2014). The four action steps of PAR are:

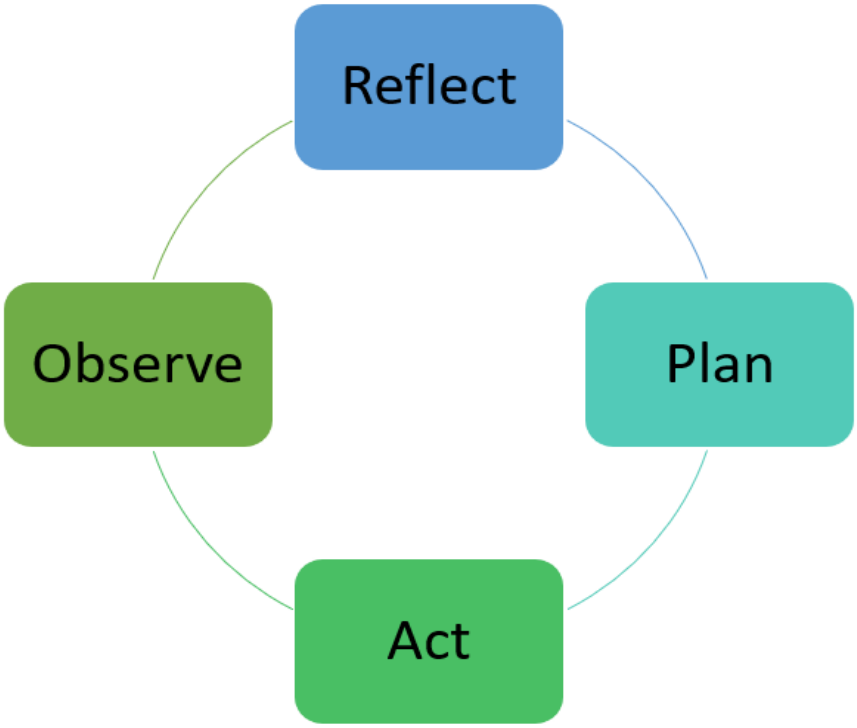


Figure 6. 1 A diagram illustrating the four action steps of PAR adapted from Kemmis and McTaggart (1988) (Willis & Edwards, 2014)

Reflect: The traditional counsellors reflected on the relationship of the natural/ traditional contraceptives which were promoted during the initiation ceremonies and the high number of teenage pregnancies in the community.

Plan: Together (the traditional counsellors, HSA and I) developed a plan to mitigate the identified challenges/ problems. The plan aimed to improve what was already happening.

Act: In unison with the counsellors, HSA and I, we acted to circumvent the barriers and hindrances to the availability of modern contraceptives and their understanding on the same.

Observe: The counsellors observed the effects of action (the training) in the context in which they happened and were pleased with it, suggesting that the project be taken to other villages, so that they can benefit from it too.

Together with the HSA and the traditional counsellors, we deliberated on the logistics of adding new content to the counselling sessions during the initiation ceremonies. They then agreed to introduce the concept to *ndakula* the 1-week puberty rite. This seemed the most appropriate because, there was enough time for a group or individual motivation talks on family planning/ contraceptives. We also agreed to focus the talk on the benefits of short-term contraceptives, with emphasis on condoms because of their dual protection (Aventin et al., 2021) and where to find them, if interested. They further asked, how the plan would materialise, since they had limited knowledge of modern (Western) contraceptives. The HSA and I reassured them of our support with the necessary information and materials. Their main role during the puberty rite would be to advise the young women on how to prevent pregnancy and to refer them to the HSA if they showed interest for more counselling and provision of the chosen method.

They were so enthusiastic about the idea, such that they suggested that the training should commence immediately after the feedback meeting. When asked if they would also be interested to know more about the reproductive cycle, mainly on menstrual blood and the likely days for conception, they instantly responded saying '*yes, you should have taught us this, the first time you came to this village, and by now all these girls we have taken to the initiation camps would have known about these issues*'. Then the HSA reassured them that since it's a requirement to attend other girls' initiation rites once initiated, all girls would

have the opportunity of learning the new content eventually. Then we planned for the training of the counsellors, and the first one took place a week later.

6.2.2. Feedback meetings with the young women

Like with the traditional counsellors, I gave feedback to a group of 7 young women, out of the ten I had previously interviewed. This was done to share insights and identify solutions (Eelderink et al., 2020) as stipulated in the research objectives. This time, the discussion was less formal as all the participants were younger than me. While the counsellors were identified because of their expertise on indigenous SRH knowledges, rituals and traditions the young women were considered because the youth are considered drivers of change and their participation in social policymaking and SRH have been identified as priority areas by the Malawi Government (Wigle et al., 2020).

Further, youth participation is recognised as a human right, as per Article 12 in the UN *Convention on the Rights of the Child* (CRC) (Wigle et al., 2020) which stipulates young people's right to participate in decisions that affect them, including those regarding their health and well-being (Anderson,1989; Wigle et al., 2020). This is also in line with the *African Youth Charter's* Article 11 which outlines States' commitments to ensuring youth participation in all aspects of society, including parliamentary decision-making bodies, and to developing and supporting mechanisms for youth participation at all levels of decision-making (e.g., local, national and continental) (Union, 2006; Wigle et al., 2020).

As highlighted in the previous section, I asked them to do a mini evaluation of the counselling process, in terms of how they had benefited from the initiation rites, and if they were ready to be mothers, when they became pregnant. All of them responded by saying they

were not ready when they became pregnant, and when I asked them about what might have contributed to the high teenage pregnancies in the community, they all suggested that inadequate knowledge on SRH issues was the main problem. This was also observed by Munthali et al. (2004), Munthali and Zulu (2007), Munthali et al. (2018) and Schroeder et al. (2022) as highlighted in chapter 1. When I shared my findings, they agreed, saying that what I found was correct, as most of them did not have adequate information on SRH issues at the time they fell pregnant. They went on to make a request, saying that they would appreciate if their two 'aunts' (the HSA and myself) provided them with adequate information, specifically, about conception and how to prevent a pregnancy. The feedback meeting ended with a discussion on the logistics of the subsequent trainings.

6.2.3. Details of the training sessions

This step entailed addressing some of the problems and gaps in knowledge identified during the preliminary analysis through training sessions delivered to the traditional counsellors and the young women. To enhance the learning process, I relied on visual teaching aids (see figure 6.1) which were adapted to the local needs to increase project uptake and success (Eelderink et al., 2020), and for easy understanding, as most of them could not read and write. Although the content was almost the same, there was a slight difference in the way I presented the material and handled the two groups, taking into consideration, their ages and the societal norms (Wigle et al., 2020). With the aid of red, brown and white beads (depicting the three phases of the menstrual cycle) (USAID & fhi360, 2021) I taught them what menstrual blood is, what ovulation is (Wilson-Smith et al., 2013) and the fertile days of a woman, starting with what happens when a girl attains puberty and showing them the female reproductive organs to aid understanding (see figure 6.2).

The class went as follows and covered the following: As a girl reaches puberty, her body starts to change from being the body of a child to that of an adult (Kapur, 2015; Zaky, 2016). These changes also affect some chemicals in the body. As such it is not always easy to navigate through as they begin to experience sexual feelings. They may feel tingling or warm feelings when they think about a boy they like, or when they are touched by that boy (Action for the Rights of Children (ARC), 2009). These feelings can run round their body like an electric current causing arousal and excitement, and they may be able to think of nothing else but that boy (ARC, 2009). These feelings are a natural part of growing up. Although they may be sexually active, they are often ill-equipped and/or powerless to deal with the consequences of sex (ibid.). Without access to information, contraception and equal rights, they are at a high risk of contracting STIs and HIV infections and having unplanned pregnancies (ARC, 2009).

Figure 6.2. A photo showing the researcher illustrating a point to young women with the aid of a diagram, during a training session

I also emphasised that there is no ‘safe’ time to have sex to avoid pregnancy during the menstrual cycle (see figure 6.3), if not using contraception (Wilson-Smith et al., 2013 p. 21). So, to avoid pregnancy, a girl must use contraceptives. For easy understanding, I used the reproductive cycle diagram to explain periods in more detail in preparation for a contraceptive sexual health session. I also linked the contraceptives to the reproductive cycle and encouraged them to advise young women or each other to go for contraceptives, while menstruating rule out pregnancy and for optimal effectiveness.

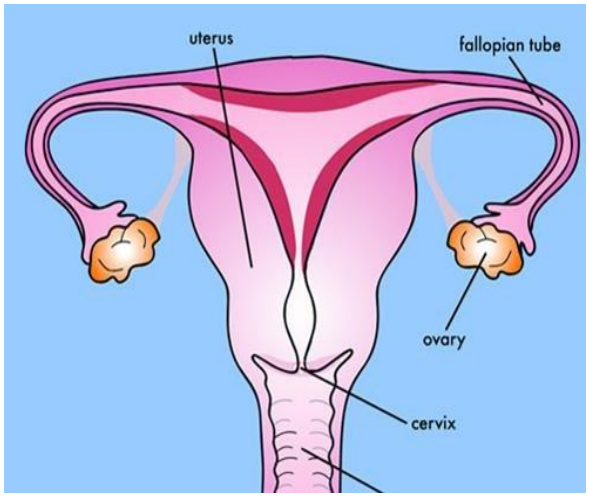


Figure 6.2. A diagram showing the female reproductive organs.

Source: https://i.ytimg.com/vi/Wez-qS0a5N0/maxresdefault.jpg

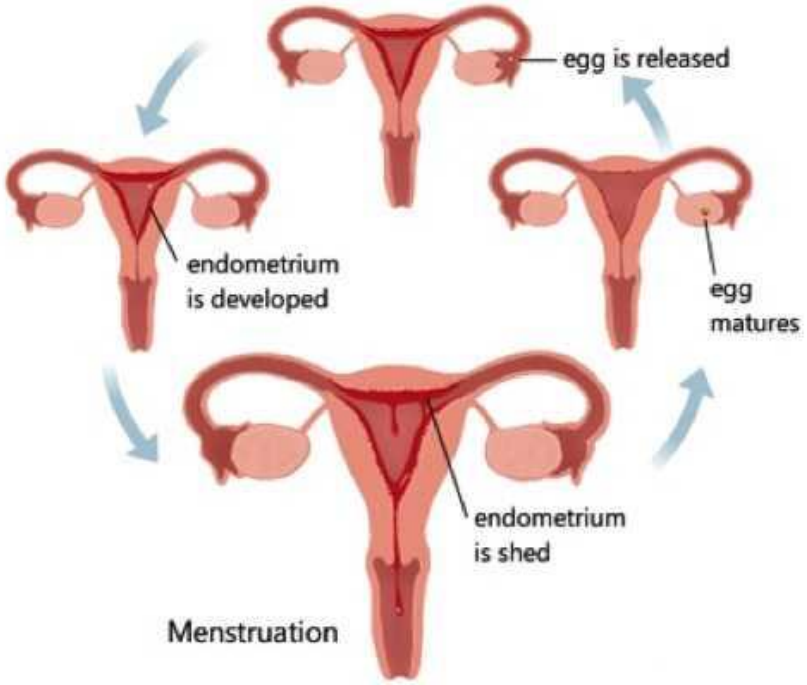


Figure 6.3. A diagram Illustrating the 4 phases of the reproductive cycle.

Source: https://healthgeeky.com/wp-content/uploads/2019/07/menstruation.jpg

The 4 phases of the reproductive cycle

1. **Follicular phase:** An egg starts to develop in the ovary.

2. **Ovulation phase:** An egg is released from the ovary and the lining of the uterus starts to thicken.

3. **Luteal phase:** The egg reaches the uterus, but it is not fertilised, and the lining of uterus gets ready to dissolve. The girl may experience pre-menstrual symptoms (PMS) such as mood changes, headaches, bloating, acne and breast tenderness.

4. **Menstrual phase:** The lining of the uterus sheds and comes out of the body as menstrual blood and the girl may have cramps and become emotional. The cycle then begins again as another egg starts to mature in the ovary and the uterus grows its thick lining again (Wilson-Smith et al., 2013). This process is controlled by hormones (substances or chemicals that act as messengers in the body) which change in their concentrations in the blood stream at different points throughout the reproductive cycle (Wilson-Smith et al., 2013). I emphasised in particular that if the girl/ young woman meets a boy/ man during ovulation, the egg may be fertilised, and a baby starts growing in the uterus and she will not see her periods. To avoid this, she has to see a health worker while menstruating to give her contraceptives, such as condoms, pills or injections.

The training noted that, there are many types of contraceptives, each with its own advantages and disadvantages, but during the training, I concentrated on the short-term methods and barrier methods as I mentioned earlier on, namely pills, injections and condoms (Wilson-Smith et al., 2013; WHO, 2012), as they are readily available within the community. Emphasis was put on condoms because of their dual protection (prevention of pregnancy, HIV and STIs) (Aventin et al., 2021) and I advised the counsellors to refer the girls to the HSA for the provision of the chosen method, more information or in case of any problem like

adverse effects, such as heavy menstrual periods. Then I went on to talk about sex and rights, beginning with the difference between menstruating and sex.

Sex and rights

I explained that while menstruation is only a physical issue, having sex is more than that, as it involves the interaction of both the physical and emotional being of a person (Wilson-Smith et al., 2013; ARC, 2009). As such, a girl needs to be physically and emotionally ready for it.. Therefore, the girls need to be encouraged to express their feelings towards their boyfriends/ husbands and to initiate a conversation with them on intimate issues (ARC, 2009). Subsequently, it will minimise the risks of STIs and HIV infection, as issues of lacerations and bruises will be minimal since they are both personally ready for it (Wilson-Smith et al., 2013; ARC, 2009). In respect of their culture and religious beliefs on menstrual blood, acknowledging the wisdom of indigenous knowledge, I just commented in passing that scientifically menstrual blood is safe minus STIs or HIV infection. This is because, I felt the practice was not only beneficial to the man, but also to the woman, considering that blood is a good media for STIs and HIV infection, and it is difficult to know if one has the disease, unless he/ she goes for a test (Da Ros & da Silva Schmitt, 2008).

6.2.4. Checking the knowledge following the training

After (most) activities of the action plan were executed, there was a need for participants to evaluate the outcomes of each activity (Eelderink et al., 2020) and its impact on their level of understanding on SRH issues. At the end I evaluated the training to determine achievement of the lesson objectives (Capwell et al., 2000) and there was positive feedback from both groups. The counsellors specifically mentioned that, they liked the use of pictures, saying it made the lessons interesting and easier to follow. They also asked for a reference booklet

(see Appendix 14), and that I should initiate a similar project in the neighbouring villages, so that, they too can benefit. I then evaluated the class by asking them questions and they showed that they had understood. While the young ones simply said, if they had had this information then, they would not have had unplanned pregnancies, and that they would not want others to go through what they went through. Thus, implying that, most of them became pregnant because they did not have adequate information about the reproductive cycle and contraceptives. This was also observed by Munthali et al.'s (2018) study on initiation rites among the Yao women of Machinga district in Malawi.

6.3. Step 3: Adoption and termination of the relationship

This phase involved acknowledging the participants contribution towards the project, as well as reminding them that our relationship was coming to an end. We reminded each other on how the new knowledge and skills would be utilised, as well as presentation of the reference booklet and farewell. For the counsellors, the information about contraceptives, would be added to the advice they give during initiation ceremonies. The concept will be introduced to the 1-week puberty initiation rite as highlighted earlier on, using the quiet moments, when the initiation house is less crowded for motivation talks. Once the girls show interest, they would be referred to the HSA for detailed counselling and provision of the chosen method. This is because counselling and provision of short-term contraceptives falls under the mandate of a community health worker (MoH, 2009). As for the young women, the peer education would be taking place during their youth groupings such as village bank (locally known as *bank nkhonde*). A Village bank is a community-based financial institution that operates at the local level, often in rural or underserved areas. Members contribute to a common pool of savings, which is then used to provide loans to group members. The interest earned from loans and savings contributes to the sustainability of the village bank.

6.3.1. Presentation of the reference booklet

On this day I met the two groups separately again, the young women in the morning and the counsellors in the afternoon. Again, I started by expressing my gratitude for availing themselves during the feedback meetings and the training. Afterwards, I reminded them about the previous lessons, and then I guided them on how to use the booklet and to answer any query. Then I presented the SRH guide (booklet) to the leaders of the two groups, who were also responsible for its safe keeping (see figure 6.4). The HSA was also given a notebook to be used as a register for those seeking contraceptives and teen pregnancies, in addition to the government register for monitoring.

Figure 6.4. A photo showing the researcher guiding the counsellors on what the booklet is all about.

6.3.2. Terminating the researcher – participant relationship

Termination issues began long before the last session of the engagement. During the meetings, group members (traditional counsellors and young women) knew that, as each meeting concluded, there was one fewer time that we would be together. Prior to engaging in this research process, I was unsure on how important the relationships with participants would be and how difficult it would be to end the relationships at the conclusion of the project. This made it difficult to leave the field at the end of the research especially as personal relationships had developed. This is because the project had run over an extended amount of time; as a result, participants had some questions about whether the relationship would extend beyond the research project (McHugh & Kowalski, 2009). It was inevitable that group members would have some feelings attached to the unavoidable ending of the group. Having engaged in a school-based group intervention for young women with eating disorders, Daigneault (2000) argues that some group members will experience a sense of loss when research inevitably comes to an end and also recognising that, the group facilitator may not be immune to such feelings.

A good termination of a group has to be planned by the group facilitator so that participants are protected from harm by such feelings (Daigneault, 2000). In an effort to guard against possible feelings of betrayal, Haverkamp (2005) suggests that researchers monitor and clarify expectations throughout the duration of the research project. This was accomplished by mentioning the number of meetings remaining and asking group members how they wanted to use their last meeting, were ways of bringing up the issues of termination. Prior to the last meeting, the counsellors, the HSA and I had discussed how we would like to structure the last meeting (farewell). We decided that it would be helpful to bring the two groups (young women and the counsellors) together to foster the working relationship between them.

The last meeting felt like a celebration of what had happened in the groups. Processing questions that helped with termination were “What will you take with you from your experience in the group? What, if any, changes have you made in your SRH life since you started coming to the group (Daigneault, 2000)? Although sadness was present because something valued was ending, there was also a sense of joy and accomplishment, with some counsellors suggesting that I take this project to other villages so that, they also benefit. I gave each one of them a wrapper as a token of appreciation. I was confronted with mixed feelings. Satisfied that I had met my objectives, as the project had come to completion while at the same time feeling sad to leave those who had assisted me throughout the research process, as well as being uncertain about the adoption and implementation of the blended knowledge on SRH issues.

6.4. Evaluating the health improvement project

Having established many relationships throughout the duration of this research process, I was confident that I had met the participants’ expectations in the way the relationships ended at the conclusion of this EPAR. There were two primary reasons why participants reported no unmet expectations. First, because I was constantly communicating with the participants, they understood that I was only going to be part of the community until the end of the project in November, as I had to return to school. Second, this research project coincided with the beginning of the rainy season, and the participants were busy preparing their fields for planting.

However, there were few who wished the relationship had continued, by constantly sending a representative to my parents’ house to find out how I was doing in school. Understanding that I had to return to school, there was no real sense of loss when this group came to an end in

November 2021. In retrospect, I am contented that there was an open dialogue between the participants and I about the relationships as they developed; this open dialogue fostered the successful development and end of the various relationships. Even though, I was unable to monitor and evaluate the project myself, as I had to return to UK to continue with my studies, the HSA who acted as the research assistant was provided with a register to record the number of girls coming for the contraceptives and antenatal services. Then we would compare the figures before and after the project to assess its impact in terms of reducing the negative SRH outcomes and replan for the next course of action and the cycle would continue.

Although the impact of the project in terms of SRH outcomes will take many months or even years to evaluate , the project had met its objectives in terms of enabling the rural women to become critically conscious about the social realities affecting young women's SRH and well-being, and then addressing the factors limiting their ability to control their sexual and reproductive lives. Thus, the training helped to satisfy the group's own educational needs, to be more assertive and revive their culture. With the intergenerational approach, use of locally available resources, and the pictorial reference booklet, the changes could be self-sustaining.

6.5. Conclusion

The chapter has shown that group interventions on SRH issues utilising indigenous and Western knowledges can bring about social change in a rural community. It has also demonstrated how the EPAR approach benefitted both the researcher and the participants and how they both learnt many lessons as they actively participated in finding solutions to the challenges affecting them. Throughout the action cycles, participants and the researcher were

able to empower themselves and to provide the community with much-needed knowledge and skills about aspects of SRH, rituals and traditions.

Chapter 7 Analysis of findings

7.0. Introduction to the Chapter

This chapter describes in detail the process of analysing the data to create themes and interrelated sub-themes. Data from the interviews with the three generations and focus group discussions with traditional and religious counsellors are included as well as data from my fieldnotes and my participant observations of the two initiation rites (*ndakula* and *litiwo)* to have a holistic picture of what young women are taught during these initiation ceremonies. The analysis thus offers an in-depth understanding of the intergenerational transmission of SRH issues taking cognisance of the constraints of qualitative research explained in the Methodology chapter.

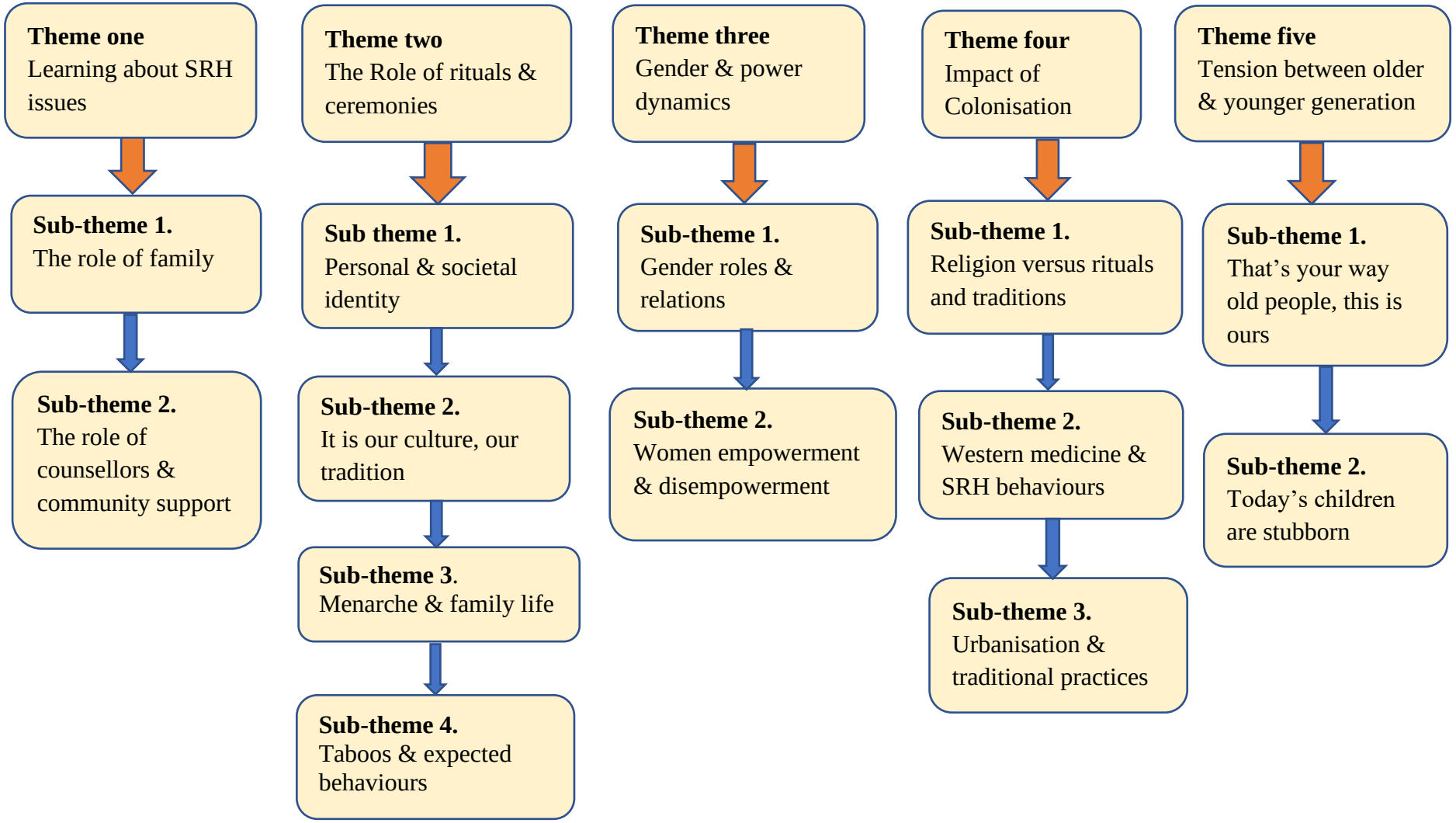
The analysis was conducted inductively by intergenerational and intra-generational comparison. In other words, the grandmothers' generation were collectively analysed for similar and dissimilar responses. This approach was also applied to their daughters' and granddaughters' generation. Thereafter, an intergenerational analysis was conducted among the three generations to identify what has changed and what has not. Nevertheless, I was aware that no study could be completely inductive, taking into consideration Strauss and Corbin's (1998) observation that researchers' background knowledge and concepts have a bearing on how they analyse, understand and make sense of their data (Merrick, 2020).

7.1. Key themes

On my return to the UK from my immersive field work in Malawi, I conducted a rigorous analysis of the data using the thematic analysis (TA) approach of Braun and Clarke (2006). Five themes emerged: learning about SRH issues; the role of rituals and ceremonies; gender

and power dynamics; impact of colonisation; tension between older and younger generation. The process through which the data were analysed and how the themes were identified has been explained in full in the Methodology chapter (see Appendix 15a, 15b, 15c, 15, 15e & 15f). The final themes were generated after first analysing the data separately for the young women, mothers and grandmothers, key informants and finally with the FGDs with the traditional and religious counsellors (See Appendices 16b, 16c, 16d, 15e & 16f). Finally, I looked at each group for commonalities and differences. What was striking was the similarity of themes across the generations and groups. Whilst each group placed a different emphasis on each theme and there were differences to those which they foregrounded, overall, the degree of similarity suggested that the key themes were stable. The combination of the themes from all the groups is displayed below in figure 7.1

Figure 7.1 – Overall themes and sub-themes for the three generations, counsellors, and key informants



7.2. Organisation of the Findings

Each theme and sub-theme are reflective of the research questions proposed by the study. Whilst many of the themes are distinct, they are not mutually exclusive; thereby highlighting the holistic approach of the thesis in explaining the experience of sharing SRH information among the three generations. The central argument of the thesis begins to emerge with the first two themes, namely *Learning about SRH issues*, which talks about how young women learn about SRH issues, and the role of family, friends, sexual advisors (counsellors) and the role of the community at large. As the African proverb says, *'it takes a whole village to raise a child'*. This is followed by *the Role of rituals and ceremonies* and together these two themes attempt to link the theoretical underpinnings of the Socio-ecological systems model by exploring the voices of the 'private' and 'public' context in shaping how women in this study come to understand SRH issues and viewed the roles of rituals and ceremonies in their sexual and reproductive lives.

Life events and transitions which participants chose to share are presented in the next theme: *Gender and power dynamics*. This forms the most personal and intimate segment of the research. It is these very experiences that impact on how a person perceives SRH issues and behaviours and how they navigate through the transition period from childhood to adulthood. *The impact of colonisation* will be presented in the penultimate section of the chapter. Responses from previous themes are drawn into the analysis to understand the influence of colonisation on indigenous knowledge systems and women's sexual and reproductive lives. This provides a holistic account of how the construction and experience of adulthood is conceptualised and lived out by young women, and how they are viewed by the older generation which leads to the final theme: *Tension between older and younger generation.*

7.2.1. Theme One: Learning about SRH issues.

This theme highlights the roles played by family, friends, SRH counsellors and the community at large in the sexual socialisation of a young woman. Common and evident among the three generations were their exposure to multiple sources of SRH information, and notable ones being family, friends, boyfriends and traditional counsellors, while teachers were only mentioned by the younger generation. One young woman said *''I used to listen to people talking about it, and I kept it in my head, yes'' (Linesi).* When asked about who these people were, she simply said:

> *Women, when they are in a group, they talk about it, so I was just listening to their stories. When you start menstruating, you take a piece of cloth and put it on, so I was just listening. When I attained puberty, I remembered, this is what you need to do. (Young woman: Linesi).*

While another young woman simply said *''when I attained puberty, I found a boyfriend, then we started meeting and during our meeting, we just knew the stuff, that's it (Daina).*While these quotations suggest that young women learned about SRH issues from different sources, clear specific roles and responsibilities were assigned, emanating into two sub-themes: *the role of the family* and *the role of counsellors and community support*. It was also apparent that in this respect there were similarities in the key messages shared among the three generations.

Sub-theme 1: The role of family

Although families play a significant role in the sexual and reproductive lives of the young ones, grandmothers took a centre stage in laying the foundation for expected general and sexual behaviours. The messages were dependent on the girl's development age. At puberty, key messages were about menstrual hygiene and its associated taboos.

Whilst all the three generations talked about the key role of grandmothers/ elders in sex education and that they informed their grandmothers when they started menstruating, some generational variations were also observed particularly in pre-puberty sex education. While the mothers and grandmothers often reported being shocked upon seeing menstrual blood when they started menstruating, the young women were all much better prepared for it, demonstrating that, the older generations were less well-informed/ prepared for menstruation as compared to the younger generation.

Several young women elaborated on the sex education they received before puberty evident in the following quotes: *When you see that the little girl's breasts are growing, her grandmother tells her about this issue of labia elongation (Zione)*. When asked about the use of the elongated labia, one said: *It is used as a ladder in the bedroom, for the man to play with during sex (Zione)*. She went further to talk about the significance of the elongated labia through this narrative:

> *I was advised by my grandmother before I attained puberty, when my breasts started growing my grandmother called me and started advising me that we do this so that you can get married, without this your marriage wouldn't last long (Young woman: Zione).*

One of the young women reported not telling anyone when she started menstruating: *I just saw blood coming out, then I didn't tell my parents, I didn't tell anyone, I just kept to myself up to a month, while menstruating (Young woman: Linesi).* She seemed very calm about this, suggesting prior knowledge on the issue. When asked why they informed their grandmothers, not their mothers, some responded by saying:

> *It's not proper for me to tell my mother (Young woman: Zione).*

> *My mother aaah no, but my grandmother. You are never free with your mother, but with your grandmother and you can tell your grandmother anything without shame (Young woman: Awetu).*

The quotes could be illustrating the cultural expectation that SRH issues ought to be discussed with grandmothers and not mothers. On the other hand, it could also depend on how close the young woman is to her mother or grandmother, as others informed their mother first, and then the mother informed their grandmothers for advice. Most of them reported being less embarrassed in the presence of their grandmothers than their mothers whose advice mostly came as a warning about pregnancy and STIs including HIV/AIDS, as evident in this quote:

> *There is nothing they [my mother] said, they just said, you are now an adult and if you become too close to men, you will have a baby on your back. (Young woman: Daina).*

Unlike the young women, the grandmothers appeared to have much less information on SRH issues when they were young. This is evident in their menarche experience, as they did not know what to do when the menstrual periods came, and this is what this grandmother had to say:

> *People [referring to children] saw me and started booing me ''iwe iwe'' [meaning that's you, that's you]. Then I cried because of the blood. They were like ''wavulala'' [meaning you are injured]. Then I was telling them I am not injured… But these people, my parents were just laughing, then they took me to this elderly person and started advising me, telling me not to cry. (Grandmother: Edina).*

This quote demonstrates how naïve and anxious the grandmother was about the menarche experience, as well as how uncomfortable the mother was talking about the issue. This

participant also went on illustrate the importance of basic SRH information prior to puberty and some of the teaching she received from her encounter with the traditional counsellors.

> *When I finished menstruating, my mom invited the anankungwi [traditional counsellor] then we went to the river to give me pieces of advice. They asked me what did you see? I said I saw this, [menstrual blood] when I finished, I saw this. Then the anankungwi told me when you finish menstruating and you see this, don't sleep with a man, the man dies, or he develops hydrocele… (Grandmother: Edina).*

This serves as a pointer to sub-theme 2 and at the same time shows appreciation for the different roles played by counsellors and others on sex education of young women in the community.

Sub-theme 2: The role of counsellors and community support

This sub-theme highlights most of the key roles of traditional counsellors. I occasionally refer to religious counsellors, although their impact was much less evident. This is because the Yaos have predominantly been identified as a people for whom Islam is synonymous with being Yao (Thorold, 1995) and as such they do not have religious counsellors, unlike tribes converted to Christianity.

The traditional counsellors are revered, not only because of their expertise on sexual and reproductive matters and general conduct, but also on protecting the initiates against evil spirits, as observed at the beginning of the *ndakula* ceremony, where a ritual was performed to protect the girls from those with ill thoughts. This attracted applause and accolades from the crowd and similar sentiments were expressed when the counsellors advised the two girls, to mend their ways of not assisting their great aunt with household chores. Others (young women, mothers and grandmother) could be heard during the *ndakula* ceremony, which I

observed, citing discipline, respect and expertise on SRH issues among counsellors as the main reasons, for attending/ sending their daughters to these initiation ceremonies.

Common among the three generations were the roles played by traditional counsellors, friends, boyfriends and other elderly females in shaping their sexual and reproductive lives. However, absent among the older generation was the impact of teachers. Evident in this narrative is how a menstrual hygiene talk from a female teacher shaped this young woman's response to her first menstrual period.

> *But also, at school, they used to talk about it, those who have just started menstruating…can come to collect pads. At school they used to provide pads. You could go, receive the pads and wear. So, I heard there, and I started thinking what are pads? What is attaining puberty? So, I then knew that attaining puberty is the blood, that's when I took pieces of cloths and started wearing them… (Young woman: Linesi).*

Further, the quote shows that if a young woman is provided with adequate SRH information, she could make rational decisions as knowledge is power. However, learning about SRH when in school was dependent on how long a girl is in school, as such talks are given to girls in senior classes (7 and 8) of primary education, implying that those who drop out in the lower classes might not have the opportunity. Instead, they are reliant on the community support, evident in this narrative of a young woman who dropped out in standard 4 and was assisted by one of the grandmothers in the village.

> *I attained puberty at this other grannie's house where we were chatting. So, when she saw that it has happened, she took me in her house and she said, this means you have attained puberty. She took a wrapper and cut a small piece and made a rope and tied it around my waist. Then took another piece of cloth and passed it on the rope and came out on the other side and secured it with a*

> *rope again. After fixing the cloth and making sure I was okay, she gave me a wrapper [the wrapper is an indication to the community, that this girl has become a woman]and I took out my skirt and she said let me escort you, I said yes, and she escorted me home... (Young woman: Daina).*

Whereas sex education from the elderly women focused on hygiene during menstruation and sometimes the need to avoid boys for fear of pregnancy, discussions with friends and boyfriends mainly centred on sexual relations and other SRH topics such as pregnancy, abortion, rather than menstrual hygiene and taboos. However, learning by listening to friends talk about SRH issues did not always result in accurate knowledge. One grandmother had this to say:

> *…, my friends told me that I need a boyfriend to attain puberty. So, I asked my friends, can a boy be your friend? And they said yes and then I accepted… (Grandmother: Edina).*

Interestingly, this theme has demonstrated that despite the generational time-gap of their childhoods and adulthood, grandmothers, mothers and granddaughters had comparable views of sex education. Correspondence of communal experiences despite the generational gap can be explained by the Life-course perspective theory, rooted in the personal and communal identity, fostered by gender dynamics, culture and traditions. This could also be related to their limited education and geographical movement, possibly creating an environment of mutual understanding among members, thus its transference over the generations. This is evident in the quotes by grandmother, mother and a young woman where they shared experiences on the sex education received on menstrual hygiene and its associated menstrual taboos.

> *I informed my grandmother, when I told my grandmother, she told me that, now that you have seen this, you need to dress like this, she tore a piece of*

cloth, when she tore the piece of cloth, she folded it, then put it here… (Grandmother: Dunia).

…I told the elders, and they told me to wait, and I waited for them, and they gave me pieces of old cloth [traditional pads] to use and after using, I should wash them and dry them and keep them somewhere where they could not be seen by anyone. They also gave me a tablet of soap to use for washing the pads… In addition to hygiene, I was told that I should not have boyfriends. I should wait until I was a fully grown up and I met someone who wanted to marry me… (Mother: Sumini).

When I told her, she went and took a piece of cloth and taught me how to use it. After teaching me, she said that you should do like this and like that, you should be putting it on your private parts, so that the blood doesn't mess you up (Young woman: Awetu).

However, there was a clear generational variation about issues related to abortion. This was noticeably absent from the personal narratives of the mothers and grandmothers but was raised by a young woman, evident in this narrative:

They get sick, but they struggle, they suffer, it's very painful hearing from what people say, taking out a pregnancy eeh…it's very painful eeh. Even when you are menstruating, you are in monthly periods you feel pain, others have severe abdominal pains, … But they say it's more painful than this. It's very painful, the pain is so severe, others say clots come out, ooh yes, it's very hard. But others are not afraid to take out the pregnancy (Young woman: Linesi).

The silence from the older generations about abortion could be due to the restrictive environment, in which the older generation grew up and talking about it would have been perceived to being pro-abortion, and they could end up being in jail, unlike now. Or it could

reflect the possibility that abortion cases were rare because the community was less aware of the risks associated with teen pregnancy.

Although, a girl can acquire knowledge on sexual matters from family and friends, it is only the counsellors who can confer her the status of belonging to a special group of adults, having gone through the puberty rite ceremony. On the final day of the ceremony, the girl is shown to the society, as an adult and the society confirms her new status, which cannot be achieved if she is just counselled by family and friends. Hence, every parent/ young woman / female strives for that recognition, which could also be a way of attracting potential suitors. This could also be a reason why counsellors were highly respected and revered in this community. Common among all the generations were the positive sentiments about the counsellors, evident in this narrative.

> *...I will tell my friend to inform you [referring to me the researcher] so that you can attend the afternoon and evening session as well as the river session and at the end of that you will surely know one or two songs. …. That woman (implying the counsellor) knows things, she can teach you a lot about singing and everything. You should come and we can spend the night together until we go to the river for more advice… (Grandmother: Dunia).*

This could also explain, why the young women, who had not gone through the puberty rite, despite being mothers expressed their interest to undergo the initiation rite and one had this to say:

> *They said that there is good advice at ndakula. We were given good advice, for instance about family life. So, I also want to go so that I can also learn about this advice [laughing], maybe my marriage failed because I didn't go to ndakula to receive the needed advice (Young woman: Alinane).*

Having looked at how women learn about SRH issues, in this community, the next section highlights the roles of rituals and ceremonies in shaping young women's sexual and reproductive lives and their perspectives.

7.2.2. Theme Two: The Role of rituals and ceremonies

This theme illustrates the role of rituals and ceremonies in shaping young women's sexual and reproductive lives. The women in this study were asked to share their views and experiences on the initiation rites *(mzondo, ndakula* and *litiwo/ m'meto).* Common and evident among the three generations were their exposure to multiple initiation rites, although there were some variations on the number of rites they had attended mainly for the younger generation. Three of the younger generation missed *ndakula* (the initiation rite at puberty) One was away from the village and two cited financial constraints, one had this to say: *My parents didn't have the necessary resources [referring to money] to send me to ndakula (Young woman: Elube).*

However, they were all interested in the *ndakula* ceremony, with two making plans to attend when their financial situations improved. Culturally, if one misses *mzondo* - the pre-puberty rite and *ndakula* – the puberty rite, she is expected to undergo the initiation rites at an opportune time. One of the young women, who had missed *ndakula* ceremony, reported to have approached a traditional counsellor, who suggested that she goes through the 1-day *ndakula*, to which she was not in agreement, as she was interested in the one with a longer duration, saying:

> *...I didn't go to ndakula, I wanted to go last year, but it finished a bit earlier, but I gave the counsellor money, and she wanted me to go through the 1-day ndakula, but I refused because I would not learn much. They say there are pieces of advice, so I want the advice too. I should feel it that I have received*

> *the advice which people talk about. So, I will go through the process this year (Young woman: Alinane).*

Whilst the younger generation could choose the number of days for the ndakula ceremony, these options were absent during the older generation's time, evident in this narrative.

> *The time I attended ndakula, they used to do it for a day, and because it was just for a day, I never got much from it. But nowadays it is done for a week, these people are fortunate, they know more about these things unlike us. In our family we all attended the one-day session… (Mother: Hadija).*

The quote could be suggesting how *ndakula* has become more valuable over time. It could also be illustrating the impact of urbanisation, as people now move more freely resulting in more intermarriages and exchange of culture. For instance, the team leader for the traditional counsellors is a Ngoni by tribe, from the neighbouring village, but she has lived in this community for more than 50 years. As such it is difficult to tell that she is not from this community, if one does not mention her name, which is distinctive of the Ngoni tribe. Hence the puberty rite has gradually evolved from a 1-day ceremony to a 7-day activity, as a result of the two cultures mingling (Yao and Ngoni) as pointed out by this mother.

> *…the Ngonis, they practice their ndakula in a form of a retreat. The Yaos, it is just a day or hours, for instance they can start now (3:00pm) with songs and dances and then give the girls some piece of advice, about two or three pieces of advice and by sunset, they have finished everything. But for our friends it's not like that. But because of mixing with other tribes, people have adopted the retreat practice (Hadija).*

The duration for *ndakula* and *mzondo* is also determined by the availability of food and other resources like new clothes, while for *litiwo* the duration is standard, half a day.

Nevertheless, it was observed that despite the variation in the number of days for the *ndakula* ceremony, there were similarities in the key messages shared among the three generations, which include menstrual taboos and expected behaviours, menarche and family life, as well as gender roles and relations. Equally for *mzondo* and *litiwo*, whose duration has not changed much. The motivation to go through the process, its significance, influences, roles, benefits, and the potential of using indigenous knowledge to promote sexual and reproductive well-being among young women is highlighted in the sub-themes*: Personal and societal identity; it is our culture, our tradition; menarche and family life; taboos and expected behaviours.*

Sub-theme 1: Personal and societal identity

The significance of this sub-theme is that it lays the foundation for understanding how, what and who influenced the expression of thought and action for the women in the study. It also unites the intersectionality of the self and society thus asserting who we are is profoundly shaped by society and culture. Celebration of the two initiation rites *(ndakula* and *litiwo)* I observed appeared to be a unifying factor among people of different generations, thereby confirming the sense of personal and community identity. However, families had to pay for the ceremonies so that if their daughters do not attend the ceremonies, it may stigmatise the family as poor. Each ceremony costed about £5 then. The two ceremonies drew large crowds of people, although some variations were observed in relation to which people could attend. Even though both ceremonies started as women's affair, it is only *litiwo* that ended as a women's activity. In contrast, for *ndakula* which I observed, people of all sexes, ages and from all walks of life, including local politicians witnessed the graduation ceremony of the two initiates.

Young women, their mothers and grandmothers were asked to describe the initiation rites they went through, and who decided that they attend, and why. Common among the

generations, was that the decision was made by their parents, and they just followed, as narrated by this young woman:

> *The tradition here is that if your parents went through all the cultural practices like mzondo, ndakula and litiwo, you must go through all the cultural practices. In my case, all the cultural practices I went through, my mom also went through the same, so my children will also go through all the cultural practices (Mana).*

As such, it could be assumed that they were simply conforming to the societal norms. Consequently, it conferred their personal and societal identity, as during the graduation ceremony, the community would be aware of their new status and they could be allowed to attend upcoming ceremonies, which is a societal expectation. As evidenced by this narrative:

> *…going through these rituals is an honour. When I travel somewhere for instance, when I go to Liwonde [a neighbouring town]and there is mzondo and they will ask me at the entrance, what did you see? I saw this and that, this, and that, this, and that. They will know you have gone through the process. About litiwo? What did you see? I saw this and that, this, and that, I was advised this and this, then you will hear ululation… (Grandmother: Dunia).*

This quote thus suggests that for parents sending their girls for the initiation rites was important as they contribute to young people's identities and a more respected social standing in their communities. During the cultural ceremonies, initiates are exposed to several rituals and riddles and are expected to master them, as through these acts, they would be distinguished from those who have not gone through the process. This could also explain the silence, as initiation ceremonies are a taboo topic, as evidenced by this narrative: *They didn't tell me anything, they said I should go there and see for myself (Young woman: Elube)* upon being asked, what did your friends, who has gone through the process, say about what

happens at *ndakula*. Further, this could be a strategy to encourage those who have not been there to attend the ceremony, while at the same time, it could be a source of revenue for the counsellors, as they are paid for conducting the initiation rites.

Sub-theme 2: It is our culture, our tradition

This sub-theme highlights some of the explanations women gave for attending/ sending their daughters to these initiation rites. Common among all the generations was that they all went through the three initiation rites for the Yao women. Although, one of the young women said she had not gone to *mzondo*. However, the younger generations questioned the benefits of some of the cultural practices mainly *mzondo,* with many of them considering *mzondo* to be a waste of resources, and that they only went through it because it's their culture and tradition, as evidenced by this narrative:

> *There is nothing helpful at mzondo, I just went there because our parents have gone through it and wanted us to experience too. So, as a child you cannot refuse your parents. But there is nothing concrete that happens there [laughing]. We just went there because it's our tradition (Young woman: Alinane).*

Further, they also cited that *mzondo* practice is not acceptable in the Islamic teaching. They suggested that they could do away with it, and that the advice could be given by their grandmothers. Others said that they would not allow their daughters to go to *mzondo,* despite they themselves having been to the initiation ceremony, evident in this narrative: *For us in this house, me and my husband, we agreed, she will not go to mzondo, but her grandmothers are saying they will take her to mzondo (Young woman: Linesi).*

On the other hand, *ndakula* was highly esteemed among all the generations, with many saying that they learnt a lot mainly about respect and family life and that it is also mentioned

in the Quran. However, one young woman was quick to say that the success of her marriage was not dependent on the *ndakula* advice, but upon her good behaviour, saying:

> *It [ndakula]has helped me on respect, but I wouldn't say my family life is going on well because of the advice I received, it's because of my behaviour. If I am doing what my husband wants, if he wants to appreciate, he will, if he doesn't like what I am doing for him, he can end our marriage. Any way it's good [referring to her marriage] (Young woman: Linesi).*

Interestingly when asked which of the Yao cultural practices would they prefer to see going forward to the next generation, *mzondo* was on the list. One of the young women explained: *We are encouraged as Yao people not to abandon our culture and its traditions, as such the practices of mzondo, ndakula and m'meto [litiwo] are being encouraged to go forward (Young woman: Amina).*

Thus implying, that for all the generations placing their children within a social structure was valuable as was the propagation of their culture and its traditions.

Sub-theme 3: Menarche and family life

This sub-theme focuses on the significance and meaning attached to the onset of menstrual period and its relationship to family life. As such, it draws on the participants' experiences and perspectives of rituals particularly the *ndakula* initiation rite. Common among the three generations was the emphasis on the importance of the first menstrual period. According to them, a girl's first menstrual period indicates that she is mature for marriage and getting married at this time is what attracts the highly esteemed initiation ceremony – *ndakula*.

A similar experience among the generations was the confirmation of menarche by the sexual advisors, in which the young women were asked to describe what they saw at puberty by

pointing at the three lines red, black and white drawn on their thighs. Pointing at a correct line brought celebrations and ululation. This was acknowledgment of the transition of a girl child from childhood to adulthood, which is seen as a crucial period in a woman's life, during which sexuality, gender norms and expectations are learned and regulated by the society. According to one of the mothers: *…at ndakula, I was told there, that now you are a grown up, you are no longer a child. What you have seen, I mean this blood, will be coming out every month... (Mother: Esime).*

The following quote summarises what is included in *ndakula,* and this mother had this to say:

> *During ndakula, the girl is advised on how to live with her husband, for instance when she is menstruating, she is told on how to take care of herself and her husband. If she is not advised, she could be sleeping with the husband while menstruating, instead of excusing herself and this could bring a big problem. She is also told on how to welcome and receive visitors at the house, so that the family is not embarrassed... She is also advised about respecting parents from both sides… In terms of family life, she is also advised on what to do once she finds a marriage suitor. She is also counselled on the dangers of unplanned pregnancy and if the girl is smart, she keeps all this in her head. (Mother: Atuweni).*

Whilst the quotes display both the expected and the unexpected behaviours associated with menstrual blood and family life, implicitly the girl could think of putting into practice the knowledge she has acquired as narrated by this mother:

> *…They are told not to indulge in promiscuous behaviours, but to help them when they find a marriage suitor, you must do this and that [referring to the sex demonstrations]. But today's girls, when you tell them this, it's like you are giving them a ticket to promiscuous behaviours. But the advice is meant to*

help them with their marriage, so that they do not experience any problem (Mother: Atuweni).

During my observation of a *ndakula* ceremony, the emphasis seemed to be on sex education, with more than 2 pairs of counsellors demonstrating sex moves. However, none of the three generations explicitly mentioned this, when asked what they learnt at *ndakula*. Popular among the three generations was the significance of labia elongation, perceived to be a prerequisite for a successful marriage by many. Such that marriage failures were attributed to the absence or not the right size of the elongated labia, evident in this quote.

... But this could be [referring to marriage failure] due to lack of elongated labia. In the past, the Yaos never took the issue of elongated labia seriously like the Ngonis. They used to have elongated labia, but not to the size of those of the Ngonis. It's only now, they have started emphasising on them…. that's ... that's why their [Yaos] marriage never lasted long. (Grandmother: Hawa).

Some advice was dependent on the initiates' behaviour, as identified during my participant observation. The two girls who were cousins, were strongly admonished for not assisting their great aunt with household chores. They were advised to stop forthwith lest risk being brought back to the riverbank and being kept awake the whole night and asked to dive into the river repeatedly during the winter season in the early morning when the water is very cold. This is the suffering the counsellor is referring to in this quote: *For those who are rude you will just hold your hand on the chin, they really suffer, and you will even say why do this to her. They really suffer, it's not a joke (Traditional counsellor: Andechele).* This punishment is used to ensure that the girls' behaviours are congruent with societal expectations.

Sub-theme 4: Taboos and expected behaviours.

Common among the generations was the advice on handling of menstrual periods and how to inform their husbands on the same, as well as its associated taboos and expected behaviours. Evident in this narrative:

> *…When you are married, make sure your husband doesn't see this [menstrual blood] and when you are in periods, don't sleep with your husband, he will get sick, he will suffer from abdominal pains, especially on the umbilicus (Mother: Esime).*

To uphold the secrecy of menstrual periods, the initiates are provided with red and white beads/ cloths, with red beads symbolising menstrual blood, while the white ones indicate that it's over, as illustrated by the following narrative:

> *At ndakula, I was given beads, red beads and white ones. And I was told to put the red beads on the sleeping mat when am in menstrual periods, then he will know my wife is sick. When I finished, I had to wait for two days, and then put the white beads on the mat and he will know I am alright (Mother: Esime).*

Common among the three generations was the clear emphasis on how dangerous menstrual blood is. This included all menstrual blood whether associated with childbirth, miscarriage or abortion. Such that menstrual taboo was the most popular topic mentioned by the participants when asked about the *ndakula* ceremony. Non-compliance with this taboo could lead to repercussions from the family/ society, evident from this narrative:

> *…if the child is stubborn, when she goes to ndakula, she changes her behaviour, because of the things you are told there, scares you somehow. For instance, there are some people who still meet men when they are in their menstrual periods, this is being childish as they don't know that this could bring problems tomorrow.... (Young woman: Zione).*

From the above quote, it is clear that menstrual taboos are used to reinforce expected behaviours. Compliance was marked among all research participants although there were some generational variations. All generations accepted the 6 months abstinence following childbirth, even when the hospital gave different advice saying that 6 weeks postnatal abstinence was sufficient. This is what this young woman had to say:

> *When I came here, according to our custom, they said to both of us, the baby is born, don't be childish in the house, no, then to the man, you Mr. if you try to enter the house [referring to sex] you could die, because not everything has come out [referring to products of conception]. If you want to live, stay away for 6 months, I mean 6 months, but at the hospital, they said after 6 weeks, it's alright. But the parents said after 6 months. We took our parents' advice, we stayed for 6 months. After 6 months then we started entering the house [referring to resumption of sex] (Young woman: Linesi).*

On the other hand, the older generation suggested that some young people 'complied' by using condoms to avoid male contact with menstrual blood, which could be the impact of modernity or Western medicine. Such behaviour was disapproved of and viewed as risky by the counsellors as evidenced by this narrative:

> *They say we use ''chishango'' [condoms]. Can't the condom break, and they suck little bit the menstrual blood? When it burst, can't they catch diseases? (Traditional counsellor: Andechele).*

While the older generation seem uncertain about the effectiveness of condoms, the young woman in this narrative seemed to be confident saying: *He will take condoms and put them on to protect himself. Other men are stubborn eeh, he will say I will see myself, but they use condoms (Young woman: Linesi).* She went further to provide mode of action for the

condoms when asked, how will the man be protected? *Yes, he can't get sick, because he will not meet the blood as the blood will remain on the condom (Young woman: Linesi).*

To ensure that there is no sex outside marriage while observing postnatal abstinence, the man is informed that if he goes out with other women and comes home to hold the baby, it will suffer from unexplained illness, evident this in this quote*: ...you will injure the baby, the baby will have a protruding tummy and will look miserable… (Traditional counsellor: Anagama).* Scientifically, these signs could be suggestive of nutritional deficiency, most likely a combination of marasmus and kwashiorkor. However, for those struggling to observe the prescribed 6 months abstinence, an alternative was put in place and that is having sex on the wife's thighs, evident in this narrative:

> *... now you want to injure the baby. Go back, go back, no condom, this is the third month, your wife still has a backache, just tell her to give you, her thighs. Your heart will be relieved… (Traditional counsellor: Anagama).*

7.2.3. Theme Three: Gender and power dynamics

This theme focuses on the role and status of women on sexual matters and the impact it has on their sexual and reproductive lives. Notwithstanding the matrilineal norm in this society, this is not reflected in the gender relationships between a man and his wife. The two sub-themes are:

Sub-themes 1: Gender roles and relations

This sub-theme emphasises gender roles and relations which are implicit in the key sexual messages young women were exposed to during the puberty rite. Common among all the generations was the instruction to never say no to sex when their husbands are interested in

them except when menstruating or unwell, because by consenting to marriage, you also consent to sex, and one had this to say:

> *The emphasis was on the bedroom issue, as it's the core reason people get married. They said that, never refuse your husband every time he wants you, except when you are menstruating, or you are sick, and you must tell him that you are sick. If you refuse him, he will go out looking for other women (Young woman: Zione).*

This implies that a woman is obliged to have sex with her husband and that failure to have sex on demand could be used by the husband to justify extra marital affairs, which could have negative consequences for the woman, as articulated by this young woman: *You may lose your marriage; he could also bring HIV/AIDS (Young woman: Zione).* The young woman is further advised to be respectful towards her husband, not to be promiscuous rather to concentrate on her marriage and see what the husband does for her in return, evident in this narrative: *They advised me that first don't be cheeky to your husband, if he says I want this, you must do that for him. Don't be promiscuous, just concentrate on your husband and see what he does (Young women: Awetu).*

Further tips for a successful marriage, were based on the traditional roles of a woman, which mainly centred on the husband's general welfare and this mother had this to say:

> *I tell them, you are married, you have a husband, the most important thing is respect. …. If you respect your husband and assist him with basic needs, for instance giving him hot water to bath, and after the bath you give him porridge, he may have girlfriends, but he will never leave you (Mother: Sumini).*

Submissiveness in sexual relations was seen as a sign of being properly advised and that the counsellors had done a good job on you, evident in this narrative:

> *…When you got married, you met the anankungwis [counsellors] who advise you on married life, …. When you have reached this stage, you don't refuse the man. Some people when they are married and if they are not advised on this, they run away from the bedroom. When the man wants to touch them, they refuse, when the man wants to touch them, they refuse [this was a repeat in the verbatim]. But when you are at this stage, you must give the man what he wants (Young woman: Zione).*

This demonstrates the ambiguity of the matrilineal concepts. While the matrilineal system accords women some respect on sexual matters, cemented by going through initiation ceremonies and having some say about whom to marry and preparing them for a married life through sex education, it also removes their power by giving authority to their husbands and them becoming subordinates. Further, the narrative seem to be insensitive to the psychological needs of the woman, who may not always be ready for sex all the time. To demonstrate this, they are advised to sleep without anything on, so that the man has easy access if wants sex. This young woman had this to say:

> *… in a marriage when sleeping, you don't sleep with clothes. Everyone sleeps naked, that's what a marriage is, everyone must sleep naked. Why are we saying this? If you sleep with clothes, you are giving a ban to your husband. (Young woman: Awetu).*

However, if the man sleeps with clothes on and he does not have sex with her, the young woman is encouraged to report to the marriage witnesses and the marriage would be dissolved, evident in this narrative:

> *…Tell your marriage witnesses, there is no marriage in this case. There is nothing happening in this marriage. He sleeps with his clothes on, he doesn't touch me. I didn't do the work; I was supposed to do, the piece of cloth you*

> *gave me it's just lying there [referring for a cloth, used for cleaning up after sex]. Is there a marriage... (Traditional counsellor: Andechele).*

The sex education goes further to prescribe the roles and responsibilities of a married woman on their sexual life, which are of a lower status to that of a man. For instance, the general hygiene after sex, evident in this quote: *After you have sex, it's your responsibility to clean the man, and if you do it again, you must clean the man again (Traditional counsellor: Andechele).*

Communication to the husband about menstrual periods using the red and white beads described earlier was also paramount. As such, the husband could be psychologically prepared that, 'there is nothing for me today' and to avoid disappointments, as illustrated by the quote below:

> *The type of advice that are there are, when you have started menstruating, if you have a boyfriend or you are married, you need to tell him. If it has started in the morning, you need to tell him in the morning or afternoon, saying I am in my periods, so that the man knows in advance, … (Young woman: Amina).*

This sub-theme has demonstrated how the gender relations and division of gender roles on sexual matters in this community operate. The next sub-theme highlights how the traditional ceremonies have been used to reinforce the traditional gender roles of women on SRH issues.

Sub-theme 2: Women empowerment and disempowerment

While the initiation ceremonies granted women/ counsellors some autonomy and dignity in choosing the content and medium of instruction of the sex education, as evidenced during my participant observation, indirectly they were propagating the authority of men over young women, thereby empowering and disempowering themselves. Responses about the impact of the initiation ceremonies on their sexual and reproductive lives were varied and mixed among

the three generations. Common among all the generations were that they felt empowered by the sexuality lessons (Arnfred, 2007) included in the initiation rites and felt that the sexual counsellors contributed to a successful marriage. One had this to say: *It helps you a lot in your family life, since you know what to do, because if you are not advised, the man could send you back to be advised (Young woman: Zione).* For others good behaviour also contributed to a positive married life. This mother had this to say when asked about how she had benefitted from the sex education, during the puberty rite.

> *…The advice I received during ndakula was used in my family. I was doing what I was told for my husband and my family was good. I have followed the advice… until today. I feel the advice I was given during ndakula has helped me in my family life... (Mother: Atuweni).*

Yet, for other young women sex education and good behaviour did not secure a good marriage. For example, Daina a young woman, who reported during the in-depth interviews to have experienced gender-based violence from her husband, had this to say:

> *…My husband used to beat me a lot that time. Every time we had a misunderstanding, instead of saying what you have done is not good, it's bad, instead of talking, he will just take his hand and start beating me…. I reached a point of saying it's better I should go home, than staying here, even if it means struggling with the children. (Young woman: Daina).*

However, being married could be empowering to the young woman, as her status could be elevated, and her financial burden lessened. This may be good for her self-esteem and psychological care, relief for financial burden as well as a source of envy to others who are not married, as evident in these narratives:

> *…We want a marriage suitor, so that people can celebrate at the house, a boyfriend no, they will just lie to you, leave you when you get pregnant, you will bring problems to your parents… (Traditional counsellor: Andechele).*

> *…You can become pregnant when you are not married and there will be no one to look after you… (Young woman: Aida).*

On the other hand, being married could also be disempowering, as not all men are financially secure. As was the case with Daina's husband whose behaviour deteriorated which coincided and was perhaps caused by financial pressures he was facing. Further, being married could also make a women lose her independent status and identity as she adopts her husband's name implying, she belongs to him, and ceases being addressed by her father's name and/or clan name. This was evident too in Daina's case, as the husband appeared not to respect Daina's rights and freedom, and she had this to say:

> *…. When I am going somewhere, he will just be following me, If I meet some boys and we will be chatting, he will beat the boys and beat me too. As a result, I could not go anywhere. I stayed for almost a year, just sitting on the veranda. I was afraid, if I go and visit my parents I will be beaten, I will just eat nsima and sit on the veranda. I could miss my friends, if I just leave the house, he will be hunting me. …(Young woman: Daina).*

Another positive impact of the initiation rites is the sexuality education. Sexuality issues are considered to be a taboo topic (Wamoyi et al., 2010a; Manu et al., 2015; Dessie et al., 2015; Mpondo et al., 2018; Svodziwa et al., 2016; Kamangu et al., 2017) and such ceremonies create a favourable space for discussing it freely. Daina's narrative also provided an example of women's resistance to male supremacy and power. She mocked her husband, saying:

> *Aah I was very annoyed... Whenever, he came home, I will be just singing incomprehensible songs, mixing Yao and Chichewa, knowing that I am being*

> *sarcastic, and because he knows Yao, he knew this song is about me (Young woman: Daina).*

Further, Daina reported his bad behaviour to his grandmother, her family and to the Police. She said:

> *I want him locked up; I want him punished. The way he beats me, he should experience the pain I go through. Please punish him for me, maybe I can see some changes at home. I am no longer interested in the marriage anymore (Young woman: Daina).*

She also went to the Chief's residency asking to dissolve the marriage.

The rituals were both empowering and disempowering. On one hand, once initiated the young women felt empowered and like every woman in the community, they could take part in future rituals of initiation ceremonies and enjoy their position of increasing seniority. On the other hand, the rituals could be perceived as intimidating for the initiates, as they are treated as underdogs (Arnfred, 2015) and the initiation ceremonies could be a source of discomfort to the initiates, as their menarche issues have been brought to the public. Further, the initiation rites could be considered to be disempowering and also not respecting their sexual rights, as the girl are socialized to be passive and accommodating, contrary to the boys who have to demonstrate their physical and social power.

The rituals reinforce the message that women should accept what pleases her husband, regardless of her thoughts and feelings, in the name of being a good wife. While ascribing to the gender roles, relations and responsibility, which are deep rooted in history and traditions, this theme has highlighted how they can be interpreted as both empowering and disempowering for women.

7.2.4. Theme Four: Impact of Colonisation

Although colonialism had formally ended in Africa, its aftermath continues and impacts on gender issues including sexual and reproductive matters. As discussed above, while the initiation ceremonies elevated women's role in the society, it also disempowered them, as the final say on sexual matters remained in the hands of their husbands and male relatives. This situation is further compounded by colonialism and the introduction of a patrilineal system of kinship (Semu, 2002). The impact of this colonial legacy is emphasised by the three sub-themes (*religion versus rituals and traditions, Western medicine and SRH behaviours, urbanisation and traditional practices*). Consequently, this theme aims to unpack the legacy of colonialism, in terms of how it has shaped and influenced directly or indirectly the traditional gender roles of men and women on sexual and reproductive issues and behaviours.

Sub-theme 1: Religion versus rituals and traditions

This sub-theme focuses on the impact on religion on gender roles, rituals and traditions. The majority of the Yao people converted to Islam, such that being a Yao is synonymous with being a Muslim. Islam like Christianity was introduced to Africa as a male dominated religion (Semu, 2002) although, unlike Christianity Islam, largely did not interfere with their native customs such as polygamy and initiation rites (Msiska, 1995). However, Islamic teaching resulted in some changes in the way certain rituals and traditions were conducted. For example, during the female initiation rites, it became a custom on the last day for the traditional counsellors to invite a sheikh to pray for the girls at the river, before the girls are welcomed back to the community, evident in this narrative:

> *Then in the morning, they [counsellors, mentors, initiates and other women] will go to the river, and at the river they [traditional counsellors] will call a sheikh to pray for the girls… (Grandmother: Dunia).*

This could be an illustration of men's attempt to show their dominance and authority over women, which could be emanating from the Islamic teaching, which promotes the subordination of women (Arnfred, 2007). Islam has been integrated to some extent into the rituals rather than replacing them and both traditions have co-existed in the past, evident in this narrative*: …we found our parents, practicing Islam, but the culture of initiation rites was also there. They would send us to initiation camps… (Key informant: Alima).*

Though, over the years, the co-existence seems to be weakening and in the process, causing friction between Islam and the traditions, hence, threatening the survival of some of the rituals and traditions. For example, *mzondo* whose popularity appear to be diminishing, evident in this narrative:

> *…Only very few people are sending their children to mzondo, I have also stopped taking my children to mzondo after realising that it is not helpful at all. We are only sending our children to the second initiation (ndakula) because it is very important… (Mother: Hadija).*

This is because some of the aspects of the *mzondo* initiation rite are considered to be sinful, such as the beating of drums which takes place during the *mzondo* ceremony. However, it is widely accepted that Islam and culture are separate matters but can co-exist. One can practice the two concurrently and Islam must respect culture. Evident in this narrative:

> *…Culture and Islam are different. You are a Muslim, but you don't abandon your culture. Culture is very important, even us at home we cannot abandon our traditions. Religion, we put on one side and culture on the other side yes. The Muslims should accept that these people are the Yaos and the two must move together (Key informant: Alima).*

The women were resistant to some of the changes suggested by Islamic teaching, for example, they continued to include drumming as part of *mzondo*. They even defied the Government's directive, that all initiation camps should be closed by the time schools opened. The *mzondo* ceremony ended two weeks after schools had opened. Despite these women's resistance, Islam and colonialism still impacted on their rituals and traditions in one way or the other. For instance, the timing of the initiation ceremonies such as *mzondo* and *ndakula* are determined by Ramadan and the Western school calendar, evident in this narrative:

> *soon, there will be one after this harvesting period and after the Ramadan. nowadays, it's because of school, after school closes then ndakula will take place... (Grandmother: Hawa).*

Sub-theme 2: Western medicine and SRH behaviours

This sub-theme explores the impact of Western medicine, brought into the area with colonialism on women's sexual and reproductive lives. Evident, although varied among the three generations, was how their sexual and reproductive behaviours have been shaped and impacted by Western medicine. The findings from this study demonstrate that rural women continue to rely on traditional doctors/ herbalists and traditional medicine for their sexual and reproductive needs, particularly among the older women whose choices were more limited as evident in this narrative:

> *...In the past we never knew the hospital, we used to give birth at home. When we were pregnant, we would be advised about motherhood... Then when we went into labour, they used to make a wreath [made of a piece of cloth] ...She would sit on the wreath and open the legs, one will be a guardian, holding her by the shoulders encouraging her to push hard and one will be a village*

> *doctor. She would push hard, and the baby will be born. Nowadays we go to the hospital, to the hospital (Traditional counsellor: Andechele).*

Nowadays, there are different pathways to and different health care systems which women can choose from, depending on their preference and the origin of the problem or illness. The Yaos believe that illnesses occur because of physical factors, spiritual factors, curses or by breaking cultural taboos (Elie, 2019). In situations where illness is believed to have come from curses or by breaking cultural taboos (folk illnesses), people will rarely consult bio-medical health facilities. Some folk illnesses include *''undubidwa''* (an illness affecting breastfeeding children due to jealousy from a sibling), and various *"ndaka"* illnesses that stem from contact that is made between those who are sexually active with those who are not (hot and cold) (Elie, 2019).

For example, when a pregnant woman is towards term, she stops having sex and her body becomes cold, equally the newly born baby's. When she is back home, she is advised to remain in the house until the umbilical cord falls off, and during this time any person who has had sex is not allowed to hold the baby because their bodies are hot. While the baby's is cold, contact with a hot body can lead to an illness, as illustrated in this quote:

> *They say that someone who has slept with a man, should not hold the baby, because the baby's body is cold, since the parents are not being intimate… (Young woman: Zione).*

The practice could be a way of helping the baby to build immunity and also protecting it from infections. Since, it is culturally unacceptable to send visitors away, the elders might have thought of using abstinence from sex to deter them. However, the traditional healers also provide medicines to protect the baby from *ndaka* (Elie, 2019 p.14).

Common among all three generations was their preference to use both indigenous and Western medicine. For instance, if the illness was caused by breaking a cultural taboo or unexplained illness then traditional medicine was sought, evident in this narrative in which a herbalist described the medicine provided to the man who had accidentally come into contact with menstrual blood. She had this to say:

> *The ash from the fireplace, the middle one which looks red, you take and put it in a cup, add water and give the man to drink, that's the end of it, because it was an accident. (Key informant: Alima).*

However, for maternal and child health services the findings demonstrated that women in this community relied on both indigenous and Western medicine. Common among all generations were the preference for young women/ women to deliver at a hospital, evident from my participant observation of the *litiwo* ceremony and the participants' narratives. One had this to say, when asked about the birthplace of her children:

> *I chose to go to the hospital, because there are a lot of benefits, for instance, if you lose a lot of blood during delivery, the doctor will know, you have lost a lot of blood and what to do. If you don't have enough water, the doctor will know what to do. If you get a tear, they doctor will stitch it and you will go back to normal, just like the way you were born (Mother: Atuweni).*

This implies that their preference for Western medicine during childbirth is related to the perceived advantages in case of emergencies. However, after delivery their preferences tend to lean more towards the indigenous ways as their interest is to protect the baby from people with ill intentions which Western medicine can neither prevent nor treat. As such, they are advised to follow certain rituals and practices and to be vigilant all the time so that no harm comes near the baby, as illustrated by this quote:

> *I was advised that, when I give people the chance to hold the baby, I should be careful to check, if they are holding the baby very well and if they don't have bad intentions. If someone visits you and you give them the baby, you have to remain with them until they leave, never leave them alone with the baby (Young woman: Aida).*

Further, the study revealed that, how the umbilical cord fell and where it was disposed was significant among these rural women. As such, the young women were advised to be watchful, to make sure that the cord does not fall on the wrong position, evident in this narrative:

> *I was advised to make sure that the umbilical cord, do not fall off while the baby is lying down, but in my hands, and that the cord should not fall downwards while the baby is in supine position. (Young woman: Aida).*

When asked what would happen if the cord fell on the wrong position, the young woman, simply said: *The baby will not be able to have children of his own (Young woman: Aida).* Once the cord had fallen off, the young women are advised to dispose the cord in a place where it cannot be found by anyone, such as the rubbish area, pit latrine or on the riverbank, so that the baby is protected from people with ill intentions, as illustrated by this quote:

> *When the cord fell off, I picked it up and my mom told me not to throw it anywhere, and she took it to the rubbish area, made a hole, put it there and buried it…They said, if I threw it anyhow some people could find it and make medicine, and others could do something that they know, so the cord must be put on a hidden place (Young woman: Daina).*

Knowing that once the baby is taken out of the house and it would be difficult to limit the number of people who hold the baby, or to isolate those with ill intentions and to ascertain whether their bodies are hot or not (have had sex or not) certain rituals and practices are

performed on the baby. One of the mothers gave a detailed account of the rituals and practices that are conducted to protect the welfare and life of a child and she had this to say:

> *... Upon reaching 6 months, the elders would come and instruct them, now this baby is of age, and since the baby was born at the hospital, so we need to make medicine for you two, and then you can resume sex. Then the elders would bring the medicine, the medicine would be taken in a form of porridge or tattoos on the lower abdomen for the man (Mother: Esime).*

The findings also revealed that none of the young women reported having followed the 6 weeks postnatal abstinence advocated by the health workers, rather opting for the 6 months advice provided by the elders and the counsellors to ensure that all the products of conception were out, evident in this narrative:

> *The elders used to ask, how old is the baby, I would say 2 months, like that. My friend asked me too. Then she asked is your child 6 months now, then I said yes, and she said you can now sleep together. Then I said alright thanks, then I followed what my friend had said (Young woman: Elube).*

However, before the resumption of sex almost all the young women reported to have gone back to the hospital for contraceptives, with the majority opting for implants. One had this to say:

> *When I noted that 6 months was over, I first went to the hospital for contraceptives. I started this [having sex] when I was on a method (Young woman: Linesi).*

When asked if the elders or counsellors had spoken about modern contraceptives when 6 months of abstinence was over, the younger generation reported: *They didn't tell me anything, but I just found a way for myself. I went to the hospital, and I have an implant*

(Young woman: Alinane). They might have been informed about contraception during antenatal visits or postnatal care they received. This theme has clearly demonstrated that despite, being exposed to the Western medicine with all its advantages, women in this community have not abandoned their indigenous ways, but rather utilise each according to the perceived needs and gains.

Sub-theme 3: Urbanisation and traditional practices

This theme focuses on the impact of urbanisation and modernity on traditional practices and how it has shaped women's sexual and reproductive lives. Evident among all the generations were how traditional practices have changed over the years with some rituals and traditions being abandoned or repatterned due to the influence of urbanisation and modernity. For instance, SRH issues are culturally considered taboo topics, only to be discussed in secrecy, but now the issues are being discussed in classrooms where the little ones can eavesdrop:

> *…The female teachers used to invite all girls who had attained puberty to a class, and they would be told, you need to do this and that and us the young ones we would be standing on the window and listen... (Young woman: Linesi).*

As a result, this girl never saw the need to inform her parents, when she attained puberty. Further, urbanisation and modernity have impacted on how certain rituals and traditions are conducted and perceived (Rasing, 2021), and this has affected *ndakula* and *litiwo,* and particularly *mzondo* being the most affected one and at risk of disappearing. Reflecting on the participants' narratives, it was clear that some rituals and practices associated with the ceremonies have been abandoned due to modernity and urbanisation.

For instance, the practice of shaving a girl's head during *litiwo* was stopped. This could be attributed to the women becoming more aware of their rights and challenging the practice. After the country transitioned to a multiparty system of government, there was an influx of non-governmental organisation (NGOs) in the rural areas raising awareness of human rights issues, and this might have facilitated the abandonment of the practice (Semu, 2002). Further, during the *litiwo* ceremony, the girl would be provided with wrappers and dressed in a wrapper from the breast downwards (as described in chapter 5) and in the past the girl was expected to use wrappers only until delivery. These two practices have both been repatterned. Nowadays, the *anankungwi* only puts a pair of scissor on the girl's head to symbolise the shaving ritual, and she is dressed in a wrapper only for the ceremony and thereafter allowed to use her preferred attire. This grandmother had this to say:

> *We say kumeta [meaning shaving], but it's not about shaving only. We go there to advise her, give her pieces of advice. In the past, they were removing her hair, and will remain with nothing. I went through that one. They removed all my hair (laughing) I remained clean shaven, with no clothes [referring dresses and blouses]. We only had a wrapper, wrapping ourselves around the breast downwards until delivery, without wearing clothes (Grandmother: Dunia).*

Nowadays, the practice is modified, and the wrappers are being used on top of a dress/ blouse. This trend I observed among all the pregnant women that I met during my fieldwork. This could be attributed to the comfort it accords or the economic factor, as it can used on all occasions, compared to maternity dresses, which become less useful after delivery.

One notable tradition that has been abandoned during a *litiwo* ceremony is the practice of *chiwilo* [swearing in a sarcastic way] at the girls' husband and his family, as a way of demonstrating their happiness. One grandmother had this to say:

> *…The only problem with litiwo was chiwilo …they used to swear at the man, who was seated quietly there and was responsible for the pregnancy, swearing at him, that's how it ended, that men were being embarrassed for nothing (Grandmother: Edina).*

When asked why this practice had stopped, they replied that times are changing. However, reflecting on the above narrative, there could be some evaluation taking place on the relevance of the rituals and traditions to modern times, and in the process doing away with or repatterning some of the practices. As Felix Houphouet-Boigny, former President of Côte d'Ivoire once said *"We should see culture as a river leading us forward, not a stagnant pool where we stay in one place. Culture is a guide that enables us to progress, not a heavy weight that holds us back"* (Action for the Rights of Children (ARC), 2009 P. 5).

Therefore, it could be suggested that the women in this community are repatterning/ abandoning the cultural practices which are perceived to be hindering their progress or not serving their interests. However, other factors seem to be playing a role in some cases. For instance, the views of some to do away with *mzondo* initiation rite were based on religion (highlighted in the earlier section) and economic factors, evident in this narrative:

> *…but the children we have given birth today, they have brought bad practices, they say their children cannot go to mzondo, because there are sins at mzondo because of their Islamic teaching, that's it, yes (Key informant: Alima).*

Money also seemed to play a major role in the minds of those advocating for the abandonment of *mzondo*, as highlighted by this young woman:

> *The problem with mzondo is that we just go there to eat nsima that's all. It's a waste of resources [referring to food and money] we just sit. It's better if the child doesn't go through it, but should go to ndakula, because at ndakula you*

> *learn about good things but at mzondo you just waste food… (Young woman: Awetu).*

This could also reflect the worsening economy of the community as the people seem to be getting poorer. In the past, I observed that almost every household had a granary for surplus maize, whereas now I only saw one at the Senior chief's residence. A similar observation was made by one of the participants, who reported that: *Maybe it is because of lack of resources that's why we have stopped [mzondo] and concentrated on the middle one [ndakula] (Mother: Hadija).* However, this participant also pointed out that sending children or not to *mzondo* was personal preference, saying:

> *This depends on people's choices, some are still sending their children to mzondo, while others have stopped. Those who have seen that mzondo is not helping their children much have stopped sending their children there. (Mother: Hadija).*

A child's behaviour was also a determining factor as the *mzondo* initiation rite was used as a means for correcting behaviour perceived not to conform to the expected cultural norms. Even though, they were sceptical about its value, evident in this narrative:

> *There is nothing important at mzondo, you just sit there and eat nsima, there is nothing scary too. But when the time for advice come, that's when they start advising you, if you were not well behaved, you are told to change there. (Young woman: Elube).*

One other impact of modernity has been to enhance the visibility of initiation rites. The last day celebrations reach further with modern equipment such as musical instruments, whereas in the past there were only traditional drums. They now attract people of all ages and from all walks of life, which also means more money for the initiates, the mentors and the counsellors.

It is a custom for people to reward the initiates, the parents and those who took part in mentoring and advising them during the initiation ceremony.

Thus, this theme has demonstrated how religion, Western medicine and urbanisation have shaped women's sexual and reproductive behaviours, as well as sharing of SRH information and practices from the perspectives of three generations. It has also illustrated that culture is dynamic and that people respond differently, which leads to the final theme, the tension between older and younger generation.

7.2.5. Theme Five: Tension between older and younger generation

This theme takes into consideration the social, economic and political environments in which the three generations have grown up, to understand their philosophical understanding of issues relating to sexual and reproductive matters. The older generation had limited exposure to the wider world due to one party system of government, with discipline and obedience being the order of the day (Ngwende et al., 2010). The younger generation, however, grew up in a more open society, with a multiparty system of government, where freedom of expression was encouraged (Semu, 2002). As such they are not afraid to question the relevance of indigenous knowledge with its associated rituals and traditions, consequently, leading at times to a strained relationship between them and the older generation, and in the process being considered stubborn. Therefore, this theme aims to provide a holistic account of how the construction and experience of adulthood is conceptualised and lived out by young women, and how they are viewed by the older generation and vice versa.

Sub-theme 1: That's your way grandmothers, this is ours

This sub- theme describes the views of the younger generation towards the older generation and their indigenous knowledge system versus the Western knowledge system. While all the generations acknowledged that things have changed and are changing and there is need to move with the times, the pace at which change should be undertaken appeared to vary. Although, they shared a common understanding on some traditions and practices like menstrual hygiene and taboo, variations were observed in following some indigenous knowledge practices. For instance, on umbilical cord care, a young woman opted for Western medicine with the support of her parents, describing the traditional remedies as useless, saying:

> *On cord care, I was told that I should be scraping the dirty from the piston [wooden rod used for pounding food]. I should scrape it and then apply on the cord…Aah my mom and dad said, why should you apply those useless things on the baby, so I just bought spirit. And I used to put it on the cord periodically. I would put few drops on the cord and when I have gone to check on the baby if she is awake, I would put few drops again, then 2 – 3 days later the cord fell off (Young woman: Daina).*

Equally, whilst all generations adhered to the taboo of sex during menstruation, the use of red and white beads to communicate about this, appeared to be another source of tension between the older and younger generation. While the older generation emphasised the use of beads for communication about monthly periods, the younger generation seemed less keen, rather opting to use word of mouth, evident in this narrative:

> *I just tell him, but in the past the elders would take red beads or a red piece of cloth and put on the sleeping place (Young woman: Amina).*

Thus, they appeared to be suggesting to the grandmothers that much as we respect these traditions and practices, we do not agree with everything you teach us, but we have found an alternative way of communicating with our husbands/ boyfriends on menstrual issues. Likewise on the use of traditional pads, even though the young women had been taught on how to use them, they seemed not to be in favour of them, but preferred to use more modern ones and one had this to say:

> *…That time people used to wear ‘’nyanda’’ [meaning traditional pads] … But some of us aah we don’t like these nyandas (Young woman: Daina).*

To demonstrate their dislike about the traditional pads, a traditional counsellor apprentice was observed booing the old counsellors during a focus group discussion, when they were querying the effectiveness of modern pads due to their smaller size. Evident in this narrative:

> *Nowadays, when they want to wear nthete, they put it on the underwear, will that cover the area properly, no, no it’s childishness, can’t it come out like that? (Traditional counsellor: Andechele).*

The apprentice counsellor also responded to the query with a question, and she had this to say: *aah you want people to wear those ropes [referring to traditional pads] again aah, aah today? (Young traditional counsellor: Abiti).* To which the older counsellor responded laughingly by saying: *‘’awa ndi amene akuyendera China’’ [meaning these are the ones who are moving with time] (Andechele).* Further, the older counsellors appeared to be acknowledging that, while the younger generations have embraced change and are moving with modernity, they are rooted in the old ideologies of rituals and traditions.

Further, not only do the older generation blame modernity for their children's selective respect for rituals and traditions, but they also seemed to criticize the health workers trained in Western medicine for being responsible for the young women's ideologies of undermining the authority of indigenous knowledge systems, evident in this narrative: *This is what people say at times, that the hospital disturbs people's minds. Have you heard? (Traditional counsellor: Andechele).*

The quotes could reflect that the younger generation who grew up in the multiparty system of government are not afraid to express themselves. In addition, the older generation's limited exposure to the world outside the village, is likely to have been advantageous for the propagation of indigenous knowledge system in its purest form, unlike now when its relevance is being questioned, thus posing a threat to its survival in this modern era and *mzondo* being the most affected rite. Even though, most of the participants reported to have gone through the *mzondo* initiation rite, the majority of the younger generation and some of the older generation seem to question the validity and significance of the rite

The young women could be advocating for the cessation of *mzondo* as they consider it to be of less value. While for the older generation the responses varied, with some suggesting the promotion of all the three initiation ceremonies, evident in this narrative: *...I would promote all our cultural practices, so that our children could follow the right path (Mother: Atuweni).*

Sub-theme 2: Today's children are stubborn

This sub- theme seeks to unearth the views of the older generation towards the younger generation reflecting the tension between the Western knowledge system and the indigenous ways, and how this has shaped their sexual and reproductive lives. Although all the participants acknowledged that things have changed, and it is inevitable to move with the

time, the older generation were reluctant to change at times describing the young ones as being stubborn:

> *…Today's youngsters have abandoned the old practices… as they feel that when they attain puberty, they just need to be told on how to wear pads, … they think that this is enough. They are refusing the old practices, yeah (Mother: Esime).*

Further, the quote could be suggesting that the younger generation, have embraced modernity and consider the old practices as primitive, or it may imply that they have multiple SRH information sources from which to choose from, unlike the older generation. At the same time, the older generation could be promoting the indigenous knowledge, by suggesting that, there is more at initiation ceremonies than learning how to wear sanitary pads, evident in this narrative:

> *…They are refusing to go for our cultural practices, where they could learn this and that. If they had accepted, to go through these cultural practices, they could be disciplined, and they would know the consequences of their decisions and behaviour… (Mother: Atuweni).*

This was echoed by another participant who stressed the value of mzondo, saying:

> *…Those who have been at mzondo are well mannered, are afraid of engaging in bad behaviours as they always remember what they were told at mzondo. But those who have not been at mzondo are not disciplined... (Grandmother: Esitere).*

However, knowledge does not always translate into expected behaviours and young women may consider putting into action the sex moves taught during *ndakula*, omitting the clause that says to be used when you are married. Such behaviour resulted in the older generation's disapproval, evident in this narrative: *They just sneak. They sneak to go to the hospital to get*

an injection [contraceptive]. They just sneak to go to the hospital to get an injection (Grandmother: Hawa).

There are a number of reasons why the young women may not follow the advice to abstain from having sex until marriage or talk to the elders about this. Firstly, there is a thin line between a boyfriend and marriage suitor, which a young woman might not differentiate. Or as a teenager, she might be exploring and want to keep things to herself which the elders might not understand. Or she might not want them to know about her behaviour, because telling them that she is going to the hospital for contraceptives, would be like admitting to having sex and not following their advice. One young woman talked of regretting not taking heed of the advice given and ended up with an unplanned pregnancy. She had this to say:

> *I used to be advised, don't do this, don't do this, like other girls I didn't listen to the advice, then I became pregnant, and I was told to do my own way, to buy clothes for myself, that's when I realised that it's good to listen to parents' advice (Young woman: Aida).*

The quote could also be an illustration of peer pressure, as the girl is narrating that, like other girls I did not listen to my parents' advice, thus suggesting that, she might have done what she did, because other girls were doing it. However, the older generation were interpreting it as a sign of being stubborn, evident in this narrative:

> *These girls are stubborn, even if you beat them, they don't listen to the advice. They just go to the man and start living there. The next thing, they are pregnant, because they don't listen to parents' advice (Grandmother: Esitere).*

However, the older generation seemed to realise that there is nothing more they can do to make the younger generation listen to their advice, rather accept the reality that things have changed and move forward. This eases the tension between the older and younger generation.

7.3. Conclusion

In this chapter I have discussed how rural women come to understand SRH issues and viewed the roles of rituals and ceremonies in their sexual and reproductive lives from the perspectives of three generations. The findings have revealed that young women are socialised into their sexual and reproductive lives and expected behaviours by families, friends, traditional counsellors, teachers and health workers. There is also an organised process of achieving this at different stages of their life, pre-puberty, puberty and with first pregnancy, each with its own dictates. Unlike families, friends, teachers and health workers, sexual advisors use initiation ceremonies to socialise girls and young women into their future roles as women, wives and mothers.

However, this has changed over time, due to the influence of Western ideologies, which has resulted in some practices being re-patterned or even abandoned. This can create tension between the older and younger generation, as the younger generation appeared to lean more towards the Western ideas, medicine and modernity than traditional medicine and indigenous ways with its rituals and traditions, which are highly respected by the older generation. Though, intergenerational solidarity seemed to encourage continued support for girls and young women from grandmothers and sexual advisors on SRH issues. Further, they appeared to agree on healthcare seeking behaviours, as they all rely on both traditional and Western medicine, depending on the perceived origin of the disease/ illness.

Nevertheless, for sexual health young women mainly rely on indigenous ways and utilised Western medicine for reproductive issues such as antenatal care, labour and delivery. With postnatal care they went back to their traditional roots just returning to the hospital for contraceptives. While initiation ceremonies are aimed at empowering young women on SRH issues, they could also be a source of disempowerment as they appeared to promote power

imbalance between women and men on sexual relations, thus indirectly predisposing young women to HIV infections and unplanned pregnancies. However, within all this, the accounts from both the younger and older generation showed a strong sense of duty and obligation to support their girls and young women on SRH matters. Intergenerational solidarity observed during initiation ceremonies seemed to encourage continued support for girls and young women from childhood to adulthood and motherhood.

There were multiple factors that influenced or could potentially influence the accounts participants gave about the of future of initiation ceremonies, rituals and traditions. These included the impact of religion, Western medicine, modernity and urbanisation, as well as the personal needs of the girls and young women. This left many of the older generation with worries and concerns about the future, their main concern being the future of initiation ceremonies, rituals and traditions, as well as the well-being of their girls and young women. Furthermore, the narratives from the participants highlighted the importance of looking at SRH of young women as a community issue rather than an individual's problem. This demonstrated a strong sense of cohesiveness among these rural women, although not ignoring the individuality of each person which was apparent in their perspectives, as well as in their interpretation and utilisation of the indigenous ways versus the Western ways.

Chapter 8 Discussion

8.0 Introduction to the Chapter

This chapter discusses how the main research findings relate to the literature reviewed in chapters 2 and 3 and responds to the objectives and research questions set out in chapter 1. The socio-ecological framework presented in chapter 3 and the supporting frameworks are briefly discussed to show the reader how the socio-ecological framework and the supporting frameworks (the Life course perspective, Paulo Freire's philosophy of conscientization (Emancipatory theory), writings on Decoloniality; and African feminism) relate to the findings of the study. Finally, the chapter outlines the contribution the thesis has made to the existing body of knowledge on SRH communication practices, knowledges, rituals and traditions.

8.1 Linking findings about SRH knowledge and communication to the socio-ecological framework

The objectives of the research were as follows:

- To explore females' practices, attitudes and communication about SRH from the perspective of three generations.

- To identify factors which facilitate or inhibit intergenerational SRH communication in the community.

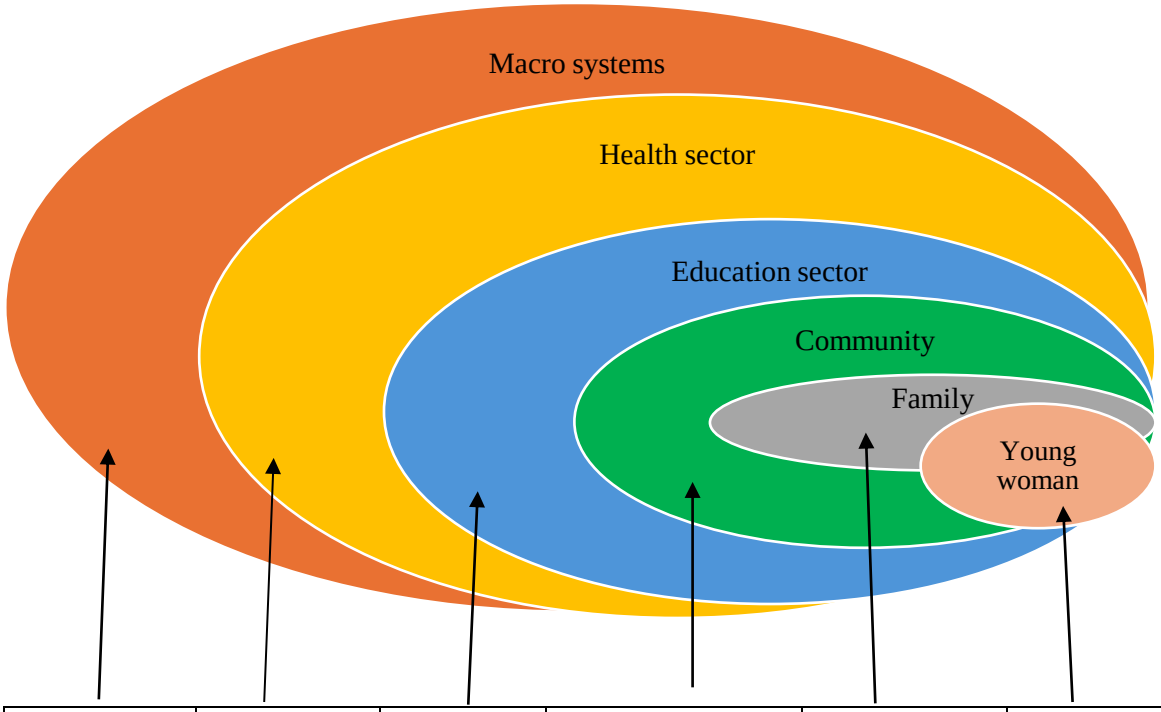
- To explore how SRH knowledge and communication may influence young peoples' sexual behaviours.

- To explore how patriarchy, the legacy of colonialism and modernity has shaped and influenced the traditional gender roles of women on the social context of SRH issues.

- To examine the relationship between indigenous and bio-medical knowledges in order to develop a culturally- appropriate intervention.

Figure 8.1 links the thesis findings in relation to these objectives and the socio-ecological framework. It is important to note that some of the factors were cross-cutting in that the factors perceived to be associated with SRH risk among young women were also identified in the responses of family (mothers, grandmothers) and the community (traditional and religious SRH counsellors). Further, cultural factors associated with traditional gender roles of women operated almost at every level of the socio-ecological framework.

Figure 8.1 Factors shaping risky and healthy SRH behaviours and decision making in this study.



Political history (single party versus pluralism government)	Biomedical approach to SRH service provision	Sex education in schools and not addressing the real SRH needs of girls	The gendered nature of SRH and tension between a matrilineal society but men having power in sexual relationships	Culture of secrecy whereby discussion about sex is taboo	Inadequate knowledge on SRH issues
History, religion, colonialism modernity & its impact	Lack of community engagement on provision of health services	Education fails to meet the needs of many girls in rural areas who tend to drop out at an early age	Social norms & vulnerability of young women	Selective application of indigenous and Western ways of health care approaches	Young age

Legal restrictions on abortion	Insufficient notice taken of the important role played by indigenous teaching about SRH in the traditional rituals		Role of counsellors, rituals & traditions: - Key for learning SRH - Sex education promotes gender imbalance	Key role of grandmothers regarding SRH education	Lack of guidance about how traditional knowledge transmitted during rituals interfaces with biomedical approach delivered by the health service (e.g. contraception and support with labour)
			Inadequate knowledge on some of the biological aspects of SRH issues among counsellors	Inadequate knowledge on some of the biological aspects of SRH issues among grandmothers	Poverty which predisposes them to leave education early and marry young
			Indigenous approach to SRH issues and lack of clarity about how this interfaces with biomedical approach provided by the health service	Poverty – encourages early marriage, as economic relief	

The socio-ecological model appeared to be appropriate for understanding the development of sexual behaviours for young women in this study, because evidence show that sexual behaviour is a product of multiple factors (Muheriwa Matemba, 2023; Kar et al., 2015). As demonstrated above this model views behaviour as a function of the relationship between the individual and contextual factors occurring at multiple levels of influence within the social

environment. However, their level of influence is not always sequential as the model depicts, rather contextual and they vary between individuals and societies, as was the case in this study. Although, several factors appeared to have played a role in shaping young women's sexual and reproductive behaviours in this study, it is important to note the crucial role of family (particularly grandmothers) and the community. This finding could be somehow different if this study was conducted in the West, where the societies tend to lean more towards individualism than in many LMICs.

To address the research objectives, I draw upon the different components of this diagram. Linked to the study objectives, I sought to find out and analyse how the rural tribal women, interpret and understand SRH communication practices. I also considered the broader historical, economic and socio-political contexts that shape the SRH communication practices and experiences as illustrated in the socio-ecological model. The thesis thus draws on layers and intersectional understandings of how SRH issues are learnt, understood and encoded into everyday cultural practices among the three generations of these tribal women.

Key thematic areas for discussion have been structured as follows:

- Social norms, the role of women, rituals and traditions which broadly address the first three study objectives about communication related to how young women learn about SRH, the factors that influence this and the impact it may have on their SRH behaviours.
- Gender relations and power which addresses the objective about the impact of patriarchy, colonialism and modernity upon gender roles and women's SRH

- Western knowledge, versus culture, indigenous ways and knowledges which addresses the objective about the relationship between indigenous and bio-medical knowledges.
- Transforming knowledges through recovering the past and accepting the present. This final theme draws together the key findings on which I based the intervention.

8.1. Social norms, the role of women, rituals, and traditions

Under this thematic area, the experiences and views were similar across the three generations (young women, mothers and grandmothers, including counsellors). The views and experiences revealed the value and respect the rural women placed on the teaching, rituals and traditions conferred to them by their grandmothers and the counsellors. This study showed that young women in this community mainly rely on cultural knowledge with support from grandmothers and traditional SRH counsellors, to understand what it means to be a female, to learn about sex and their future roles as women in the society as well as their cultural identity. Unlike, grandmothers, sexual advisors use initiation ceremonies to socialise girls and young women into their future roles as women, wives and mothers.

The learning took place in a sequential manner starting at an individual level privately under the tutelage of a grandmother. At family level, the girl was supported to understand what puberty is all about with its associated menstrual hygiene and taboos. From there the girl would be taken to the next level of the socio-ecological model (exosystems) which is at community level. At this level the girl was advised by the traditional counsellors who conferred her the status of an adult with emphasis on expected cultural norms and behaviours, and at the same time revealed her to the public for affirmation. Similar findings were noted

by Rasing (2021), who reported that initiation ceremonies are not only meant to transform the young girls into women, but also to establish a tribal identity. Later their sexual and reproductive health perspectives and behaviours were shaped by their exposure to Western knowledge systems through religious and education institutions, health facilities and modernity, e.g., government initiatives such as routine outreach clinics.

8.1.1. The role of women, rituals, and traditions

In this study the rural Yao women reported to discern SRH information, values and societal norms about sexual attitudes and behaviours from multiple sources with grandmothers and sexual counsellors being the most preferred informants. Through talks, demonstrations and songs, the counsellors provided explanations and meanings about the rituals and traditions associated with the initiation ceremonies, as well as the value attached to them. Further, through the rituals and traditions, girls and young women were empowered by the secret knowledge and skills which contribute to their SRH maintenance, as well as their cultural identity. The education during *ndakula* and *litiwo* emphasised that motherhood was central to the identity of women in this community.

Unlike a patrilineal kinship system, within the matrilineal kinship system, a man's biological children belong to the matrilineage. Women usually remain within their maternal villages at marriage and live close to their mothers and matrilineal kin. They are allocated land by the matrilineal when they are married and farm this land along with their husbands and children (Sear, 2008). My study area is a matrilineal kinship system although, this has been influenced by the impact of colonialism and westernisation, which is based on a patriarchal model. This was significant because it had an impact on how rural women communicated and socialised young women on sexual and reproductive matters.

Despite the effects of external forces, the matrilineal system has persisted, although in an altered form. For example, initiation ceremonies have survived and Yao Women and the Bemba women, both from matrilineal societies in Malawi and Zambia respectively, have used/ use initiation ceremonies and their fertility to claim their power in the society and to challenge the status quo.

Johnson (2018) who studied a community in rural Malawi cites the following example to demonstrate the importance women attach to these initiation ceremonies. To deal with the economic challenges arising from a poor harvest in this community, the chief called for a meeting and a man proposed a postponement of the initiation ceremonies as way to save food and money meant for gifts during these occasions. The women refused and challenged their husbands saying that *Bola lithe!* '*meaning it would be better if the marriage ended'* rather than their daughters to forgo the initiation ceremonies (Johnson, 2018 p.790). This was also observed in this study, when women prolonged the *mzondo* initiation rite for 2 weeks, consuming school time, despite the government's order to close all initiation houses before school commenced. This implies that women still have some autonomy in matrilineal societies and the importance attached to the female initiation rites.

This is supported by others who have reported about the existence of sexual advisors in the rural community, and the use of initiation ceremonies in matrilineal societies to communicate rituals and traditions on sexuality, adulthood and gender roles, cultural assumptions and expectations of being a mature female to young women (Limaye et al., 2013); Munthali & Zulu, 2007); Munthali et al., 2004) and Schroeder et al., 2022). Rasing (2021) in her study on the female initiation rites of the Bemba people in Zambia, reports that such interactions were a means, not only to transform a girl into a woman and to establish ancestral lines, but also to

establish tribal coherence, which are central tenets of Decoloniality and the *Ubuntu* philosophy.

My study found that rituals and traditions carry important messages on SRH information for girls and young women in this community with many of these rituals and traditions being embedded in the young women's everyday lives. For instance, the ritual of writing red, black and white lines on a girl's thigh, while teaching her about the presence of menstrual blood, near and the end of her monthly period, was significant in communicating about menstrual taboos. Equally, in the health improvement intervention following from my early research results, I utilised the rituals and traditions to teach about the reproductive cycle and when to access contraceptives, as learning becomes meaningful through associations, between knowledge, collective practices and actions.

Furthermore, my study found that the rituals, traditions and the advice given during the initiation ceremonies were key to the construction of a holistic understanding of the SRH communication practices and experiences. Similar findings were reported by Talakinu's (2019) study on *chinamwali* in Zambia. Talakinu reported that a woman who had not undergone the initiation ceremonies was considered unfit and uncultured among the Bemba women. In addition to cultural identity, initiation ceremonies convey expected societal norms and behaviours. For example, respect for parents, elders and self, demonstrated in their mode of dress (as highlighted in chapter 5) and kneeling before the parents and the elders. Emphasis was placed on respect for parents, and all the participants reported being advised not to enter their parents' bedroom/ house as sex is considered a private matter, not meant for the public. This was also reported on by Perianes and Ndaferankhande (2020) who noted that

respect for elders entailed *Umunthu* as a way of being and it is manifested in a variety of social dynamics including respect for one's privacy.

In my study each girl/ young woman was expected to uphold the secrecy of the rituals and traditions associated with the initiation rites. This is because sharing the rituals and traditions could undermine their relevance and significance, which could also impact the counsellors' negatively. This could threaten their social standing and the respect they are accorded in the society, as they could become irrelevant, as people would not see the importance of attending the ceremonies, as the information would be readily available. In this way the community could lose its cultural identity which it is trying to preserve for future generations. This secrecy was also observed by Bagnol (2011) in a study on female initiation rites and sexuality in northern Mozambique.

In my study, those who had gone through the puberty rite were unwilling to share what they had been taught during the ceremony to those not initiated, rather, encouraging them to go through the process. I was also encouraged to go through the process and learn for myself more about the rituals and traditions of initiation rites, to which I did as a participant observer. After taking part in the initiation ceremony, I was informed, that I was ready for a marriage, and I was provided with red and white beads for communicating about the presence and absence of menstrual periods. Thus, it could be assumed that the rituals and traditions of these initiation ceremonies are the keystone for any interpretation and understanding of gender roles, relations and sexuality.

Further, my study revealed the existence of beliefs and taboos associated with SRH issues such as menstrual blood which were a means to control sexual behaviours and enhance

compliance among sexual partners. The women in this community strongly believed that menstrual blood was dangerous, could cause bad luck, contamination and death. If sexual partners were exposed to it, they could suffer from unexplained sickness and death, as well as STIs, HIV and AIDS. While, it is understandable that menstrual blood could cause contamination as blood is a good medium for infection, it is more difficult to comprehend how menstrual blood could make someone unlucky.

The taboo about menstrual blood supports an earlier study by Kangwa (2011), who reports that women are perceived to possess dangerous power during menstruation which could harm men if they came into contact with blood. This was further compounded by the Islamic beliefs and teaching that when a woman is menstruating, she is considered to be unclean and is unfit go to the mosque for prayers, even to fast. There was a strong belief that sanitary pads combined with witchcraft, could be used to harm a woman and she could have prolonged menstrual periods, which could be detrimental to her physiological and psychological health. As such, each woman was urged to keep sanitary pads in a place where their husbands or anyone else could not find them, preferably washing and keeping them at the grandmother's house. Interestingly, even the local community health worker, strongly felt the same about menstrual blood, despite being exposed to the Western education system which states that menstrual blood is not dangerous per se.

While the rural women may not be exposed to the scientific knowledge about menstrual blood, viruses and bacteria, there could a clear rationale behind some of the taboos. The counsellors might have thought it wise to use threats and warnings to deter some risky sexual behaviours. The taboos could also be viewed largely as protective, such as postnatal

abstinence, which gave the woman ample time to recover from her pregnancy and to breast feed her baby which also lowers the risk of a closely spaced pregnancy.

8.1.2. Conservatism and sexuality

Open discussion about sex in this community was limited to initiation ceremonies. This could explain why the sexual advisors repeatedly demonstrated sex moves and why every girl, parent/ guardian was in favour of the puberty rite, and parents strived to save up and send their daughters to the ceremony. Culturally and religiously sex before marriage is regarded as an immoral act. Equally, the consequences of unsafe sex such as teenage pregnancy, STIs, HIV/AIDS infection are also viewed by the society through a "moral lens" instead of being seen as a public health problem (Godia, 2012).

To avoid bringing shame to their families with unplanned pregnancies, some girls in this study were forced into early marriage due to a lack of alternative options. The sexual advisors in this study repeatedly warned the girls against being sexually active, and to abstain until a marriage suitor was found. This might have left the young women without really understanding their own bodies, or their sexual needs or contraception. Further, other cultural expectations might have contributed to teenage pregnancy. There was a general expectation in this community that, once a girl got married, her economic situation and that of her parents' lives would improve, as they would have someone to provide for them and they would belong to the higher status of married women. The young women in this study all wanted to be married as they perceived marriage as beneficial.

Poverty might have also contributed to young women's desire to find a partner. This was also noted by Moyo (2004) who argues that while the church believed that men engage in sexual

relationships to meet their sexual needs, women do so mainly to meet their socio- economic needs as beneficiaries of male sponsors. This finding is also consistent with Talakinu (2019) and Moyo's (2004) observations that women are expected to offer themselves completely in their services to the men to whom they are indebted in order to safeguard their marriage. Such gender imbalance in sexual relationships is discussed in detail in the subsequent section.

However, the current findings in this regard were mixed. There were some similarities to Moyo's findings (2004), in that in both participants' narratives and when observing the initiation ceremonies, I noted a lack of emphasis on affection and mutual sexual pleasure as the foundation of any sexual relationship. However, there were also differences as the young women in my study had the opportunity of choosing whom to go out with or marry, suggesting an element of liking and love was there, as shown by Daina's narrative in chapter 7 who spoke about the beginning of her marriage, in which the two young people liked each other and started living together. However, when the young man failed to meet his family obligations of providing for his wife Daina and family, as culturally and religiously expected, the marriage fell apart. About half of the young women in this study had been divorced within the first two years of their married life, mainly as a result of infidelity of their spouses and fear of contracting HIV and AIDS. As noted by Johnson (2018) in her ethnographic work, there is a higher incidence of divorce and remarriages in matrilineal societies than in patrilineal areas as women have more power.

8.2. Gender relations and power

In matrilineal societies, the birth of a child confers greater status to the woman's family, expanding the social wealth of the lineage and enhancing the status of their uncle(s). In contrast, within the patrilineal communities, the birth of a child confers greater status to the

husband's family. An interplay of historical processes in pre-colonial times and during colonial rule, and of political rhetoric in the post- independence era, have created ambiguity in the application of concepts of culture and gender in Malawi (Semu, 2002). Though women have some autonomy in the matrilineal kinship system, men have largely enjoyed considerable power within both matrilineal and patrilineal systems (Ibid.).

A number of historical factors have contributed to the erosion of the status of women in matrilineal societies: the introduction of slavery, from 1810; the coming of patrilineal societies into Malawi, from the early 1870s with the introduction of Christianity and colonisation; and the introduction of the money economy (Semu, 2002 p. 79). With slavery, women lost control of their sexuality and were valued only for the children they could bear for their masters. With the arrival of Islam and Christianity, both of which male-dominated religions, anything that was incompatible with this perspective, including the matrilineal system was crushed, consequently acquiring control over women and their children.

Missionaries and Western modernising agents compounded the situation through their lack of commitment to women's education (Semu, 2002). As a result, in both matrilineal and patrilineal systems, new ways of relating to women emerged (Ibid.). Furthermore, in patrilineal systems dependence on cash income resulted in more controls on women's labour and fertility, (Ibid.) and with an increasing dependence on cash and labour migration (mainly of men), women became increasingly dependent on men economically, and continued to weaken the value that women had in the rural community'. (Semu, 2002). As a result, the autonomy that women had enjoyed has decreased (Ibid.).

There is also an expectation that the boy should take a lead in sexual relations. The social expectations and complexities around boy-girl relationships seem to have a major influence on young people's sexual behaviours and decision making, such as negotiating for safer sex and accessing SRH services when needed. Boys/ men are socialised to be active and to take a leading role in sexual relations while girls/ women are advised and encouraged to be passive and to be led. The social constructs around adolescent sexuality brand girls who are sexually active as "spoilt", while sexually active boys are regarded as "men" (Godia, 2012 p. 263). The net effect is that both boys and girls could end up having secretive sexual relationships, and sexual activity tends to occur by chance without proper planning and discussion around contraception or condom use. This creates a complex dynamic regarding gender relations and power. For example, the counsellors constantly reminded the initiates in the ceremonies that the sexual skills which they demonstrated were meant to be used within the marriage bounds, and sex before finding a long-term partner was discouraged. However, pre-marital sex and subsequent childbearing were viewed as common in this community, and not explicitly frowned upon.

Culturally, among the Yao people, a girl is considered to be an adult, once she has gone through the puberty rite *(ndakula)* and she becomes a complete adult after giving birth, and passing through *litiwo* ceremonies, in that sequence (Jimmy-Gama, 2009). If she becomes pregnant before the puberty rite, she is not considered to be a complete adult, because she jumped a step and she is not given the same respect as others, and she is not allowed to attend other young women's puberty rites. However, if the girl gives birth after going through *ndakula* and *litiwo* rites, she is considered to be a complete adult and she is elevated to the higher position of mothers, regardless of her age or marital status. Likewise, even if you are

27 years, but you have not gone through these two initiation rites, culturally you remain a child.

While key messages during the initiation ceremonies were meant to empower the young women on sexual matters, the rural women's emphasis and interpretations of the messages are influenced by their gendered cultural expectations of the boyfriend/ husband's responsibilities. Reinforcement of key messages through these intergenerational gathering, helps to develop a collective identity among persons of the same age group (Stanton, 2014). Therefore, to understand the gendered nature and SRH issues/ problems and sexual relations, one has to consider matriarchy as well as expectations of male dominance in sexual relationships.

8.2.1. The gendered nature of SRH issues/ problems

The findings in this study showed that the SRH problems young people experience were similar across the three generations (young women, mothers, grandmothers, including counsellors). These included early sexual activity, unwanted pregnancy, unsafe abortion, intimate partner violence and inadequate information on some aspects of the reproductive cycle. Underlying factors, reported to contribute to these problems/ issues were also similar among the participants and included the following: lack of proper parental/ community guidance, early school dropout, poverty and peer pressure. Poverty and dropping out of school might have led to boredom, which in turn may predispose young women into early marriage or risky sexual behaviours.

Young women in the study reported that sexual initiation among young people, especially girls occurred at an early age, as early as 13 years. Early and unprotected sex among

adolescents may result in early and unplanned pregnancy, STIs and HIV infection. As stated earlier in this thesis young motherhood is more common in Balaka than the other districts. The recent Malawi demographic health survey (MDHS) indicate that in Balaka, the adolescent birth rate for women aged 15-19 years is at 173/1000 live births higher than the whole southern region, the whole country, which is at 162 and 143 respectively. A study conducted in the Northern region by Mwale and Muula (2018) with young people from different social backgrounds also reported similar results on sexual initiation and found that young people from the rural areas had earlier sexual debut, than those from the urban areas (Ibid.). This could be due to boredom, as after working in their fields and doing household chores, there is nothing else to be done.

A study by Munthali et al. (2015) reported that young girls from households with lower socio-economic status and those with lower education initiate sex, marriage and pregnancy at an earlier age than their counterparts from households of higher socio-economic status and with higher education. Another study in Malawi conducted by Muheriwa Matemba et al. (2023) found that adolescent girls in rural areas faced more challenges than those in urban areas which increased their risk for premature sexual debut. As a result of leaving education early, adolescent girls in the rural areas may not receive Life Skills Education course, particularly comprehensive sexual education which is offered later in the educational system (Ibid.). Malawi delivers comprehensive sexual education at the secondary school level, usually in the third year, when the girls are 15 years or older. Muheriwa Matemba et al. (2023) add by this time, over half would have experienced a sexual debut and would be sexually active, and others would have dropped out of school (NSO & ICF, 2017).

Similarly, the findings presented in my study suggest that early and unwanted pregnancy is a SRH problem affecting young women. The young women gave an indication that young girls may get pregnant due to five main reasons: i) engaging in early sex without having a clear understanding of the consequences of early and unprotected sex, ii) lack of discussion on contraceptive use during initiation ceremonies, among young friends and sexual partners, iii) engaging in sex for material and financial gain due to poverty, iv) dropping out of school due to lack of interest, and v) peer pressure. Early and unwanted pregnancy leaves many girls with very little or no other options other than early marriage. The young women reported that once young girls become pregnant, they are forced into early marriage due to lack of alternative options; if they are in school, they often drop out.

In this study, it was reported that in some cases, school girls with unwanted pregnancy sought abortion services from the community or clandestine medical practitioners if the sexual partner denied responsibility or refused to marry them, often leaving them with some complications such as severe pain, discomforts and infections. Girls with an unwanted pregnancy could end up being disowned by their partners, parents and ridiculed by the community in general. Similar findings by Atumbaye et al. (2005) have been reported in Uganda where pregnant adolescents and adolescent mothers were said to be disowned by their sexual partners and parents and were subjected to physical and psychological violence by their parents, sexual partners and the community in general (Godia, 2012).

However, the picture is quite complex as, at times pre-marital pregnancies could be a deliberate move to get married, because once the girl is pregnant, and the boy has accepted the responsibility, a marriage follows, and the girl automatically attains a higher status. This is the pattern on which most marriages were instigated in this community. As noted by

Perianes and Ndaferankhande (2020), within Malawi the pressures of the motherhood paradigm are a necessary reality for girls to achieve as marriage and motherhood are considered to be the core aspects of women's identity.

In addition, they claim that having children is viewed as a communal responsibility and that inability to bear children is a legal ground for a divorce in a traditional court (Ibid.). Motherhood is considered to a be a source of power from the African feminism discourse, contrary to Western feminism where being a wife and mother is viewed as means of disempowerment (Perianes & Ndaferankhande, 2020). Therefore, the young women could be aspiring to be a mother to conform to the societal norms. This might also provide an insight, on why there were more teenage pregnancies and early marriages in rural communities than in cities, as culturally it is considered to be an achievement.

8.2.2. Gender imbalance in sexual relationships

Although the Yaos are of the matrilineal society, the women are still very vulnerable and lack power in many domains. The study revealed that the traditions in this community are rooted in the matrilineal norms, which give women some say on issues such as whom to marry, easy access to divorce, and in the case of divorce gaining custody of the matrimonial house and children. All the participants who were either divorced or widowed stayed with their children. However, as stated earlier, authority is exercised through their uncles, male cousins and brothers (Semu, 2002). Hence, the women are still very vulnerable and powerless in many aspects of their lives. For example, if a girl found a marriage suitor, she had to inform either her maternal uncle, maternal male cousin, or her brother. It is one of them who would be her marriage witness, who would also be speaking on behalf of the family and taking the lead in the wedding preparations and on the wedding day.

Equally with divorce, as was the case with one of the young women is this study, who had experienced persistent intimate partner violence (IPV) and was seeking divorce. The divorce was granted only after the girl's maternal uncle intervened following the girls' physical injury, although the violence had occurred for some time. This is because culturally, marriage issues are regarded as a family matter. This was also observed by Chepuka's (2013) study in Lilongwe, Mangochi and Blantyre, whose aim was to understand the health service responses to IPV in Malawi from a wide range of perspectives. Chepuka reports that IPV in its various forms was seen as widespread and normalised, except perhaps in the most severe forms such as femicide and child rape.

Findings from my study revealed aspects of gender dynamics associated with intimacy issues between young sexual partners. Young men were given the authority to dictate when they wanted sex and how it should be done, with the young women expected to comply to their sexual partners' demands. The sexual advisors (counsellors) also prescribed young women's role during intimacy which were of a lower status to that of a man. For example, girls were responsible for cleaning up after the sexual act and there were no instructions on reciprocity from the man. This was also observed by other studies conducted in Malawi (Moyo, 2004; Munthali et al., 2004; Munthali et al., 2018), which reported that most sexual socialisation subordinates young women's sexual lives to men's, and in the process, young women and mature women find themselves in a position of sexual powerlessness as sexual objects at the service of men.

Positioning women as weak subjects gives renewed legitimacy to patriarchally motivated discourses of control and protection, which is seen as legitimatising the continuity of coloniality, a notion which decoloniality theory opposes (Arnfred, 2015, Mendoza, 2020).

Giving sexual power to male partners might put young women at risk of negative SRH outcomes as they may be unable to negotiate for safer sex. Similarly, Nyalapa and Conn (2019) report that young women in Malawi are particularly vulnerable to HIV infection as a result of harmful gender norms and social injustices.

Further, the practice of labia elongation, which is seen as important for men's sexual pleasure and as a door to the vagina, was highly respected by all these rural women. The young women were encouraged to follow this practice in order to allow their sexual partners to play with their bodies, the way it pleased them, since the girls' bodies are considered to be flowers. This practice could be viewed as demeaning to the young women as there was no instructions to reciprocate it, rather to accept whatever pleased the man. The findings of this study supports earlier observations by Munthali et al. (2018) which considered the labia elongation practice as subjecting women and girls to a subordinate position. It should though be noted that, Rasing (2021) argues that the elongated labia helps the woman to take control of a sexual encounter, with the man complying to her demands on where to touch her, for her personal gratification. Nevertheless, women in this society are by no means without power. As alluded to earlier on, the older women's behaviour and attitude and the respect afforded to them could be attributed to the power women have in the matrilineal society of having authority over children.

8.3. Western knowledge and indigenous ways and knowledges

Having discussed the role of women, the meaning and importance of rituals and traditions, gender relations and power, I now delve into the impact of colonisation, religion and Western medicine, and link this to the tension I identified between the older and younger generations. Indigenous ways and knowledges have been labelled as inferior and unscientific by many of

those propagating Western knowledge systems (Mignolo & Walsh, 2018). As highlighted earlier on in chapter 3, section 3.3 Decoloniality denotes ways of thinking, knowing, being, and doing that preceded the colonial enterprise and invasion (Ibid.). It emphasises re-learning and recovery of knowledge that has been pushed aside, forgotten, buried or discredited by the forces of modernity and colonialism (Mendoza, 2020; Mignolo & Walsh, 2018). It aspires to restore, elevate, renew, rediscover and acknowledge the multiplicity of lives, lived-experiences, culture and knowledge of indigenous people, gender hierarchies and racial privilege (Ibid.). Linked to this and also described in chapter 3 section 3.4 is African feminism which was founded on the principle of communalism and holism, based upon relative terms of power sharing rather than absolute power (Mukoni, 2015).

Evident in all the generations was how culture has been impacted by religion, Western medicine and modernity, resulting in some rituals and traditions changing or being abandoned, and in the process directly or indirectly shaping the traditional gender roles of men and women on sexual and reproductive issues and behaviours as explained in section 8.1.1. Manala (2013) and Acquah (2011) in their study on the impact of Christianity on sub-Saharan Africa, suggest that missionaries introduced the 'formal education' of Africans, which Mji (2019) Owusu-Ansah and Mji's (2013) have referred to as alternative ways of knowing. However, my study has revealed that the populace in this mostly Muslim community were less influenced by the formal religion and education brought by the missionaries, compared to those who converted to Christianity (Mchombo, 2004; Msiska, 1995).

The impact of not having formal education was more apparent among the older generation of women in this study than the younger ones, such that only one person from this group, who

had a Christian background could read and write. However, even though the younger generation attended some formal education, many of them dropped out of school in the junior primary classes. In reflecting on their narratives, I have considered if this relative lack of education was advantageous for the preservation and propagation of indigenous knowledge in its pure form of rituals and traditions, as they were not exposed to the notion that it was inferior to Western knowledge systems (Acquah, 2011; Manala, 2013). This might have contributed to the rural women's reverence of the sexual advisors, their rituals and traditions.

However, the lack of progress in educational attainment also posed a challenge for the existence of indigenous knowledge as formal education is required to write their own history, rituals and traditions. As noted by Acquah (2011) and Manala (2013) that those who followed the churches' education system and embraced Western culture were equipped with knowledge and skills which enhanced their social mobility, but at the same time this might have led to the disruption and breakdown of some of the traditional values on their lives and being alienated from their families and cultural identity. Acquah (2011); Hawley (2013) and Mji (2019) state that some of those educated in Western ideas turned their back on their own cultural values, in favour of everything Western. Likewise, the men in the village where I conducted my study, who left for work in South Africa, on their return have brought new Islamic teaching, which has gained popularity among the young people, and has resulted in them considering some of the initiation rites to be sinful, hence threatening their very existence and survival.

8.3.1. Medical pluralism

The study revealed that young women rely on both indigenous and Western knowledge systems, although the indigenous knowledge takes a central role, starting at an early stage and

across the life span in the form of initiation rites and at a later stage, they are exposed to Western knowledge as illustrated in figure 8.1. While the majority of the participants in this study appeared to have adopted Western medicine for childbirth issues because of its perceived advantages, they have by no means completely abandoned the indigenous ways. Rather they appeared to evaluate the two knowledge systems (indigenous and Western) and utilise the one which seemed to be more advantageous at that particular point in time, as well as the perceived origin of the disease/illness/condition.

Other scholars (e.g., Mji, 2019; Mokgobi, 2014; Abdullahi, 2011; Jimmy-Gama, 2009) have reported similar findings, noting that Africans did not completely abandon their traditional African health care system and African religious beliefs, but rather continued to practice both concurrently starting with the traditional health system as a primary source of care, and using Western health care if traditional health care was perceived ineffective (Mji, 2019; Jimmy-Gama, 2009). In my study the rural women relied on indigenous ways for sexual health yet sought Western healthcare for antenatal care, labour and delivery.

Despite the availability of contraceptives at no cost, within the village, the young women in this study did not routinely utilise the opportunity, rather using them after childbirth or after experiencing negative SRH outcomes, such as STIs or an abortion. From the younger generation's narratives, the study showed that young women relied on both Western and traditional medicine for an abortion. Abortions were conducted in secrecy without the knowledge of authorities and parents/ family with the client promising not to disclose the service provider in the event of an unfavourable outcome, such as severe bleeding.

Malawi has restrictive laws on abortion, and it is only permitted when it is necessary to save the life of the woman (Muheriwa Matemba, 2023). For example, anyone with complications of unsafe abortion can receive treatment whenever they visit a health facility, and contraceptives are part of the post-abortion care package. The restrictive law could contribute to unsafe abortion, as there are no walk-in abortion clinics. As a result, young woman could resort to clandestine services from a health worker or a local herbalist for fear of jail, as it is considered to be a criminal case, as reported by one of the participants in this study. This finding confirms earlier observations made by James et al. (2018) and Mji (2019) that traditional medicine is used for abortions and in the treatment of STIs. Additionally, other factors like personal preference or distance are also taken into consideration when deciding what support to seek.

The majority of the older generation appeared not to approve the use of contraceptives. This could be due to their limited knowledge on modern contraceptives or the societal expectation that unmarried young women should practice abstinence, and that contraceptives are for those who have had at least one child. Thus, contraception was construed by the society to be used mainly within the context of "child spacing" as opposed to preventing unwanted teen pregnancy or delaying childbirth. Other studies have reported similar findings where contraceptive use by young girls was not approved by the parents, teachers and community members, because it was considered to affect young girls' fertility (Ajayi et al., 2021; Bornstein et al., 2021).

A study in Kenya by Ajayi et al. (2021), Digitale et al. (2017) and Bornstein et al. (2021) in Malawi found that the majority of girls used contraceptives after their first childbirth as they were certain about their fertility. Myths about infertility might have caused younger

participants to be afraid of using contraception. Even if they were not afraid, lack of support from parents, sexual advisors might have prevented young people from successfully seeking out family planning information or services, despite having a community health worker in their midst, as was the case in this community. Also reflecting on the narratives of the traditional herbalists/ healers, I came to appreciate the significance of the rituals performed to a new-born, which were based on valuing the existence of God, ancestors and the universe, and stems from the traditional African philosophy of illness (Mji, 2019; Mokgobi, 2014; Olausson, 2001). Thus, the services by traditional healers went beyond the uses of herbs for physical illnesses, and also included the performance of certain rituals, prayers and veneration of ancestors. This verified the philosophical understanding of indigenous knowledge that a person becomes human only in the midst of others and strives for both individual and collective harmony in the process of becoming a true human being (Owusu-Ansah & Mji, 2013).

Reflecting further, on the sexual advisors' narratives and observing them performing the functions of a traditional healer during the puberty initiation ceremony, I had mixed feelings on how to categorise them. Their role as traditional healers was not highlighted during the FGD which prompted me to interview the key informants - traditional healers. Finding the traditional sexual healers difficult to categorise is supported by other researchers who claim that it is difficult to separate traditional African healing from traditional African religion or spirituality because of dual or multiple roles. Mokgobi (2014) and Olausson (2001) argue that, in many cases traditional healers doubled as religious leaders, counsellors, social workers and skilled psychotherapists as well as custodians of indigenous knowledge systems. This might originate from the fact that cultural practices associated with spirituality and healing are encoded in everyday experiences and activities.

This study also revealed the power of oral communication versus written. Oral communication is perceived to be an informal method of learning, acquiring and transmitting knowledge, beliefs, traditions and values, involving among other things, parables, myths, proverbs and artwork, and has some advantages (Ikuenobe, 2018). For example, it reinforces the relationships between a community and individuals and relevant values and beliefs are sustained by the informal oral methods of learning about cultural traditions (Ikuenobe, 2018). The oral tradition is reliant on elders as repositories/ libraries of knowledge, which is based on the principles of epistemic communalism.

Further, the oral tradition in African traditional cultures captures not only the communal processes or methods of creating, justifying, accepting, encoding, archiving and preserving knowledge, but also as the source of the content of such knowledge, in terms of cultural beliefs, practices and values (Ikuenobe, 2018). The effectiveness of the oral tradition as a method of interpreting, retrieving, articulating, understanding and reconstructing knowledge, thought systems and philosophies of African peoples were evident in my study. The sexual advisors and traditional healers relied on the oral tradition to learn their trades from parents and relatives through apprenticeship. This supports the findings of Mokgobi (2014) on how traditional healers acquire the desired knowledge and competency. Hence, the role of the traditional SRH counsellor is much more than being eloquent on menstrual hygiene and sexuality issues, which might explain why they were highly respected by everyone in the community, including the village chief. However, this knowledge risks being lost with the passing on of the elders in the community as the young ones seemed to spend increasingly less time with the elders.

Further, the participants' narratives show that, there has been a shift in terms of the information that the current young women received, compared to what the older women did, thereby demonstrating that culture and knowledge is dynamic. This might have also affected how young women understood and interpreted the rituals and traditions associated with SRH issues. While the older rural women appeared to acknowledge the advantages of medical pluralism but placed more value on traditional knowledge, the young women appeared to lean more towards the Western medicine and culture, creating some tension between the older and younger generations.

8.3.2. The conflicting views between the younger and older generation

The study confirmed that relationships between the older and the younger generation were strong, full of learning and contributed to how young women were socialised on their sexual behaviours and decision making. The input of the older generation was significant, but it was also clear that some things had changed over time in relation to rural sexual health communication, initiation rites inclusive. Common among the older generation was their stating how easy it is nowadays for the young women to access SRH information as compared to their times, an observation also made by Mpondo et al. (2018) in an intergenerational study of rural women of South Africa.

When responses from the two groups in this study were compared, a clear generational gap and tension emerged, which has been attributed to a clash between traditional norms and the rapidly changing society, as echoed in the work done by Welch (2010) and Sah (2017). The young women did not accept all the teachings and sometimes openly challenged the older counsellors. Their narratives showed that they had their own construction of sexuality based on their socio-cultural, historical and current political times. Nor did the traditional views of

grandmothers always limit the sexual behaviours of the young women as a number of unplanned pregnancies and unsafe abortions were reported. When conflicting views or behaviours arose, the older counsellors attributed (i.e., blamed) this on the influence of modernity and urbanisation. The older generation seemed to foresee the potential loss of their culture and traditions, because the Western approach was seen to undermine the value of non-Western beliefs, knowledge and ways of knowing and living, which would contribute to their loss of power and identity.

This tension was expressed by the young women as the older ones being stuck in old ideologies and not embracing change, and by the older women complaining that the younger women do not respect and value rituals and traditions. The older generation considered modernisation as being responsible for the 'bad behaviours' seen among young people while the younger ones, accused the older generation of failing to keep up with societal changes. The younger generation seemed more likely to embrace modernity and were questioning the relevance of some indigenous knowledge with its associated rituals and traditions, in the process creating tension between them and the older generation. Consequently, the grandmothers and sexual advisors were concerned that their SRH knowledge might be lost once they are gone. This was also observed by Mji (2019) while working with the elite older Xhosa women, who were traditional healers, whose concerns were that there were no newcomers to fill their position in the future.

Further, the older generation in this study, shared their perspectives on the cause of this disconnection with the young women, by accusing the health workers trained from a Western perspective of being responsible for the confusion because the SRH education given at health facilities is different from what is taught during initiation ceremonies. The disconnectedness

could also result from the SRH counsellors and grandmothers' failure to adapt the sex education to modern times, to which they indirectly admitted by saying that they were using the same practices handed over to them by their ancestors.

This finding supports Mpondo et al.'s (2018) Jimmy-Gama (2009) Munthali et al.'s (2018) claim that rural families do not see the importance of adapting cultural practices to be congruent with the modern times. To bridge this generation gap and in line with the study objectives, and following other researchers' recommendations (e.g., Schroeder et al., 2022; Ohajunwa & Mji, 2021; Munthali et al., 2018; Owusu-Ansah & Mji, 2013; Kangwa, 2011), I initiated a health improvement intervention, which brought both the younger and older generations together, as highlighted in chapter 6, while taking into consideration the tenets of PAR and Paulo Freire's philosophy of conscientization.

8.4. Transforming knowledges through recovering the past and accepting the present

This study revealed a wealth of knowledge and creativity carried by the sexual advisors and older women in supporting young women with menstrual hygiene and sexuality, and in the process highlighting the rich complexities of indigenous knowledge systems, found in rituals and traditions as noted by Owusu-Ansah and Mji (2013). It also revealed the limitations of the rituals and traditions such as conflicting messages and inadequate knowledge on the biological aspects of SRH issues, among the traditional counsellors, such as informing the young women that once they saw the white vaginal discharge, after their menstrual periods, it was safe to have sex. This might have inadvertently led to early sexual debut and teenage pregnancies.

Western medicine generally failed to take full account of the social aspects of SRH issues. The findings on this study confirms an earlier observation by Munthali et al. (2018) who argue, that while the school curricula gave girls the biological aspect of procreation it evaded the social responsibilities, which was provided by the traditional advisors. Reflecting on the study findings, I was able to recognise the positive and negative side of the two knowledge systems, as well as their differences and similarities. For instance, learning is communal from an African perspective, while in Western it is individualised.

However, in both situations knowledge production is local and situated, and that knowledge assembly is achieved by making connections and negotiating similarities between the heterogeneous components of the isolated knowledges (le Grange, 2004). As such the two knowledge systems should be considered as complementary and not competitors and they could work together to enhance learning among these rural women, hence this was the guiding principle for the health improvement intervention and was reinforced during the thematic analysis. This potential role of traditional knowledge and use of ceremonies supports a claim by Owusu-Ansah and Mji's (2013) that African knowledge can make contributions to the world by understanding and being grounded in its own knowledge and those of others. Promoting indigenous knowledge on SRH issues is also consistent with the Decoloniality theorists like Mendoza (2020) Mignolo and Walsh (2018).

My study has demonstrated the value of indigenous knowledge and suggested how it could be incorporated into sustainable strategies and initiatives related to SRH. It highlights the need to merge indigenous and conventional Western methods of sex education in order to promote positive sexual behaviours and decision making among young women. As such it promotes Decoloniality and African feminism and reaffirms the production of transformative

knowledge by announcing the presence of traditional knowledge, the identity of African women and claiming their lost or distorted past (Mukoni, 2015). This was evident in chapter 6 (health improvement intervention) which capitalised on the positives of the two knowledge systems (Western and indigenous) to come up with blended knowledges which are culturally congruent.

The intervention also supported the notion advocated by Owusu-Ansah and Mji (2013) and Mji (2019) that true education is when one has learned one's own culture and engaged in the knowledge of others, thus taking account of multiple perspectives. For instance, the scientific understanding of SRH issues which promotes the bio-medical model and the indigenous understanding which focusses on the social and cultural aspect of it, consequently, resulting into a holistic view. Reflecting on Owusu-Ansah and Mji's (2013) claim, I consider myself to have gone through a 'true education', as I have been exposed to both knowledge systems, the global north and global south, which enabled me to have a borderline experience, as I was placed in-between the coloniser and the colonised. This was made possible, through my professional training and practice (nursing, midwifery and public health) and my exposure to observing the traditional practices and hearing the participants' narratives. Consequently, recovering some of my less known and hidden identity. For example, during field work, I learnt I am from a royal family and the land where my home town is built, was actually a donation by my great grandfather to the British government then.

8.5. Conclusion

This discussion chapter has highlighted the gendered nature of the intergenerational SRH communication practices with regards to menarche, sex and motherhood. Older and younger generation's views of SRH communication practices, have been discussed, as well as the role

and value of rituals, traditions and Western medicine in the sexual and reproductive lives of young women. This includes the social norms, adolescent's learning about sexuality and its relationship to views about marriages, motherhood and contraceptive use and young women's vulnerability to negative SRH outcomes. In reflecting on the perspectives and experiences shared by the participants, there was a clear generation gap and tension. In addition, the narratives could only be fully understood within their historical, socio-cultural and political location thus implying that the knowledge is fluid and what is relevant and acceptable today in this community may not be tomorrow and in another area. This also applies to knowledge generated in this study, which has to be understood within its historical, socio- cultural and political location.

Chapter 9 Conclusion and recommendations

9.0 Introduction to the Chapter

This chapter considers if the research process has answered the research questions and met the objectives the study set out to achieve. The chapter begins with an overview of current concerns in the area of Balaka and considers the project in three sections, section one looks at the implications of the thesis. Section two offers some of my journal reflections in undertaking the study and section three discusses future research recommendations, limitations and offers a summary of the thesis.

The SRH problems of young women remain a major public health problem in the rural areas of Balaka today, leading to early and unprotected sexual activity, infection with HIV/AIDS and other STIs, unwanted teenage pregnancy, unsafe abortion and sexual violence. Lack of accurate and timely information about SRH increases young women's vulnerability, and limited knowledge on the biological aspects of SRH matters, power imbalance, poverty and the influence of cultural norms were the major driving forces identified in this community, that predisposed young people to adverse SRH outcomes. My study revealed that young women required more information on SRH, to include information around the reproductive cycle, consider the gender imbalance in their communities and learn about contraceptives.

Currently these SRH issues/ problems among young women remain a challenge for the rural areas in Malawi, in spite of the availability of other sources of SRH information, in addition to grandmothers, friends and sexual counsellors. For example, there have been government initiatives such as schools, health facilities and the allocation of a local community health worker. However, their impact in terms of averting negative SRH outcomes appeared to be

minimal, as young women mostly utilised the health facilities for reproductive health (antenatal care, labour, delivery and post-natal services) rather than sexual health.

Alongside the availability of these modern facilities and medicines, the rural women in this community have largely retained their indigenous ways of thinking, knowing, being, doing and living and it was this philosophy which seemed to guide the initiation ceremonies and their SRH decision making and behaviours. All the three generations in the study relied on both traditional and Western medicine although, the younger generation appeared to lean more towards the Western medicine and modernity (i.e. contraception and or abortions) than the older generation. The older generation seemed to value more the traditional medicine and indigenous ways, with its rituals and traditions, in the process creating some tension between generations.

Based on my findings and, realising that both knowledge systems were valued and to bridge this generation gap and to respond to the issues/ problems identified I initiated a health improvement intervention. The initiative brought the two groups (the younger and older) together while taking into consideration the tenets of PAR and Paulo Freire's philosophy of conscientization. The interventions brought some social changes to the rural women such as becoming more assertive and claiming their rights for information. They became organised and undertook a project which satisfied their needs, and the intervention was innovative leading to cultural revitalization. For sustainability the project relied on local resources (sexual counsellors) and the intergenerational approach. Involving the three generations would help to propagate indigenous knowledge from one generation to the other, and in keeping with Freire's philosophy of conscientization, the participants had the power to communicate their views and participate in the health improvement intervention.

9.1. Study implications.

I begin this section by interrogating the implications of this study in relating to the current research findings as discussed in other related reviewed literature. Then I reflect upon the methodology and theories used in this study.

9.1.1. Revisiting literature to identify key contributions of this study.

A literature search of scholarly works in Malawi confirmed that this is the first documentation of Yao ceremonies using ethnographic and PAR methodology. The few earlier studies identified utilised different methodologies and considered other aspects of SRH (Munthali et al., 2018; Munthali et al., 2004; Wittenberg et al., 2007; Limaye et al., 2012; Limaye et al., 2013; Limaye et al. 2015). The use of semi-structured in-depth interviews, focus group discussions, participant observation and field notes, as well as the use of multiple data sources (young women, mothers, grandmothers, key informants [herbalist/traditional healers], traditional and religious counsellors) assisted with triangulation of the research findings.

Unlike other scholars, I had a unique position as an insider and an outsider. My insider status gave access to information, rituals and traditions on these sensitive topic areas, which I am sure I would not have gained if I was not an indigenous researcher with several connections to their culturally imbedded identities. Also because of my insider status, I was able to access specific, culturally based reasoning behind their perspectives on this issue.

An original contribution of this research is the construction of SRH communication practices from a non-Western perspective amongst a minority group of rural women, through the ‘lens’ of African feminism. I also drew upon Decoloniality theory which acknowledges the multiplicity of lives, lived-experiences, culture and knowledge of indigenous people and

seeks to make visible and open up alternative knowledge systems (Owusu-Ansah and Mji, 2013; Mendoza, 2020; Mignolo & Walsh, 2018). Previous studies in Malawi on SRH communication practices have delivered perspectives primarily from a Western point of view (Banda & Kunkeyani, 2015; Munthali et al., 2018; Schroeder et al., 2022; Nash et al., 2019; Limaye et al. 2015; Jimmy-Gama, 2009; Munthali & Zulu, 2007; Munthali et al., 2004) which have undervalued non-Western beliefs, knowledge and ways of knowing and living (Mignolo & Walsh, 2018).

African feminism is based on the on the *'ubuntu'* or *'umunthu'* philosophy of Southern Africa which emphasises commonality or relationality between beings (Perianes & Ndaferankhande, 2020). It highlights a communal notion of existence which Harris (2003) refers to as 'we are, therefore, I exist' (Perianes & Ndaferankhande, 2020). This philosophy was embraced by the women of this community, as opposed to the Western, liberal, tradition of individualism.

In many Western societies, mothers have been observed to be at ease with their children on sexual matters (Lenciauskiene & Zaborskis, 2008). This is contrary to mothers in this community who were not comfortable to talk about sexual issues with their daughters and tended to emphasise the danger of sexual behaviour, particularly before marriage, warning about pregnancy, HIV and AIDS. This finding is consistent with earlier studies from sub-Saharan Africa, which confirms that discussing sexual matters is a taboo topic in many cultures and that parents are uncomfortable talking about it and mostly rely on extended family members, mainly aunts and grandmothers (Wamoyi et al., 2010a; Manu et al., 2015; Dessie et al., 2015; Mpondo et al., 2018; Svodziwa et al., 2016; Kamangu et al., 2017). This study also revealed that some of the young women found it odd to talk about sexual issues with their mothers.

Another unique aspect of this study is that it supports and confirms African feminism and the Decoloniality writings which describe tribal women and initiation ceremonies in a positive light. This affirmation departs from the negative conceptualisations of women, rituals and traditions as being inferior, harmful and being responsible for early sexual debut and child marriage by Western scholars (Munthali et. al, 2018; MHRC, 2006; Banda & Kunkeyani, 2015; Schroeder et al., 2022). The study has revealed that girls are exposed to the influence of urbanisation/ Western culture more than their grandmothers thus, they had greater knowledge about SRH at an earlier stage than in the past. However, initiation ceremonies were recognised for fostering family and communal relationships and cohesion, as well as for providing guidance on day to day lives, in addition to sexual matters.

9.1.2. Methodological and theoretical reflections

Reflections on methodology

Ethnography as a means to learn about SRH communication practices proved to be a suitable approach for data collection. It allowed me to be close to the participants' stories, rituals and traditions, experiencing the stories 'with' them rather than merely experiencing the story 'about' them. For the secondary goal of exploring the potential of using indigenous knowledge to promote SRH and wellbeing of young women, PAR was appropriate (Strauss & Corbin, 1998; Creswell, 2014; Su, 2018).

This EPAR research has created an emerging understanding and knowledge about significant events that impact on the knowledge, views and experiences of SRH communication practices amongst the rural women of Balaka district. The importance of intergenerational transmission (communication) of SRH knowledge and practices provides a unique contribution to public health research in Malawi. The use of the EPAR approach was

advantageous because participants expressed themselves on issues affecting them in their familiar languages and they could easily relate their experiences to their local environment.

This EPAR also allowed me to wear different hats during data collection, as highlighted in chapter 5, section 5.3 as I positioned myself both as a facilitator and co-learner. The first hat was that of a learner, coming from a privileged middle-class group of mixed heritage trying to appreciate her tribal roots. The second hat was that of a facilitator, who had been exposed to Western knowledge (both practical and theoretical) about SRH issues through my training in nursing and midwifery. Through EPAR, I appreciated the power of co-learning with the participants. Co-learning enriched my experiences on what it means to be a young woman in this community as I was collecting the data. This also allowed me to reflect on the tools I used to collect the data. I am aware that my particular findings from this research are not definitive. I am telling a story, and this story is a truth but not the absolute truth of these rural women. It is a descriptive interpretation of a cultural group within its social context; therefore, I do not consider it the only possible descriptive interpretation.

However, with my prolonged fieldwork, along with taking seriously the meanings the rural women attach to their rituals and traditions, I retain a sense of trust in the authenticity of my own interpretation of the data. The additional strength of the study was its ability of bringing the two knowledge systems (Western and indigenous) together and creating a blended knowledge system, which is culturally congruent and user-friendly with the use of pictures to convey key messages in the reference booklet used in the intervention.

Another, considerable strength of the research is that it is among the first to go beyond recognising problems/ issues and assets among the hard-to-reach communities to partnering

with them in identifying solutions, to planning and implementing a health improvement intervention, which has often been neglected in SRH strategies and initiatives.
The study has shown the benefits of using PAR in local communities affected by health problem/ challenges. The PAR process provides an evidence-based solution as participants owned the study and were part of the process that identified areas of concern and considered solutions. Similar studies by Sullivan et. al (2005), Khalesi et al. (2020) and Vaughan et al. (2020) acknowledge the benefits of PAR methodology amongst vulnerable communities.

I was uncertain about how the participants had benefitted from the research, as I only evaluated the lessons during the trainings, but not the impact of the entire research process. If I had an opportunity to conduct this research again, I would conduct a mini survey, highlighting the participants' experiences of the research and suggestions for improvement. I was clear about the knowledge improvement on the biological aspects of SRH issues, specifically the reproductive cycle, as well as the less tangible benefits of the research process, such as the participants feeling respected, valued and heard.

Despite these strengths, there were some limitations I encountered during the development and interpretations of the findings. As previously mentioned in chapter 4, one of the important limitations of this study was the exclusion of young and older men who would have brought in alternative perspectives of their initiation ceremonies for a more balanced view of the gender relationships in the rural area. Further, the project was negatively impacted by the Covid-19 pandemic. Due to the Covid-19 pandemic travel restrictions, fieldwork was delayed. The Covid -19 pandemic also affected the school calendar in Malawi, and this resulted into the *mzondo* initiation ceremony taking place while schools were open.

As such I was unable to observe and ascertain what I had been told with what was actually taking place during the ceremony.

Another challenge I encountered was related to the logistics of conducting PAR research in Malawi and studying in UK at the University of Essex. As a result, this research was unable to ascertain if the utilisation of the new knowledge was included during initiation ceremonies. Time and travel allowing, I would have followed this direction. However, upon my return to Malawi, I have met some women, the village chief and the local community health worker, who have shared some positives stories about the intervention I conducted and the field work as a whole, which was encouraging.

Theoretical perspective.

The Socio-ecological model

Adopting a socio-ecological perspective helped to show how a young woman's sexual and reproductive life is shaped by her biological and psychological factors, as well as the interaction with the family (grandmothers and mothers), community (sexual advisors and teachers) and the society (socio-economic conditions). In my study to avert the negative SRH outcomes among young women/ people, there was a need to use the bottom-up approach in the initiation and implementation of a community health improvement intervention.

Furthermore, the theory has revealed the need for both the community and young women to work as a team in order to overcome the challenges affecting them such as limited knowledge on SRH matters and rights. This study has also shown the need to empower the young women at an individual and community level. Only when the community feels respected, valued and empowered, are they likely to assist in sustainable social change. Partnering with

the rural women in the implementation of a health improvement intervention seemed to have worked well in this study.

Freire's conscientization model of empowerment

The use of Freire's conscientization model of empowerment assisted the rural women to question and reflect on the relationship of the initiation ceremonies to the development of risky sexual behaviours and the increase on negative SRH outcomes among young women, notably teen pregnancies as well as to seek solutions to the identified problems/ needs. The health improvement intervention described in chapter 6 was based on this model rather than the provision of the bio-medical model of health care in Malawi (MoH, 2008).

The Freirean approach advocates for dialogue or discussion between the service providers and clients on how best they can explain and address the health problem (Jimmy-Gama, 2009). Likewise, this study through feedback meetings, provided a two-way discussion during which the root causes and solutions for the negative SRH outcomes among young women were established. This demonstrated that it is possible for a researcher to work alongside the gatekeepers and participants from the inception of the research project, as well as in designing and implementing a health improvement intervention, and in the process generating transformative/ co-produced blended knowledge, which is culturally congruent.

9.2. Reflecting on my role as a researcher.

In Chapters 1, 4 and 5 of this study, I set out in detail my background and values justifying my social justice perspective and recognising how that has influenced my research approach. I wanted to raise the voices of those not often heard and so placed the tribal women at the centre of this research. I chose an EPAR design and the Social Constructionism and

Transformative conceptual framework to reconcile conflicting views of the meaning of SRH and wellbeing. To achieve the potential of a social justice framework, I tried to be as inclusive as possible of all participants' views, and recommendations made based on my findings were guided by the evidence from this and other studies.

9.2.1. Personal reflections

Like the participants in my study, I am influenced by my socio-cultural and professional training and practice in the medical field. The field work year for my PhD project was special for me personally − I got to learn about my family history, which comes from both the colonisers and colonised. These enlightening moments reinforced for me the importance of choice and agency for the tribal women and the development of the themes which have featured largely in this study. Learning about my family history helped to put to rest the puzzles and jigsaws of my heritage and life experiences. Interestingly, the Socio-ecological model prompted and allowed me to reflect in different ways on my own SRH and well-being.

In undertaking this thesis, I have grown personally and professionally and Chapter 4 section 4.11 provides my reflections on carrying out this qualitative research. It was also a valuable opportunity to use and build on my knowledge and experience of working in rural areas of Malawi. With that, I hope I have made my respect for the Yao culture clear and that has been an important guiding principle. This was possible through reading various articles on indigenous knowledge and the African people, history and culture, from both lenses, of the colonisers and the colonised, and various interactions with my critical friend and my supervisors.

There were many admirable aspects of the Yao culture that I feel grateful to have experienced, particularly its rich community spirit, friendliness and pride, and not least the welcome I received during my field work. Many people went out of their way to give up their free time in support of the study and showed me hospitality – most notably the local health worker and the participants. I acknowledge my responsibility to the participants to disseminate the findings of the study so that their voices and the potential use of the project can be considered. The findings of this study will be provided to the Malawi government through the Balaka District Commissioner and District Health Office.

9.3. Implications and recommendations.

9.3.1. Implications for research

Not only has this thesis demonstrated that intergenerational partnerships can be a powerful means of nurturing social responsibility and helping current and future generations address SRH challenges, but it has also unearthed alternative descriptions of rural women in the context of intergenerational SRH communication practices.

My study focused on a rural indigenous community and could be replicated with other indigenous communities, to utilise and build on the findings, and to design SRH improvement interventions for young women. Further, studies based on perspectives of indigenous knowledge could provide a better understanding of rituals and traditions, associated with SRH communication practices in particular.

Although, the study did not intend to provide an in-depth evaluation of the SRH improvement intervention, strategies were put in place to find out if the new knowledge has been

incorporated into the puberty initiation rite and if the peer education is taking place. As such areas for exploration in future research could be to ascertain the use of the transformative knowledge and peer education in influencing young women's decision making and SRH behaviours.

My research was entirely qualitative and future research could build on this by conducting a quantitative study that explores the relationships that exist between initiation ceremonies, young women's sexual behaviours, and the health outcomes of the young women. Further, this study was conducted among rural women who live in a matrilineal society. As such findings cannot be generalised to rural women living in a patrilineal society. Therefore, there is a need to conduct a comparative research in patrilineal societies.

While the study was insightful on the roles of female teachers in shaping young women's sexual and reproductive lives, the study was unable to capture their views. Therefore, in future studies, there is need to include the female teachers, as they could bring multiple perspectives on the study topic, since they have been exposed to both, the indigenous and the Western ways of knowing.

9.3.2. Implications for practice

There is scope for health providers to work with traditional SRH counsellors. The latter are key in terms of socialising the young women on the expected sexual behaviours and gender roles and identity, whereas health providers are not. Local health care providers could reach out to them with the biological, psychological and the human rights aspects of SRH issues, as these were missing during the initiation ceremonies. If the health care providers and traditional SRH counsellors worked together, young women would be provided with a

holistic view of SRH issues and in the process empowered to make informed choices and avoid risky sexual behaviours.

Rural women and young women would also use services more if they felt their cultural views were part of the health care system as, noted by Jimmy-Gama (2009) and Welch (2010), health promotion interventions that are not culturally congruent are less effective. In this manner the weaknesses of the initiation rites shown in this thesis could be turned into opportunities by utilising the existing cultural structures and associations to reach out to young women/ people with a holistic view of SRH issues and in developing culturally congruent SRH improvement interventions and programmes.

The findings from this study imply that there is a need to strengthen the training and education of Community health workers mainly HSAs on community engagement, and on SRH issues, as the practice component for community engagement is currently not included in the Training Manual for HSAs (MoH, 2009). This can be achieved by equipping HSAs with knowledge and skills on how to work with traditional SRH counsellors and young women in these communities.

9.3.3. Implications for policy

The tension between indigenous knowledge, medicine and ways of living could be addressed by developing a policy that facilitates community engagement and successful implementation of community health programmes at different levels, within the health care delivery system (national, district and community). Currently there are no policies at all levels to coordinate community health as highlighted in the National Community Health Strategy 2017 – 2022 by MoH (2017). Therefore, this study calls for the development of a community health policy

and the use of a bottom-top approach in its development and implementation, to promote community participation in, and ownership of community health.

Furthermore, this study calls for a change in the mindset among the local health service providers, so that young women and communities are seen as partners in SRH issues, and not solely as recipients of their services. As such the HSA who has become aware of the concept of community engagement, by taking part in this project, could start advocating for this change which is in line with principle IV of the Primary health care (PHC) concept. This Principle states that people have the right and duty to participate individually and collectively in the planning and implementation of their health care, which Malawi adopted after the 1978 Alma-Ata Declaration, to guide primary health care services (WHO, 2023). The failure to implement this concept fully might be attributed to the inexistence of the implementation policy or the labelling of indigenous knowledge with its rituals and traditions as unscientific, primitive and harmful using the bio-medical lens.

To sum up, this thesis offers originality on four points, which could inform policy. Firstly, it has affirmed the unique and multifaceted role of rituals and traditions to promote the sexual well-being of rural young women. Secondly, the intergenerational research perspective has revealed how some rituals and traditions have persisted, shifted and changed, and conveyed the historical, political and socio-cultural contexts which have shaped the three generations' interpretation of SRH communication. Thirdly, it has demonstrated how girls and young women were empowered, by the secret knowledge and skills they acquire during the rituals and traditions, thereby contributing to their SRH and well-being. Conversely it has also established how the rituals and traditions could be a source of disempowerment, thus indirectly predisposing girls and young women to negative SRH outcomes. Finally, it has

demonstrated how the weaknesses of the initiation rites could be turned into opportunities by working with the community to develop a culturally congruent SRH improvement intervention.

9.4. Final words

In this study I set out to understand the intergenerational SRH communication practices, mainly the female initiation rites among the rural Yao women of Balaka, Southern Malawi, from a gendered perspective in order to establish how they can be utilised in the promotion of SRH and well-being of young women. This study has shown the positive side of initiation rites which can critique patriarchy from within and empower young women in the context of averting negative SRH outcomes.

An important contribution of this research lies in its role of valuing the indigenous knowledge which has relied on people's narratives. With the older generation passing on from this life, this study contributes to the local intellectual material in this field of public health, which in the past has relied on non-indigenous sources, often with their underlying assumptions and biases.

The study has provided a framework in which both traditional and Western approaches could be used in the promotion of SRH and wellbeing of young women, which has the potential to be applied elsewhere. The SRH improvement intervention training was a partnership between the researcher (myself) and the indigenous community (traditional SRH counsellors and young women) and employed PAR to empower the community to drive the change. Some of the effects of the programme included strengthening the sense of self-worth and resilience, and the capacity to address sexual and reproductive issues within the community. The 1996

joint WHO/UNICEF/UNFPA statement emphasises the role cultural practices play in the sustenance of societal cohesion (MHRC, 2006). It states that: *''Human behaviours and cultural values however senseless or destructive they may appear from the personal and cultural standpoint of others, have meaning and fulfil a function for those who practice them.''*

Equally, the women of this rural community are no exception to enjoying the rights of practicing their culture. However, it was observed that these rural women were at risk of losing their rituals and traditions, as they (the traditions and rituals) had been accused of fuelling HIV infections, promoting early sexual debut and teenage pregnancies, without an attempt to understand the complex gender roles and identities associated with them. Therefore, this study sought to gain an understanding on the experience and influencing factors on SRH communication practices among rural women, from the perspectives of three generations which helped to assist the rural women to act in solving SRH problems and issues amongst themselves.

9.4.1. Lesson learnt and what the research meant to me.

In undertaking this EPAR study, I realised that the meaning of participatory research was not only about the rural women but for myself too. Through this research, and working with the rural women, I have learnt that local problems/ issues require local solutions and with community engagement and partnership most health issues/ problems including SRH can be solved. Further, this study has made me to be more critical about indigenous histories written by scholars from a Western perspective, knowledge and culture. Furthermore, this research meant moments of agony and ecstasy. Agony as undertaking this study seemed to deviate from the more established Western perspective, which was at times challenging and

frustrating. I experienced the reluctance of some researchers which might have emanated from my expressions of anti-establishment views and highlighting the value of traditional Yao ways, which made me lose my confidence at times. However, the excitement of coming up with something new was ultimately rewarding.

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Appendices

Appendix 1a – Letter requesting authorisation from Balaka District Assembly

Appendix 1a – Letter requesting authorisation from Balaka District Assembly

University of Malawi – Kamuzu College of Nursing,
P/Bag 1, Lilongwe.
7th January 2021

The District Commissioner
Balaka District Assembly,
PO. Box 510, Balaka.

Dear Sir/Madam

Request to conduct a research study at Mbatamila village under Traditional Authority Nsamala

I am a Doctoral student at the University of Essex, in the United Kingdom and a lecturer at the University of - Kamuzu College of Nursing. In fulfilment for the award of a Doctor of Philosophy Degree in Public Health, I am required to conduct a research project. The purpose of this letter is to ask for your permission to carry out the study at Mbatamila village under Traditional Authority Nsamala. My research topic is: ***"An Ethnographic and Participatory Action Research on intergenerational sexual and reproductive health communication in rural Balaka"***

The study will recruit approximately 10 young women and four mothers and four grandmothers for in-depth interviews and 12 – 16 traditional and religious counsellors for focus group discussions. There are no risks involved in this study and once complete the knowledge and skills generated would be used to initiate and implement woman-centred interventions as well as in designing and delivering effective policies, programmes and services intended to address young women's sexual and reproductive health needs. Should I be given the permission, I intend to conduct this study during the months of February 2021 to July 2021.

Your favourable consideration will be highly appreciated.

Yours, Sincerely

Lucia Collen (Email: lcollen@kcn.unima.mw Mobile: 088 7413741)

Appendix 1b – Letter requesting support from Balaka District Health Office

Appendix 1b – Letter requesting support from Balaka District Health Office

University of Malawi – Kamuzu College of Nursing,
P/Bag 1,
Lilongwe.
7th June 2020.

The District Health Officer
Balaka District Health Office,
PO. Box 138, Balaka.

Request for permission to work with the Disease Control Assistant based at Mbatamila village

I am a Doctoral student at the University of Essex, in the United Kingdom and a lecturer at the University of - Kamuzu College of Nursing. In partial fulfilment for the award of a Doctor of Philosophy Degree in Public Health, I am required to conduct a research project. The purpose of this letter is to ask for your permission to work with the Disease Control Assistant responsible for Mbatamila village in a research study. My research topic is**: *''An Ethnographic and Participatory Action Research on intergenerational sexual and reproductive health communication in rural Balaka''***

The study will recruit 10 young women and four mothers and four grandmothers for in-depth interviews and 12 – 16 traditional and religious counsellors for focus group discussions. There are no risks involved in this study and once complete the knowledge and skills generated would be used to initiate and implement woman-centred interventions as well as in designing and delivering effective policies, programmes and services intended to address young women's sexual and reproductive health needs. Should I be given the permission, I intend to conduct this study during the months of February 2021 to July 2021.

Your favourable consideration will be highly appreciated.

Yours, Sincerely

Lucia Collen (Email: lcollen@kcn.unima.mw Mobile: 0887413741)

Appendix 2a – Village headman/woman/Gatekeeper's access letter

University of Malawi – Kamuzu College of Nursing,
P/Bag 1, Lilongwe.
7th June 2020.

To…….
Village headman/woman
Balaka

Request to access participants for the research study

I am a Public Health Trainee in the School of Health and Social Care at Essex University, United Kingdom. I grew up at Mpulula village, Balaka District, but currently living and working in Lilongwe. As part of my training, I am carrying out this study to understand how sexual and reproductive health issues are communicated among girls, mothers and grandmothers in this community and work with them to improve their overall health and wellbeing.

I am writing to enquire whether you would give me permission to speak to girls, mothers, grandmothers, traditional and religious sexual and reproductive health counsellors in your village about the project. I will also be glad, if you would call for a general meeting on my behalf, requesting them to volunteer to take part in the research study and to meet me (the researcher) for more information. These research activities will be done during their free time and in their homes.

If you have any comment or question about this research, please could you contact my supervisors, Professor Gill Green and Dr. Lindsey Nicholls, and they can be reached on gillgr@essex.ac.uk, lindsey.nicholls@essex.ac.uk respectively. The study has been approved by the Universities of Essex and Malawi Research and Ethics Committee. If you wish you can contact the University's Research Governance and Planning Manager, Sarah Manning-Press at: sarahm@essex.ac.uk and the Chairperson of the National Committee on Research in the Social Sciences and Humanities at ncrsh@ncst.mw

If you would be willing to give me permission, I would appreciate. Many thanks in advance for your consideration of this project. Please let me know if you require further information.

Regards

Lucia Collen
Researcher (mobile: 0881687824 email: lcollen@kcn.unima.mw or lc19116@essex.ac.uk)

Appendix 2b – Village headman/woman/Gatekeeper's access letter – Chichewa version

University of Malawi – Kamuzu College of Nursing,
P/Bag 1, Lilongwe.
7th June 2020.

To…….
Village headman/woman
Balaka

Kalata yopempha kukumana ndi anthu m'mudzi

Ine dzina langa ndi Lucia Collen, wophunzira kusukulu yazaumoyo ndi chikhalidwe ku Mangalande, ku Ulaya, komanso ndinakulira ku mudzi konkuno kwa amfumu a Mpulula. Pakali pano ndimakhala ku Lilongwe, komwe ndikugwira ntchito. Ngati mbali imodzi ya maphunziro anga, ndikupanga kafukufuku ofuna kuwona momwe zokambirana zokhudza nkhani za ku chipinda komanso uchembere wabwino zimayendera pakati pa atsikana, amayi ndi agogo ku mudzi kuno. Komanso kugwira nawo ntchito pofuna kutukula uchembere wabwino pakati pa atsikana ndi amayi.

Cholinga cholembera kalatayi, ndikupempha, kuti ngati nkotheka mundilole ndidzacheze ndi atsikana, azimayi, agogo komanso anankungwi pa nkhani za kuchipinda komanso uchembere wabwino. Ndidzakhalanso wokondwa ngati mutayitanitsa msonkhano, ndikuwapempha anthu m'mudzi muno kuti atenge nawo mbali mukafukufuku ameneyu. Komanso kuwapempha kuti akumane nane mwapadera, ngati angakonde kumva tsatane tsatane wa kafukufukuyi. Zochitika zonse zokhudzana ndi kafukufukuyi zizidzachitika pa nthawi imene iwo angakonde, komanso mumakomo mwawo. Ngati muli ndi ndemanga kapena funso pa kafukufuku ameneyu, chonde tumizani uthenga wanu pa makina a intaneti (email) kwa akulu akulu akafukufukuyu awa; Porofesa Gill Green pa gillgr@essex.ac.uk, kapena dokotola Lindsey Nicholls pa lindsey.nicholls@essex.ac.uk.

Kafukufukuyi waunikiridwa bwino lomwe ndi bungwe loona ufulu wachibadwidwe wa anthu otenga mbali mukafukufuku la sukulu ya ukachenjede ya za umoyo ndi chikhalidwe ya Essex ku Mangalande, ku Ulaya, komanso bungwe loyang'anira kafukufuku wokhuza za chikhalidwe kwathu komkuno la. Mabungwe awiriwa ntchito yawo ndiyoteteza ufulu wa anthu otenga mbali mukafukufuku.

Ndidzakhala wokondwa mutaganizirapo pa pempho langali. Zikomo kwambiri chifukwa chidwi chanu pa kafukufukuyi.

Chonde ndidziwitseni ngati mungakonde kumva zambiri za kafukufukuyi.

Ine mwana wanu

Lucia Collen (mobile: 0887413741 email: lcollen@kcn.unima.mw or lc19116@essex.ac.uk)

Appendix 3a (i) Participants' recruitment letter for young women (18 – 24 years)

"An Ethnographic and Participatory Action Research on intergenerational sexual and reproductive health communication in rural Balaka"

Required Participants: Young women, sexually active, aged 18 - 24 years.
Contact: Lucia Collen – on 0887413741 lcollen@kcn.unima.mw or lc19116@essex.ac.uk

Introduction

I am a Public Health Trainee in the School of Health and Social Care at Essex University, United Kingdom. I grew up at Mpulula village, Balaka District, but currently living and working in Lilongwe. As part of my training, I am carrying out this study to understand how sexual and reproductive health issues are communicated among girls, mothers and grandmothers in this community and work with them to improve their overall health and wellbeing.

I am writing to enquire whether you will be interested to share your views and experiences on the sex education you received in this community in a one-to-one semi- structured interview. This will last for 45 – 90 minutes and will take place at a convenient time and place for you. Your permission will be asked to audio-record our talk and will be treated with confidentiality. The study has been approved by the Universities of Essex Research and Ethics Committee and the National Committee on Research in the Social Sciences and Humanities in Malawi.

I would be very grateful if you would be willing to take part in my study. If you are interested, please read the enclosed participants information sheet (Appendix 4a) and then contact me on the above contacts. If you do so, you will have the chance to find out more about the study before coming to any decision. You would be under no obligation to take part. My study is being supervised by Professor Gill Green and Dr. Lindsey Nicholls, and they can be contacted on gillgr@essex.ac.uk, lindsey.nicholls@essex.ac.uk respectively.

Many thanks in advance for your consideration of this project.

Lucia Collen (Researcher)

Appendix 3a (ii) Participants' recruitment letter for young women (18 – 24 years) – Chichewa version – Kalata yopempha atsikana azaka za pakati pa khumi zisanu ndi zitatu ndi makumi awiri ndi anayi kutenga mbali mukafukufukuyi

Kafukufuku, ofuna kuwona momwe zokambirana zokhudza nkhani za kuchipinda komanso uchembere wabwino zimayendera pakati pa atsikana, amayi ndi agogo ku mudzi.

Mawu oyamba

Ine dzina langa ndi Lucia Collen, wophunzira ku sukulu ya zaumoyo ndi chikhalidwe ku Mangalande, ku Ulaya koma ndinakulira ku mudzi konkuno mwa amfumu a Mpulula. Pakali pano ndimakhala ku Lilongwe, komwe ndikugwira ntchito. Ngati mbali imodzi ya maphunziro anga, ndikupanga kafukufuku ofuna kuwona momwe zokambirana zokhudza nkhani za kuchipinda komanso uchembere wabwino zimayendera pakati pa atsikana, amayi ndi agogo ku mudzi kuno. Komanso kugwira nawo ntchito limodzi pofuna kutukula uchembere wabwino pakati pa atsikana ndi amayi.

Cholinga cholembera kalatayi, ndikukupemphani kuti mundithandize potenga mbali mu kafukufukuyi. Mukavomera kutero, mudzapemphedwa kuyankha mafunso, okhudzana ndi uphungu umene munalandira pa nkhani za kuchipinda komanso uchembere wabwino. Macheza amenewa adzakutengerani mphindi zosachepela makumi anayi ndi asanu (45 minutes) komanso osapitilira makumi asanu ndi mphambu zinayi (90 minutes), ndiponso adzachitika mwa chinsinsi, komanso pa nthawi ndi malo amene inu mungakonde. Ndimapemphanso ngati nkotheka ndidzajambule mawu pa zokambirana zonse mu nthawi imeneyi.

Kafukufukuyi waunikiridwa bwino lomwe ndi bungwe loona ufulu wachibadwidwe wa anthu otenga mbali mukafukufuku la sukulu ya ukachenjede ya za umoyo ndi chikhalidwe ya Essex ku Mangalande, ku Ulaya, komanso bungwe loyang'anira kafukufuku wokhuza za chikhalidwe kwathu komkuno.

Ndidzakhala wokondwa ngati mungatenge mbali mukafukufukuyi. Ngati muli wosangalatsidwa kutero, chonde werengani uthenga umene uli muchikalata chinacho (Appendix 4a) kapena kunditchayira lamya, kapenanso kutumiza uthenga pa makina a intaneti (internet) pa manambala ali mmunsiwo. Mukatero mudzakhala ndi mwayi wodziwa zambiri za kafukufuku ameneyu, musanapange chiganizo chilichonse. Dziwaninso kuti simuli wokakamizidwa kutenga mbali mukafukufukuyi.

Kafukufukuyi akuyang'aniridwa ndi akulu akulu awa Porofesa Gill Green ndi Dokotala Lindsey Nicholls amene mungawapeze pa makina aintaneti (internet) awa gillgr@essex.ac.uk, lindsey.nicholls@essex.ac.uk.

Zikomo kwambiri chifukwa cha chidwi chanu pa kafukufukuyi.

Ine wanu

Lucia Collen – on 0887413741 lcollen@kcn.unima.mw or lc19116@essex.ac.uk

Appendix 3B (i) Recruitment letter for adult females

''An Ethnographic and Participatory Action Research on intergenerational sexual and reproductive health communication in rural Balaka''

Required Participants: Mothers and grandmothers (with daughters & granddaughters 16 years and over)

Contact: Lucia Collen – mobile: 0887413741 lcollen@kcn.unima.mw or lc19116@essex.ac.uk

Introduction

I am a Public Health Trainee in the School of Health and Social Care at Essex University, United Kingdom. I grew up at Mpulula village, Balaka District, but currently living and working in Lilongwe. As part of my training, I am carrying out this study to understand how sexual and reproductive health issues are communicated among girls, mothers and grandmothers in this community and work with them to improve their overall health and wellbeing.

I am writing to enquire whether you will be interested to share your views and experiences on the sex education which takes place in this community, in a one-to-one semi- structured interview. This will last for 45 – 90 minutes and will take place at a convenient time and place for you. Your permission will be asked to audio-record our talk and will be treated with confidentiality. The study has been approved by the Universities of Essex Research and Ethics Committee and the National Committee on Research in the Social Sciences and Humanities in Malawi.

I would be very grateful if you would be willing to take part in my study. If you are interested, please read the attached participants information sheet (Appendix 4b) and then contact me on the above contacts. If you do so, you will have the chance to find out more about the study before coming to any decision. You would be under no obligation to take part.

My study is being supervised by Professor Gill Green and Dr. Lindsey Nicholls, and they can be contacted on gillgr@essex.ac.uk, lindsey.nicholls@essex.ac.uk respectively.

Many thanks in advance for your consideration of this project.

Lucia Collen (Researcher)

Appendix 3b (ii) Participants' recruitment letter for adult females - Chichewa version – Kalata yopempha amayi ndi agogo kutenga mbali mukafukufukuyi.

Kafukufuku, ofuna kuwona momwe zokambirana zokhudza nkhani za kuchipinda komanso uchembere wabwino zimayendera pakati pa atsikana, amayi ndi agogo ku mudzi.

Mawu oyamba

Ine dzina langa ndi Lucia Collen, wophunzira kusukulu ya zaumoyo ndi chikhalidwe ku Mangalande, ku Ulaya, koma ndinakulira ku mudzi konkuno mwa amfumu a Mpulula. Pakali pano ndimakhala ku Lilongwe, komwe ndikugwira ntchito. Ngati mbali imodzi ya maphunziro anga, ndikupanga kafukufuku ofuna kuwona momwe zokambirana zokhudza nkhani za kuchipinda komanso uchembere wabwino zimayendera pakati pa atsikana, amayi ndi agogo ku mudzi kuno. Komanso kugwira nanu ntchito pofuna kutukula uchembere wabwino pakati pa atsikana ndi azimayi.

Cholinga cholembera kalatayi, ndikukupemphani kuti mundithandize potenga mbali mu kafukufukuyi. Mukavomera kutero, mudzapemphedwa kuyankha mafunso, okhudzana ndi uphungu umene atsikana amalandira pa nkhani za kuchipinda komanso uchembere wabwino. Macheza amenewa adzakutengerani mphindi zosachepela makumi anayi ndi asanu (45 minutes) komanso osapitilira makumi asanu ndi mphambu zinayi (90 minutes), ndiponso adzachitika mwa chinsinsi, komanso pa nthawi ndi malo amene inu mungakonde. Ndimapemphanso ngati nkotheka ndidzajambule mawu pa zokambirana zonse mu nthawi imeneyi.

Kafukufukuyi waunikiridwa bwino bwino ndi bungwe loona ufulu wachibadwidwe wa anthu otenga mbali mukafukufuku la sukulu ya ukachenjede ya za umoyo ndi chikhalidwe ya Essex ku Mangalande, ku Ulaya, komanso bungwe loyang'anira kafukufuku wokhudza za chikhalidwe kwathu komkuno.

Ndidzakhala wokondwa ngati mungatenge mbali mukafukufukuyi. Ngati muli wosangalatsidwa kutero, chonde werengani uthenga umene uli muchikalata chinacho (Appendix 4b) kapena kunditchayira lamya kapenanso kutumiza uthenga pa makina aintaneti (internet) pa manambala ali m'munsiwo. Mukatero mudzakhala ndi mwayi wodziwa zambiri za kafukufukuyi musanapange chiganizo chilichonse. Dziwaninso kuti simuli wokakamizidwa kutenga mbali mukafukufukuyi.

Kafukufukuyi akuyang'aniridwa ndi akulu akulu awa Porofesa Gill Green ndi Dokotala Lindsey Nicholls amene mungawapeze pa makina aintaneti (internet) awa gillgr@essex.ac.uk, lindsey.nicholls@essex.ac.uk.

Zikomo kwambiri chifukwa cha chidwi chanu pa kafukufukuyi.

Ine wanu

Lucia Collen – on 0887413741 lcollen@kcn.unima.mw or lc19116@essex.ac.uk

Appendix 3c (i) Participants' recruitment letter for traditional and religious counsellors

"An Ethnographic and Participatory Action Research on intergenerational sexual and reproductive health communication in rural Balaka"

Required Participants: Traditional and religious sexual and reproductive health counsellors
Contact: Lucia Collen – 0887413741 or lcollen@kcn.unima.mw or lc19116@essex.ac.uk

Introduction

I am a Public Health Trainee in the School of Health and Social Care at Essex University, United Kingdom. I grew up at Mpulula Village, Balaka District, but currently living and working in Lilongwe. As part of my training I am carrying out this study to understand how sexual and reproductive health issues are communicated among girls, mothers and grandmothers in this community and work with them to improve their overall health and wellbeing. The study has been approved by the Universities of Essex and the National Committee on Research in the Social Sciences and Humanities (NCRSH) in Malawi.

I am writing to enquire whether you will be interested to take part in a focus group discussion, where your views and experiences on young women's sex education will be shared. The discussion will last for 60 – 120 minutes and will take place at a convenient time and place for you. The conversation will be audio-recorded and will be treated with confidentiality. I would like to ask your permission if I can observe you as you counsel young women on sexual and reproductive health issues, all information will be treated with confidentiality.

I would be very grateful if you would be willing to take part in my study. If you are interested, please read the attached participants information sheet (Appendix 4c) and then contact me on the above contacts. If you do so, you will have the chance to find out more about the study before coming to any decision. You would be under no obligation to take part. My study is supervised by Professor Gill Green and Dr. Lindsey Nicholls, and they can be contacted on gillgr@essex.ac.uk, lindsey.nicholls@essex.ac.uk respectively.

Many thanks in advance for your consideration of this project.

Lucia Collen (Researcher)

Appendix 3c (ii) Participants' recruitment letter for religious and traditional counsellors - Chichewa version – Kalata yopempha anamkungwi a ku mudzi ndi ku tchalichi kutenga mbali mu Kafukufuku, ofuna kuwona momwe zokambirana zokhudza nkhani za kuchipinda komanso uchembere wabwino zimayendera pakati pa atsikana, amayi ndi agogo ku mudzi.

Chichewa version – Kalata yopempha anamkungwi a ku mudzi ndi ku tchalichi kutenga mbali mu Kafukufuku, ofuna kuwona momwe zokambirana zokhudza nkhani za kuchipinda komanso uchembere wabwino zimayendera pakati pa atsikana, amayi ndi agogo ku mudzi.

Ine ndine Lucia Collen, wophunzira ku sukulu ya zaumoyo ndi chikhalidwe ku Mangalande, ku Ulaya, komanso ndinakulira ku mudzi konkuno kwa amfumu a Mpulula. Pakali pano ndimakhala ku Lilongwe, komwe ndikugwira ntchito. Ngati mbali imodzi ya maphunziro anga, ndikupanga kafukufuku ofuna kuwona momwe zokambirana zokhudza nkhani za ku chipinda komanso uchembere wabwino zimayendera pakati pa atsikana, amayi ndi agogo ku mudzi kuno. Komanso kugwira nanu ntchito pofuna kutukula uchembere wabwino pakati pa atsikana ndi amayi.

Cholinga cholembera kalatayi, ndikukupemphani kuti mundithandize potenga mbali mu kafukufukuyi. Mukavomera kutero, mudzakhala ndi mwayi wotenga mbali muzokambirana zokhudzana ndi uphungu umene atsikana amalandira pa nkhani zakuchipinda komanso uchembere wabwino. Zokambirana zimenezi zidzakutenga mphindi zosachepela makumi asanu ndi mphambu imodzi (60 minutes) komanso osapitilira maola awiri (120 minutes). Zokambiranazi zidzachitika mwa chinsinsi, komanso pa nthawi ndi malo amene inu mungakonde. Ndimapemphanso ngati nkotheka ndidzajambule mawu pa zokambirana zonse mu nthawi imeneyi. Ndimapemphanso ngati nkotheka ndidzakhale nawo komanso ndikuonerera pa nthawi yimene muzidzapereka uphungu kwa atsikana pa nkhani zakuchipindazi komanso uchembere wabwino. Zonsezi zidzachitika mwachinsinsi.

Kafukufukuyi waunikiridwa bwino bwino ndi bungwe loona za ufulu wachibadwidwe wa anthu otenga mbali mukafukufuku la sukulu ya ukachenjede ya za umoyo ndi chikhalidwe ya Essex ku Mangalande, ku Ulaya, komanso bungwe loyang'anira kafukufuku wokhudza za chikhalidwe kwathu komkuno.

Ndidzakhala wokondwa ngati mungatenge mbali mukafukufukuyi. Ngati muli wosangalatsidwa kutero, chonde werengani uthenga umene uli muchikalata chinacho (Appendix 4c) kapena kunditchayira lamya kapenanso kutumiza uthenga pa makina aintaneti (internet) pa manambala ali mmunsiwo. Mukatero mudzakhala ndi mwayi wodziwa zambiri za kafukufukuyi, musanapange chiganizo chilichonse. Dziwaninso kuti simuli wokakamizidwa kutenga mbali mukafukufukuyi.

Kafukufukuyi akuyang'aniridwa ndi akulu akulu awa Porofesa Gill Green ndi Dokotala Lindsey Nicholls amene mungawapeze pa makina aintaneti (internet) awa gillgr@essex.ac.uk, lindsey.nicholls@essex.ac.uk.

Zikomo kwambiri chifukwa cha chidwi chanu pa kafukufukuyi.

Ine mwana wanu

Lucia Collen – 0887413741 or lcollen@kcn.unima.mw or lc19116@essex.ac.uk

Appendix 3d (i) Recruitment letter for young women (16 and 17 years) sought from parents

''An Ethnographic and Participatory Action Research on intergenerational sexual and reproductive health communication in rural Balaka''

Required Participants: Young women, sexually active, aged 16 and 17 years
Contact: Lucia Collen –0887413741 or lcollen@kcn.unima.mw or lc19116@essex.ac.uk

Introduction

I am a Public Health Trainee in the School of Health and Social Care at Essex University, United Kingdom. I grew up at Mpulula village, Balaka District, but currently living and working in Lilongwe. As part of my training I am carrying out this study to understand how sexual and reproductive health issues are communicated among girls, mothers and grandmothers in this community and work with them to improve their overall health and wellbeing. The study has been approved by the Universities of Essex and the National Committee on Research in the Social Sciences and Humanities in Malawi.

I am writing to ask if you would be willing to give permission for me to ask your daughter if she would like to take part in my research. This will involve interviewing her to share her views and experiences on the sex education she received in this community in a one to one semi- structured interview. This will last for 45 – 90 minutes and will take place at a convenient time and place for her. Your permission will be required to audio-record the talk and will be treated with confidentiality.

I would be very grateful if you would be willing to allow your daughter to take part in my study. If you are interested, please read the attached participants information sheet (Appendix 4a) and then contact me on the above contacts. If you do so, you will have the chance to find out more about the study before coming to any decision. You would be under no obligation to allow your daughter to take part in the study. My study is being supervised by Professor Gill Green and Dr. Lindsey Nicholls, and they can be contacted on gillgr@essex.ac.uk, lindsey.nicholls@essex.ac.uk respectively.

Many thanks in advance for your consideration of this project.

Lucia Collen (Researcher)

Appendix 3d (ii) Recruitment letter for young women (16 and 17 years) sought from parents Chichewa version – Kalata yopempha chilolezo kwa makolo kuti ana awo akazi azaka khumi, zisanu ndi chimodzi, komanso khumi, zisanu ndi ziwiri, kutenga mbali mu Kafukufuku, ofuna kuwona momwe zokambirana zokhudza nkhani za kuchipinda komanso uchembere wabwino zimayendera pakati pa atsikana, amayi ndi agogo kumudzi.

Ine dzina langa ndi Lucia Collen wophunzira waku sukulu ya zaumoyo ndi chikhalidwe ku Mangalande, ku Ulaya, koma ndinakulira ku mudzi konkuno mwa amfumu a Mpulula. Pakali pano ndimakhala ku Lilongwe, komwe ndikugwira ntchito. Ngati mbali imodzi ya maphunziro anga, ndikupanga kafukufuku ofuna kuwona momwe zokambirana zokhudza nkhani za kuchipinda komanso uchembere wabwino zimayendera pakati pa atsikana, amayi ndi agogo ku mudzi. Komanso kugwira nanu ntchito pofuna kutukula uchembere wabwino pakati pa atsikana ndi amayi.

Cholinga cholembera kalatayi, ndikukupemphani kuti ngati nkotheka mundilole, kuti ndimupemphe mwana wanu wa mkazi ngati angakonde kulowa mu kafukufukuyi. Ngati angakonde kutero, adzapemphedwa kuyankha mafunso, okhudzana ndi uphungu umene analandira pa nkhani zakuchipinda komanso uchembere wabwino. Macheza amenewa adzatenga mphindi zosachepela makumi anayi ndi asanu (45 minutes) komanso osapitilira makumi asanu ndi mphambu zinayi (90 minutes), ndiponso adzachitika mwa chinsinsi, komanso pa nthawi ndi malo amene iye angakonde. Ndimapemphanso ngati nkotheka ndidzajambule mawu pa zokambirana zonse mu nthawi imeneyi.

Kafukufukuyi waunikiridwa bwino lomwe ndi bungwe lowona za ufulu wachibadwidwe wa anthu otenga mbali mukafukufuku la sukulu ya ukachenjede ya za umoyo ndi chikhalidwe ya Essex ku Mangalande, ku Ulaya, komanso bungwe loyang'anira kafukufuku wokhuza za chikhalidwe kwathu komkuno.

Ndidzakhala wokondwa ngati mutalola mwana wanuyu kutenga mbali mukafukufukuyi. Ngati muli wosangalatsidwa kutero, chonde werengani uthenga umene uli muchikalata chinacho (Appendix 4a) kapena kunditchayira lamya, kapenanso kutumiza uthenga pa makina a intaneti (internet) pa manambala ali mmunsiwo.

Kafukufukuyi akuyang'aniridwa ndi akulu akulu awa Porofesa Gill Green ndi Dokotala Lindsey Nicholls amene mungawapeze pa makina aintaneti (internet) awa gillgr@essex.ac.uk, lindsey.nicholls@essex.ac.uk.

Zikomo kwambiri chifukwa cha chidwi chanu pa kafukufukuyi.

Ine mwana wanu

Lucia Collen – 0881687824 or lcollen@kcn.unima.mw or lc19116@essex.ac.uk

Appendix 4a (i) Participant information sheet for young women (16 – 24 years)

''An Ethnographic and Participatory Action Research on intergenerational sexual and reproductive health communication in rural Balaka''

Introduction and an invitation to participants

I am Lucia Collen, a Public Health Trainee in the School of Health and Social Care at Essex University, United Kingdom. I grew up at Mpulula Village, Balaka District, but am currently living and working in Lilongwe. As part of my training I am carrying out this study to understand how sexual and reproductive health issues are communicated among girls, mothers and grandmothers in this community and work with them to improve their overall health and wellbeing. The study has been approved by the Universities of Essex and the National Committee on Research in the Social Sciences and Humanities.

I would like to invite you (young women) to take part in this research on how people learn about sexual and reproductive health issues. Before you decide whether to take part, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully.

What is the purpose of the study?

I am interested in how sexual and reproductive health issues are communicated from grandmothers and mothers to their daughters, from religious and/or traditional counsellors and from friends. I also want to know how young girls learn about sex and their future roles as women in this community. I also intend to work with women in this community to promote their sexual health and wellbeing.

Why have I been invited to participate?

You have been invited to take part in this study because you are in the reproductive age group, and you might know something about sexual and reproductive health. I am wondering if you could be kind enough to assist me by taking part in this study, which I am doing as a requirement for my studies in Public Health. Your contribution to the study will help me to identify gaps and potentials in the sexual and reproductive health (SRH) communication processes and it will give you a voice. It will also generate new knowledge and skills which could assist in developing woman-centred interventions to address young people's SRH needs. Therefore, I would be very grateful if you could have a chat with me on your experiences and views on the sex education you received in this community. If you do not mind, I would also like to audio-record all the conversations made, while we are chatting. Approximately 10 young women will be invited to take part in this study.

Do I have to take part?

No. Participation in this study is voluntary and there is no obligation to take part. If you wish not to take part, your decision will be respected. You are free to withdraw at any time, without giving a reason. This will not affect you in any way. Before you decide whether to take part, it is important for you to understand why the research is being done and what participation in the study will involve for you. Please take time to read the information sheet carefully or discuss it with others if you wish. If you have any question or you need some clarification or would like more information, please contact me (Lucia Collen) on this number 0887413741.

What are the possible disadvantages and risks of taking part?

There are no known risks associated with taking part in this study, only that you may find some of the content of the discussions to be personal and could trigger unpleasant memories. If it occurs, you will be provided with the necessary support. You will also be asked if you wish to stop or proceed with the interview and if you opt to leave, this will not affect you in any way.

What are the possible benefits of taking part?

I cannot promise that the study will help you personally. However, the knowledge generated from this study will help to develop sexual and reproductive health (SRH) improvement interventions and to improve SRH communication among young people, mothers, and grandmothers.

What information will be collected?

The information to be collected will include your experiences and views on the sex education which takes place in this community, as well as your views on the potential of using indigenous knowledge and skills to promote sexual health and wellbeing of young people.

Will my information be kept confidential?

Privacy and confidentiality will be maintained throughout the research period. This will be done by making sure that interviews are conducted at a quiet place, away from other people and that all the data collected are not open to other people, other than the researcher herself and the research supervisors. After each interview, all information will be stored anonymously, which means no body will know who said what. Of course, some people in the village will know that you have taken part in this study. No names of participants will be indicated on research tools or the audio records, instead pseudo names will be used to maintain anonymity and confidentiality. The responses you provide will be treated in confidence. No identifying information will appear in any document or in the final report. Unless, you are involved in the project and you want to be acknowledged.

Your rights are protected under the UK Data Protection Act of 1998 and any information that might identify you will not be shared outside the research team. After the dissertation has been examined, hard copies of the research material will be kept for a period of five years before being destroyed, and recordings being erased.

What is the legal basis for using the data and who is the Data Controller?

Ethical and legal practice will be followed in data collection, analysis, and use. Clearance to conduct the study will be sought from Universities of Essex and the National Committee on Research in the Social Sciences and Humanities in Malawi. The collected data will be controlled by the University of Essex through the office of the University Information Assurance Manager (Sara Stock) on dpo@essex.ac.uk.

What should I do if I want to take part?

If you are interested in taking part, you will be asked to complete and sign or put a thumb print on the enclosed consent form. Then you will be asked some questions on your views and experiences on the sex education you received in this community. I (Lucia Collen) will be the one asking you questions, and the interview will be audio recorded. The chat will last for 45 – 90 minutes and will take place at a convenient time and place for you. If you would like to find out more about the research before taking part, please do not hesitate to contact the research team, Lucia Collen at: lc19116@essex.ac.uk or lcollen@kcn.unima.mw or 0887413741 or my supervisors Professor Gill Green and Dr. Lindsey Nicholls, on gillgr@essex.ac.uk, lindsey.nicholls@essex.ac.uk respectively.

What will happen to the results of the research study?

The data will be analysed and made available to a range of people, including myself (Lucia Collen), yourself, (if interested) health professionals and researchers through written reports, presentations, and journal publications. Copies of the dissertation will be submitted to the universities of Essex and Malawi. However, it will not be possible to identify any individual participant from these reports or publications.

Who is organising and funding the research?

This research is part of a Programme of study to fulfil the requirements of PhD Dissertation (18106358) and therefore it has no funding attached.

Who has reviewed the study?

This study has been reviewed and given ethical approval by University of Essex Research and Ethics Committee and the National Committee on Research in the Social Sciences and Humanities in Malawi. Consent to take part in the study will be obtained by myself (Lucia Collen).

Concerns and Complaints

If you have any concerns about any aspect of the study or you have a complaint, please feel free to ask me Lucia Collen at: lc19116@essex.ac.uk or lcollen@kcn.unima.mw or 0887413741. If you are still concerned, you think your complaint has not been addressed to your satisfaction or you feel that you cannot approach the Principal Investigator, please contact the Postgraduate Research Director responsible for this project, Dr. Winifred Eboh at: w.eboh@essex.ac.uk . If you are still not satisfied, please feel free to contact the University's Research Governance and Planning Manager, Sarah Manning-Press at: sarahm@essex.ac.uk and the Chairperson of the National Committee on Research in the Social Sciences and Humanities at ncrsh@ncst.mw

Name of the Researcher/Research Team Members

If you want to know more about the research, please contact the research team. I (Lucia Collen) the researcher, can be contacted on: lc19116@essex.ac.uk or lcollen@kcn.unima.mw or 0887413741. You can also contact my supervisors Professor Gill Green and Dr. Lindsey Nicholls in the School of Health and Social Care on gillgr@essex.ac.uk, lindsey.nicholls@essex.ac.uk respectively.

Thank you for taking your time to read this study information sheet.

Appendix 4a (ii) Participant information sheet for young women (16 – 24 years) – chichewa version – Kalata ya uthenga wa kafukufuku kwa atsikana azaka za pakati pa khumi, zisanu ndi chimodzi ndi makumi awiri ndi anayi, mu Kafukufuku, ofuna kuwona momwe zokambirana zokhudza nkhani za kuchipinda komanso uchembere wabwino zimayendera pakati pa atsikana, amayi ndi agogo ku mudzi

Mau oyamba

Ine dzina langa ndi Lucia Collen, m'modzi mwaophunzira ku sukulu ya za umoyo ya Essex, ku Mangalande, ku Ulaya. koma ndinakulira ku mudzi konkuno kwa amfumu a Mpulula. Pakali pano ndikukhala ku Lilongwe, komwe ndikugwira ntchito, Ngati mbali imodzi ya maphunziro anga, ndikupanga kafukufuku ofuna kuwona momwe zokambirana zokhudza nkhani za kuchipinda komanso uchembere wabwino zimayendera pakati pa atsikana, amayi ndi agogo ku mudzi. Komanso kugwira nanu ntchito limodzi pofuna kutukula uchembere wabwino pakati pa atsikana ndi amayi. Kafukufukuyi waunikiridwa bwino lomwe ndi bungwe lowona za ufulu wachibadwidwe wa anthu otenga mbali mukafukufuku la sukulu ya ukachenjede ya za umoyo ndi chikhalidwe ya Essex ku Mangalande, ku Ulaya, komanso bungwe loyang'anira kafukufuku wokhuza za chikhalidwe kwathu komkuno.

Muli kupemphedwa kutenga mbali mu kafukufukuyi, wofuna kuwona momwe zokambirana zokhudza nkhani za kuchipinda komanso uchembere wabwino zimayendera pakati pa atsikana, amayi ndi agogo ku mudzi. Koma musanaganize zotenga mbali, mukupemphedwa kuwerenga uthenga uli mu kalatayi. Zimenezi zidzakuthandizani kuti mudziwe cholinga cha kafukufukuyi, komanso kutenga mbali mukafukufukuyi zikuthanthauzanji.

Kodi cholinga cha kafukufukuyi ndichiti?

Cholinga chake ndikufuna kudziwa momwe zokambirana zokhudza nkhani za kuchipinda komanso uchembere wabwino zimayendera pakati pa amayi ndi atsikana, agogo ndi atsikana, komanso ndi anamkugwi aku mudzi ndiku tchalichi komwe. Ndikufunanso kudziwa m'mene atsikanawa anazidziwira, nkhani zogonana, komanso za udindo wawo ngati amayi a mtsogolo. Komanso kugwira nanu ntchito pofuna kutukula uchembere wabwino pakati pa atsikana ndi amayi.

Chifukwa chiyani ndapemphedwa kulowa mu kafukufukuyi?

Mwapemphedwa kutenga mbali mukafukufukuyi, chifukwa mwafika pa msinkhu wobereka, komanso mukudziwapo zina ndi zina zokhudza nkhani za kuchipinda komanso uchembere wabwino. Ndimapempha, ngati nkotheka mutenge nawo mbali mu kafukufukuyi, yemwe ndikupanga ngati mbali imodzi ya maphunziro anga aza umoyo. Kutenga mbali kwanu mukafukufukuyi zidzathandiza kuti, ndidziwe zinthu zimene zikuyenda bwino, kapena zimene zikufooka pa nkhani za kuchipinda komanso uchembere wabwino. Zidzathandizanso kuti mawu anu amveke kutali, komanso kupeza njira za tsopano zotukulila uchembere wabwino pakati pa achinyamata. Choncho, ndidzathokoza kwambiri ngati mungapeze mpata wocheza nane kuti tidzagawane maganizo pa zimene munaphunzitsidwa zokhuzana ndi nkhani za kuchipinda komanso uchembere wabwino. Ndimapemphanso ngati nkotheka ndidzajambule mawu pa nthawi yonse imene tidzakhale tikucheza. Pafupifupi atsikana khumi adzapemphedwa kutenga mbali mu macheza amenewa.

Kodi ndine wokakamizidwa kulowa mukafukufukuyi?
Ayi, kutenga mbali mukafukufukuyi ndikodzipereka, ndipo simuli wokakamizidwa kutero. Ngati mutaganiza kuti musatenge nawo mbali mukafukukufuyi, maganizo anu adzalemekezedwa. Mungathenso kusiya kutenga mbali nthawi iliyonse popanda kupereka chifukwa chimene mwatichira zimenezo, ndipo sipadzakhala chovuta chilichonse. Koma musanaganize zotenga nawo mbali, pafunika kuti mudziwe cholinga cha kafukufukuyi, komanso kutenga nawo mbali mukafukufukuyi zikuthanthauzanji kwa inu. Chonde werengani uthenga uli mu kalatayi mosamala, komanso mutha kukambirana ndi anzanu ngati mungafune. Ngati muli ndi funso lililonse, kapena pena pake simunamvetsetse, kapenanso mukufuna kumva zambiri zakafukufukuyi, chonde nditchayireni lamya pa nambala iyi 0887413741.

Kodi pali kuopsya kotani polowa mu kafukufukuyi?
Kafukufukuyi alibe zoopsya zeni zeni. Kungoti mwina mukhoza kudzasowa mtendere, chifukwa nkutheka kuti zokambiranazi zikhoza kukumbutsani zomwe zinakuchitikirani, komanso zinali zodandaulitsa. Zimenezi zikadzachitika mudzalandira chithandizo choyenera. Mudzafunsidwa ngati mungakonde kupitiriza ndi zokambiranazo, kapena ayi. Mukadzasankha kusiya, sipadzakhala chovuta chilichonse.

Kodi pali phindu lanji polowa mu kafukufukuyi?
Ndisalonjeze pano kuti inu mudzapeza phindu lililonse ngati mutaganiza kulowa mu kafukufuku ameneyi, koma zotsatira zake zidzathandiza kupeza njira zopititsira pa tsogolo nkhani za uchembere wabwino.

Kodi ndi uthenga wanji umene mukufuna kutolera?
Uthenga umene ndikufuna kutolera ndi wokhuza zimene munakumana nazo, komanso maganizo anu pa momwe zokambirana zokhuza nkhani za ku chipinda komanso uchembere wabwino zimachitikira m'mudzi muno. Komanso kumva maganizo anu pa khumbo lofuna kugwiritsa ntchito chikhalidwe ndi miyambo yathu potukula uchembere wabwino pakati pa achinyamata.

Kodi chinsinsi changa chidzasungidwa?
Chinsinsi chanu chidzasungidwa mu nthawi yonse ya kafukufukuyi. Zimenezi zidzachitika poonetsetsa kuti zokambirana zonse zikuchitikira pa malo a chinsinsi, kutali ndi anthu ena. Komanso zonse zimene mudzayankhule zidzasungidwa mwachinsinsi pogwiritsa nchito manambala ndi mayina opeka, osati mayina anu eni eni. Zimenezi zikutanthauza kuti palibe adzaziwe kuti izi zinayankhulidwa ndi wakuti wakuti. Ngakhale kuti ena adzaziwa kuti inuyo mwatenga mbali mu kafukufukuyi. Mayina eni eni adzagwiritsidwa ntchito pokha pokhapo ngati mwatenga nawo mbali pokonza ndondomeko zothandiza kutukula uuchembere wabwino m'mudzi muno. Zikalata ndi zojambula zonse zidzasungidwa mwachinsinsi kwa zaka zisanu zisanang'ambidwe ndikuotchedwa, mogwirizana ndi malamulo a kafukufuku a sukulu ya ukachenjede ya za umoyo ndi chikhalidwe ya Essex ku Mangalande, ku Ulaya.

Kodi ndingatani, kuti ndilowe mu kafukufukuyi?

Ngati mwasangalatsidwa kulowa mukafukufukuyi, mudzapemphedwa kuti musayinire kapena kudinda ndi chala kutsikimiza kuti mwamvetsetsa za uthenga wokhuza kafukufukuyi, ndipo mwavomera kutenga nawo mbali. Kenako ndidzakufunsani mafunso wokhuza zimene munakumana nazo, komanso maganizo anu pa momwe zokambirana zokhuza nkhani za ku chipinda komanso uchembere wabwino zimachitikira m'mudzi muno.

Ndidzakhalanso ndikujambula zokambirana zathuzi, zimene zidzatitengere mphindi zosachepela makumi anayi ndi asanu (45 minutes) komanso osapitilira makumi asanu ndi mphambu zinayi (90 minutes). Machezawa adzachitika pa nthawi ndi malo malingana ndikukonda kwanu. Ngati mukufuna kumva zambiri zakafukufukuyi, mungathe kunditchayira lamya pa nambala iyi 0887413741 kapenanso kutumiza uthenga pa makina aintaneti (internet) pa lcollen@kcn.unima.mw kapena lc19116@essex.ac.uk. Kapena aphunzitsi anga awa Porofesa Gill Green kapena dokotala Lindsey Nicholls, pa makina aintaneti (internet) awa gillgr@essex.ac.uk, lindsey.nicholls@essex.ac.uk.

Kodi zotsatira za kafukufukuyi zidzayenda bwanji?
Zotsatira za kafukufukuyi, zidzalembedwa mma'buku ndi kusiyidwa ku malo owerengera (library) a ku sukulu ya Essex ku Mangalande, komanso kwathu konkuno, ku sukulu ya Anamwino ndi Azamba ya Kamuzu. Inunso, kuphatikizanso anthu ena ogwira ntchito ya zaumoyo adzakhala ndi mwayi omva nawo zotsatira zakafukufukuyi, kudzera mu misonkhano yosiyana siyana, komanso mu zolembalemba.

Kodi kafukufukuyi akuthandizidwa ndi ndani?
Kafukufukuyi akupangidwa ngati mbali imodzi ya maphunziro anga, motero palibe bungwe limene lathandizapo pa kafukufukuyi.

Kodi awunikira kafukufukuyi ndindani?
Kafukufukuyi waunikiridwa bwino lomwe ndi bungwe lowona za ufulu wa chibadwidwe wa anthu otenga mbali mukafukufuku la sukulu ya ukachenjede ya za umoyo ndi chikhalidwe ya Essex ku Mangalande, ku Ulaya, komanso bungwe loyang'anira kafukufuku wokhuza za chikhalidwe kwathu komkuno. Koma ine (Lucia Collen) ndi amene ndidzatenge chilolezo kwa onse olowa mu kafukufukuyi.

Kodi ndingatani nditakhala ndi mafunso kapena madandaulo okhudzana ndi kafukufukuyi?
Mutakhala ndi mafunso kapena madandaulo okhudzana kafukufukuyi, muli omasuka kulumikizana ndi mayi Lucia Collen pa nambala iyi: 0887413741, kapena pa uthenga wa pa intaneti (email) pa keyala iyi: lcollen@kcn.unima.mw kapena lc19116@essex.ac.uk. Koma mutaona kuti simunakhutitsidwe ndim'mene mwathandizidwira, muli ndi ufulu wokatula nkhawa zanu kwa aakulu a kafukufukuyi a dokotala Winifred Eboh pa keyala iyi: w.eboh@essex.ac.uk. Ngati simunakhutitsidwebe muli ndi ufulu wokatula nkhawa zanu kwa a pampando a bungwe loyang'anira za ufulu wa anthu otenga nawo mbali mukafukufuku a Sarah Manning-Press pa keyala iyi:sarahm@essex.ac.uk kapena a pampando a bungwe loyang'anira kafukufuku wokhuza za chikhalidwe kwathu komkuno pa keyala iyi: ncrsh@ncst.mw

Ndindani akuyendetsa kafukufukuyi
Ngati mukufuna kumva zambiri za kafukufukuyi, chonde lumikizanani ndi anthu awa, powatchayira lamya kapena potumiza uthenga pa makina aintaneti (internet). Mayi Lucia Collen pa nambala iyi: 0887413741, kapena pa uthenga wa pa intaneti (email) pa keyala iyi: lc19116@essex.ac.uk kapena lcollen@kcn.unima.mw. Kapenanso aphunzitsi anga awa a Porofesa Gill Green kapena a dokotala Lindsey Nicholls, pa makina aintaneti (internet) awa gillgr@essex.ac.uk, lindsey.nicholls@essex.ac.uk.

Zikomo potenga nthawi yanu kuwerenga uthenga umenewu.

Appendix 4b (i) Participant information sheet for adult females

''An Ethnographic and Participatory Action Research on intergenerational sexual and reproductive health communication in rural Balaka''

Introduction and an invitation to participants

I am Lucia Collen, a Public Health Trainee in the School of Health and Social Care at Essex University, United Kingdom. I grew up at Mpululu Village, Balaka District, but am currently living and working in Lilongwe. As part of my training I am carrying out this study to understand how sexual and reproductive health issues are communicated among girls, mothers and grandmothers in this community and work with them to improve their overall health and wellbeing. The study has been approved by the University of Essex Research and Ethics Committee and National Committee on Research in the Social Sciences and Humanities in Malawi.

I would like to invite you (mothers and grandmothers) to take part in this research on how people learn about sexual and reproductive health issues. Before you decide whether to take part, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully.

What is the purpose of the study?

I am interested in how sexual and reproductive health issues are communicated from grandmothers and mothers to their daughters, from religious and/or traditional counsellors and from friends. I also want to know how young girls learn about sex and their future roles as women in this community. I also intend to work with women in this community to promote their sexual health and wellbeing.

Why have I been invited to participate?

You have been invited to take part in this study because you are a mother and you might know something about sexual and reproductive health. I am wondering if you could be kind enough to assist me by taking part in this study, which I am doing as a requirement for my studies in Public Health. Your contribution to the study will help me to identify gaps and potentials in the sexual and reproductive health (SRH) communication processes and it will give you a voice. It will also generate new knowledge and skills which could assist in developing women-centred interventions to address young people's SRH needs.

Therefore, I would be very grateful if you could have a chat with me on your experiences and views on the sex education which takes place in this community. If you do not mind, I would also like to audio-record all the conversations made, while we are chatting. Approximately four mothers and four grandmothers will be invited to take part in this study.

Do I have to take part?

No. Participation in this study is voluntary and there is no obligation to take part. If you wish not to take part, your decision will be respected. You are free to withdraw at any time, without giving a reason. This will not affect you in any way. Before you decide whether to take part, it is important for you to understand why the research is being done and what participation in the study will involve for you. Please take time to read the information sheet carefully or discuss it with others if you wish. If you have any question or you need some clarification or would like more information, please contact me Lucia Collen) on this number 0887413741.

What are the possible disadvantages and risks of taking part?

There are no known risks associated with taking part in this study, only that you may find some of the content of the discussions to be personal and could trigger unpleasant memories. If it occurs, you will be provided with the necessary support. You will also be asked if you wish to stop or proceed with the interview and if you opt to leave, this will not affect you in any way.

What are the possible benefits of taking part?

I cannot promise that the study will help you personally. However, the knowledge generated from this study will help to develop sexual and reproductive health (SRH) improvement interventions and to improve SRH communication among young people, mothers, and grandmothers.

What information will be collected?

The information to be collected will include your experiences and views on the sex education which takes place in this community, as well as your views on the potential of using indigenous knowledge and skills to promote sexual health and wellbeing of young people.

Will my information be kept confidential?

Privacy and confidentiality will be maintained throughout the research period. This will be done by making sure that interviews are conducted at a quiet place, away from other people and that all the data collected are not open to other people, other than the researcher herself and the research supervisors. After each interview, all information will be stored anonymously, which means no body will know who said what. Of course, some people in the village will know that you have taken part in this study. No names of participants will be indicated on research tools or the audio records, instead pseudo names will be used to maintain anonymity and confidentiality. The responses you provide will be treated in confidence. No identifying information will appear in any document or in the final report. Unless, you are involved in the project and you want to be acknowledged.

Your rights are protected under the UK Data Protection Act of 1998 and any information that might identify you will not be shared outside the research team. After the dissertation has been examined, hard copies of the research material will be kept for a period of five years before being destroyed, and recordings being erased.

What is the legal basis for using the data and who is the Data Controller?

Ethical and legal practice will be followed in data collection, analysis, and use. Clearance to conduct the study will be sought from University of Essex Research and Ethics Committee and the National Committee on Research in the Social Sciences and Humanities in Malawi. The collected data will be controlled by the University of Essex through the office of the University Information Assurance Manager (Sara Stock) on dpo@essex.ac.uk.

What should I do if I want to take part?

If you are interested in taking part, you will be asked to complete and sign or put a thumb print on the enclosed consent form. Then you will be asked some questions on your views and experiences on the sex education you received, or which takes place in this community. I (Lucia Collen) will be the one asking you questions, and the interview will be audio recorded. The chat will last for 45 – 90 minutes and will take place at a convenient time and place for you. If you would like to find out more about the research before taking part, please do not hesitate to contact the research team, Lucia Collen at: lc19116@essex.ac.uk or lcollen@kcn.unima.mw or 0887413741 or my supervisors Professor Gill Green and Dr. Lindsey Nicholls, on gillgr@essex.ac.uk, lindsey.nicholls@essex.ac.uk respectively.

What will happen to the results of the research study?

The data will be analysed and made available to a range of people, including myself (Lucia Collen), yourself, (if interested) health professionals and researchers through written reports, presentations, and journal publications. Copies of the dissertation will be submitted to the universities of Essex and Malawi. However, it will not be possible to identify any individual participant from these reports or publications.

Who is organising and funding the research?

This research is part of a Programme of study to fulfil the requirements of PhD Dissertation (18106358) and therefore it has no funding attached.

Who has reviewed the study?

This study has been reviewed and given ethical approval by University of Essex Research and Ethics Committee and the National Committee on Research in the Social Sciences and Humanities in Malawi. Consent to take part in the study will be obtained by myself (Lucia Collen).

Concerns and Complaints

If you have any concerns about any aspect of the study or you have a complaint, please feel free to ask me Lucia Collen at: lc19116@essex.ac.uk or lcollen@kcn.unima.mw or 0887413741. If you are still concerned, you think your complaint has not been addressed to your satisfaction or you feel that you cannot approach the Principal Investigator, please contact the Postgraduate Research Director responsible for this project, Dr. Winifred Eboh at: w.eboh@essex.ac.uk . If you are still not satisfied, please feel free to contact the University's Research Governance and Planning Manager, Sarah Manning-Press at: sarahm@essex.ac.uk and the Chairperson of the National Committee on Research in the Social Sciences and Humanities (NCRSH) at ncrsh@ncst.mw

Name of the Researcher/Research Team Members

If you want to know more about the research, please contact the research team. I (Lucia Collen) the researcher, can be contacted on: lc19116@essex.ac.uk or lcollen@kcn.unima.mw or 0887413741. You can also contact my supervisors Professor Gill Green and Dr. Lindsey Nicholls in the School of Health and Social Care on gillgr@essex.ac.uk, lindsey.nicholls@essex.ac.uk respectively.

Thank you for taking your time to read this study information sheet.

Appendix 4b (ii) Participant information sheet for adult females– chichewa version – Kalata ya uthenga kwa amayi ndi agogo, mu Kafukufukuyi, ofuna kuwona momwe zokambirana zokhudza nkhani za kuchipinda komanso uchembere wabwino zimayendera pakati pa atsikana, amayi ndi agogo ku mudzi

Mau oyamba

Ine dzina langa ndi Lucia Collen, m'modzi mwaophunzira ku sukulu ya zaumoyo ya Essex ku Mangalande, ku Ulaya, koma ndinakulira ku mudzi konkuno mwa amfumu a Mpulula. Pakali pano ndikukhala ku Lilongwe, komwe ndikugwira ntchito, Ngati mbali imodzi ya maphunziro anga, ndikupanga kafukufukuyi ofuna kuwona momwe zokambirana zokhudza nkhani za kuchipinda komanso uchembere wabwino zimayendera pakati pa atsikana, amayi ndi agogo ku mudzi. Komanso kugwira nanu ntchito pofuna kutukula uchembere wabwino pakati pa atsikana ndi amayi. Kafukufukuyi waunikiridwa bwino lomwe ndi bungwe lowona za ufulu wachibadwidwe wa anthu otenga mbali mukafukufuku la sukulu ya ukachenjede ya za umoyo ndi chikhalidwe ya Essex ku Mangalande, ku Ulaya, komanso bungwe loyang'anira kafukufuku wokhudza za chikhalidwe kwathu komkuno.

Muli kupemphedwa kutenga mbali mu kafukufukuyi, wofuna kuwona momwe zokambirana zokhudza nkhani za kuchipinda komanso uchembere wabwino zimayendera pakati pa atsikana, amayi ndi agogo ku mudzi. Koma musanaganize zotenga mbali, mukupemphedwa kuwerenga uthenga uli mu kalatayi. Zimenezi zidzakuthandizani kuti mudziwe cholinga cha kafukufukuyi, komanso kutenga mbali mukafukufukuyi zikuthanthauzanji.

Kodi cholinga cha kafukufukuyi ndichiti?

Cholinga chake ndikufuna kudziwa momwe zokambirana zokhudza nkhani za kuchipinda komanso uchembere wabwino zimayendera pakati pa amayi ndi atsikana, agogo ndi atsikana, komanso ndi anamkugwi aku mudzi ndiku tchalichi komwe. Ndikufunanso kudziwa m'mene atsikanawa anazidziwira, nkhani zogonana, komanso za udindo wawo ngati amayi a mtsogolo. Komanso kugwira nanu ntchito pofuna kutukula uchembere wabwino pakati pa atsikana ndi amayi.

Chifukwa chiyani ndapemphedwa kulowa mu kafukufukuyi?

Mwapemphedwa kutenga mbali mukafukufukuyi, chifukwa mukudziwapo zina ndi zina zokhudza nkhani za kuchipinda komanso uchembere wabwino. Ndiye ndimapempha, kuti ngati nkotheka mulowe mu kafukufukuyi, yemwe ndikupanga ngati mbali imodzi ya maphunziro anga azaumoyo. Kutenga mbali kwanu mukafukufukuyi zidzathandiza kuti, ndidziwe zinthu zimene zikuyenda bwino, kapena zimene zikufooka pa nkhani za kuchipinda komanso uchembere wabwino. Komanso zidzathandiza kuti mawu anu amveke kutali, komanso kupeza njira za tsopano zotukulila uchembere wabwino pakati pa achinyamata.

Choncho, ndidzathokoza kwambiri ngati mungapeze mpata wocheza nane kuti tidzagawane maganizo pa zam'mene macheza a nkhani za kuchipinda komanso uchembere wabwino zimayendera m'mudzi muno. Ndimapemphanso ngati nkotheka ndidzajambule mawu pa nthawi yonse imene tidzakhale tikucheza. Pafupifupi amayi anayi komanso agogo anayi adzapemphedwa kutenga mbali mu macheza amenewa.

Kodi ndine wokakamizidwa kulowa mukafukufukuyi?
Ayi, kutenga nawo mbali mukafukufukuyi ndikodzipereka. Ndiponso simuli wokakamizidwa kutero. Ngati mutaganiza kuti musatenge mbali mukafukukufuyi, maganizo anu adzalemekezedwa. Mungathenso kusiya kutenga mbali nthawi iliyonse popanda kupereka chifukwa chimene mwatichira zimenezo, ndipo sipadzakhala chovuta chilichonse. Koma musanaganize zotenga mbali, pafunika kuti mudziwe cholinga cha kafukufukuyi, komanso kutenga mbali mukafukufukuyi zikuthanthauzanji kwa inu. Chonde werengani uthenga uli mu kalatayi mosamala, komanso mutha kukambirana ndi anzanu ngati mungakonde. Ngati muli ndi funso lililonse, kapena pena pake simunamvetsetse, kapenanso mukufuna kumva zambiri zakafukufukuyi, chonde nditchayireni lamya pa nambala iyi 0887413741

Kodi pali kuopsya kwanji polowa mu kafukufukuyi?
Kafukufukuyi alibe zoopsya zeni zeni. Kungoti mwina mukhoza kudzasowa mtendere, chifukwa nkutheka kuti zokambiranazi zikhoza kukumbutsani zomwe zinakuchitikirani, komanso zinali zodandaulitsa. Zimenezi zikadzachitika mudzalandira chithandizo choyenera. Mudzafunsidwa ngati mungakonde kupitiriza ndi zokambiranazo, kapena ayi. Mukadzasankha kusiya, sipadzakhala chovuta chilichonse.

Kodi pali phindu lanji polowa mu kafukufukuyi?
Ndisalonjeze pano kuti inu mudzapeza phindu lililonse ngati mutaganiza kulowa mu kafukufukuyi, koma zotsatira zake zidzathandiza kupeza njira zopititsira pa tsogolo uchembere wabwino.

Kodi ndi uthenga wanji umene mukufuna kutolera?
Uthenga umene ndikufuna kutolera ndi wokhudza zimene munakumana nazo, komanso maganizo anu pa momwe zokambirana zokhuza nkhani za ku chipinda komanso uchembere wabwino zimachitikira m'mudzi muno. Komanso kumva maganizo anu pa khumbo lofuna kugwiritsa ntchito chikhalidwe ndi miyambo yathu potukula uchembere wabwino pakati pa achinyamata.

Kodi chinsinsi changa chidzasungidwa?
Chinsinsi chanu chidzasungidwa mu nthawi yonse ya kafukufukuyi. Zimenezi zidzachitika poonetsetsa kuti zokambirana zonse zikuchitikira pa malo a chinsinsi, kutali ndi anthu ena. Komanso zonse zimene mudzayankhule zidzasungidwa mwachinsinsi pogwiritsa nchito manambala ndi mayina opeka, osati mayina anu eni eni. Zimenezi zikutanthauza kuti palibe adzaziwe kuti izi zinayankhulidwa ndi wakuti wakuti. Ngakhale kuti ena adzaziwa kuti inuyo mwatenga mbali mu kafukufukuyi. Mayina eni eni adzagwiritsidwa ntchito pokha pokhapo ngati mwatenga mbali pokonza ndondomeko zothandiza kutukula uchembere wabwino m'mudzi muno. Zikalata ndi zojambula zonse zidzasungidwa mwachinsinsi kwa zaka zisanu zisanang'ambidwe ndikuotchedwa, mogwirizana ndi malamulo a kafukufuku a sukulu ya ukachenjede ya za umoyo ndi chikhalidwe ya Essex ku Mangalande, ku Ulaya.

Kodi ndingatani, kuti ndilowe mu kafukufukuyi?
Ngati mwasangalatsidwa kutenga mbali mukafukufukuyi, mudzapemphedwa kuti musayinire kapena kudinda ndi chala kutsimikiza kuti mwamvetsetsa za uthenga wokhuza kafukufukuyi, ndipo mwavomera kutenga mbali. Kenako ndidzakufunsani mafunso wokhuza zimene munakumana nazo, komanso maganizo anu pa momwe zokambirana zokhuza nkhani za ku chipinda komanso uchembere wabwino zimachitikira m'mudzi muno. Ndidzakhalanso ndikujambula zokambirana zathuzi zimene zidzatitengere mphindi zosachepera makumi anayi ndi asanu (45 minutes) komanso osapitilira makumi asanu ndi mphambu zinayi (90 minutes). Machezawa adzachitika pa nthawi ndi malo malingana ndikukonda kwanu. Ngati mukufuna kumva zambiri zakafukufukuyi, mungathe

kunditchayira lamya pa nambala iyi 0887413741 kapenanso kutumiza uthenga pa makina a intaneti (internet) pa lcollen@kcn.unima.mw kapena lc19116@essex.ac.uk. Kapenanso aphunzitsi anga awa Porofesa Gill Green kapena dokotala Lindsey Nicholls, pa makina aintaneti (internet) awa gillgr@essex.ac.uk, lindsey.nicholls@essex.ac.uk.

Kodi zotsatira za kafukufukuyi zidzayenda bwanji?
Zotsatira za kafukufukuyi, zidzalembedwa m'mabuku ndi kusiyidwa ku malo owerengera (library) a ku sukulu ya Essex ku Mangalande, komanso kwathu konkuno, ku sukulu ya Anamwino ndi Azamba ya Kamuzu. Inunso, kuphatikizanso anthu ena ogwira ntchito ya za umoyo adzakhala ndi mwayi omva zotsatira zakafufukuyi, kudzera mu misonkhano yosiyana siyana, komanso mu zolembalemba.

Kodi kafukufukuyi akuthandizidwa ndi ndani?
Kafukufukuyi akupangidwa ngati mbali imodzi ya maphunziro anga, motero palibe bungwe limene lathandizapo pa kafukufukuyi.

Kodi awunikira kafukufukuyi ndindani?
Kafukufukuyi waunikiridwa bwino lomwe ndi bungwe loona za ufulu wachibadwidwe wa anthu otenga nawo mbali mu kafukufuku la sukulu ya ukachenjede ya za umoyo ndi chikhalidwe ya Essex ku Mangalande, ku Ulaya, komanso bungwe loyang'anira kafukufuku wokhuza za chikhalidwe kwathu komkuno. Koma ine (Lucia Collen) ndi amene ndidzatenge chilolezo kwa onse olowa mu kafukufukuyi.

Kodi ndingatani nditakhala ndi mafunso kapena madandaulo okhudzana ndi kafukufukuyi?

Mutakhala ndi mafunso kapena madandaulo okhudzana kafukufukuyi, muli womasuka kulumikizana ndi mayi Lucia Collen pa nambala iyi: 0887413741, kapena pa uthenga wa pa intaneti (email) pa keyala iyi: lcollen@kcn.unima.mw kapena lc19116@essex.ac.uk. Koma mutawona kuti simunakhutitsidwe ndim'mene mwathandizidwira, muli ndi ufulu wokatula nkhawa zanu kwa akulu a kafukufukuyi dokotala Winifred Eboh pa keyala iyi: w.eboh@essex.ac.uk. Ngati simunakhutitsidwebe muli ndi ufulu wokatula nkhawa zanu kwa a pampando a bungwe loyang'anira za ufulu wa anthu otenga nawo mbali mukafukufuku a Sarah Manning-Press pa keyala iyi:sarahm@essex.ac.uk kapena a pampando a bungwe loyang'anira kafukufuku wokhuza za chikhalidwe kwathu komkuno pa keyala iyi ncrsh@ncst.mw

Ndindani akuyendetsa kafukufukuyi
Ngati mukufuna kumva zambiri za kafukufukuyi, chonde lumikizanani ndi anthu awa, powatchayira lamya kapena potumiza uthenga pa makina aintaneti (internet). Mayi Lucia Collen pa nambala iyi: 0887413741, kapena pa uthenga wa pa intaneti (email) pa keyala iyi: lcollen@kcn.unima.mw kapena lc19116@essex.ac.uk. Kapenanso aphunzitsi anga awa a Porofesa Gill Green kapena a dokotala Lindsey Nicholls, pa makina a intaneti (internet) awa gillgr@essex.ac.uk, lindsey.nicholls@essex.ac.uk.

Zikomo potenga nthawi yanu kuwerenga uthengawu

Appendix 4c (i) Participant information sheet for traditional and religious counsellors

''An Ethnographic and Participatory Action Research on intergenerational sexual and reproductive health communication in rural Balaka''

Introduction and an invitation to participants

I am Lucia Collen, a Public Health Trainee in the School of Health and Social Care at Essex University, United Kingdom. I grew up at Mpulula Village, Balaka District, but am currently living and working in Lilongwe. As part of my training, I am carrying out this study to understand how sexual and reproductive health issues are communicated among girls, mothers and grandmothers in this community and work with them to improve their overall health and wellbeing. The study has been approved by the Universities of Essex and the National Committee on Research in the Social Sciences and Humanities.

I would like to invite you (traditional/religious counsellors) to take part in this research on how people learn about sexual and reproductive health issues. Before you decide whether to take part, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully.

What is the purpose of the study?

I am interested in how sexual and reproductive health issues are communicated from grandmothers and mothers to their daughters, from religious and/or traditional counsellors and from friends. I also want to know how young girls learn about sex and their future roles as women in this community. I also intend to work with women in this community to promote their sexual health and wellbeing.

Why have I been invited to participate?

You have been invited to take part in this study because, you might have been involved in conducting sex education to young women and you might know something about sexual and reproductive health. I am wondering if you could be kind enough to assist me by taking part in this study, which I am doing as a requirement for my studies in Public Health. Your contribution to the study will help me to identify gaps and potentials in the sexual and reproductive health (SRH) communication processes and it will give you a voice. It will also generate new knowledge and skills which could assist in developing women-centred interventions to address young people's SRH needs.

Therefore, I would be very grateful if you could take part in a group discussion on sex education for young people in this community. I would also like to observe you, as you counsel young women on sexual and reproductive health issues.

If you do not mind, I would also like to audio-record all the conversations made, and to take notes while you counsel the young women. Twelve – sixteen counsellors will be invited to take part in this study.

Do I have to take part?

No. Participation in this study is voluntary and there is no obligation to take part. If you wish not to take part, your decision will be respected. You are free to withdraw at any time, without giving a reason. This will not affect you in any way. Before you decide whether to take part, it is important for you to understand why the research is being done and what participation in the study will involve for you. Please take time to read the information sheet carefully or discuss it with others if you wish. If you have any question or you need some clarification or would like more information, please contact me on this number 0887413741.

What are the possible disadvantages and risks of taking part?

There are no known risks associated with taking part in this study, only that you may find some of the content of the discussions to be personal and could trigger unpleasant memories. If it occurs, you will be provided with the necessary support. You will also be asked if you wish to stop or proceed with the interview and if you opt to leave this will not affect you in any way.

What are the possible benefits of taking part?

I cannot promise that the study will help you personally. However, the knowledge generated from this study will help to develop sexual and reproductive health improvement interventions and to improve SRH communication among young people, mothers, and grandmothers.

What information will be collected?

The information to be collected will include your experiences and views on the sex education which takes place in this community, as well as your views on the potential of using indigenous knowledge and skills to promote sexual health and wellbeing of young people.

Will my information be kept confidential?

Privacy and confidentiality will be maintained throughout the research period. This will be done by making sure that discussions are conducted at a quiet place, away from other people and that all the data collected are not open to other people, other than the researcher herself and the research supervisors. After each discussion and observation, all information will be stored anonymously, which means no body will know who said what. Of course, some people in the village will know that you have taken part in this study. No names of participants will be indicated on research tools, field notes or the audio records, instead pseudo names will be used to maintain anonymity and confidentiality.

The responses you provide will be treated in confidence. No identifying information will appear in any document or in the final report. Unless, you are involved in the project and you want to be acknowledged. Your rights are protected under the UK Data Protection Act of 1998 and any information that might identify you will not be shared outside the research team. After the dissertation has been examined, hard copies of the research material will be kept for a period of five years before being destroyed, and recordings being erased.

What is the legal basis for using the data and who is the Data Controller?

Ethical and legal practice will be followed in data collection, analysis, and use. Clearance to conduct the study will be sought from the University of Essex Research and Ethics Committee and the National Committee on Research in the Social Sciences and Humanities. The collected data will be controlled by the University of Essex through the office of the University Information Assurance Manager (Sara Stock) on dpo@essex.ac.uk.

What should I do if I want to take part?

If you are interested in taking part, you will be asked to complete and sign or put a thumb print on the enclosed consent form. Then you will be asked to take part in a discussion, where your views and experiences on young women's sex education will be shared. I (Lucia Collen) will be the one facilitating the discussion which will be audio recorded. The discussion will last for 60 – 120 minutes and will take place at a convenient time and place for you. You will also be observed as you counsel young women on sexual and reproductive health issues, and I will be taking notes on the same. If you would like to find out more about the research before taking part, please do not hesitate to contact the research team, Lucia Collen at: lc19116@essex.ac.uk or lcollen@kcn.unima.mw or 0887413741 or my supervisors Professor Gill Green and Dr. Lindsey Nicholls, on gillgr@essex.ac.uk, lindsey.nicholls@essex.ac.uk respectively.

What will happen to the results of the research study?

The data will be analysed and made available to a range of people, including myself (Lucia Collen), yourself, (if interested) health professionals and researchers through written reports, presentations, and journal publications. Copies of the dissertation will be submitted to the universities of Essex and Malawi. However, it will not be possible to identify any individual participant from these reports or publications.

Who is organising and funding the research?

This research is part of a Programme of study to fulfil the requirements of PhD Dissertation (18106358) and therefore it has no funding attached.

Who has reviewed the study?

This study has been reviewed and given ethical approval by University of Essex Research and Ethics Committee and the National Committee on Research in the Social Sciences and Humanities. Consent to take part in the study will be obtained by myself (Lucia Collen).

Concerns and Complaints

If you have any concerns about any aspect of the study or you have a complaint, please feel free to ask me Lucia Collen at: lc19116@essex.ac.uk or lcollen@kcn.unima.mw or 0887413741. If you are still concerned, you think your complaint has not been addressed to your satisfaction or you feel that you cannot approach the Principal Investigator, please contact the Postgraduate Research Director responsible for this project, Dr. Winifred Eboh at: w.eboh@essex.ac.uk . If you are still not satisfied, please feel free to contact the University's Research Governance and Planning Manager, Sarah Manning-Press at: sarahm@essex.ac.uk.

Name of the Researcher/Research Team Members

If you want to know more about the research, please contact the research team. I (Lucia Collen) the researcher, can be contacted on: lc19116@essex.ac.uk or lcollen@kcn.unima.mw or 0887413741. You can also contact my supervisors Professor Gill Green and Dr. Lindsey Nicholls in the School of Health and Social Care on gillgr@essex.ac.uk, lindsey.nicholls@essex.ac.uk respectively.

Thank you for taking your time to read this study information sheet.

Appendix 4c (ii) Participant information sheet for traditional and religious counsellors – chichewa version – Kalata ya uthenga wa kafukufuku kwa anamkungwi a ku mudzi ndi ku tchalichi, ofuna kuwona momwe zokambirana zokhudza nkhani za kuchipinda komanso uchembere wabwino m'mene zimayendera pakati pa atsikana, amayi ndi agogo ku mudzi

Mau oyamba ndi malonje

Ine dzina langa ndi Lucia Collen, m'modzi mwa ophunzira ku sukulu ya zaumoyo ndi chikhalidwe ya Essex ku Mangalande, ku Ulaya. koma ndinakulira ku mudzi konkuno mwa amfumu a Mpululа. Pakali pano ndimakhala ku Lilongwe, komwe ndikugwira ntchito. Ngati mbali imodzi ya maphunziro anga, ndikupanga kafukufuku ofuna kuwona momwe zokambirana zokhudza nkhani za kuchipinda komanso uchembere wabwino zimayendera pakati pa atsikana, amayi ndi agogo ku mudzi. Komanso kugwira nanu ntchito pofuna kutukula uchembere wabwino pakati pa atsikana ndi amayi. Kafukufukuyi waunikiridwa bwino lomwe ndi bungwe lowona za ufulu wachibadwidwe wa anthu otenga mbali mukafukufuku la sukulu ya ukachenjede ya za umoyo ndi chikhalidwe ya Essex ku Mangalande, ku Ulaya, komanso bungwe loyang'anira kafukufuku wokhudza za chikhalidwe kwathu komkuno.

Muli kupemphedwa kutenga mbali mu kafukufukuyi, wofuna kuwona momwe zokambirana zokhudza nkhani za kuchipinda komanso uchembere wabwino zimayendera pakati pa atsikana, amayi ndi agogo ku mudzi. Koma musanaganize zotenga mbali, mukupemphedwa kuwerenga uthenga uli mu kalatayi. Zimenezi zidzakuthandizani kuti mudziwe cholinga cha kafukufukuyi, komanso kulowa mukafukufukuyi zikuthanthauzanji.

Kodi cholinga cha kafukufukuyi ndichiti?

Cholinga chake ndikufuna kudziwa momwe zokambirana zokhudza nkhani za kuchipinda komanso uchembere wabwino zimayendera pakati pa amayi ndi atsikana, agogo ndi atsikana, komanso ndi anamkugwi aku mudzi ndiku tchalichi komwe. Ndikufunanso kudziwa m'mene atsikanawa anazidziwira, nkhani zogonana, komanso za udindo wawo ngati amayi a mtsogolo. Komanso kugwira nanu ntchito pofuna kutukula uchembere wabwino pakati pa atsikana ndi amayi.

Chufukwa chiyani ndapemphedwa kulowa mu kafukufukuyi?

Mwapemphedwa kutenga mbali mukafukufukuyi, chifukwa mukudziwapo zina ndi zina zokhudza nkhani za kuchipinda komanso uchembere wabwino. Ndiye ndimapempha, ngati nkotheka mulowe kafukufukuyi, yemwe ndikupanga ngati mbali imodzi ya maphunziro anga aza umoyo. Kutenga mbali kwanu mukafufukuyi zidzathandiza kuti, ndidziwe zimene zikuyenda bwino, komanso zimene zikufooka pa nkhani za kuchipinda ndi uchembere wabwino.

Zidzathandizanso kuti mawu anu amveke kutali, komanso kupeza njira za tsopano zotukulila uchembere wabwino pakati pa achinyamata. Choncho, ndidzathokoza kwambiri ngati mungapeze mpata ndikutenga nawo mbali mu zokambiranazi, zokhudza uphungu womwe atsikana amalandira pa nkhani za kuchipinda komanso uchembere wabwino. Ndimapemphanso ngati nkotheka ndikhale nanu ndikuwonenerera mwambo wophunzitsa atsikana nkhani za kuchipinda komanso uchembere wabwino. Ndimapemphanso kuti ngati nkotheka ndidzajambule mawu, komanso kulemba zochitikazo. Anankungwi a pakati pa khumi ndi awiri – mpaka asanu ndi m'modzi (twelve – sixteen) adzapemphedwa kutenga mbali mu macheza amenewa.

Kodi ndine wokakamizidwa kulowa mukafukufukuyi?

Ayi, kutenga mbali mukafukufukuyi ndikodzipereka. Ndiponso simuli wokakamizidwa kutero. Ngati mutaganiza kuti musatenge nawo mbali mukafufukufuyi, maganizo anu adzalemekezedwa. Mungathenso kusiya kutenga mbali nthawi iliyonse popanda kupereka chifukwa chimene mwatichira zimenezo, ndipo sipadzakhala chovuta chilichonse. Koma musanaganizire zotenga mbali, pafunika kuti mudziwe cholinga cha kafukufukuyi, komanso kutenga mbali mukafukufukuyi zikuthanthauzanji. Chonde werengani uthenga uli mu kalatayi mosamala, komanso mutha kukambirana ndi anzanu ngati mungafune. Ngati muli ndi funso lililonse, kapena pena pake simunamvetsetse, kapenanso mukufuna kumva zambiri zakafukufukuyi, chonde nditchayireni lamya pa nambala iyi 0887413741.

Kodi pali kuopsya kwanji polowa mu kafukufukuyi?

Kafukufukuyi alibe zoopsya zeni zeni. Kungoti mwina mukhoza kudzasowa mtendere, chifukwa nkutheka kuti zokambiranazi zikhoza kukumbutsani zomwe zinakuchitikirani, komanso zinali zodandaulitsa. Zimenezi zikadzachitika mudzalandira chithandizo choyenera. Mudzafunsidwa ngati mungakonde kupitiriza ndi zokambiranazo, kapena ayi. Mukadzasankha kusiya, sipadzakhala chovuta chilichonse.

Kodi pali phindu lanji polowa mu kafukufukuyi?

Ndisalonjeze pano kuti inu mudzapeza phindu lililonse ngati mutaganiza kulowa nawo mu kafukufuku ameneyi, koma zotsatira zake zidzathandiza kupeza njira zopititsira pa tsogolo nkhani za uchembere wabwino.

Kodi ndi uthenga wanji umene mukufuna kutolera?

Uthenga umene ndikufuna kutolera ndi wokhudza zimene munakumana nazo, komanso maganizo anu pa momwe zokambirana zokhudza nkhani za ku chipinda komanso uchembere wabwino zimachitikira m'mudzi muno. Komanso kumva maganizo ano pa khumbo lofuna kugwiritsa ntchito chikhalidwe ndi miyambo yathu potukula uchembere wabwino pakati pa achinyamata.

Kodi chinsinsi changa chidzasungidwa?

Chinsinsi chanu chidzasungidwa mu nthawi yonse ya kafukufukuyi. Zimenezi zidzachitika poonetsetsa kuti zokambirana zonse zikuchitikira pa malo a chinsinsi, kutali ndi anthu ena. Komanso zonse zimene mudzayankhule zidzasungidwa mwachinsinsi pogwiritsa nchito manambala ndi mayina opeka, osati mayina anu eni eni. Zimenezi zikutanthauza kuti palibe adzaziwe kuti izi zinayankhulidwa ndi wakuti wakuti. Ngakhale kuti ena adzaziwa kuti inuyo mwatenga mbali mu kafukufukuyi. Mayina eni eni adzagwiritsidwa ntchito pokha pokhapo ngati mwatenga mbali pokonza ndondomeko zothandiza kutukula uchembere wabwino m'mudzi muno. Zikalata ndi zojambula zonse zidzasungidwa mwachinsinsi kwa zaka zisanu zisanang'ambidwe ndikuotchedwa, mogwirizana ndi malamulo a kafukufuku a sukulu ya ukachenjede ya za umoyo ndi chikhalidwe ya Essex ku Mangalande, ku Ulaya.

Kodi nditani, kuti ndilowe mu kafukufukuyi?

Ngati mwasangalatsidwa kutenga nawo mbali mukafukufukuyi, mudzapemphedwa kuti musayinire kapena kudinda ndi chala kutsikimiza kuti mwamvetsetsa za uthenga wokhudza kafukufukuyi, ndipo mwavomera kulowa mukafukufukuyi. Kenako mudzapemphedwa kutenga nawo mbali mu zokambirana, m'mene mudzakhale ndi mwayi wopereka maganizo anu, pa zimene mumakumana nazo popereka uphungu kwa atsikana pa nkhani za ku chipinda ndi uchembere wabwino m'mudzi muno. Ndidzakhalanso ndikujambula zokambirana zathuzi zimene zidzatitengere mphindi zosachepela makumi asanu ndi mphambu imodzi (60 minutes) komanso osapitilira ma ola awiri (120 minutes). Machezawa adzachitika pa nthawi ndi malo malingana ndikukonda kwanu. Komanso ndidzaonerera m'mene mwambo wopereka uphungu kwa atsikana, pa nkhani za ku chipinda ndi uchembere wabwino umayendera m'mudzi muno. Pa nthawi, imeneyi ndidzakhalanso ndi kulemba zochitikazo. Ngati mukufuna kumva zambiri zakafukufukuyi, mungathe kunditchayira lamya pa nambala iyi 0887413741 kapenanso kutumiza uthenga pa makina aintaneti (internet) pa lcollen@kcn.unima.mw kapena lc19116@essex.ac.uk. Kapenanso aphunzitsi anga awa Porofesa Gill Green kapena dokotala Lindsey Nicholls, pa makina a intaneti (internet) awa gillgr@essex.ac.uk, lindsey.nicholls@essex.ac.uk.

Kodi zotsatira za kafukufukuyi zidzayenda bwanji?

Zotsatira za kafukufukuyi, zidzalembedwa m'mabuku ndi kusiyidwa ku malo owerengera (library) a ku sukulu ya Essex ku Mangalande, komanso kwathu konkuno, ku sukulu ya Anamwino ndi Azamba ya Kamuzu. Inunso, kuphatikizanso anthu ena ogwira ntchito ya za umoyo adzakhala ndi mwayi omva nawo zotsatira zakafufukuyi, kudzera mu misonkhano yosiyana siyana, komanso mu zolembalemba.

Kodi kafukufukuyi akuthandizidwa ndi ndani?

Kafukufukuyi akupangidwa ngati mbali imodzi ya maphunziro anga, motero palibe bungwe limene lathandizapo pa kafukufukuyi.

Kodi awunikira kafukufukuyi ndindani?

Kafukufukuyi waunikiridwa bwino lomwe ndi bungwe lowona za ufulu wachibadwidwe wa anthu otenga mbali mu kafukufuku la sukulu ya ukachenjede ya za umoyo ndi chikhalidwe ya Essex ku Mangalande, ku Ulaya, komanso bungwe loyang'anira kafukufuku wokhuza za chikhalidwe kwathu komkuno. Koma ine (Lucia Collen) ndi amene ndidzatenge chilolezo kwa onse olowa mu kafukufukuyi.

Kodi ndingatani nditakhala ndi mafunso kapena madandaulo okhudzana kafukufukuyi?

Mutakhala ndi mafunso kapena madandaulo okhudza kafukufukuyi, muli womasuka kulumikizana ndi mayi Lucia Collen pa nambala iyi: 0887413741, kapena pa uthenga wa pa intaneti (email) pa keyala iyi: lcollen@kcn.unima.mw kapena lc19116@essex.ac.uk. Koma mutaona kuti simunakhutitsidwe ndim'mene mwathandizidwira, muli ndi ufulu wokatula nkhawa zanu kwa akulu a kafukufukuyi a dokotala Winifred Eboh pa keyala iyi: w.eboh@essex.ac.uk. Ngati simunakhutitsidwebe muli ndi ufulu wokatula nkhawa zanu kwa a pampando a bungwe loyang'anira za ufulu wa anthu otenga mbali mukafukufuku a Sarah Manning-Press pa keyala iyi:sarahm@essex.ac.uk kapena a pampando a bungwe loyang'anira kafukufuku wokhudza za chikhalidwe kwathu komkuno pa keyala iyi ncrsh@ncst.mw

Ndindani akuyendetsa kafukufukuyi

Ngati mukufuna kumva zambiri za kafukufukuyi, chonde lumikizanani ndi anthu awa, powatchayira lamya kapena potumiza uthenga pa makina aintaneti (internet). Mayi Lucia Collen pa nambala iyi: 0887413741, kapena pa uthenga wa pa intaneti (email) pa keyala iyi: lcollen@kcn.unima.mw kapena lc19116@essex.ac.uk. Kapenanso aphunzitsi anga awa a Porofesa Gill Green kapena a dokotala Lindsey Nicholls, pa makina a intaneti (internet) awa gillgr@essex.ac.uk, lindsey.nicholls@essex.ac.uk.

Zikomo potenga nthawi yanu kuwerenga uthenga umenewu

Appendix 5a (i) Consent form for participants 18 years and above

''An Ethnographic and Participatory Action Research on intergenerational sexual and reproductive health communication in rural Balaka''

Please read the statements below and if you agree put your initials or a tick in the box against each statement.

1. I confirm that I have read and understood the information sheet for the above study, and I have had the opportunity to ask questions and they have been answered satisfactorily. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason or my legal rights being affected. ☐
3. I understand that relevant sections of data collected during the study, may be looked at by individuals from the research team and other experts.
   I give permission for these individuals to have access to my records. ☐
4. I understand that my participation will be audio -recorded and analysed, anonymised quotes may be used in publications about the research however, it will not be possible to identify me from this information. I give my permission for this. ☐
5. I understand that the results from this work may be published however, it will not be possible to identify any participant from this. ☐
6. I agree to take part in the above study. ☐

.....	.....	.. ..
Name of Participant	Signature/thumb print	Date
.....	.....	.....
Researcher	Signature	Date

Appendix 5a (ii) Consent form for participants 18 years and above - chichewa version – chilolezo kwa amene akwana zaka khumi ndi zisanu ndi zitatu (18 years) komanso kuposera mu kafukufuku ofuna kuwona momwe zokambirana zokhudza nkhani za kuchipinda ndi uchembere wabwino zimayendera ku mudzi

Chonde werengani mosamala uthenga uli munsiwu, ndipo ngati mukugwirizana nawo chongani mu bokosi lili pa mbali pa uthengawo

1) Ndikutsimikiza kuti ndawerenga ndipo ndamvetsa za uthenga wakafukufukuyi, ndipo anandipatsa mwayi wofunsa mafunso, ndipo ndakhutira ndi mayankho omwe andipatsa ☐

2) Ndamvetsa kuti sindili wokakamizidwa kulowa mukafukufukuyi, ndipo ndili ndi ufulu wosiya nthawi ili yonse osapereka chifukwa ☐

3) Ndamvetsa kuti zigawo zosiyanasiyana za kafukufukuyi, zidzaonedwa ndi gulu limene likupanga kafukufukuyi, komanso akatswiri ena. Ndavomera kuti akhoza kutero. ☐

4) Ndavomereza kuti zokambiranazi zidzajambulidwe, komanso zidzagwiritsidwe ntchito pa zolembalemba zakafukufukuyi. Ndamvetsanso kuti sindidzaziwika ndi dzina langa lenileni ndipo zomwe ndalankhula sizidzadziwika kuti ndalankhula ndi ine. ☐

5) Ndamvetsa kuti zotsatira za kafukufukuyi zidzasindikizidwa, koma padzakhala povuta kuwadziwa anthu amene alowa mu kafukufukuyi. ☐

6) Ndikuvomera kulowa mu kafukufukuyi ☐

.....	.....	.. ..
Dzina la wotenga mbali mukafukufuku	Sayini/chidindo cha chala	Tsiku
.....	.....	.....
Wochita kafukufuku	Sayini	Tsiku

Appendix 5b (i) Consent form to be completed by parents/guardians for 16- and 17-year participants

''An Ethnographic and Participatory Action Research on intergenerational sexual and reproductive health communication in rural Balaka''

Please read the statements below and if you agree that your daughter participates in the study, put your initials or a tick in the box against each statement.

1. I confirm that I have read and understood the information sheet for the above study, and I have had the opportunity to ask questions and they have been answered satisfactorily. ☐

2. I understand that my daughter's participation is voluntary and that I am free to withdraw her at any time without giving any reason or my legal rights and hers being affected. ☐

3. I understand that relevant sections of data collected during the study, may be looked at by individuals from the research team and other experts.
   I give permission for these individuals to have access to my daughter's records. ☐

4. I understand that my daughter's participation will be audio -recorded and analysed, anonymised quotes may be used in publications about the research however, it will not be possible to identify my daughter from this information. I give my permission for this. ☐

5. I understand that the results from this work may be published however, it will not be possible to identify any participant from this. ☐

6. I agree for my daughter to take part in the above study. ☐

.....	.....	.. ..
Name of parent/guardian	Signature/thumb print	Date
.....	.....	.....
Researcher	Signature	Date

Appendix 5b (ii) Consent form to be completed by parents/guardians for 16- and 17-year participants - chichewa version – chilolezo chochokera kwa makolo cha atsikana zaka khumi ndi zisanu ndi chimodzi ndi khumi ndi zisanu ndi ziwiri (16 and 17 years) mu kafukufuku ofuna kuwona momwe zokambirana zokhudza nkhani za kuchipinda ndi uchembere wabwino zimayendera ku mudzi

Chonde werengani mosamala uthenga uli munsiwu, ndipo ngati mukuvomera kuti mwana wanu wa mkazi alowe mukafukufukuyi chongani mu bokosi lili pa mbali pa uthengawo

1) Ndikutsimikiza kuti ndawerenga ndipo ndamvetsetseta za uthenga wakafukufukuyi, ndipo anandinapatsa mwayi wofunsa mafunso, ndipo ndakhutira ndi mayankho omwe andipatsa. ☐

2) Ndamvetsa kuti mwana wanga siwokakamizidwa kulowa mukafukufukuyi, ndipo ndili ndi ufulu womusiyitsa nthawi ili yonse osapereka chifukwa. ☐

3) Ndamvetsa kuti zigawo zosiyanasiyana za kafukufukuyi, zidzaonedwa ndi gulu limene likupanga kafukufukuyi, komanso akatswiri ena. Ndavomera kuti akhoza kutero.
. ☐

4) Ndavomereza kuti mwana wanga akalowa mukafukufukuyi, zokambiranazo zidzajambulidwe. Komanso kuti zoyankhulidwazi zidzagwiritsidwe ntchito pa zolembalemba zakafukufukuyi. Ndamvetsanso kuti dzina lopeka lidzagwiritsidwa ntchito mukafukufukuyi, motero kudzakhala kovuta kudziwa kuti izi analankhula ndi mwana wanga. ☐

5) Ndamvetsa kuti zotsatira za kafukufukuyi zidzasindikizidwa m'mabuku koma padzakhala povuta kuwadziwa amene analowa mu kafukufukuyi. ☐

6) Ndikuvomera kuti mwana wanga alowe mu kafukufukuyi ☐

.....	.....	.....
Dzina la kholo la mwana	Sayini/chidindo cha chala	Tsiku
.....	.....	.....
Wochita kafukufuku	Sayini	Tsiku

Appendix 5c (i) Assent form for 16- and 17-year participants

''An Ethnographic and Participatory Action Research on intergenerational sexual and reproductive health communication in rural Balaka''

I have read or have had another person read the information to me and have understood the content of the information. I have also understood the aim of the research, what is expected of me and the expected duration of my participation. I have been given an opportunity to ask questions about the study where necessary. I understand that the information I will give will be kept confidential and will only be accessed by the researcher and those people who are directly concerned with the study. I understand that I will not have any direct benefits for taking part in the study however, the knowledge generated will help to develop sexual and reproductive health improvement interventions and to improve SRH communication among young people, mothers and grandmothers.

I understand that my participation will be audio -recorded may be used in publications about the research and it will not be possible to identify me from this information. I also know where to complain if my rights are violated during the study. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason or my legal rights being affected. I also know that my parents/guardians know about this study and my participation.

I voluntarily agree to take part in this study.

.....	.....	.. ..
Name of Participant	Signature/thumb print	Date
.....	.....	.....
Researcher	Signature	Date

Appendix 5c (ii) Assent form for 16- and 17-year participants - chichewa version – Kalata ya atsikana zaka khumi ndi zisanu ndi chimodzi ndi khumi ndi zisanu ndi ziwiri (16 and 17 years) yovomereza kulowa mu kafukufuku ofuna kuwona momwe zokambirana zokhudza nkhani za ku chipinda ndi uchembere wabwino zikuyendera ku mudzi.

Appendix 5c (ii) Assent form for 16- and 17-year participants - chichewa version – Kalata ya atsikana zaka khumi ndi zisanu ndi chimodzi ndi khumi ndi zisanu ndi ziwiri (16 and 17 years) yovomereza kulowa mu kafukufuku ofuna kuwona momwe zokambirana zokhudza nkhani za ku chipinda ndi uchembere wabwino zikuyendera ku mudzi

Ndawerenga kapena andiwerengera uthenga wakafukufukuyi ndipo ndamvetsa. Komanso ndamvetsa cholinga cha kafukufukuyi, ndi zimene ndapemphedwa kuchita, komanso nthawi yimene ndidzakhale ndikutenga mbali mukafukufukuyi. Ndapatsidwanso mwayi wofunsa mafunso wokhuza kafukufukuyi pamene panafunika kutero. Ndamvetsanso kuti zonse zimene ndiwafotokozere mukafukufukuyi, zidzasungidwa mwachinsinsi, okhawo akupanga kafukufukuyi ndi amene adzazione. Ndamvetsanso kuti sindidzapeza phindu lililonse polowa mu kafukufukuyi, koma zotsatira zake zidzathandiza kupeza njira zopititsira pa tsogolo uchembere wabwino pakati pa achinyamata.

.

Ndavomereza kuti zokambiranazi zidzajambulidwe, komanso zidzagwiritsidwe ntchito pa zolembalemba zakafukufukuyi. Ndamvetsanso kuti padzakhala povuta kudziwa zimene ndinalankhula. Ndikudziwanso kokadandaula ngati ufulu wanga wachibadwidwe utaphwanyidwa. Ndamvetsanso kuti sindili wokakamizidwa kulowa mukafukufukuyi, ndipo ndili ndi ufulu wosiya nthawi ili yonse osapereka chifukwa. Makolo anga akudziwa za kafukufukuyi, komanso zakulowa kwanga.

Mosakakamizidwa, ndikuvomera kulowa mukafukufuyi

.....	.....	.....
Dzina la wotenga mbali mukafukufuku	Sayini/chidindo cha chala	Tsiku
.....	.....	.....
Wochita kafukufuku	Sayini	Tsiku

Appendix 6a - In-depth interview guide for the young women

Introduction

I will introduce myself and why I am in their community. I will go through the participants information sheet and consent form with her, then ask her to sign or put a thumb print if she agrees. I will also ask her to state her age, religion, education, and marital status.

- What do you do during your free time? Ice breaker
- How did you learn about sex, sexuality, and your future roles as woman? How was your experience?
- How has the sexual and reproductive health counselling, helped you?
- What are your views in relation to the way SRH information is shared in this community?
- In your view what are the factors which promote a talk about SRH between girls and their mothers or grandmothers?
- In your view what are the factors which hinder a talk about SRH between girls and their mothers or grandmothers?
- In your own assessment what are the major sexual and reproductive health challenges young women face in rural areas?
- In your opinion what are the main risk factors that lead to poor sexual and reproductive health of young women in rural communities? (Prompt if necessary, i.e. condoms use, multiple partners, lack of education and access to services)
- In your own assessments what would be the best way of improving SRH communication practices in rural areas?
- In your own views what is the relationship between SRH communication practices and young women's sexual behaviours? (Prompt if necessary, initiation ceremonies)
- What are your views on potentials of using indigenous knowledge and skills to promote sexual health and wellbeing of young women?
- Is there any additional information that you would like to share with me about SRH?
- Do you have any question on what we have discussed?

Thank you for your time and valuable information

Appendix 6b - In-depth interview guide for the young women – Chichewa version – Ndondomeko yofunsira mafunso kwa atsikana a mukafukufuku

Mawu oyamba

Ndidzazifotokoza, komanso chimene chandibweretsa ku mudziko. Kenako tonse pa modzi tidzawerenganso uthenga wa kafukufuku, komanso kalata ya chilolezo. Kenako ndidzamupempha kuti asayinire kapena kuyika chidindo cha chala ngati akugwirizana nazo. Kenako ndidzamupempha kuti anene zaka zake, mpingo wake, pamene anafika nayo sukulu, komanso ngati ali pa banja kapena ayi.

- Mumatani pa nthawi yopuma? Ice breaker
- Munazidziwa bwanji nkhani za kuchipinda, uchembere wabwino, komanso za udindo wanu ngati amayi amtsogolo? Mungafotokozeko m'mene zinayendera?
- Zakuthandizani bwanji zimene munaphunzira nthawi imeneyi?
- Maganizo anu ndi wotani ndi m'mene uthenga wokhuza nkhani za kuchipinda komanso uchembere wa bwino umagawidwa m'mudzi muno?
- Mumaganizo mwanu, ndi zinthu ziti zimene zimathandiza kupititsa pa tsogolo zokambirana zokhuza nkhani za kuchipinda komanso uchembere wa bwino pakati pa atsikana ndi makolo awo kapena ndi agogo awo?
- Mumaganizo mwanu, ndi zinthu ziti zimene zimabwerezetsa mbuyo zokambirana zokhuza nkhani za kuchipinda komanso uchembere wa bwino pakati pa atsikana ndi makolo awo kapena ndi agogo awo?
- Mwakuona kwanu, ndi mavuto anji amene achinyamata aku madera aku midzi amakumana nawo pa nkhani zokhudza za ku chipinda komanso uchembere wa bwino?
- Mwakuganiza kwanu, ndi zinthu ziti zimene zimaika pa chiopsyezo miyoyo ya achinyamata aku madera a ku midzi pa nkhani za ku chipinda komanso uchembere wabwino (Prompt if necessary, i.e. condoms use, multiple partners, lack of education and access to services)
- Mwakuona kwanu, ndi njira ziti zimene zingathandize kupititsa pa tsogolo, zokambirana zokhudza nkhani zaku chipinda komanso uchembere wabwino ku madera a ku midzi?
- Mwakuganiza kwanu, pali ubale wanji, pakati pa miyambo ndi chikhalidwe yokhuza zaku chipinda komanso uchembere wabwino ndi khalidwe la achinyamata pa nkhani zogonana (Prompt if necessary, initiation ceremonies)
- Mungandiuzeko maganizo anu, pa khumbo lofuna kugwiritsa ntchito miyambo ndi chikhalidwe chathu pofuna kutukula miyoyo ya achinyamata pa nkhani za uchembere wabwino
- Ngati muli ndizoonjezera zina zili zonse pa zomwe timakambiranazi mutha kutero tsopano?
- Ngati muli ndi funso pa zomwe takambiranazi mutha kufunsa tsopano?

Zikomo chifukwa cha nthawi yanu ndi mayankho anu

Appendix 7a - In-depth interview guide for an adult female

Appendix 7a - In-depth interview guide for an adult female

Introduction

I will introduce myself and why I am in their community. I will go through the participants information sheet and consent form with her, then ask her to sign or put a thumb print if she agrees. I will also ask her to state her age, religion, education, and marital status.

- How were the rains this year? How many bags of maize did you harvest? Ice breaker
- How did you learn about sex, sexuality, and the roles a woman in a community? How was your experience?
- What are your views in relation to the way SRH information is shared in this community?
- In your view what are the factors which promote a talk about SRH between girls and their mothers or grandmothers?
- In your view what are factors which hinder a talk about SRH between girls and their mothers or grandmothers?
- In your own assessment, what are the main sexual and reproductive health challenges, young women face in rural areas?
- In your opinion what are the major risk factors that lead to poor sexual and reproductive health of young women in rural communities? (Prompt if necessary, i.e. condoms use multiple partners, lack of education and access to services)
- In your own assessment, what would be the best way of improving SRH communication practices in rural areas?
- In your own views what is the relationship between SRH communication practices and young women's sexual behaviours? (Prompt if necessary, initiation ceremonies)
- What are your views on potentials of using indigenous knowledge and skills to promote sexual health and wellbeing of young women?
- Is there any additional information that you would like to share with me about SRH?
- Do you have any question on what we have discussed?

Thank you for your time and valuable information

Appendix 7b - In-depth interview guide for an adult female - Chichewa version – Ndondomeko yofunsira mafunso kwa amayi ndi agogo a mukafukufuku

Appendix 7b - In-depth interview guide for an adult female - Chichewa version – Ndondomeko yofunsira mafunso kwa amayi ndi agogo a mukafukufuku

Mawu oyamba

Ndidzazifotokoza, komanso chomwe chandibweretsa ku mudziko. Kenako tonse pamodzi tidzawerenganso uthenga wa kafukufuku, komanso kalata ya chilolezo. Kenako ndidzawapempha kuti asayinire kapena kuyika chidindo cha chala ngati akugwirizana nazo. Kenako ndidzawapempha kuti anene zaka zawo, mpingo wawo, pamene anafika nayo sukulu, komanso ngati ali pa banja kapena ayi.

- Mvula inali bwanji chaka chino? Mwakolola matumba angati? Ice breaker
- Munazidziwa bwanji nkhani za kuchipinda, uchembere wabwino, komanso za udindo wanu ngati amayi amtsogolo? Mungafotokozeko m'mene zinayendera?
- Maganizo anu ndi wotani ndi m'mene uthenga wokhudza nkhani za kuchipinda komanso uchembere wa bwino umagawidwa m'mudzi muno?
- Mumaganizo mwanu, ndi zinthu ziti zimene zimathandiza kupititsa patsogolo zokambirana zokhudza nkhani za kuchipinda komanso uchembere wa bwino pakati pa atsikana ndi makolo awo kapena ndi agogo awo?
- Mumaganizo mwanu, ndi zinthu ziti zimene zimabwerezetsa mbuyo zokambirana zokhudza nkhani za kuchipinda komanso uchembere wa bwino pakati pa atsikana ndi makolo awo kapena ndi agogo awo?
- Mwakuona kwanu, ndi mavuto anji amene achinyamata aku madera aku midzi amakumana nawo pa nkhani zokhudza za ku chipinda komanso uchembere wa bwino?
- Mwakuganiza kwanu, ndi zinthu ziti zimene zimaika pa chiopsyezo miyoyo ya achinyamata aku madera a ku midzi pa nkhani za ku chipinda komanso uchembere wabwino (Prompt if necessary, i.e. condoms use, multiple partners, lack of education and access to services)
- Mwakuona kwanu, ndi njira ziti zimene zingathandize kupititsa pa tsogolo, zokambirana zokhudza nkhani zaku chipinda komanso uchembere wabwino ku madera a ku midzi?
- Mwakuganiza kwanu, pali ubale wanji, pakati pa miyambo ndi chikhalidwe yokhudza zaku chipinda komanso uchembere wabwino ndi khalidwe la achinyamata pa nkhani za zogonana (Prompt if necessary, initiation ceremonies)
- Mungandiuzeko maganizo anu, pa khumbo lofuna kugwiritsa miyambo ndi chikhalidwe chathu pofuna kutukula miyoyo ya achinyamata pa nkhani za uchembere wabwino
- Ngati muli ndizoonjezera zina zili zonse pa zomwe timakambiranazi mutha kutero tsopano?
- Ngati muli ndi funso pa zomwe takambiranazi mutha kufunsa tsopano?

Zikomo chifukwa cha nthawi yanu ndi mayankho anu

Appendix 8a – Focus group discussion guide for traditional and religious counsellors.

Appendix 8a – Focus group discussion guide for traditional and religious counsellors

Introduction

I will introduce myself and why I am in their community. I will go through the participants information sheet and consent form with them, each member will also be asked to sign or put a thumb print if she agrees. Then I will ask them to introduce themselves by stating their ages, religion, education, and marital statuses. I will also ask them to go through the focus group discussion (FGD) guide and to be free to add or subtract to the list. Then the amended guide will be used during the discussion.

Ice breaker: How were the rains this year? How many bags of maize did you harvest?

I understand being a traditional /religious sexual and reproductive health counsellor is an honour

- ✓ How did you become a traditional/religious counsellor?

From the time you started working as traditional/religious sexual and reproductive health counsellors.

- ✓ How has your work as traditional/religious sexual and reproductive health counsellors been like? (prompt if necessary, challenges and successes).
- ✓ How do you see the future of traditional/religious counsellors in this community? (prompt if necessary, rationales).

Please add to the list……

Is there any additional information that you would like to share with me about SRH?

Thank you for your time and valuable information

Appendix 8b – Focus group discussion guide for traditional and religious counsellors - Chichewa version – Ndondomeko yofunsira mafunso kwa anamkungwi a ku mudzi ndi ku tchalichi

Mawu oyamba

Ndidzazifotokoza, komanso chomwe chandibweretsa ku mudziko. Kenako tonse pamodzi tidzawerenganso uthenga wa kafukufuku, komanso kalata ya chilolezo. Kenako aliyense adzapemphedwa kuti asayinire kapena kuyika chidindo cha chala ngati akugwirizana nazo. Kenako aliyense adzapemphedwa kuti anene zaka zake, mpingo wake, pamene anafika nayo sukulu, komanso ngati ali pa banja kapena ayi. Kenako tonse limodzi tidzawerenga chikalata cha mafunso, ndipo anamkungwiwo adzapemphedwa kuwonjezera kapena kuchotsa mafunso mu chikalatachi. Kenako chikalata cha mafunso chija chidzasinthidwa.

Ice breaker: Mvula inali bwanji chaka chino? Mwakolola matumba angati

Ndikudziwa kuti kukhala namkungwi, ndi ntchito yopambana kwambiri

- ✓ Chinachitika ndi chiyani kuti mukhale anamkungwi?

Kuchokera pa nthawi yimene munayamba ntchito yimeneyi ya unamkungwi kufikira lero.

- ✓ Kodi ntchito yanu yakhala ikuyenda bwanji? (prompt if necessary, challenges and successes).
- ✓ Mukuliwona bwanji tsogolo la ntchito yimeneyi? (prompt if necessary, rationales).

Chonde onjezerani mafunso mu kalatayi……...

Kodi muli ndizoonjezera zina zili zonse pa zomwe timakambiranazi?

Zikomo chifukwa cha nthawi yanu ndi mayankho anu

Appendix 9 - Observational guide for traditional and religious counselling session

Appendix 9 - Observational guide for traditional and religious counselling session

Date……..

Start time…….. Finish time……

Total number of counsellors…… Total number of girls……

Questions to guide the observation

- What is happening in this situation? What is the situation of the girls?
- What is the general condition of the counselling room? How are the people organised? How are they interacting? What are the factors that are facilitating/hindering the discussion?
- What type of behaviours, actions and activities are displayed in this setting? How are the girls responding to the actions and activities?
- What are the verbal and non-verbal cues being displayed by the counsellors as they interact with the girls? Who speaks to who, how and why? What is the conversation about? What is the response of each party? What are the consequences of the conversation?
- How do the counsellors perceive and interpret their actions in the various interactions with the girls? How do the girls perceive and interpret the counsellors' actions?
- What cues are being displayed by the girls during the discussion? How do the counsellors respond to the cues and how do the girls respond to the counsellors' response?
- What circumstances appear to make the girls comfortable or uncomfortable? How are the counsellors responding to the girls and how are the girls responding to the counsellors' response?
- What else is important of this situation?

Thank you for your time and valuable information

Appendix 10- Ethical Clearance Letter from the University of Essex

Decision - Ethics ETH1920-1750: Miss Lucia Collen

E

ERAMS
Fri 22/01/2021 14:21

To:

- Collen, Lucia Y

University of Essex ERAMS

22/01/2021

Miss Lucia Collen

Health and Social Care

University of Essex

Dear Lucia,

Ethics Committee Decision

I am writing to advise you that your research proposal entitled "Understanding intergenerational sexual and reproductive health communication in a rural community Malawi: An Ethnographic Participatory Action study" has been reviewed by the Ethics Committee 2.

The Committee is content to give a favourable ethical opinion of the research. I am pleased, therefore, to tell you that your application has been granted ethical approval b the Committee.

Please do not hesitate to contact me if you require any further information or have any queries.

Yours sincerely,

Beverley Pascoe

Ethics ETH1920-1750: Miss Lucia Collen

Appendix 11 – Ethical Clearance Letter from the National Committee on Research in the Social Sciences and Humanities

NATIONAL COMMISSION FOR SCIENCE & TECHNOLOGY
Lingadzi House
Robert Mugabe Crescent
P/Bag B303
City Centre
Lilongwe
Tel: +265 1 771 550
+265 1 774 189
+265 1 774 869
Fax: +265 1772 431
Email:directorgeneral@ncst.mw
Website:http://www.ncst.mw

NATIONAL COMMITTEE ON RESEARCH IN THE SOCIAL SCIENCES AND HUMANITIES

Ref No: NCST/RTT/2/6 **10th March 2021**

Ms Lucia Collen,

Principal Investigator,

School of Health and Social Care,

University of Essex,

Wivenhoe Park,

Colchester CO4 3SQ.

Email: lcollen@kcn.unima.mw

Dear Ms Collen,

RESEARCH ETHICS AND REGULATORY APPROVAL AND PERMIT FOR PROTOCOL NO. P.02/21/545: AN ETHNOGRAPHIC AND PARTICIPATORY ACTION RESEARCH ON INTERGENERATIONAL SEXUAL AND REPRODUCTIVE HEALTH COMMUNICATION IN RURAL BALAKA

Having satisfied all the relevant ethical and regulatory requirements, I am pleased to inform you that the above referred research protocol has officially been approved. You are now permitted to proceed with its implementation. Should there be any amendments to the approved protocol in the course of implementing it, you shall be required to seek approval of such amendments before implementation of the same.

This approval is valid for one year from the date of issuance of this approval. If the study goes beyond one year, an annual approval for continuation shall be required to be sought from the National

Committee Address:
Secretariat, National Committee on Research in the Social Sciences and Humanities, National Commission for Science and Technology, Lingadzi House, City Centre, P/Bag B303, Capital City, Lilongwe3, Malawi. Telephone Nos: +265 771 550/774 869; E-mail address: ncrsh@ncst.mw

Committee on Research in the Social Sciences and Humanities (NCRSH) in a format that is available at the Secretariat. Once the study is finalised, you are required to furnish the Committee and the Commission with a final report of the study. The committee reserves the right to carry out compliance inspection of this approved protocol at any time as may be deemed by it. As such, you are expected to properly maintain all study documents including consent forms.

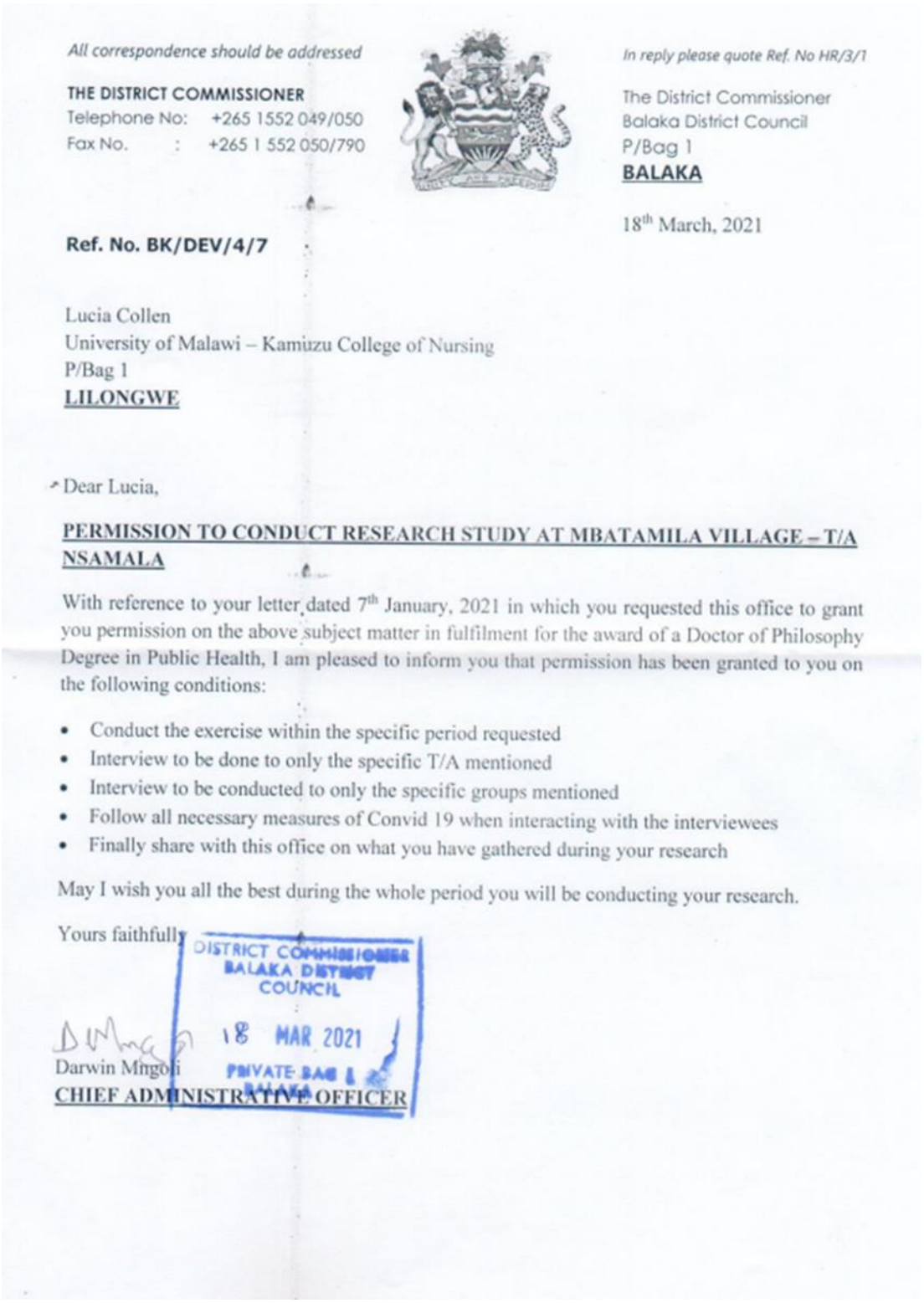
Wishing you a successful implementation of your study.

Yours Sincerely,

Yalonda .I. Mwanza
NCRSH ADMINISTRATOR
HEALTH, SOCIAL SCIENCES AND HUMANITIES DIVISION

For: CHAIRMAN OF NCRSH

Appendix 12 – Approval letter from the District Commissioner



All correspondence should be addressed

THE DISTRICT COMMISSIONER
Telephone No: +265 1552 049/050
Fax No. : +265 1 552 050/790

In reply please quote Ref. No HR/3/1

The District Commissioner
Balaka District Council
P/Bag 1
BALAKA

18th March, 2021

Ref. No. BK/DEV/4/7

Lucia Collen
University of Malawi – Kamuzu College of Nursing
P/Bag 1
LILONGWE

Dear Lucia,

PERMISSION TO CONDUCT RESEARCH STUDY AT MBATAMILA VILLAGE – T/A NSAMALA

With reference to your letter dated 7th January, 2021 in which you requested this office to grant you permission on the above subject matter in fulfilment for the award of a Doctor of Philosophy Degree in Public Health, I am pleased to inform you that permission has been granted to you on the following conditions:

- Conduct the exercise within the specific period requested
- Interview to be done to only the specific T/A mentioned
- Interview to be conducted to only the specific groups mentioned
- Follow all necessary measures of Convid 19 when interacting with the interviewees
- Finally share with this office on what you have gathered during your research

May I wish you all the best during the whole period you will be conducting your research.

Yours faithfully

DISTRICT COMMISSIONER
BALAKA DISTRICT
COUNCIL
18 MAR 2021
PRIVATE BAG 1
BALAKA

Darwin Mngoli
CHIEF ADMINISTRATIVE OFFICER

Appendix 13 - A table demonstrating the relationship of emerging themes and sub-themes.

Category	Theme one	Theme two	Theme three	Theme four	Theme five	Theme six
Young women	Family and Friends	Gender dynamics	Role of traditional practices	Impact of external influences	Preferred indigenous practices	Tension between older & younger generation
	Sub-theme 1. The role of grandmothers	**Sub-theme 1.** Women empowerment	**Sub-theme 1.** Cultural identity	**Sub-theme 1**. Health services		
	Sub-theme 2. The role of counsellors	**Sub-theme 2.** Women disempowerment	**Sub-theme 2.** Taboos reinforce behaviour	**Sub-theme 2.** Police services		
		Sub-theme 3. Gender roles and relations	**Sub-theme 3.** Preparation for motherhood	**Sub-theme 3.** Education services		
		Sub-theme 4. Challenges young women encounter	**Sub-theme 4.** Preparation for family life	**Sub-theme 4.** Urbanisation		
				Sub-theme 5. Religion		
Mothers	The role of grandmothers & counsellors	Gender dynamics	Role of traditional practices	Impact of external influences	Preferred indigenous practices	Tension between older & younger generation
		Sub-theme 1. Gender roles & relations	**Sub-theme 1.** Cultural identity	**Sub-theme 1.** Urbanisation		
		Sub-theme 2. Women empowerment & disempowerment	**Sub-theme 2.** Taboos to reinforce behaviour	**Sub-theme 2.** Religion		
		Sub-theme 3. Challenges among young women	**Sub-theme 3.** Preparation for family life	**Sub-theme 3.** Western medicine		
		Sub-theme 4. Ways to reduce challenges	**Sub-theme 4.** Preparation for motherhood			

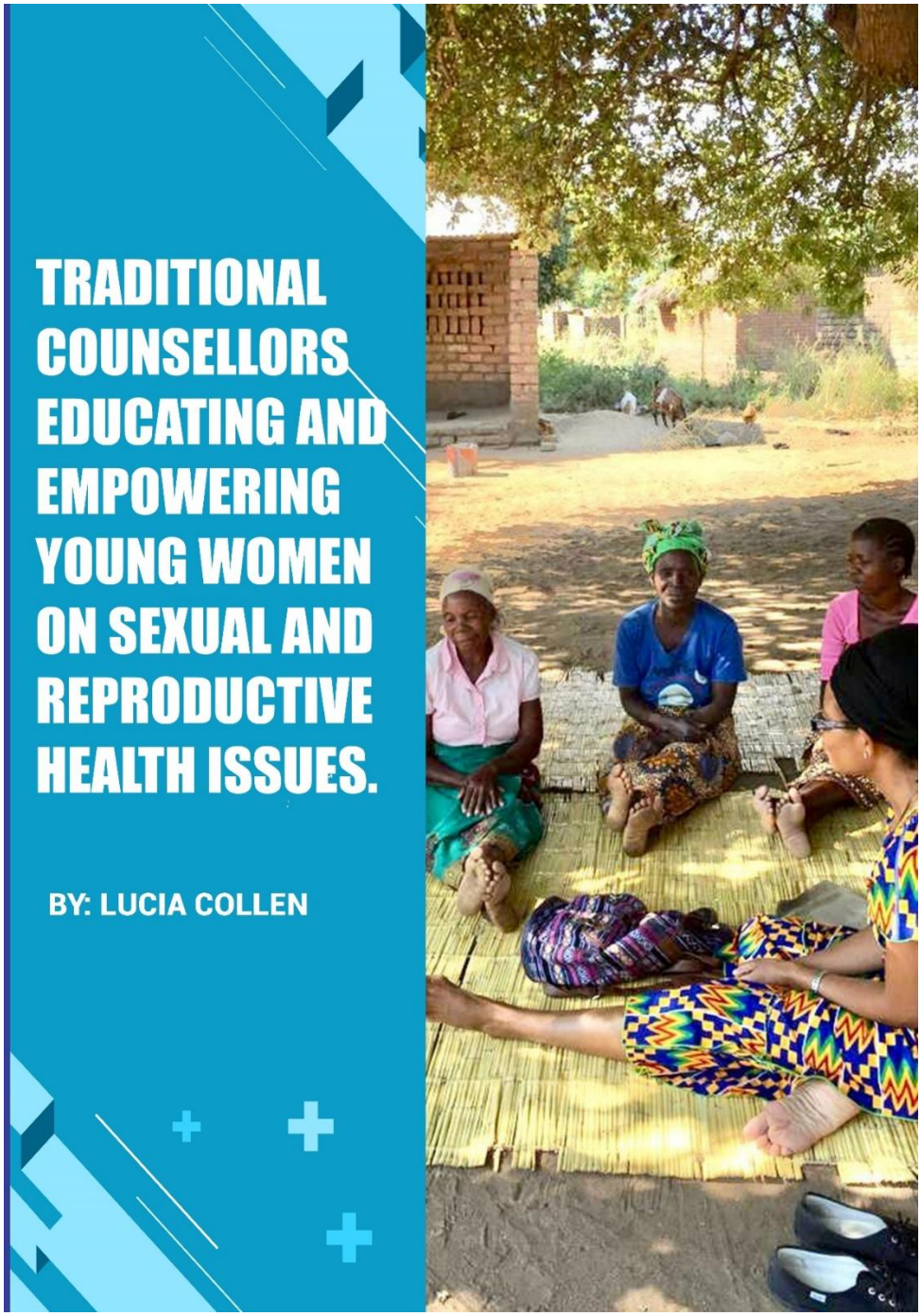
Grandmothers	Family and Friends	Gender dynamics	Role of traditional practices	Impact of external influences		
	Sub-theme 1. The role of grandmothers	**Sub-theme 1.** Gender roles & relations	**Sub-theme 1.** Cultural identity	**Sub-theme 1.** Urbanisation		
	Sub-theme 2. The role of counsellors	**Sub-theme 2.** Women empowerment & disempowerment	**Sub-theme 2.** Cultural taboos	**Sub-theme 2.** Religion		
			Sub-theme 3. Preparation for family life	**Sub-theme 3.** Western medicine		
			Sub-theme 4. Preparation for motherhood			
			Sub-theme 5. Preferred cultural practices			

Traditional counsellors	Family and Friends	Gender dynamics	Role of traditional practices	Impact of colonisation	Tension between older & younger generation	
	Sub-theme 1. The role of family	**Sub-theme 1.** Gender roles & relations	**Sub-theme 1.** Personal & societal identity	**Sub-theme 1.** Urbanisation	**Sub-theme 1.** Tension related to contraceptives	
	Sub-theme 2. The Role of counsellors	**Sub-theme 2.** Women empowerment	**Sub-theme 2.** Preparation for marriage	**Sub-theme 2.** Western medicine	**Sub-theme 2.** Tension related to Postnatal abstinence	
		Sub-theme 3. Women disempowerment	**Sub-theme 3.** Preparation for motherhood		**Sub-theme 3.** Tension related to traditional sanitary pads	
			Sub-theme 4. Cultural taboos		**Sub-theme 4.** Non-specific Tension	

Religious counsellors	Family and Friends	Gender dynamics	Role of traditional practices	Impact of colonisation	Tension between older & younger generation	
	Sub-theme 1. The role of family	**Sub-theme 1.** Gender roles & relations	**Sub-theme 1.** Personal & societal identity	**Sub-theme 1.** Urbanisation		
	Sub-theme 2. The Role of counsellors	**Sub-theme 2.** Women empowerment	**Sub-theme 2.** Cultural expectations	**Sub-theme 2.** Western medicine		
			Sub-theme 3. Preparation for marriage	**Sub-theme 3.** Religion		
			Sub-theme 4. Preparation for motherhood			
			Sub-theme 5. Cultural taboos			
			Sub-theme 6. Effects of traditions			
Key informants	Role of traditional Medicine	Gender dynamics	Role of traditional practices	Impact of colonisation	Family & friends	
	Sub-theme 1. Conditions treated with traditional medicines	**Sub-theme 1.** Gender roles & relations	**Sub-theme 1.** Personal & societal identity	**Sub-theme 1.** Modernity		
	Sub-theme 2. Benefits of traditional medicine	**Sub-theme 2.** Women empowerment	**Sub-theme 2.** Cultural expectations	**Sub-theme 2.** Western medicine		
	Sub-theme 3. Challenges of traditional contraceptives		**Sub-theme 3.** Cultural taboos	**Sub-theme 3.** Religion		

			Sub-theme 4. Preparation for marriage			
			Sub-theme 5. Preparation for motherhood			

Appendix 14a - Reference booklet – English version – designed by Chamata Chosamata



Young women,
you have the right and power to make decisions over your bodies, including sexual and reproductive health issues

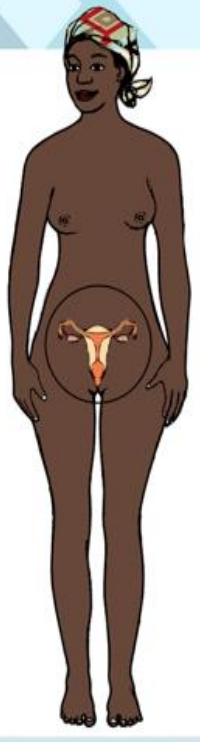
Table of content

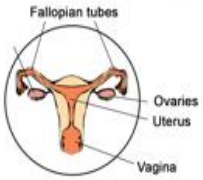
- What is puberty?
- Anatomy of sexual and reproductive organs
- What are menses?
- The menstrual cycle
- Conception
- How to avoid unintended pregnancy
- Readily available contraceptives
- Sexual and reproductive rights

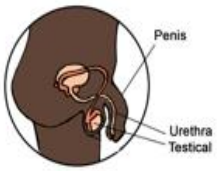
1

Definitions of terms

- Puberty - is when a child changes to become an adult, and a girl can have a baby.
- Sexual and reproductive organs – refer to those organs which can help a woman/girl to get pregnant or a man to impregnate a woman/girl.
- Menses - every month the uterus prepares itself for a baby, if there is no pregnancy the thick lining of the uterus and the unfertilised egg comes out of the body as menstrual blood.
- Menses are safe and cannot make a man sick, unless the woman has sexually transmitted infections or HIV/AIDS



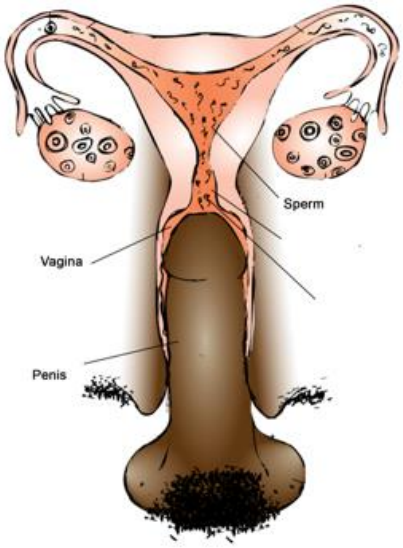




These images show the female and male reproductive system

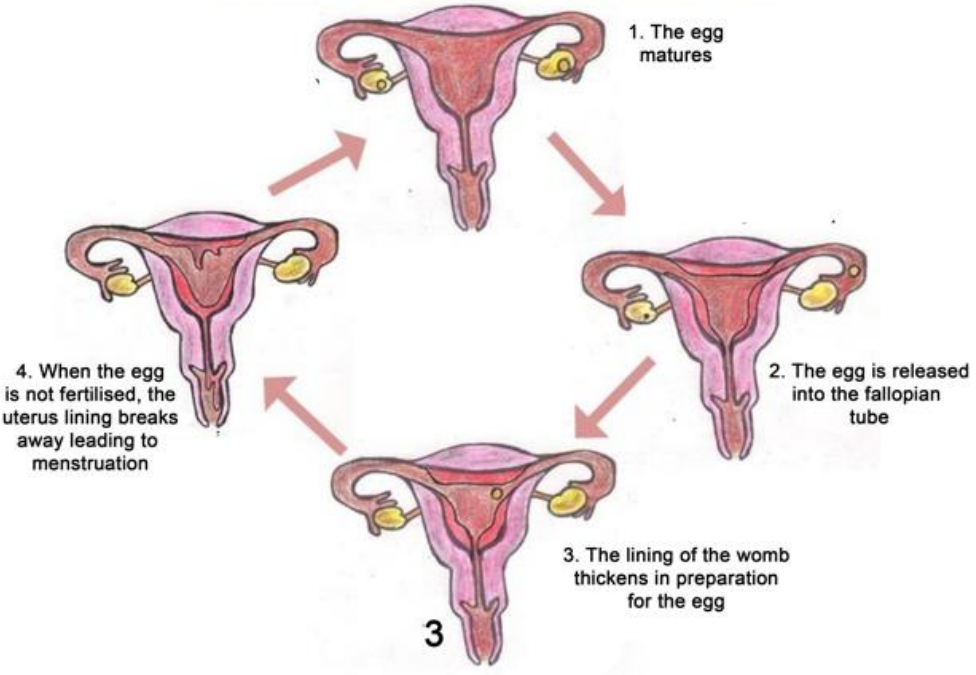
2

This diagram shows a man and a woman being intimate



The egg is fertlised by
the sperm for
the female to get pregnant

These diagrams show the menstrual cycle



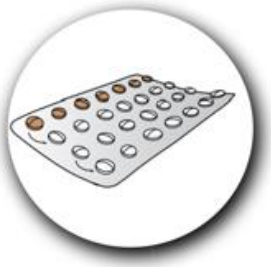
3

How can we prevent unplanned pregnancies?

You can prevent unplanned pregnancies with any of the following contraceptive methods

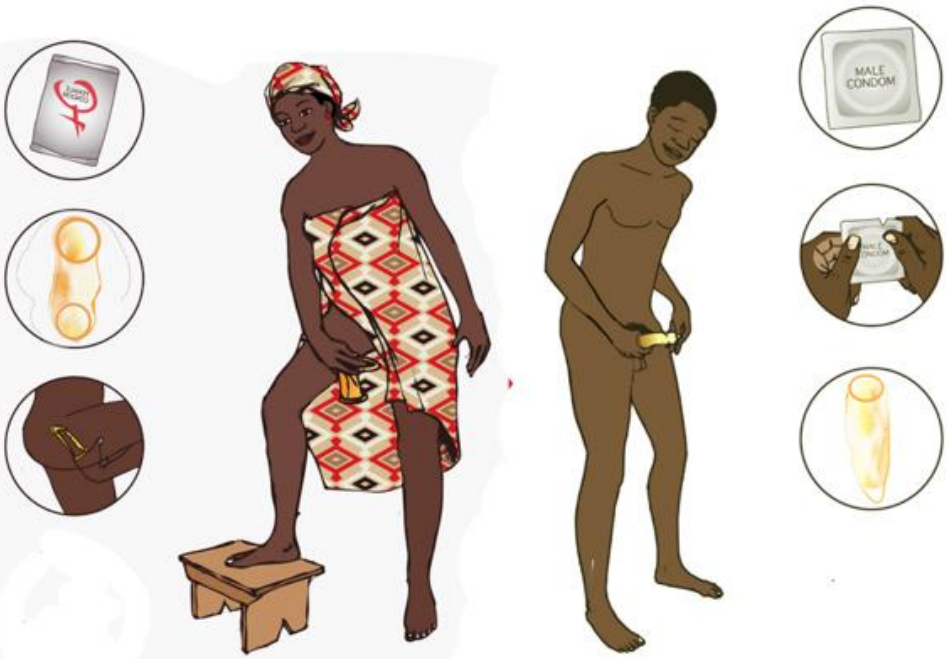
i. Injection

ii. Pills



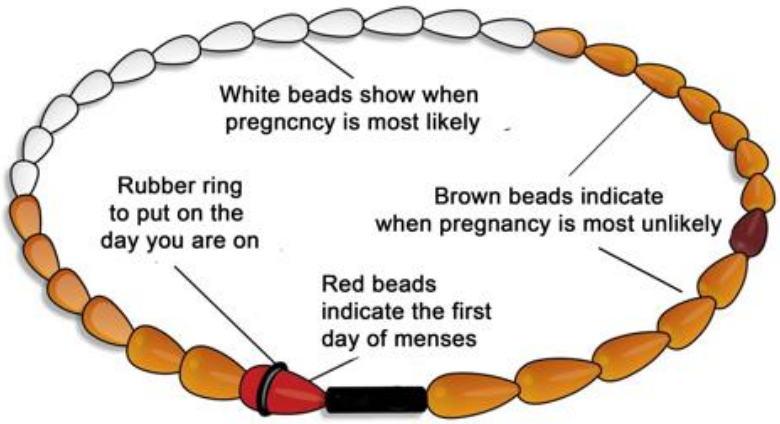
4

iii. Condoms for either males or females



The condom is the only method that
can protect you from STIs and HIV/AIDS

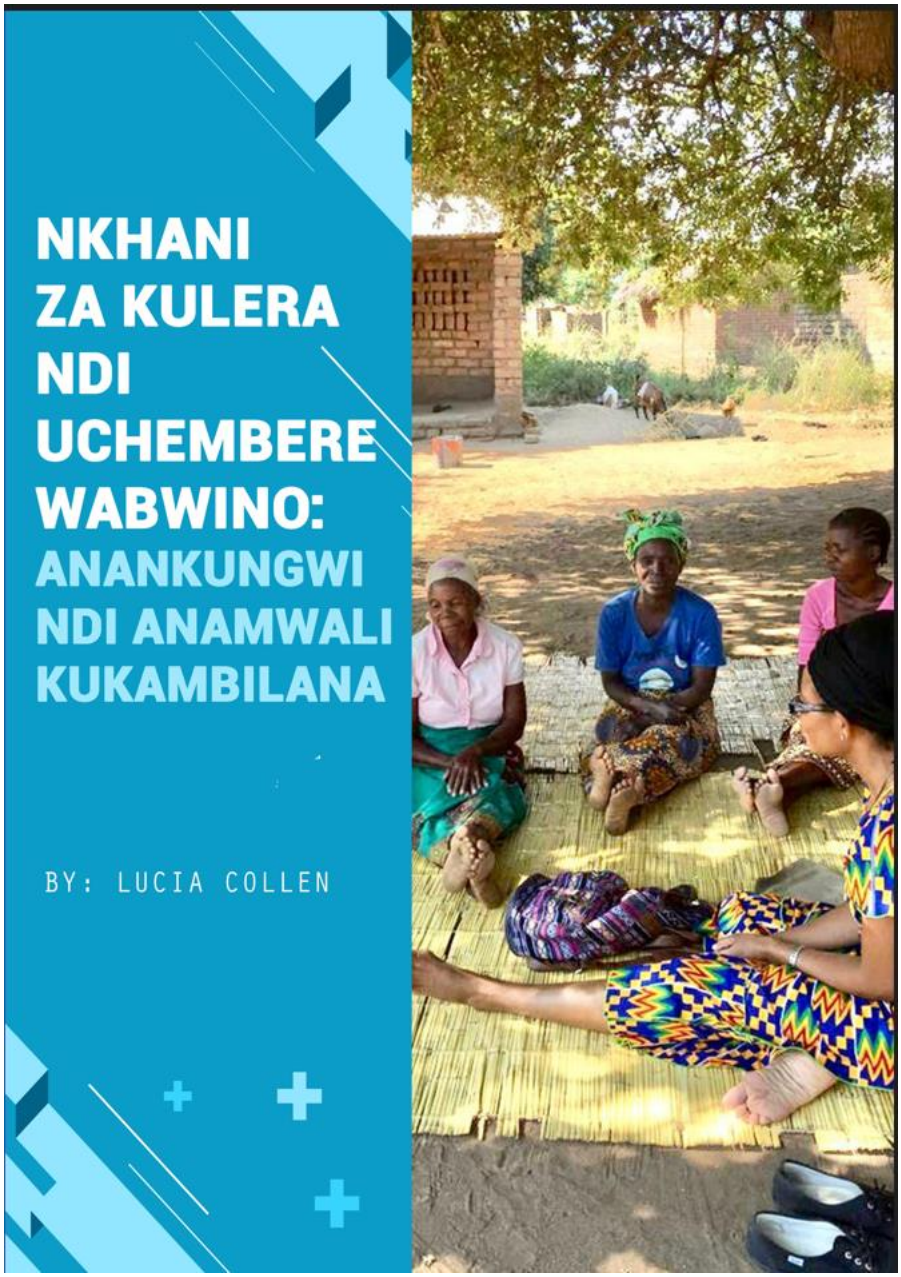
iv. These beads show the days a woman/girl can and cannot get pregnant



For more information on these contraceptive methods contact the HSA in your village

For more information on this booklet contact
Miss Collen
On this number: 0 887 413 741
Or this email: lcollen@kuhes.ac.mw

Appendix 14b – Reference booklet – Chichewa version



Azimayi ndi atsikana, muli ndi ufulu ndi mphamvu zopanga ziganizo zokhudza thupi lanu pa nkhani za kuchipinda ndi uchembere wabwino

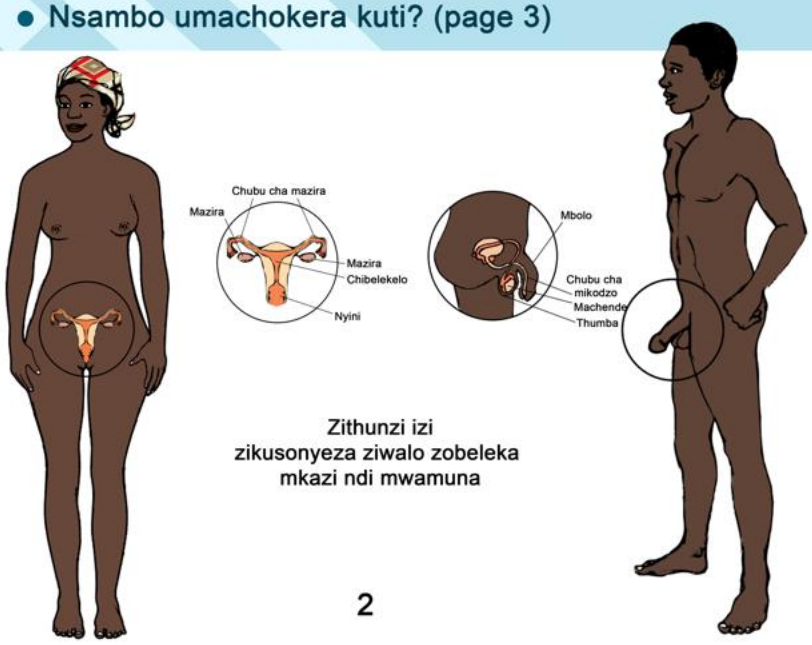
Zamkatimu

- Kutha sinkhu kutanthauza chiyani?
- Ziwalo zimene zimathandiza munthu kuti abeleke komanso kupeleka mimba
- Nsambo ndi chiyani?
- Chimachitika ndi chiyani kuti namwali kapena mzimayi azisamba mwezi ndi mwezi?
- Chimachitika ndi chiyani kuti namwali kapena mzimayi atenge mimba?
- Tingapewe bwanji mimba yosakonzekela?
- Mitundu ya njira zolelera zopezeka mosavuta
- Kulimbikitsa kuzidalira kwa amayi ndi atsikana

1

Matanthauzo ake

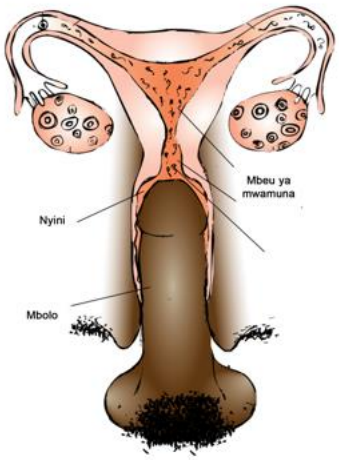
- Kutha msinkhu ndi pameme mtsikana wasiya kukhala mwana ndikukhala munthu wamkulu woti atha kubeleka
- Nsambo ndi magazi omwe amatuluka ku maliseche a msungwana kapena mzimayi mwezi ndi mwezi kupatula nthawi yomwe ali woyembekezera
- Nsambo ndi wabwino bwino koma ungadwalitse pokha pokha ngati mayiyo ali ndi matenda opatsirana pogonana kapenanso kachilombo ka HIV
- Nsambo umachokera kuti? (page 3)



Zithunzi izi zikusonyeza ziwalo zobeleka mkazi ndi mwamuna

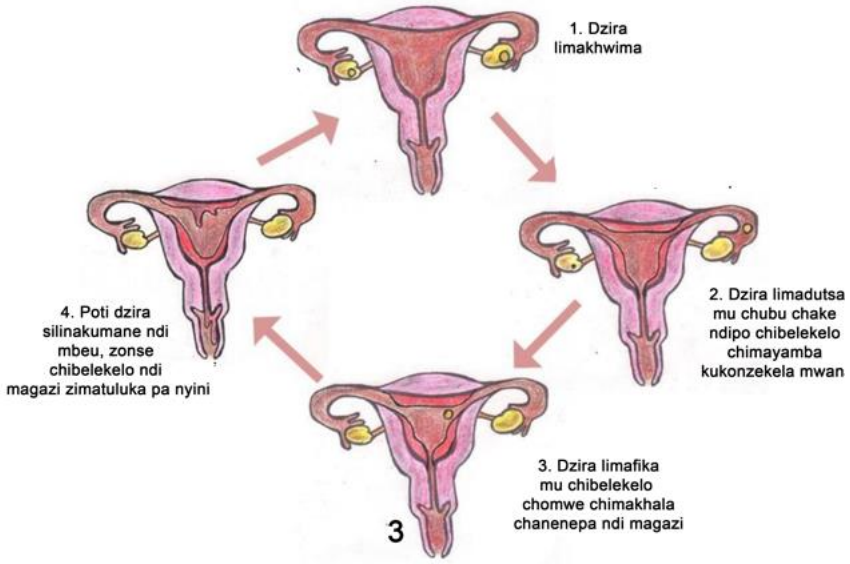
2

Chithunzi ichi chikusonyeza mwamuna ndi mkazi akugonana



Mbeu ya mwamuna imakakumana ndi dzira lokhwima la mkazi kuti atenge mimba

Chithunzi ichi chikuonetsa komwe nsambo umachokera



Tingapewe bwanji mimba yosakonzekera?

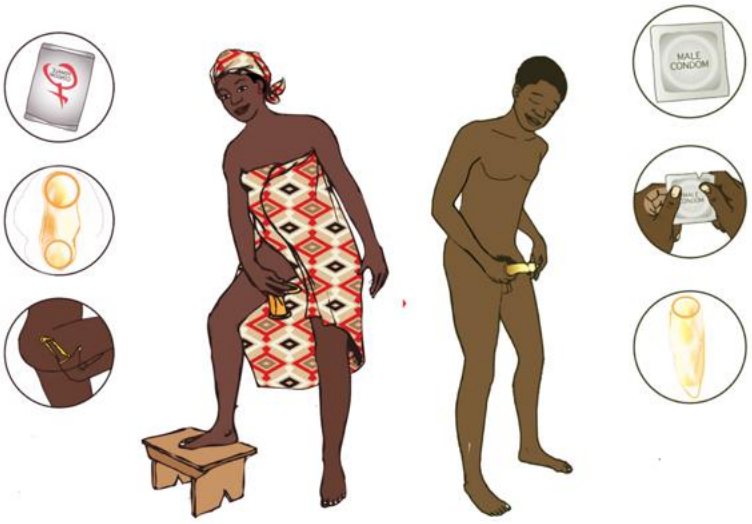
Tingapewe mimba yosakonzekera pogwiritsa ntchito njira zakulera monga izi

i. Kubayitsa jakisoni

ii. Mapilisi

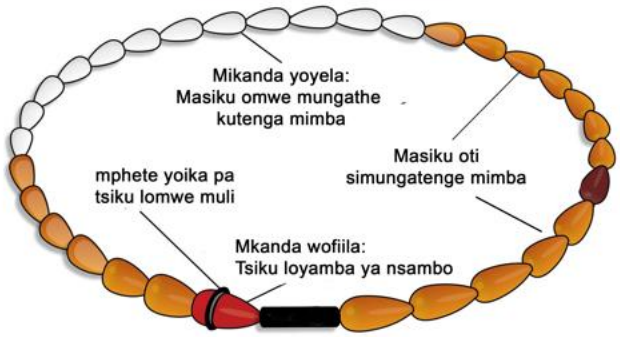
4

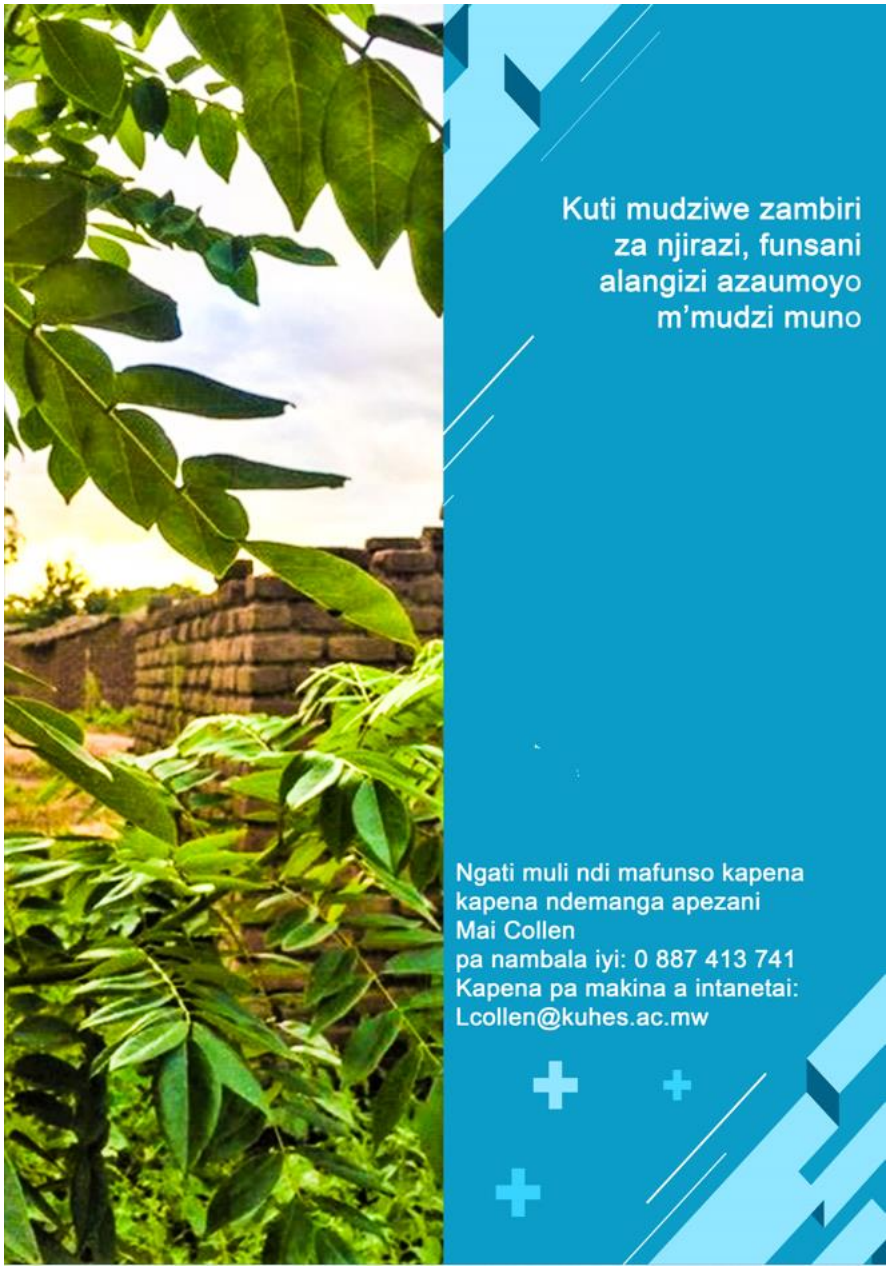
ii. Kondomu ya mkazi kapena mwamuna



Kondomu ndi njira yokhayo yoteteza
mimba komanso
matenda opatsirana pogonana ngati a HIV

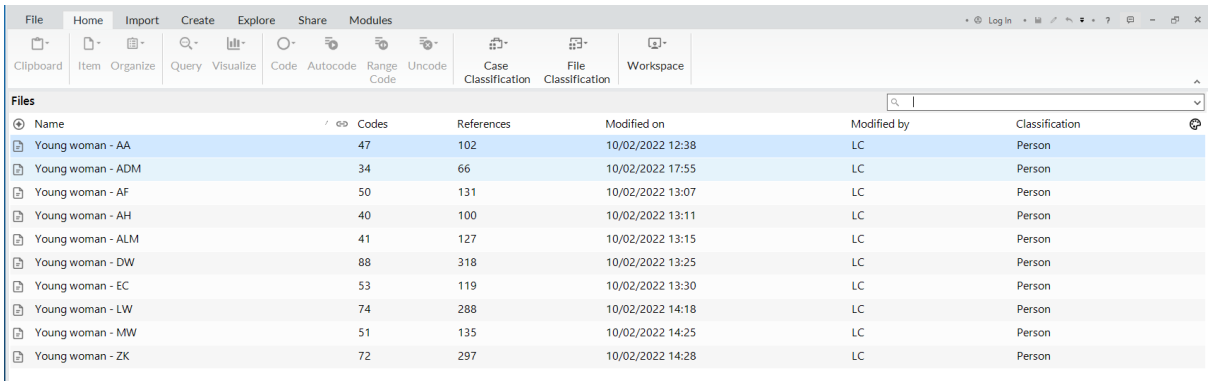
iii. Mikanda yosonyeza pamene mkazi akusamba komanso nthawi imene iye angatenge mimba




Kuti mudziwe zambiri
za njirazi, funsani
alangizi azaumoyo
m'mudzi muno
Ngati muli ndi mafunso kapena
kapena ndemanga apezani
Mai Collen
pa nambala iyi: 0 887 413 741
Kapena pa makina a intanetai:
Lcollen@kuhes.ac.mw

Appendix 15 – The coding process of data sets

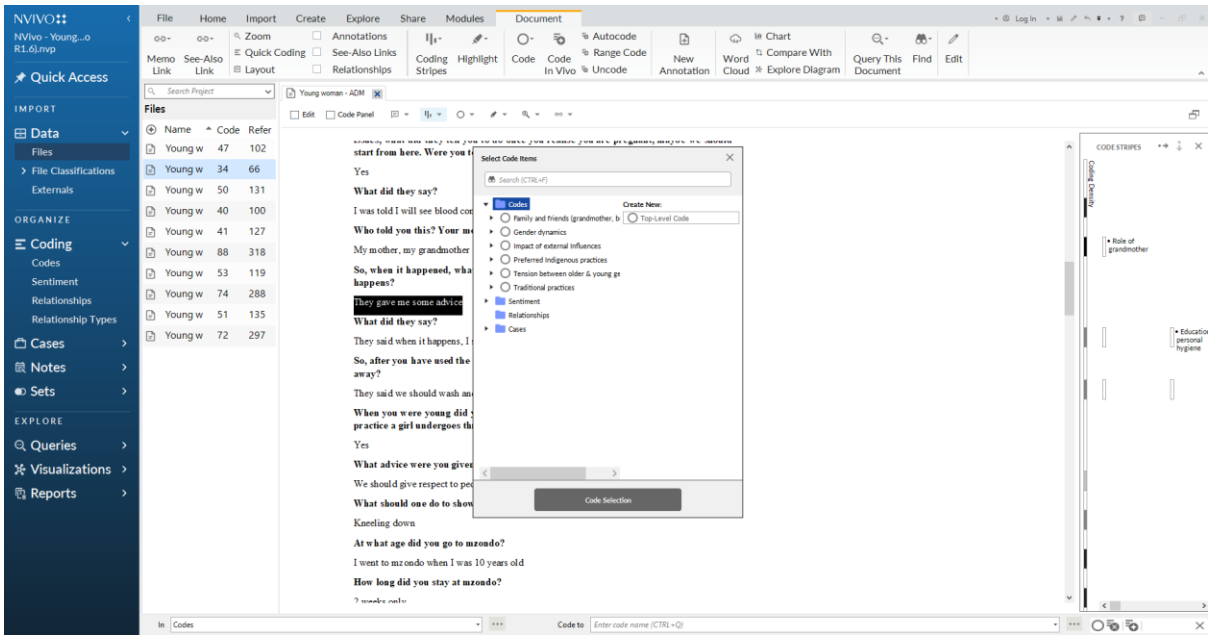
Appendix 15a – Files for young women



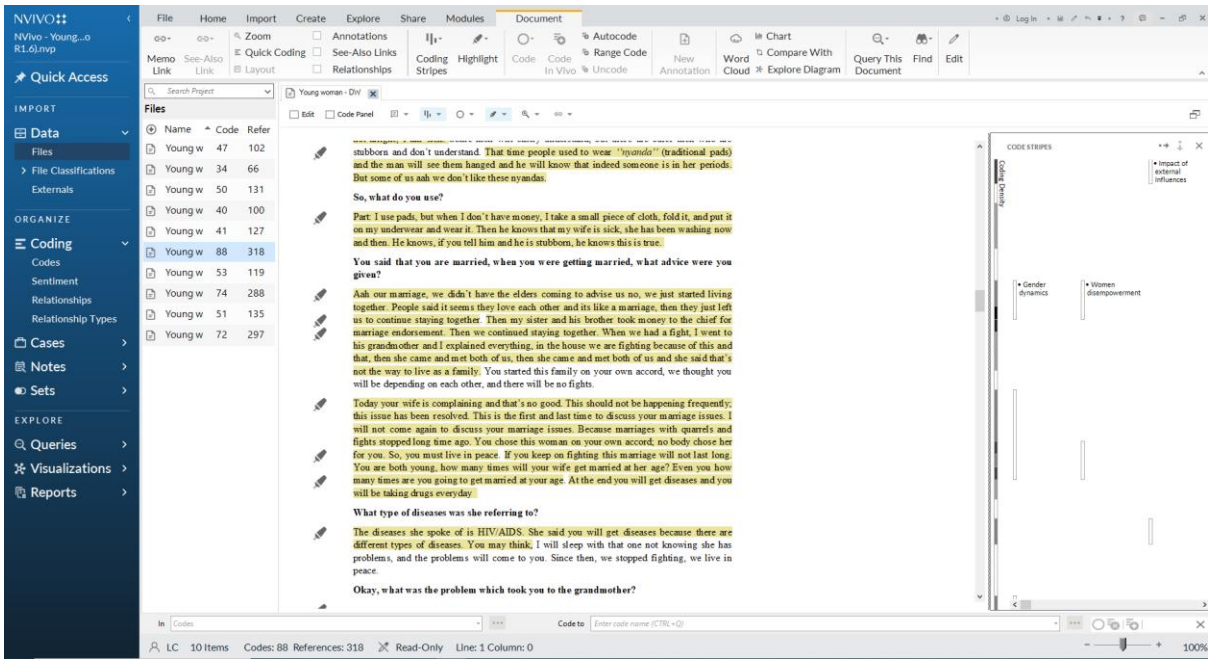
Files

Name	Codes	References	Modified on	Modified by	Classification
Young woman - AA	47	102	10/02/2022 12:38	LC	Person
Young woman - ADM	34	66	10/02/2022 17:55	LC	Person
Young woman - AF	50	131	10/02/2022 13:07	LC	Person
Young woman - AH	40	100	10/02/2022 13:11	LC	Person
Young woman - ALM	41	127	10/02/2022 13:15	LC	Person
Young woman - DW	88	318	10/02/2022 13:25	LC	Person
Young woman - EC	53	119	10/02/2022 13:30	LC	Person
Young woman - LW	74	288	10/02/2022 14:18	LC	Person
Young woman - MW	51	135	10/02/2022 14:25	LC	Person
Young woman - ZK	72	297	10/02/2022 14:28	LC	Person

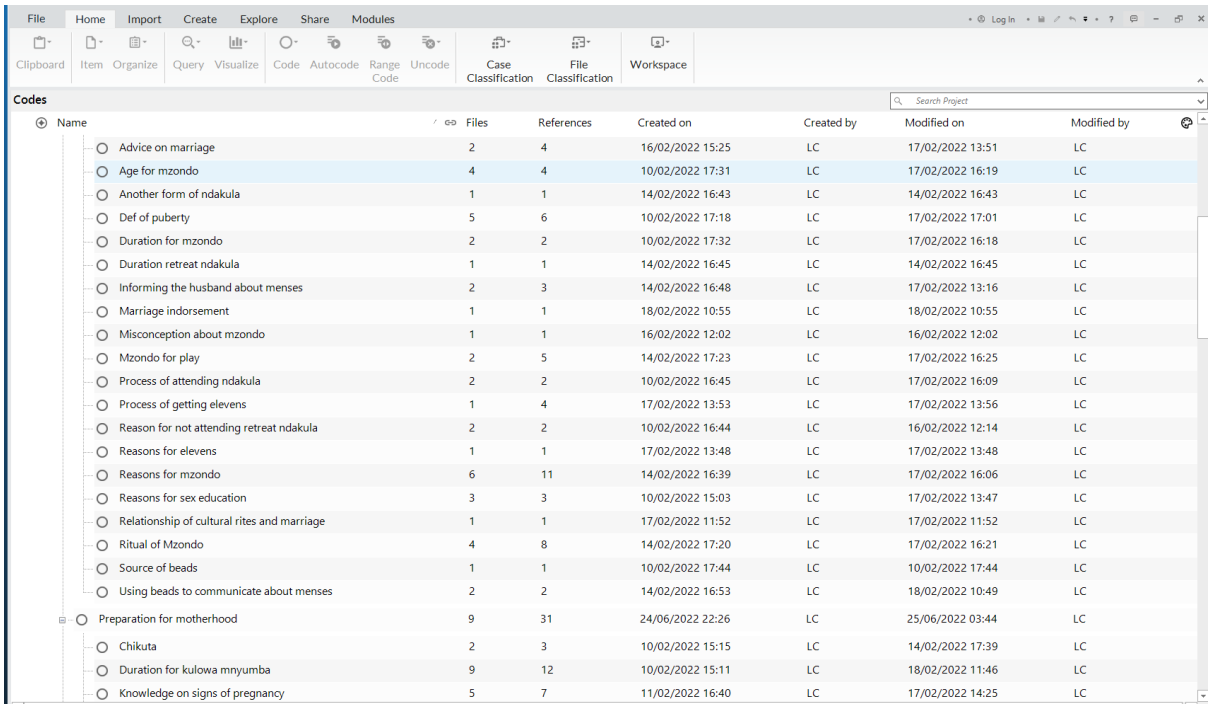
Appendix 15b – Identifying the codes.



Appendix 15c – Initial codes

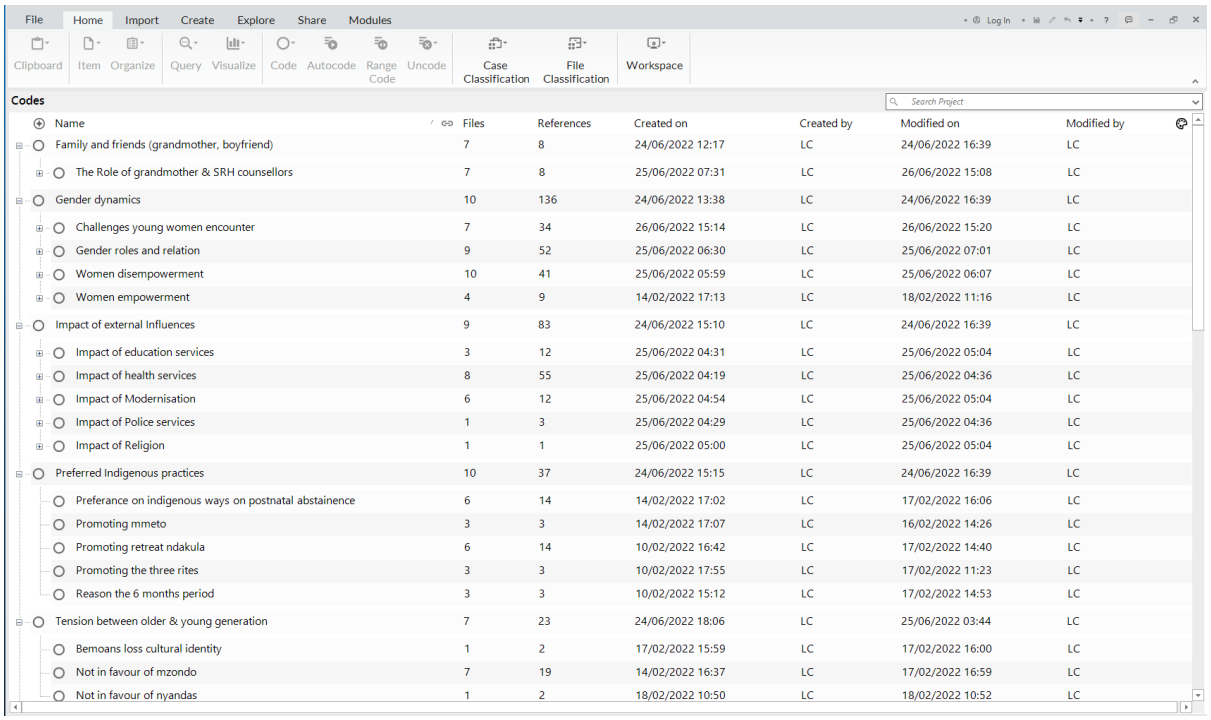


Appendix 15d – Codes



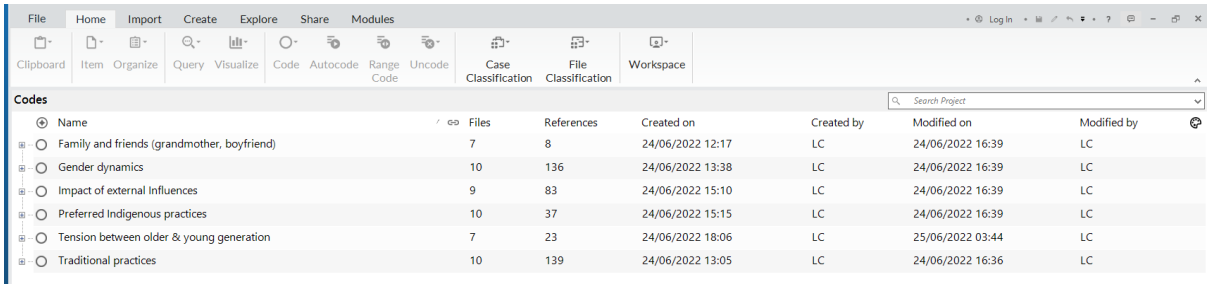
Name	Files	References	Created on	Created by	Modified on	Modified by
Advice on marriage	2	4	16/02/2022 15:25	LC	17/02/2022 13:51	LC
Age for mzondo	4	4	10/02/2022 17:31	LC	17/02/2022 16:19	LC
Another form of ndakula	1	1	14/02/2022 16:43	LC	14/02/2022 16:43	LC
Def of puberty	5	6	10/02/2022 17:18	LC	17/02/2022 17:01	LC
Duration for mzondo	2	2	10/02/2022 17:32	LC	17/02/2022 16:18	LC
Duration retreat ndakula	1	1	14/02/2022 16:45	LC	14/02/2022 16:45	LC
Informing the husband about menses	2	3	14/02/2022 16:48	LC	17/02/2022 13:16	LC
Marriage indorsement	1	1	18/02/2022 10:55	LC	18/02/2022 10:55	LC
Misconception about mzondo	1	1	16/02/2022 12:02	LC	16/02/2022 12:02	LC
Mzondo for play	2	5	14/02/2022 17:23	LC	17/02/2022 16:25	LC
Process of attending ndakula	2	2	10/02/2022 16:45	LC	17/02/2022 16:09	LC
Process of getting elevens	1	4	17/02/2022 13:53	LC	17/02/2022 13:56	LC
Reason for not attending retreat ndakula	2	2	10/02/2022 16:44	LC	16/02/2022 12:14	LC
Reasons for elevens	1	1	17/02/2022 13:48	LC	17/02/2022 13:48	LC
Reasons for mzondo	6	11	14/02/2022 16:39	LC	17/02/2022 16:06	LC
Reasons for sex education	3	3	10/02/2022 15:03	LC	17/02/2022 13:47	LC
Relationship of cultural rites and marriage	1	1	17/02/2022 11:52	LC	17/02/2022 11:52	LC
Ritual of Mzondo	4	8	14/02/2022 17:20	LC	17/02/2022 16:21	LC
Source of beads	1	1	10/02/2022 17:44	LC	10/02/2022 17:44	LC
Using beads to communicate about menses	2	2	14/02/2022 16:53	LC	18/02/2022 10:49	LC
Preparation for motherhood	9	31	24/06/2022 22:26	LC	25/06/2022 03:44	LC
Chikuta	2	3	10/02/2022 15:15	LC	14/02/2022 17:39	LC
Duration for kulowa mnyumba	9	12	10/02/2022 15:11	LC	18/02/2022 11:46	LC
Knowledge on signs of pregnancy	5	7	11/02/2022 16:40	LC	17/02/2022 14:25	LC

Appendix 15e – Sub - themes



Name	Files	References	Created on	Created by	Modified on	Modified by
Family and friends (grandmother, boyfriend)	7	8	24/06/2022 12:17	LC	24/06/2022 16:39	LC
The Role of grandmother & SRH counsellors	7	8	25/06/2022 07:31	LC	26/06/2022 15:08	LC
Gender dynamics	10	136	24/06/2022 13:38	LC	24/06/2022 16:39	LC
Challenges young women encounter	7	34	26/06/2022 15:14	LC	26/06/2022 15:20	LC
Gender roles and relation	9	52	25/06/2022 06:30	LC	25/06/2022 07:01	LC
Women disempowerment	10	41	25/06/2022 05:59	LC	25/06/2022 06:07	LC
Women empowerment	4	9	14/02/2022 17:13	LC	18/02/2022 11:16	LC
Impact of external Influences	9	83	24/06/2022 15:10	LC	24/06/2022 16:39	LC
Impact of education services	3	12	25/06/2022 04:31	LC	25/06/2022 05:04	LC
Impact of health services	8	55	25/06/2022 04:19	LC	25/06/2022 04:36	LC
Impact of Modernisation	6	12	25/06/2022 04:54	LC	25/06/2022 05:04	LC
Impact of Police services	1	3	25/06/2022 04:29	LC	25/06/2022 04:36	LC
Impact of Religion	1	1	25/06/2022 05:00	LC	25/06/2022 05:04	LC
Preferred Indigenous practices	10	37	24/06/2022 15:15	LC	24/06/2022 16:39	LC
Preferance on indigenous ways on postnatal abstainence	6	14	14/02/2022 17:02	LC	17/02/2022 16:06	LC
Promoting mmeto	3	3	14/02/2022 17:07	LC	16/02/2022 14:26	LC
Promoting retreat ndakula	6	14	10/02/2022 16:42	LC	17/02/2022 14:40	LC
Promoting the three rites	3	3	10/02/2022 17:55	LC	17/02/2022 11:23	LC
Reason the 6 months period	3	3	10/02/2022 15:12	LC	17/02/2022 14:53	LC
Tension between older & young generation	7	23	24/06/2022 18:06	LC	25/06/2022 03:44	LC
Bemoans loss cultural identity	1	2	17/02/2022 15:59	LC	17/02/2022 16:00	LC
Not in favour of mzondo	7	19	14/02/2022 16:37	LC	17/02/2022 16:59	LC
Not in favour of nyandas	1	2	18/02/2022 10:50	LC	18/02/2022 10:52	LC

Appendix 15f – Potential themes



Name	Files	References	Created on	Created by	Modified on	Modified by
Family and friends (grandmother, boyfriend)	7	8	24/06/2022 12:17	LC	24/06/2022 16:39	LC
Gender dynamics	10	136	24/06/2022 13:38	LC	24/06/2022 16:39	LC
Impact of external Influences	9	83	24/06/2022 15:10	LC	24/06/2022 16:39	LC
Preferred Indigenous practices	10	37	24/06/2022 15:15	LC	24/06/2022 16:39	LC
Tension between older & young generation	7	23	24/06/2022 18:06	LC	25/06/2022 03:44	LC
Traditional practices	10	139	24/06/2022 13:05	LC	24/06/2022 16:36	LC

Appendix 16 – Process of developing potential themes and sub-themes for each group of participants

Figure 16a – Themes and sub-themes – Young women.

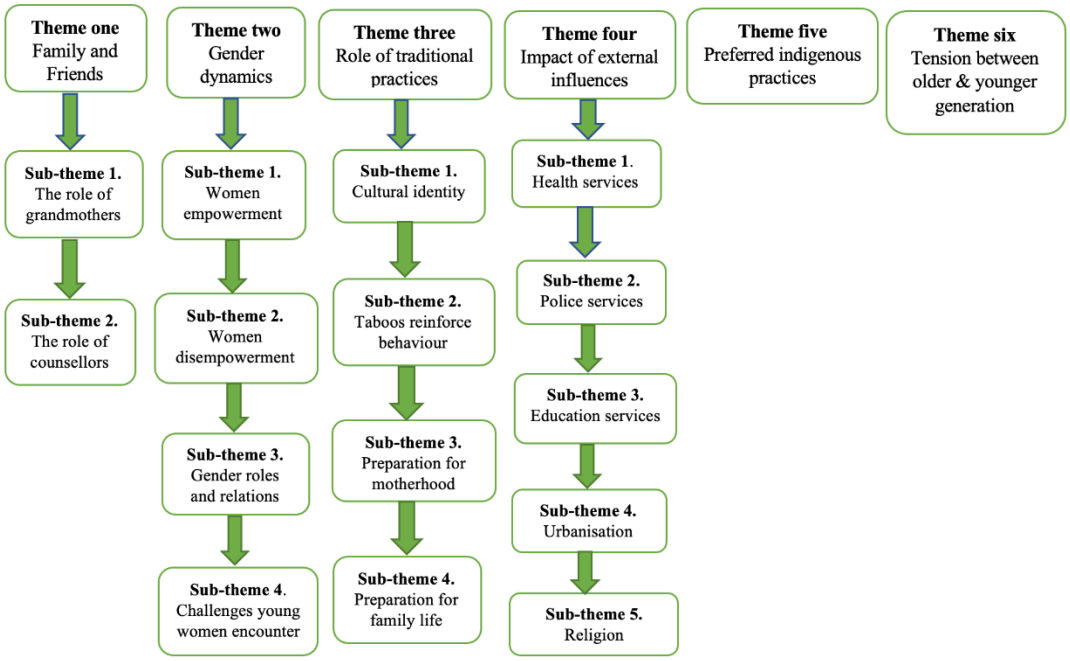


Figure 16b – Themes and sub-themes – Mothers.

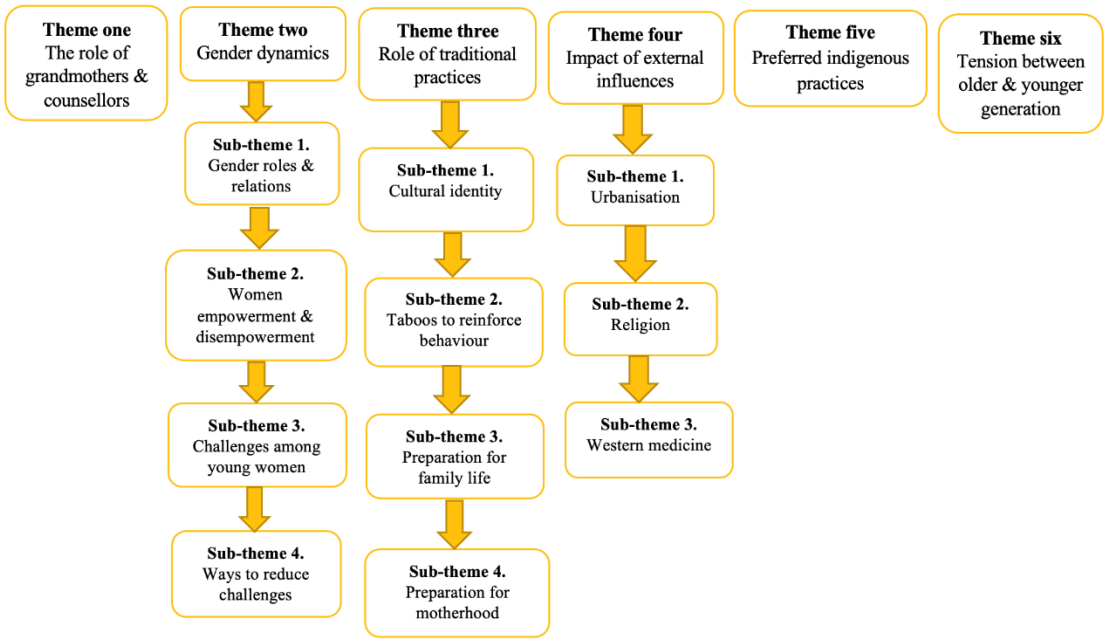


Figure 16c – Themes and sub-themes – Grandmothers.

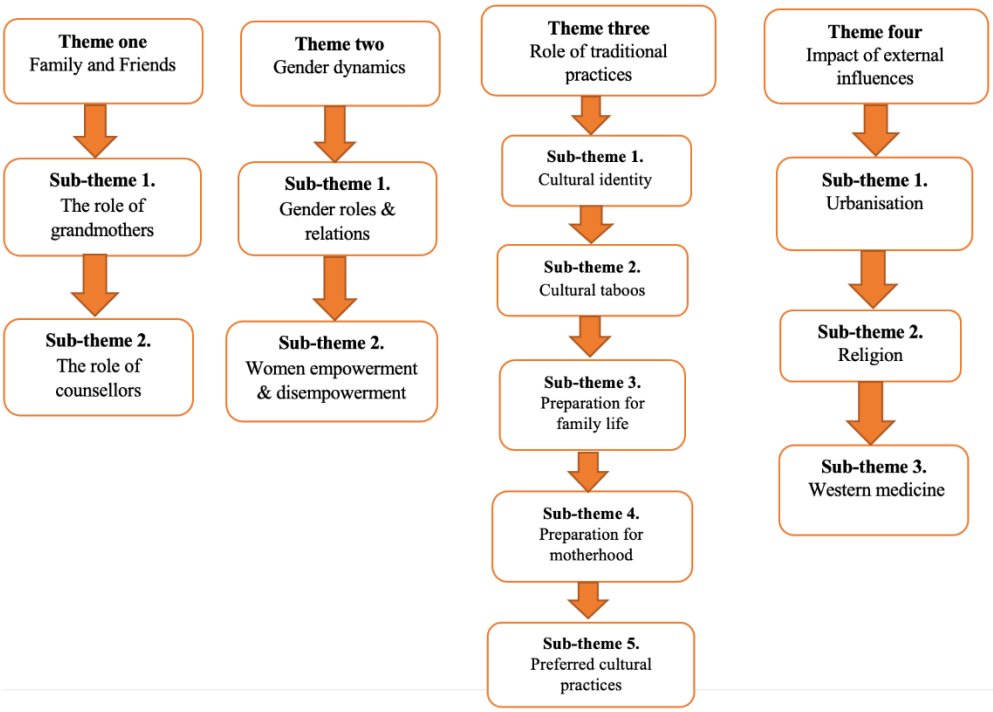


Figure 16d – Themes and sub-themes – Traditional counsellors.

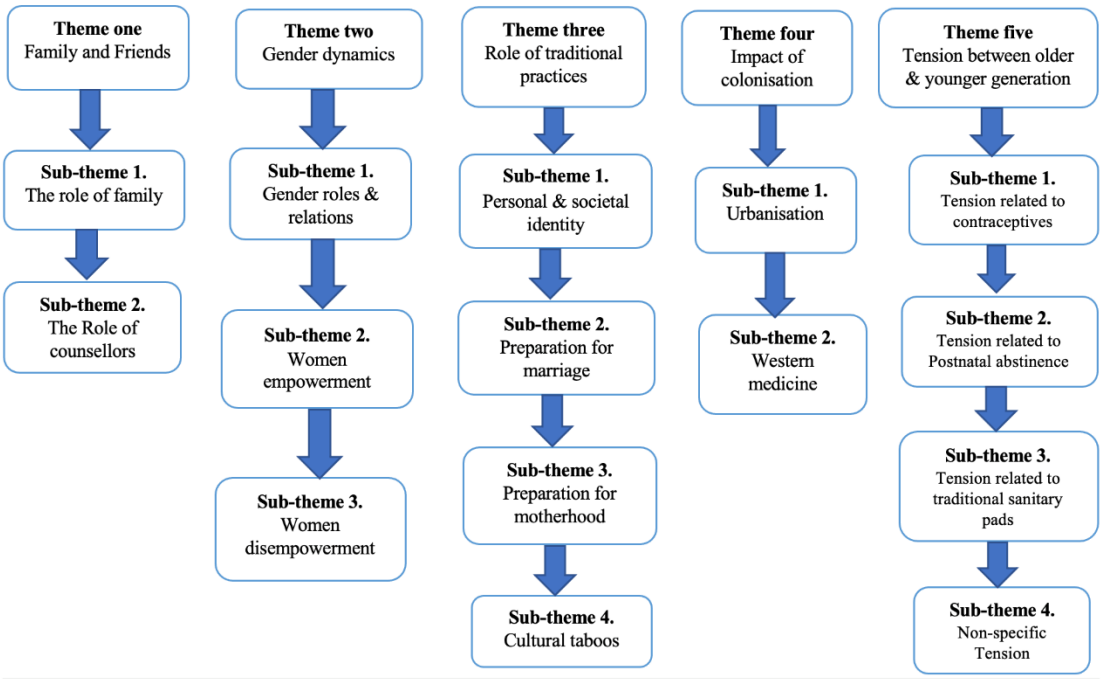


Figure 16e – Themes and sub-themes – Religious counsellors.

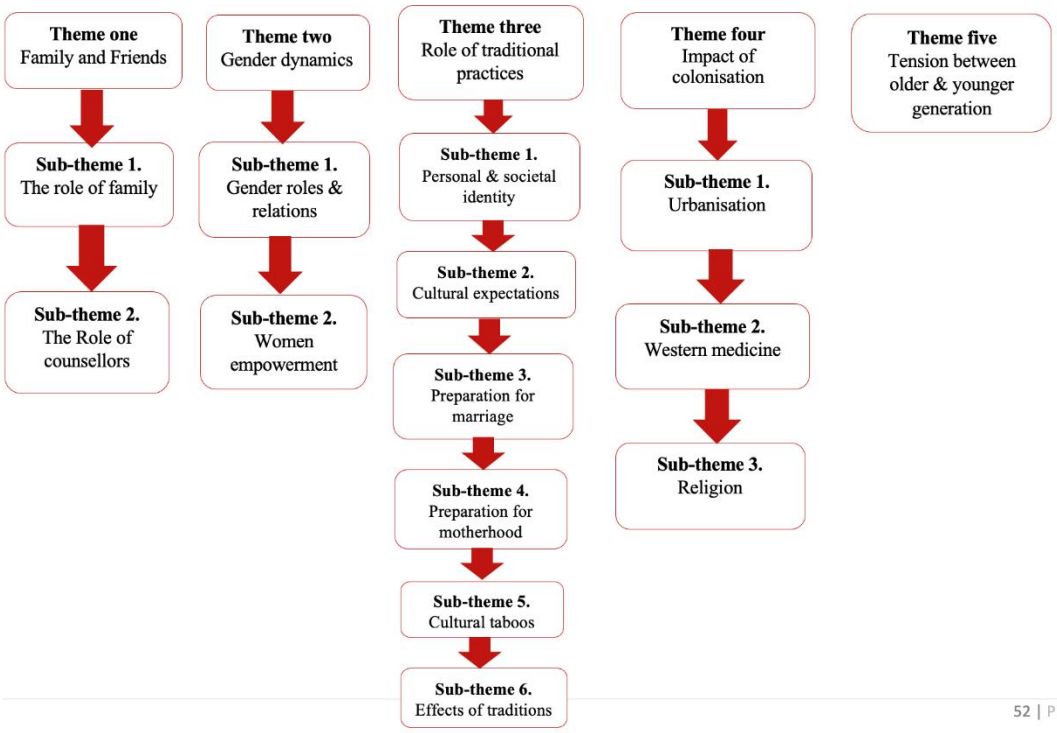
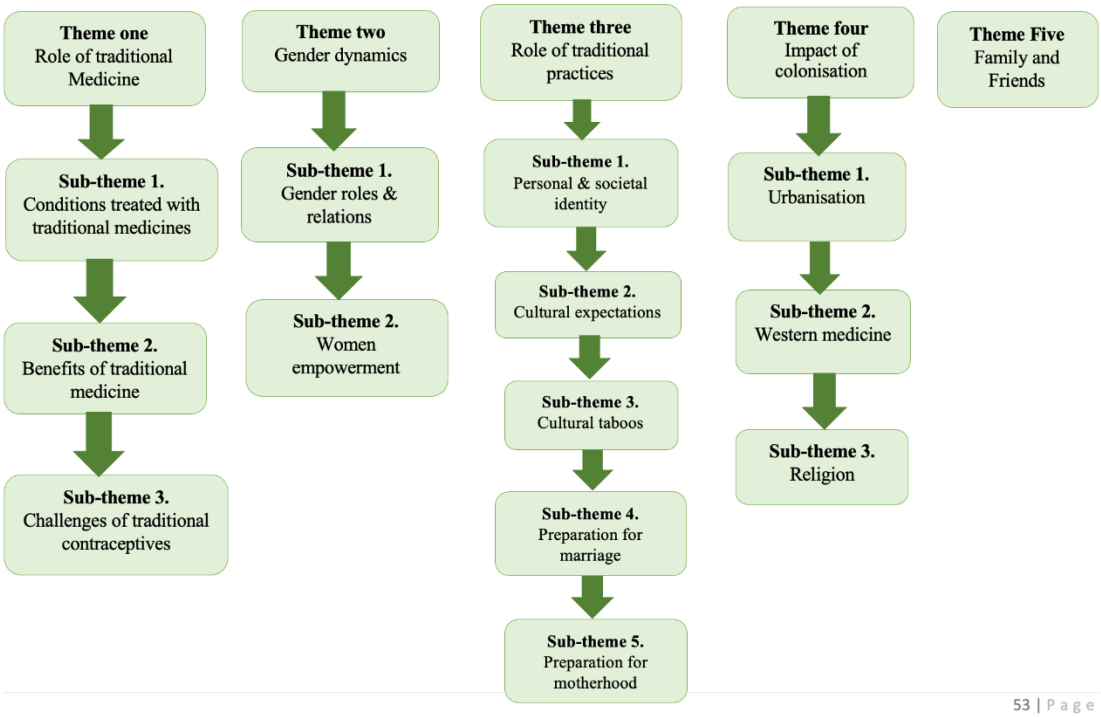


Figure 16f – Themes and sub-themes – Key informants (herbalists)



Glossary of Terms

Anamkungwi/ Anakanga: female traditional initiation counsellors

Boyfriend: an established sexual relationship between a boy and a girl

Chinamwali: initiation rite

Chipatala cha pafoni: which simply mean accessing health services using a mobile phone.

Chiwilo: is the practice of swearing in a sarcastic way at the girls' husband and his family during a *litiwo* ceremony as way of demonstrating their happiness.

Chokolo: which means wife inheritance, and it is practiced in the northern region among the Ngonis.

Fisi: a male adult who has sexual intercourse with newly initiated girls and it is practiced among the Chewa ethnic group.

Jando/ ndagala: a male initiation ceremony that involves circumcision

Litiwo/ mmeto/ kumeta: an initiation for a girl/young woman who is expecting her first child

Mzondo/ mzondo: an initiation ceremony for the Yao people for a girl child between 9 and 10 years.

Kupimbila: whereby girls as young as 9 years are given in marriage to wealthy old men as payment for their parents' debts (practiced in some districts in the northern part of Malawi).

Kupita kufa: whereby a woman is made to have sex with another man a week after her husband's death, to put the husband's spirit at rest among the Sena people.

Mbirika: which means replacement of a deceased wife and is practiced in the northern part of Malawi.

Ndaka: illnesses that stem from contact that is made between those who are not sexually active with those who are not (cold and hot)

Ndakula: an initiation ceremony for a girl who has attained puberty to mark her reception into adulthood

Sexual intercourse: intercourse that involves penetration of penis into the vagina only

Sexual relationships: refers to heterosexual relationships only

Thobwa: a traditional drink, which is a mixture of maize porridge, germinated millet flour and sugar.

Undubidwa: an illness affecting breastfeeding children due to jealousy from a sibling