

**Interpretations of gender and implications for policy: A case study of Malawi's**

**Nutrition policymaking process**

by

**Elizabeth Mkandawire (04311280)**

Submitted in partial fulfilment of the requirements for the degree of

Doctor of Philosophy (Rural Development Planning)

in the

Department of Agricultural Economics, Extension and Rural Development

at the

University of Pretoria

Supervisor: Prof SL Hendriks

May 2018

© UNIVERSITY OF PRETORIA

## **DEDICATION**

I dedicate this thesis to my Mum and Dad for their unfailing support and encouragement. To my father for encouraging me and motivating me to pursue a PhD. To my sister and my brother, Lucy and Kondwani for being positive role models who I emulate and my husband who had to endure my absence during data collection and continued to support me through it all.

## ABSTRACT

Gender equality is fundamental to reducing malnutrition. In policy practice, gender is often misconstrued to mean women, when in fact it refers to men and women's roles and responsibilities and the relationships between men and women. Nutrition policies, in particular, are understandably skewed in favour of women because children's nutrition depends on women's diet during pregnancy. However, in low-income countries, gender dynamics often constrain women's access to resources and limit their decision-making in the household, preventing women from accessing nutritious food. While policymakers committed to integrate gender in all policies by signing the Beijing Declaration and Platform for Action, gender norms prevalent in their societies influence policy decisions. These gender norms often affect policy decisions. Using Malawi as a case study, this thesis explores how interpretations of gender influenced the nutrition policy design in Malawi.

Malawi's National Nutrition Policy and Strategic Plan 2007 – 2012 and Malawi's draft National Nutrition Policy 2016 - 2020 was used as a case study. A desk review was used to assess the extent to which Malawi's NNPS (2007 – 2012) was gender-responsive using an integrated framework for gender analysis. Focus group discussions and in-depth interviews identified factors facilitating and constraining men's involvement in maternal and child nutrition. A policy dialogue which brought together a range of stakeholders from the nutrition and gender domains in Malawi validated the research findings.

While Malawi has made much progress in reducing undernutrition in under five children from 47% in 2010 to 37% in 2016, this reduction is not sufficient for achieving the Sustainable Development Goals. Gender-responsive nutrition policies could assist in accelerating progress to meeting SDG two in particular, which focuses on ending all forms of malnutrition by 2025. The study found that Malawi's National Nutrition Policy 2007 – 2012, although reported to address gender, is not gender-responsive. Weaknesses in understanding how to integrate gender in nutrition policy were identified, coupled with possible biases and ideologies that influenced decision-makers. The policy reinforces the role of women in nutrition, overlooking the gender dynamics that constrain women's access to nutritious food. The supportive role of men is overlooked. Community members' interpretations of gender differed significantly from policymakers'. Men reported taking up childcare and housework that was previously perceived to be women's responsibility, shifting traditional gender roles. In Malawi, Non-Governmental Organisation programmes that work with men to increase men's participation in housework have influenced gender roles and responsibilities in the household. In particular, the role of traditional leaders in promoting men's participation in maternal and child health has been a successful method of involving

men. However, weaknesses in the way in which these programmes are designed hinder progress toward gender equality.

While the forthcoming National Nutrition Policy is far less gender-blind compared to its predecessor, the policy remains gender-tepid. Policymakers' preconceptions around gender continue to influence policy design. Although policymakers attempt to address gender inequality through approaches such as men's involvement in maternal and child nutrition, their gender biases prevent them from recognising weaknesses in policy design that may deepen the gender gap rather than lead to equality. Dialogue between policymakers and other stakeholders is needed to ensure that policymakers become aware of their gender biases and do not perpetuate gender norms.

## DECLARATION OF ORIGINALITY

Full names of student: Elizabeth Mkandawire

Student number: 04311280

Declaration

1. I understand what plagiarism is and I am aware of the University's policy in this regard.
2. I declare that this thesis is my own original work. Where other people's work has been used (either from a printed source, the internet or any other source), this has been properly acknowledged and referenced in accordance with departmental requirements.

Signed:

.....

Student

Signed:

.....

Supervisor

## ACKNOWLEDGEMENTS

I take this opportunity to recognise all those who have been instrumental in the completion of this thesis:

- My supervisor, Prof. Sheryl Hendriks, whose confidence in me was unending. Her constant support and encouragement both academically and emotionally provided me with the motivation to complete this thesis.
- Lucy Mkandawire-Valhmu, for her support in collecting data as well as providing guidance in data analysis and writing up of results.
- The men and women who participated in this research. Their participation was pivotal to this study.
- The District Authority in Ntcheu who provided us access to the communities, as well as the traditional authorities who granted access to the study participants and supported our engagement in Ntcheu.
- The reviewers from *Biomed Central Pregnancy and Childbirth* (Linda Aldoory and Halle-Ekane Edie Gregory) and *Development Policy Review* whose constructive feedback significantly improved the manuscripts and this thesis.

This study was made possible by the Feed the Future Innovation Lab for Food Security Policy award EDH-A-00-07-00005-00 through the generous support of the American people through the United States Agency for International Development (USAID) under the Feed the Future initiative. The contents are the responsibility of the study authors and do not necessarily reflect the views of USAID or the United States Government.

## ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
AUC	African Union Commission
CAADP	Comprehensive African Agriculture Development Programme
CFS	Committee on Food Security
	Department of Nutrition, Human Immunodeficiency Virus and Acquired
DNHA	Immunodeficiency Syndrome
FAO	Food and Agriculture Organisation
GoM	Government of Malawi
HSA	Health Surveillance Assistant
HIV	Human Immunodeficiency Virus
IFPRI	International Food Policy Research Institute
MDG	Millennium Development Goals
MGDS	Malawi Growth and Development Strategy
MDHS	Malawi Demographic and Health Survey
MoFEPD	Ministry of Finance, Economic Planning and Development
MoGCDSW	Ministry of Gender, Children, Disability and Social Welfare
MoH	Ministry of Health
MNGCN	Malawi NGO Gender Coordinating Network
MVAC	Malawi Vulnerability Assessment Committee
NEPAD	New Partnership for Africa's Development
NNPSP	National Nutrition Policy and Strategic Plan
NSO	National Statistics Office
SADC	Southern African Development Community
SDG	Sustainable Development Goals
SUN	Scaling Up Nutrition
UN	United Nations
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNHCR	United Nations High Commission for Refugees
UNICEF	United Nations Children's Fund
UNSCN	United Nations System Standing Committee on Nutrition
WFP	World Food Programme
WLSA	Women and Law in Southern Africa
WHA	World Health Assembly
WHO	World Health Organisation

## TABLE OF CONTENTS

<b>Chapter 1 : Introduction .....</b>	<b>1</b>
1.1. Background and rationale .....	1
1.2. Statement of the problem .....	2
1.3. The need to accelerate progress on nutrition in Malawi .....	3
1.4. Research objectives .....	4
1.5. De-limitations .....	5
1.6. Contribution to knowledge.....	5
1.7. Thesis outline .....	6
<b>Chapter 2 : LITERATURE REVIEW .....</b>	<b>7</b>
2.1. Introduction.....	7
2.2. Gender equality as a development priority .....	7
2.3. Nutrition as a development priority .....	11
2.4. Gender divisions of labour: Care work, housework, farm work and income-generating .....	15
2.4.1. <i>Gender inequalities and nutrition</i> .....	16
2.4.2. <i>Gender equality and work associated with men</i> .....	18
2.5. Social and cultural institutions: Policymaker’s gendered frames of reference .....	20
2.6. Research gap .....	21
2.7. Synopsis.....	22
<b>Chapter 3 : Setting the scene – gender mainstreaming in Malawi’s nutrition policy.....</b>	<b>23</b>
3.1. Introduction.....	23
3.2. Gender mainstreaming and nutrition policy in Malawi .....	23
3.3. Nutrition policy .....	25
3.4. Understanding how men’s involvement emerged on the policy agenda in Malawi .....	27
3.5. Synopsis.....	31
<b>Chapter 4 : A gender assessment of Malawi's National Nutrition Policy and Strategic Plan 2007 – 2012 .....</b>	<b>32</b>
4.1. Introduction.....	32
4.2. Mainstreaming men into gender policy .....	34
4.3. Food security and nutrition with regards to women in Malawi .....	35
4.4. Research methodology .....	36
4.4.1. <i>WHO Gender Assessment Tool</i> .....	36
4.4.2. <i>FAO Gender Mainstreaming and Nutrition Framework</i> .....	37
4.4.3. <i>Policy chronology</i> .....	37



4.5. Applying the integrated framework for gender analysis in nutrition policy .....	37
4.5.1. <i>An overview of Malawi's NNPS</i> .....	39
4.6. Results and discussion .....	40
4.6.1. <i>Preliminary observations</i> .....	40
4.6.2. <i>Findings from the individual tools</i> .....	41
4.6.3 <i>Outcomes of the analysis of the integrated framework</i> .....	42
4.7. Conclusion and policy recommendations .....	50
<b>Chapter 5 : A qualitative analysis of men's involvement in maternal and child health as a policy intervention in rural Central Malawi.....</b>	<b>52</b>
5.1. Background.....	52
5.1.1. <i>Men's involvement in maternal and child health</i> .....	53
5.1.2. <i>The role of tradition leaders in afe motherhood in Malawi</i> .....	54
5.1.3. <i>Study location</i> .....	55
5.2. Methodology .....	56
5.2.1. <i>Study design</i> .....	56
5.2.2. <i>Focus group discussions</i> .....	56
5.2.3. <i>Individual interviews</i> .....	58
5.2.4. <i>Data analysis</i> .....	59
5.3. Results.....	59
5.3.1. <i>Facilitators of men's involvement</i> .....	60
5.3.2. <i>Barriers to men's involvement</i> .....	63
5.3.3. <i>Limitations to men's involvement</i> .....	65
5.4. Discussion.....	67
5.5. Conclusion and recommendations .....	69
<b>Chapter 6 : VALIDATION OF RESEARCH FINDINGS USING A POLICY DIALOGUE .....</b>	<b>71</b>
6.1. Introduction.....	71
6.2. Validating the research findings .....	71
6.3. Validation method.....	72
6.4. Validating research findings from Chapter 4 and assessing gender in the forthcoming National Nutrition Policy.....	74
6.5. Validating the research findings from Chapter 5 .....	76
6.5.1. <i>Recommendations for the draft policy</i> .....	79
6.6. Participants' comments on the integrated framework for gender analysis of nutrition policy ..	81
6.7. Researcher insights from the policy dialogue .....	82
6.8. Synopsis.....	84

<b>Chapter 7 : Conclusions and recommendations.....</b>	<b>86</b>
7.1. Synopsis .....	86
7.2. Conclusions.....	88
7.3. Recommendations.....	90
7.4. Contribution to knowledge.....	91
7.5. Recommendations for improvement of the study .....	92
7.6. Recommendations for further research .....	93
References.....	94
Appendix A: Ethics clearance for the Food Security Policy Innovation Lab .....	112
Appendix B: Letter of introduction from the District Commissioner .....	113
Appendix C: Informed consent form .....	114
Appendix D: Semi-structured interview guide (adapted from kaleidoscope model for agriculture and food security policy stakeholder mapping table) .....	115
Appendix E: Demographic data of focus group discussion participants (own work).....	116
Appendix F: Policy Dialogue Programme .....	117
Appendix G: Department of University Relations Communication and Marketing Consent Form.....	118
Appendix H: Thematic grouping of recommendations from policy dialogue .....	119
Appendix I: Policy Brief.....	122
Appendix J: Revised integrated framework for gender analysis in nutrition.....	126
Appendix K: Gender mainstreaming tools reviewed .....	127

## LIST OF FIGURES

Figure 1.1: Conceptual framework for pathways to achieving gender equality and reducing malnutrition.....	8
Figure 3.1: Institutional setup map of nutrition stakeholders in Malawi .....	26

## LIST OF TABLES

Table 2.1: ‘Women in Development’ vs ‘Gender in Development’ approach .....	10
Table 2.2: World Health Assembly Targets (DFID, 2013).....	13
Table 2.3: Chronology of events that put nutrition on the development agenda .....	14
Table 2.4: Barriers to men's involvement in maternal and child health.....	19
Table 4.1: FAO Gender Mainstreaming in Nutrition Framework .....	38
Table 4.2: WHO Gender Assessment Tool (Analysis of NNPSP) .....	43
Table 4.3: Chronology of international, African and national events and documents.....	45
Table 4.4: Integrated framework for gender analysis of nutrition policy .....	48
Table 5.1: Themes and sub-themes.....	60
Table 6.1: Policy dialogue participants.....	73
Table 6.2: Consolidated assessment of the four groups using the integrated framework.....	75

# CHAPTER 1 : INTRODUCTION

## 1.1. Background and rationale

Malawi is a signatory to the Beijing Declaration and Platform for Action (United Nations (UN), 1995) and was one of the first countries to domesticate this agreement. For example, the Malawi Platform for Action was established in 1996. In maternal and child health, efforts have been made to include men. Malawi, Kenya, Rwanda and Uganda are some of the countries that have made progress in including men in maternal and child health programmes. Several studies suggest that Malawi has been actively promoting men's involvement in maternal and child health programmes for the past seven years (Kululanga et al., 2012 and Nyondo et al., 2014). The impact of these programmes on gender equality is not clear. It is also unclear how nutrition policies integrate men's involvement in maternal and child nutrition. Nutrition is a central component of maternal and child health. Integrating gender in policy is fundamental to achieving positive nutrition outcomes (Food and Agriculture Organisation (FAO), 1992; FAO and World Health Organisation (WHO), 2014). However, policymakers' interpretations of gender often distort policy choices (Rao and Kellner, 2003). For example, nutrition policies typically emphasise the role of women, because policymaker's gendered frames of reference often associate the responsibility for child nutrition with women. Such policies can overlook the gendered dynamics that constrain men and women's access to nutritious food. While women do indeed play an important role in household and child nutrition, they often have limited control over the resources required to access nutritious food (Richards et al., 2013). Men, who are often the primary decision-makers in the household are typically excluded from maternal and child nutrition policies (Chant and Gutmann, 2002). By focusing on women, these policies are often mistakenly considered to be gender-sensitive (Cornwall, 2000; Rae, 2008). However, by definition, gender encompasses the roles of both men and women and gender equality involves the dynamic relationship between the two sexes (Moser, 1993).

Both gender equality and improved nutrition are development priorities as reflected in several international, continental and regional commitments. The Sustainable Development Goals (SDGs) outline 17 key priorities that countries have undertaken to achieve by 2030. SDG two, in particular, commits countries to end hunger and malnutrition and promote agriculture (United Nations (UN), 2016). In Africa, the Malabo Declaration on Accelerated Growth and Transformation for Shared Prosperity and Improved Livelihoods contains commitments to improve nutrition through specific food security and nutrition targets (African Union Commission (AUC), 2014).

Access to food is a fundamental human right (UN, 1948). Access to food refers to a household's ability to obtain food from the market place or other sources (WFP, 2007). However, the rationale for state investment in nutrition often requires evidence of the economic returns (Hoddinott et al., 2013). Nutrition is the process through which nutrients are obtained, absorbed by the used to support how the body functions (Zimmerman and Snow, 2012). Nutrition is essential for child growth and development. Malnutrition has implications for economic development as well as investment in public health. Malnutrition is a deficiency of nutrients and can refer to both overweight and under-nutrition. Under-nutrition is a condition that results from inadequate intake of food that provides energy or nutrients (Center for Disease Control and Prevention and the World Food Program, 2007). Undernutrition is a contributor towards early child mortality (Hoddinott, 2013). Undernutrition in infants increases the risk of chronic disease in adulthood, which increases the burden on the state as it has implications for the public health system (Hoddinott et al., 2013). Regarding economic development, a large body of evidence reports a negative correlation between undernutrition and lifetime earnings. Up to 10% or more of lifetime earnings in low-income countries are lost because of undernutrition (Haddad and Bouis, 1991; Strauss and Thomas, 1997; Hoddinott et al., 2013). Also, productivity losses due to undernutrition account for 3 – 16% loss in gross domestic product (Hoddinott, 2016). The intersections between gender and nutrition have important implications for economic development.

## **1.2. Statement of the problem**

Gender inequality is an underlying cause of undernutrition (FAO, 2012). Applying a gender lens is important for ensuring that gender is adequately and appropriately integrated in public policies. Gender mainstreaming is the process through which a gender equality perspective is included in all areas of development including policies and at all levels of policy (United Nations Educational, Scientific and Cultural Organization (UNESCO), 1997). Mainstreaming gender into policies implies more than simply focussing on women. Development programmes often focus on women, overlooking the important role men can play, not only in ensuring positive child nutrition outcomes. The omission of men reinforces gender inequality. Public policies can make men aware of their caring responsibilities, but they can also help deconstruct systematically entrenched gender roles. Policy can assist in (re)defining roles by promoting a conducive environment for men's participation in maternal and child health (Kabeer, 1996).

Policymakers' gendered frames of reference are an obstacle to the development of gender-responsive policies. Women are typically associated with child nutrition, care work, housework and farm work. While income-generating is incorrectly associated with men (Moser, 1993). The association of roles, responsibilities and activities with a particular sex is determined by social and cultural institutions which

reinforce these perceptions (Bradshaw et al., 2013; Ellemers, 2018; Ferrant et al. 2014; Kabeer and Subrahmanian, 1996;). Such gendered frames of reference can influence policymakers gender perspectives, resulting in policies that are gender-blind, gender-neutral or gender-responsive.

Gender blindness refers to the inability to recognise that gender equality has social outcomes that influence the success of policies and projects (Pederson, 2014). Gender-neutral relates to development approaches that do not improve or even worsen gender outcomes (Pederson, 2014). Gender-responsive methods do not only raise awareness; they actively address critical issues related to gender norms, roles and inequalities (WHO, 2011). These approaches ultimately influence policy outcomes.

Many scholars argue that gender mainstreaming has been unsuccessful (van Eerdewijk and Davids, 2014). The reasons for this lack of success include a lack of commitment by leaders, limited understanding of the concept, lack of enforcement organisations (for example a Ministry or Department of Gender) and limited financial resources to efficiently mainstream gender (Mitchell, 2004). According to Ravindran and Keller-Khambete (2008), one of the main reasons that gender mainstreaming has been unsuccessful in the past is because efforts are often channelled toward training and implementing gender mainstreaming in policy processes, while investment in the actual implementation is insufficient. Payne (2011), Davids et al. (2014) and Parpart (2014) argue that implementation of gender mainstreaming has been another challenge, particularly the failure to overcome gender biases ingrained in social institutions, organisations and governments. The inability to adequately implement gender mainstreaming stems from weak translations of the intentions of the Beijing Platform for Action into practice. The perception that gender means women diverts focus from the intent to renegotiate gender power dynamics (Cornwall and Rivas, 2015). While gender mainstreaming has received much criticism, misconceptions and misuse of the term has hindered successful implementation. Policymakers should re-direct focus towards gender relations as opposed to merely focusing on women (Okali, 2011).

### **1.3. The need to accelerate progress on nutrition in Malawi**

Despite Malawi ranking second on the Africa Hunger and Nutrition Commitment Index (te Lintelo et al., 2017), evidence suggests that food security and nutrition continue to constrain development. The Hunger and Nutrition Commitment Index measures countries' political commitment to addressing issues of hunger and nutrition. For the agricultural period 2015/2016, it was estimated that 17% of Malawi's population would not be able to meet their food requirements (Government of Malawi (GoM) and Malawi Vulnerability Assessment Committee (MVAC), 2015). Only a year later, an estimated 39% of Malawi's population would not be able to meet their food requirements for the agricultural period

2016/2017. The Malawi government and the MVAC (2016) attributed the increase in food insecure people by 22% between 2015 and 2016 to climatic hazards caused by the onset of El Niño.

While the erratic weather has contributed significantly to food insecurity in Malawi, access to food has been a long-standing challenge. The Malawi 2006 Food Security Policy attributed food insecurity to people's inability to produce enough food or not having the means to buy food. According to the Comprehensive Food Security and Vulnerability Analysis Survey (World Food Programme (WFP), 2012), 50% of Malawi's population was reported to live below the \$1 per day poverty line in 2010. Although issues of access play a significant role in food insecurity and undernutrition, gender dynamics that constrain access to physical, human, social, financial and natural capital are policy issues that require urgent attention (Benson, 2006; te Lintelo et al., 2014).

#### **1.4. Research objectives**

As a signatory to the Beijing Platform for Action, Malawi's National Nutrition Policy and Strategic Plan (NNPSP) (2007 – 2012), should ideally consider how men's involvement in maternal and child health approaches influence gender equality.

The primary objective of this study was to explore how interpretations of gender influence nutrition policy in Malawi. Three specific research objectives were addressed. This qualitative study applied inductive methods and made three propositions which related to each research objective.

1. The first specific research objective was to determine how adequately Malawi's NNPSP (2007 -2012) integrated gender. The first proposition related to the primary objective as well as the first objective. Drawing on literature (Kabeer and Subrahmanian, 1996; Rao and Kellner, 2003), the study proposed that policymakers gendered frames of reference influence their gender perspective. This gender perspective informs policy decisions.
2. The second specific research objective was to develop an understanding of how men's involvement in maternal and child health is defined in rural Central Malawi and what hinders and facilitates men's involvement. The second proposition was that it is possible to influence gender roles even in the most traditional rural communities.
3. The final specific research objective was to understand the implications of men's involvement in maternal and child health for gender mainstreaming in nutrition policy. The third proposition related to this objective was that gender equality was not the goal of men's involvement in



maternal and child health approaches in the nutrition and health sectors. Men's involvement in maternal and child health is necessary for women and children to meet their daily dietary requirements and receive optimal health care. However, gender equality should also factor into the design of men's involvement in maternal and child health approaches to avoid unintended consequences such as reinforcing men's decision-making power.

## **1.5. De-limitations**

A number of de-limitations are recognised in this study. The assessment of Malawi's forthcoming National Nutrition Policy was time-bound as the policy was still in draft at the time of the assessment. Therefore, the findings and recommendations of this study are only relevant to the August 2016 draft.

The study focuses on the Malawian context and might not necessarily be transferable to other countries. However, countries with similar settings may be able to use some of the approaches identified through this study to mobilise men to participate in maternal and child health (Eisenhardt and Graebner, 2007). The researcher experienced difficulty in obtaining the opinions of a large number of policymakers due to political and time constraints.

## **1.6. Contribution to knowledge**

The study makes four contributions to knowledge. The first contribution was that the study found that increasing policymakers' awareness of biases that influence their policy decisions can improve the integration of gender into nutrition policies. It can also accelerate progress toward reducing malnutrition. The second contribution to knowledge was the identification of facilitators of men's involvement in maternal and child nutrition. In this study, the facilitators of men's involvement refer to the factors that encourage men to participate in maternal and child health. Many studies on men's involvement in maternal and child health have focused on the barriers to men's participation in maternal and child health. This study not only focuses on the facilitators but also specifically considers the domain of nutrition as opposed to maternal and child health in general. The third contribution to knowledge is the contribution of a framework for gender analysis for use by other researchers and policymakers. This framework provides policymakers with a lens through which they can better integrate gender in nutrition policy. The fourth contribution was an identification of the potential role of policy dialogues in strengthening community participation in policy. Chapter 7 discusses the contributions to knowledge in detail.

## 1.7. Thesis outline

The thesis consists of seven chapters. The first chapter provides an introduction and rationale for the study. The second chapter presents the literature review on which this study and the conceptual framework was based. Chapter three provides an overview of the policy process in Malawi, setting the scene for the next two chapters. Chapter four is structured as a paper that has been published online by *Development Policy Review* (Mkandawire et al., 2017). This chapter explores how adequately Malawi's NNPS is gendered, responding to the first objective. The fifth chapter, also structured as a paper published by *Biomed Central (BMC) Pregnancy and Childbirth* (Mkandawire and Hendriks, 2018) presents a qualitative analysis of the conceptualisation of men's involvement in maternal and child nutrition in rural Central Malawi. This chapter responds to the second research objective. The sixth chapter discusses how the research findings were validated. This chapter also highlights the implications of men's involvement in integrating gender in nutrition policy, responding to the third objective. Finally, the seventh chapter provides conclusions and recommendations for further research, highlighting this study's contribution to knowledge.

## **CHAPTER 2 : LITERATURE REVIEW**

### **2.1. Introduction**

This study considers how interpretations of gender influence the maternal and child nutrition policymaking process. Chapter 2 builds the conceptual framework from a review of literature. Figure 2.1. presents the conceptual framework. Nutrition policies can both improve gender inequality as well as address issues of undernutrition (FAO, 2012). However, many policymakers have interpreted gender as women and much of the policy focus on women. Policymakers design of nutrition policies is influenced by institutionalised gender norms prevalent in society. Women are often targeted in nutrition policies because nutrition is perceived to be women's responsibility (Moser, 1993). Attention to women in policies has also increased because studies purport that improving women's diet during the first thousand days of a child's life can reduce undernutrition (Black et al., 2013). However, nutrition policies often overlook gender dynamics that constrain women's access to nutritious food. Society typically excludes men from housework and care work, underestimating men's shared responsibility for achieving positive maternal and child nutrition outcomes.

### **2.2. Gender equality as a development priority**

In the 1970s, women were considered fundamental to the development process. Improving women's economic participation in society was strongly emphasised through policy. 'Women in development' theories played a major role in placing women on both the development and policy agenda (Razavi and Miller, 1995). The main proponent of the 'women in development' approach was Ester Boserup (Boserup, 1989). In 1979, the term gender emerged through a seminal paper by Unger: Toward a redefinition of sex and gender (Unger, 1979). The paper foregrounded the 'gender and development' approach. In 1994 a shift was made from 'women in development' to 'gender and development' (Razavi and Miller, 1995; Zosuls et al., 2011) because development practitioners realised that focusing on women alone was not enough to challenge the institutionalised power relations that prevented women from participating in development (Kabeer and Subrahmanian, 1996). Concerted effort is needed to address the systematic inequalities reinforced by society that hinder women's participation (Moser, 1993).

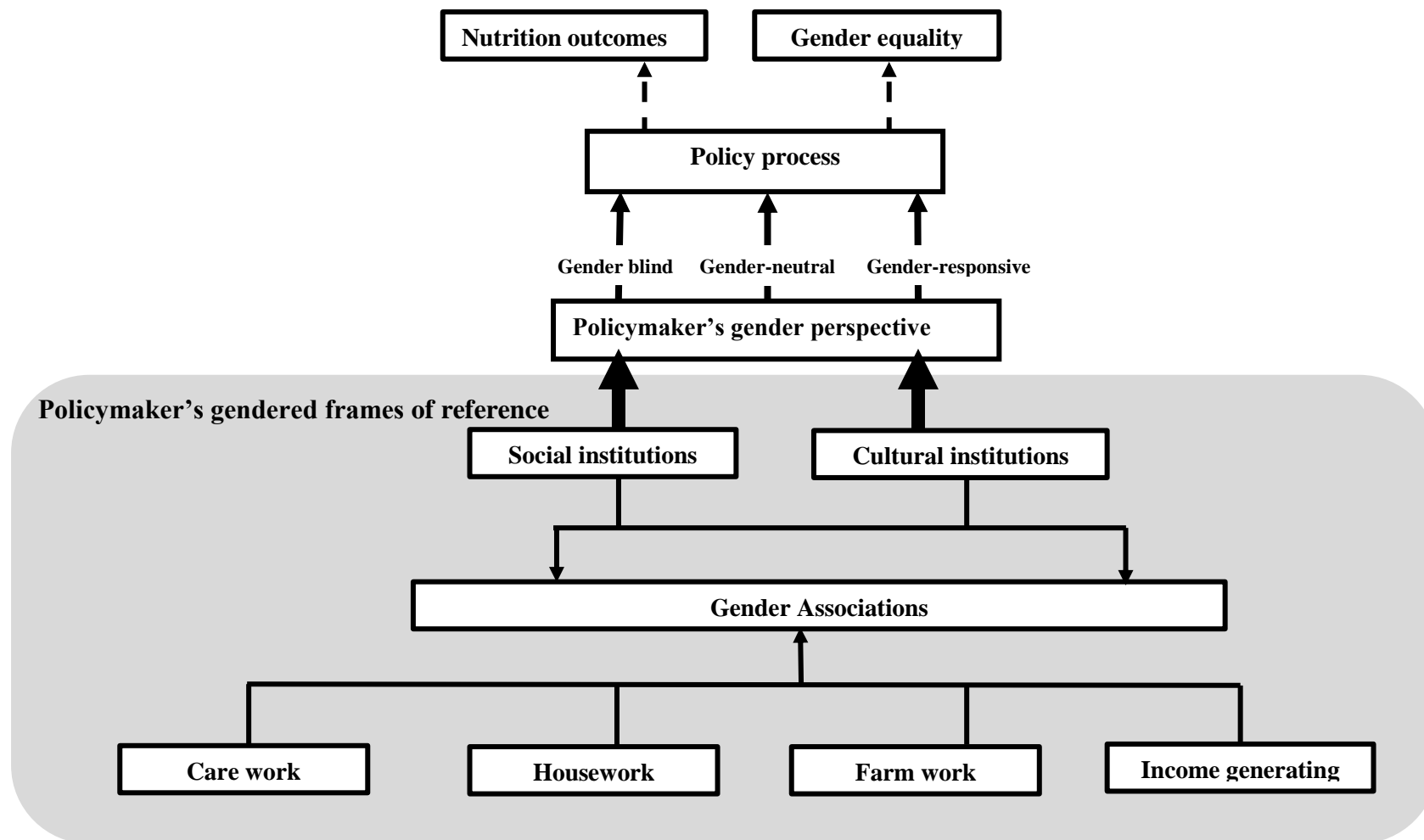


Figure 2.1: Conceptual framework for pathways to achieving gender equality and reducing malnutrition (own work)

The 'women in development' approach focused on equality and providing women with access to resources, education and income-generating opportunities. However, women were typically considered a homogenous group by development practitioners, with similar needs and solutions (Moser, 1993). The 'women in development' approach did not consider women's reproductive roles and as a result inadvertently increased women's workload by creating a demand for women's increased participation in agriculture and other economic activities (Moser, 1993). The 'women in development' approach assumed that increased income for women would automatically translate into equality between men and women (Razavi and Miller, 1995; Reeves and Baden, 2000).

The 'gender and development' approach requires understanding the systems in society that privilege men and undermine women (Kabeer and Subrahmanian, 1996). Gender refers to the responsibilities and expected behaviours society allocates to people based on their sex (Kretchmar, 2009). There is a difference between gender and sex (Eckert and Mc Connell-Ginet, 2003). Sex refers to the physiological makeup of a person. It ascribes the biological distinction between male and female. Gender, on the other hand, refers to both men and women and the interaction between the two sexes. The 'gender and development' approach, challenged socially determined gender roles by challenging gender norms. For example, in many low-income countries, men are often the main decision-makers in the household exerting sole control over resources. The 'gender and development' approach promotes women's increased control of resources. This approach focused on the causes of inequality and took into consideration both women's productive and reproductive roles (Reeves and Baden, 2000). The 'gender and development' approach emphasised the relationship between men and women. Table 2.1 below lists the factors that triggered the 'Women in Development' approach and the 'Gender and Development' approach. It also lists the aims and weaknesses of each of these approaches.

The 1994 International Conference on Population Development (UN, 1994) highlighted men's involvement in improving gender equality and emphasised that men indeed have an important role to play in achieving gender equality. The Beijing Fourth World Conference on Women (UN, 1995) reiterated men's involvement in improving gender equality. By signing the 1995 Beijing Platform for Action, countries committed to incorporating gender perspectives in all programmes and policies and at all levels. They also committed to "Ensure, through legislation, incentives and/or encouragement, opportunities for women and men to take job-protected parental leave and to have parental benefits; promote the equal sharing of responsibilities for the family by men and women, including through appropriate legislation, incentives and/or encouragement." (UN, 1995: 78).

However, many countries did not meet the expected outcomes because the implementation of gender mainstreaming has failed to apply the intended transformative approaches. A lack of understanding of the concept of gender has contributed to this failure. Policymakers continue to understand gender as

women. For example, improving gender power dynamics through policy is often overlooked by policymakers, in favour of just providing resources to women (van Eerdejiwk, 2014).

**Table 2.1: ‘Women in Development’ vs ‘Gender and Development’ approach (own analysis)**

<b>Focus</b>	<b>Women in development</b>	<b>Gender and development</b>
Trigger.	Need to integrate women as active agents in the development process.	Lack of progress of women in development.
	Women’s exclusion from the marketplace and limited control of resources.	
Aim.	Addressed women’s practical needs: increased income, education, access to resources.	Focuses on the need to redefine gender roles and
		Links production and reproduction.
Weaknesses.	Focus was on production; reproduction was neglected.	Not clearly defined for the policy context.
	Assumes that economic stability will automatically result in equitable gender relations.	
	‘Women in Development’ did not consider issues of culture, class or race. Women were considered as one unit.	

In the nutrition domain, the focus on women can be attributed to a large body of literature that suggests that women are more likely to spend the income that they control on food, healthcare and education of children (Meinzen-Dick et al., 2012; Smith and Haddad, 2015; van den Bold, 2013). For this reason, increased global commitment to nutrition has often focused on women’s empowerment as a means to reduce child undernutrition rather than on gender relations and the underlying factors that constrain men and women’s access to food.

### **2.3. Nutrition as a development priority**

Global commitment to improving nutrition has increased over the past 25 years. Several events and declarations have stimulated the demand to accelerate progress to reducing malnutrition to meet national, regional, African and international development goals (Covic and Hendriks, 2016). In as early as 1948, the Universal Declaration of Human Rights (UN, 1948) highlighted the right to food. But nutrition was only mentioned explicitly in 1976 in the International Convention on Economic, Social and Cultural Rights (UN, 1976).

The first international multi-sectoral event to place significant emphasis on nutrition was the 1990 World Child Summit (FAO, 1992a) where countries committed to improving both children and women's nutrition. The summit highlighted women's role and status as fundamental to achieving positive nutrition outcomes. At this summit, countries committed to reducing severe and moderate malnutrition by half between the period 1990 – 2000 (UN, 1990). The 1992 International Conference on Nutrition (FAO, 1992) followed soon after with 159-member states reaffirming their commitment to nutrition. Amongst the policy guidelines articulated in the World Declaration and Plan of Action for Nutrition (FAO, 1992b) was a commitment to involve communities more actively in the planning of nutrition interventions. The declaration also placed significant emphasis on gender equality, highlighting the critical role women play in providing nutritious food and seeing to the well-being of household members (FAO, 1992). The 1992 Declaration alluded to a role for men and boys in nutrition stating that: "In addition to improving education of women and taking into account the role of men in controlling resources and in determining the nutritional status of household members, the nutrition education of men and boys should be enhanced" (FAO, 1992: 6).

Eight years later, the Millennium Development Goals (MDG) renewed global commitment to nutrition (UN, 2000). While the first MDG focused on eradicating extreme poverty and hunger, the fourth MDG concentrated on reducing the under-five mortality rate by two-thirds between 1990 and 2015 (UN, 2000). The fifth MDG committed countries to reducing the maternal mortality ratio by three-quarters between 1990 and 2015. Nutrition was critical to achieving these three goals (United Nations System Standing Committee on Nutrition (UNSCN), 2004). The three goals provided an entry point for nutrition advocates to lobby governments for increased prioritisation of nutrition in development policies and programmes.

The Lancet Series, released in 2008, offered evidence-based nutrition interventions (Bhutta et al., 2008; Grantham-McGregor et al., 2008; Hoddinott et al., 2008; Vitoria, 2008). Increased commitment to nutrition, was called for, including integration of nutrition with health programmes and improved multi-

sectoral coordination. The series emphasised attention to women's diet during the period from conception until a child's second birthday (Black et al., 2013). A focus on women was increased because of their biological role in providing nutrients to children in utero and once the child is born, through breastfeeding. The release of the 2008 Lancet Series focusing on maternal and child undernutrition coincided with the 2008 world food crisis. With food prices increasing and over 923 million people classified by the FAO as food insecure (FAO, 2008), the 2008 world food crisis spurred action from governments to tackle malnutrition.

Also, in 2008, the Comprehensive Africa Agriculture Development Programme (CAADP) Framework for African Food Security was launched (AU/New Partnership for Africa's Development (NEPAD), 2009), drawing inspiration from MDG 1. The Framework for African Food Security was designed to address the third CAADP pillar. This framework aimed to increase resilience to food insecurity and to advance agricultural growth and nutrition simultaneously. It again drew focus to the importance of nutrition (NEPAD, 2009). The framework highlighted that for nutrition to improve, longer-term investments needed to be made to improve women's status and employment opportunities.

Since 2008, commitment to reducing undernutrition has increased rapidly. The Scaling Up Nutrition (SUN) Movement was established in 2010 (Sun Movement Secretariat, 2012) and the World Health Assembly (WHA) targets were agreed on in 2011 (WHO, 2012). Table 2.2 lists the WHA targets. In 2013, the first Nutrition for Growth Summit was held in London, where countries committed political and financial will to achieving the WHA targets (Department for International Development (DFID), 2013). UN member states signed the Rome Declaration (FAO, 2014) in 2014 at the second International Conference on Nutrition (FAO, 2014). More recently in 2016, the SDGs (UN, 2016) drew special attention to malnutrition.

Africa has also recognised the importance of improving maternal and child nutrition. In 2014, all African Union member states signed the Malabo Declaration on Nutrition Security for Inclusive Economic Growth and Sustainable Development dedicated to improving nutrition (AUC, 2014a) and the Malabo Declaration on Ending Preventable Child and Maternal Deaths in Africa (AUC, 2014c). The Malabo Declaration on Accelerated Agricultural Growth and Transformation for Shared Prosperity and Improved Livelihoods reinforces commitments made in the former (AUC, 2014b). Both declarations commit member states to reducing stunting by 10% and underweight by 5% by 2025. Table 2.3 presents the chronology of the events that put nutrition on the development agenda.



**Table 2.2: World Health Assembly Targets (DFID, 2013)**

Number	Target
1	40% reduction in the number of children under-5 who are stunted.
2	30% reduction in low birth weight.
3	50% reduction of anaemia in women of reproductive age.
4	No increase in childhood overweight.
5	Increase the rate of exclusive breastfeeding in the first six months up to at least 50% .
6	Reduce and maintain childhood wasting to less than 5% .

Nutrition has become a priority in the global and Africa development agendas. However, the intersection between gender equality and nutrition remains vague. Women and children have been central to many of the commitments, but gender relations that influence nutrition outcomes are less evident. Each document was reviewed by the researcher and, in some cases, specific quotations were extracted from these documents to determine whether the focus was on gender or women. In other cases, a summary was provided to indicate whether the declaration focused on gender or women. The terms ‘gender’ and ‘women’ are used interchangeably in many of the statements. Focus on women is not on increasing equality, but instead on improving their ability to provide nutritious food for themselves (during pregnancy) and children in their households. Table 2.3 illustrates that many of these documents emphasise women as opposed to gender. Most of these documents systematically overlook embedded inequalities that prevent both men and women from accessing nutritious food. In this regard, these international documents have inappropriately integrated gender. These declarations reinforce women’s reproductive roles and absolve men of responsibility. In these women are only regarded as significant when their socially prescribed functions (in this case pregnancy and child care) are fundamental to changing society (in this case reducing malnutrition). While women do indeed play a central role in nutrition, a focus on women alone is not sufficient for improving gender equality.

Distinguishing between gender and women is fundamental for policymakers to address gender equality. Policymakers need to understand how gender role prescriptions reinforce gender norms in order to challenge the barriers that prevent both men and women from accessing nutritious food. They also need to understand the process through which these roles and responsibilities become normalised.

**Table 2.3: Chronology of events that put nutrition on the development agenda**

Year	Declaration/event	Statement on gender/women
1948	Universal Declaration of Human Rights (UN, 1948).	Intersections between gender and nutrition are not made explicit.
1976	International Convention on Economic, Social and Cultural Rights (UN, 1976).	Intersections between gender and nutrition are not made explicit.
1990	World Child Summit (UN, 1990).	‘We will work to strengthen the role and status of women. We will promote responsible planning of family size, child spacing, breastfeeding and safe motherhood’ (UN, 1990:5).
1992	1 <sup>st</sup> International Conference on Nutrition (FAO, 1992), World Declaration and Plan of Action for Nutrition (FAO, 1992).	In addition to improving education of women and taking into account the role of men in controlling resources and in determining the nutritional status of household members, the nutrition education of men and boys should be enhanced.
2000	Millennium Development Goals (UN, 2000).	Intersections between gender and nutrition are not made explicit.
2003	Maputo Declaration on Agriculture and Food Security (AUC, 2003).	Intersections between gender and nutrition are not made explicit.
2004	Voluntary Guidelines on the Right to Food (FAO, 2004b).	‘States should promote women’s full and equal participation in the economy and, for this purpose, introduce, where it does not exist, and implement gender-sensitive legislation providing women with the right to inherit and possess land and other property. States should also provide women with secure and equal access to, control over, and benefits from productive resources, including credit, land, water and appropriate technologies.’ (FAO, 2004b: 17)
2008	The Lancet Series on evidence-based nutrition interventions (Vitoria et al., 2008).	Intersections between women and nutrition are made explicit.
	World food crisis.	Intersections between gender and nutrition are not made explicit.
	Launch of the CAADP Framework for African Food Security (AU/NEPAD, 2009).	‘Options for improving food access... • Investment to increase opportunities for employment and income generation, especially for women’ (NEPAD, 2008: 31). ‘Options for improving food access... • Investment to improve women’s status and employment opportunities’ (NEPAD, 2008: 32). ‘Options for improving food utilisation... • Investment in women’s education, behaviour change and social marketing’ (NEPAD, 2008: 32).

Year	Declaration/event	Statement on gender/women
2010	Scaling up Nutrition (SUN Movement Secretariat, 2012).	Agriculture: Making nutritious food more accessible to everyone, and supporting small farms as a source of income for women and families  'Health care: Access to services that enable women and children to be healthy' (The Scaling Up Nutrition Secretariat, 2014: 7).
2012	World Health Assembly global nutrition targets (WHO, 2012).	Intersections between gender and nutrition are not made explicit.
2013	Nutrition for Growth Summit (DFID, 2013).	Intersections between gender and nutrition are not made explicit.
2014	2 <sup>nd</sup> International Conference on Nutrition (FAO, 2014), Rome Declaration on Nutrition (FAO, 2014).	'...nutrition and other related policies should pay special attention to women and empower women and girls, thereby contributing to women's full and equal access to social protection and resources, including, inter alia, income, land, water, finance, education, training, science and technology, and health services, thus promoting food security and health.' (FAO, 2014: 4).
	Malabo heads of state meet	Malabo Declaration on Nutrition Security Through Inclusive Economic Growth and Sustainable Development in Africa (AUC, 2014a).
		Malabo Declaration on Accelerated Agricultural Growth and Transformation for Shared Prosperity and Improved Livelihoods (AUC, 2014b).
		Malabo Declaration on Ending Preventable Child and Maternal Deaths in Africa (AUC, 2014c).
2016	Sustainable Development Goals (UN, 2016).	Goal 5: Achieve gender equality and empower all women and girls.

## 2.4. Gender divisions of labour: Care work, housework, farm work and income-generating

Gender equality means that men and women have equal opportunities that enable them to realise their rights (Women's Commission for Refugee Women and Children, 2005). Osmani and Sen (2003) argue that gender inequality has significant implications for society. Gender inequality, a consequence of gender role socialisation, hinders economic development.

Gender role socialisation is the process through which individuals and societies internalise gender roles. From infancy, children are socialised to behave according to their sex (Kretchmar, 2009). Gender

inequality can begin as soon as the sex of the baby is known, with a societal preference for boys over girls. Often girls are taught to be passive and obedient, whereas boys are trained to be active and assertive. Societies determine how these gender roles should be practised (Kretchmar, 2009). Similarly, society determines the allocation of work to the sexes (Moser, 1993). Gender divisions of labour refer to work assigned to an individual based on his or her sex (Kabeer, 2003). Care work is unpaid work that involves looking after children, the elderly and the sick. Housework is routine unpaid work that pertains to maintenance of the house and the household, e.g. fetching water, fetching firewood, cleaning, cooking (Veerle, 2011). Housework and care work are commonly referred to as reproductive work (Moser, 1993). In low-income countries, care work and housework are often associated with women. However, women are also involved in farm work. Agrarian economies dominate most of Africa, with women participating in sowing, weeding and harvesting (Akintola, 2008). Women are often responsible for subsistence farming and while some women may be involved in paid farm work, their other responsibilities often constrain time spent on income-generating activities. Much of the care work, housework and farm work associated with women is unpaid and is consequently not considered valuable (Doss et al., 2018).

Women are also sometimes involved in income-generating activities to supplement household income. While women have income-generating responsibilities, these are often time constrained because of the demanding nature of their household responsibilities. Some authors suggest that women's increased income could raise women's decision-making power (Sultana, 2011). However, women's domestic duties constrain their ability to participate in income-generating activities (Kabeer, 2003).

Policymakers tend to overlook normative gendered divisions of labour that undermine women (Moser, 1993; Kabeer and Subrahmanian, 1996). These gendered divisions of labour often result in heavy workloads for women (Moser, 1993). While both sexes are involved in income generating activities to supplement household income, men's work is often limited to certain hours, interchanged with leisure time. Women perform reproductive work (caring for children and domestic tasks) and community work (work that benefits the collective community, for example caring for the sick). Women's reproductive work is significantly more time-demanding (Moser, 1993; Kabeer and Subrahmanian, 1996). Duties such as childcare are 24-hour responsibilities. Men's reproductive work is largely undefined (Moser, 1993).

#### **2.4.1. Gender inequalities and nutrition**

Deeply rooted structural obstacles that perpetuate gender inequalities constrain men and women's access to nutritious food (Richards et al., 2016). In many low-income countries, nutrition is considered

a woman's responsibility. However, women often do not have the same opportunities as men in terms of education, employment and engaging in income-generating activities because of socially ingrained gender roles and ideals (van den Bold et al., 2013). While women bear the responsibility for nutrition, they often lack the resources to meet their dietary requirements as well as those of household members.

Gender inequalities can perpetuate an intergenerational cycle of undernutrition. Many of the events that have called attention to maternal and child nutrition note that stunting in children is a direct result of women's inadequate dietary intake before, during and after pregnancy (Black et al., 2008). Women in low-income countries carry substantial household responsibilities, even during pregnancy (Izugbara and Kilanaga, 2010). Heavy workloads mean increased food requirements (Merchant, 2013). Small maternal size from undernutrition can restrict foetal growth. Maternal undernutrition is a major contributing factor to the low birth weight of babies (Merchant, 2013). If a baby has a low birth weight, there is an increased chance of the child being undernourished, reducing chances of them reaching their full potential as adults. They are also prone to suffering from non-communicable diseases in the future (Ruel et al., 2013). Girls who are undernourished are more likely to give birth to children who will suffer from undernutrition. It is in this way that the intergenerational cycle of undernutrition is perpetuated (Smith and Haddad, 2015; UNICEF, 2013).

Addressing undernutrition in the first thousand days of a child's life can stop the intergenerational cycle of undernutrition. The first thousand days is the period before conception up until the child's second birthday (Ruel et al., 2013). Gender inequalities can prevent women and men from taking advantage of this period. For example, exclusive breastfeeding for the first six months of a child's life is one of the recommendations for breaking the intergenerational cycle of undernutrition (Ruel et al., 2013). However, women typically have time-consuming workloads compared to men, particularly in the rural areas (Izugbara and Kilanga, 2010). Consequently, women are sometimes unable to exclusively breastfeed for the first six months because they must return to work or they must attend to other responsibilities. Women's varied responsibilities leave them with limited time to attend to children's nutritional needs as well as pursue income-generating activities. Women may have to rely on their partners for income, diminishing women's agency (Mkandawire, 2012).

Agency is a person's ability to challenge the status quo and make decisions that can transform their lives and the lives of those around them (Barandiaran, 2009). If women have agency, they can make informed decisions about their health and well-being and that of their children (van den Bold et al., 2013). They can recognise the value in accessing antenatal and postnatal services, where children can receive vaccinations and nutrition supplements such as vitamin A capsules and, in some countries, iron tablets. Accessing these services decreases pregnancy and childbirth risks for women and children and potentially improves nutrition (van den Bold et al., 2013).

## **2.4.2. Gender equality and work associated with men**

The redistribution of gender roles can accelerate progress toward gender equality. Men should take on care work and housework to give women an opportunity to pursue their economic potential (Greene et al., 2006). According to Connell (2003), Flood (2007) and the Women's Commission for Refugee Women and Children (2005), the key to addressing gender inequality is to understand the roles and responsibilities of men in gender equality and articulate positive ramifications of gender equality for men. Gender equality requires changing both men and women's lives. Most men have a vested interest in fostering gender equality (Flood, 2007). In the case of maternal and child nutrition, it is in the interest of their child's future that men participate in maternal and child nutrition-related activities, which may involve taking on roles previously reserved for women.

While involving men is essential for maternal and child health, many existing institutions and policies do not support men's involvement in maternal and child health. Policymakers often ignore men's equality regarding gender and maternal and child health. For example, nutrition policies often focus on children as beneficiaries, promoting maternity leave as an essential strategy for improving breastfeeding and optimising childcare (WHO, 2014). On the other hand, paternity leave is often not considered a priority. In fact, only 78 out of 167 countries promote paternity leave. Twenty-three of these countries are in Africa (Levtov et al., 2015). Policies that overlook men's potential to nurture and provide care for children and instead promote women in this role blatantly perpetuate socially determined gender roles. Such gender roles prevent men from playing an active role in children's development. Policymakers often do not consider the reforms needed to create a conducive environment for men to participate actively in maternal and child health (Connell, 2003).

Many Scandinavian, European Union and Latin American countries have made significant progress in creating a conducive environment for men's involvement in maternal and child health through policy incentives such as paternity leave to encourage fathers to be more engaged in maternal and child health (Levtov et al., 2015). For example, Costa Rica has developed legislation on responsible fatherhood to ensure that children know their fathers. A supportive environment is also created through educational programmes and advocacy to deconstruct socially prescribed gender roles that reinforce the notion that only women can provide care for children (Greene et al., 2006). However, given rural contexts in Africa where informal employment is the norm, policy options (such as paternity leave) are not practical. Limited literature is available on how to create a conducive environment for men's participation in maternal and child health.

Many studies conducted on men's involvement in maternal and child health in Africa, focus on the obstacles to men's participation and not on the facilitators. Table 2.4 documents these studies and the various barriers to men's involvement in maternal and child health. These studies have mostly focused on intimate partner violence, sexual and reproductive health and HIV prevention, including the role of men in the prevention of mother-to-child transmission (PMTCT) of HIV/AIDS (Wanner and Wadham, 2015).

**Table 2.4: Barriers to men's involvement in maternal and child health**

Barrier	Sub-theme	Authors
Gender role stereotyping.	<ul style="list-style-type: none"> <li>• Pregnancy is women's responsibility.</li> <li>• Traditional definitions of men's roles and cultural beliefs that lead to</li> <li>• Social stigmatization.</li> </ul>	Audet et al., 2015; Brubaker et al., 2016; Ganle and Dery, 2015; Kululanga et al., 2012; Mohlala et al., 2012; Osman et al., 2015; Singh et al., 2014; van den Berg et al., 2015.
HIV.	<ul style="list-style-type: none"> <li>• Avoiding HIV testing.</li> </ul>	Audet et al., 2015; Ganle and Dery, 2015; Kululanga et al., 2012; Mohlala et al., 2012; Osman et al., 2015; Singh et al., 2014; van den Berg et al., 2015.
Lack of definitive role for men's involvement in MCH.	<ul style="list-style-type: none"> <li>• Men are unaware of their role.</li> </ul>	Audet et al., 2015; Ganle and Dery, 2015; Kululanga et al., 2012; Mohlala et al., 2012; Osman et al., 2015
Time constraints.	<ul style="list-style-type: none"> <li>• Men have work and there is no paternity leave legislation.</li> <li>• Men need the time to engage in income generating activities.</li> </ul>	Audet et al., 2015; Brubaker et al., 2016; Kululanga et al., 2012; Osman et al., 2015; Singh et al., 2014.
Facility environment.	<ul style="list-style-type: none"> <li>• Lack of privacy.</li> <li>• Lack of services for men.</li> <li>• No agenda for men.</li> <li>• Negative staff attitudes</li> </ul>	Audet et al., 2015; Ganle and Dery, 2015; Kululanga et al., 2012; Osman et al., 2015.
Women's reservations towards male involvement.	<ul style="list-style-type: none"> <li>• It's a space for women to interact with one another.</li> <li>• Fear of losing spouses – specifically related to men's presence during childbirth</li> <li>• For the most part, women are happy to have men participate, however, the level and frequency of involvement needs to be looked at.</li> </ul>	Ganle and Dery, 2015; Kululanga et al., 2012.

Research has shown that men's attendance of antenatal visits leads to several positive maternal and child health outcomes. First, the number of births at healthcare facilities conducted by skilled birth attendants has increased (Mangeni et al., 2013). Second, the uptake of prevention of mother-to-child transmission of HIV/AIDS treatment improved (Kalembo et al., 2013). Third, the number of women

complying with proper breastfeeding and family planning through the use of contraception rose (Susin and Guigliani, 2008). Fourth, maternal knowledge and attendance of postnatal clinics improved. However, men's participation in antenatal clinics alone was not sufficient for improving maternal and child health. Investigation of other factors such as redistribution of housework and care work is needed (Aguair and Jennings, 2015).

## **2.5. Social and cultural institutions: Policymaker's gendered frames of reference**

Society and culture are both institutions that inform our gendered frames of reference. Kabeer (2003) defines institutions as 'rules of the game'. These institutions have an influential role in shaping human behaviour and outlining what is permitted and prohibited. Policymakers are social beings and as such, they too subscribe to specific social and cultural institutions and internalise cultural beliefs and ideologies. These institutionalised socio-cultural beliefs often permeate the policy environment resulting in unintended outcomes (Kabeer and Subrahmanian, 1996). Gender inequality is perpetuated by failure to adequately mainstream gender within the institutions that can assist in transforming policymaking (Okali, 2011). In reality, the social, political and economic contexts in which women live often continue to privilege men. Policy processes should challenge and contest these institutions.

Policies often overlook women's unpaid care work and housework and make assumptions about the time women have available to pursue income generating activities (Ferrant et al., 2014). Therefore, while policymakers may recognise that women's increased economic participation is needed to improve gender equality, policymakers overlook women's practical needs (Jones, 2009). For example, women's micro-finance programmes are a means of providing women with resources for increasing their participation in the economy. However, the burden on women increases because while microfinance programmes expect women to participate in paid work, society also expects women to meet their domestic and household responsibilities. Often the time women allocate to paid work is constrained and payback on loans could be delayed. Such oversights can increase women's workload and negatively affect the efficacy of development interventions. In fact, inappropriate public policy decisions not only exacerbate food insecurity but could also widen the gender gap (Armendariz and Roome, 2008; CFS, 2011).

Yeboah et al. (2015), argue that for the most part, many policies overlook men's role in gender equality. Resistance from policymakers to redefine gender roles in the development of policies constrains men's integration in gender equality interventions. Policy decisions are influenced by personal biases and ideologies that are socially constructed and institutionalised through gender role socialisation (Barker and Ricardo, 2005). These biases may influence decisions made throughout the entire policy process.



For example, nutrition policies often remain women-centred because policymakers are socialised to believe that nutrition is women's work.

Ferrant et al. (2014) suggest that defeminising care work could empower women and improve progress toward gender equality. The nutrition domain presents an opportunity to redefine how gender equality is operationalised. Men and women have a common interest in achieving improved nutrition outcomes for children. Deconstructing gender roles by harnessing this common interest can have a positive impact on both maternal and child nutrition outcomes as well as address gender equality. However, this would require conscientising policymakers who often are not aware of the underlying social and cultural institutions that reproduce inequalities (Lombardi et al., 2012).

## **2.6. Research gap**

This chapter presents the research gaps identified in the literature, outlining research opportunities for improving nutrition policies and gender mainstreaming through the men's involvement in maternal and child health approach. Men's involvement in gender equality approaches attempt to renegotiate gender roles and question gender norms, roles and relations (Pederson, 2014). However, men's participation needs to be carefully conceptualised within the context of gender transformative policy processes, particularly relating to maternal and child health. Sternberg and Hubley (2004) note that it is unclear whether men's involvement in maternal and child health leads to women's empowerment. In fact, involving men in maternal and child health could lead to reinforcing men's decision-making power. For example, if development practitioners only include men to make better decisions on behalf of their partners and not together with their partners, then they are likely to reinforce decision-making power imbalances. Therefore, it is critical to understand the implications of men's involvement in maternal and child health on gender equality. It is also important to highlight how men's involvement in maternal and child health can address gender inequalities.

Even where gender is integrated into policy, a gap exists between agenda setting and implementation (Verloo, 2007; Wanner and Wadham, 2014). Also, policies are not always supported by legislation. Even in cases where they are, enforcement of these regulations is lacking (Ayuko and Chopra, 2008). When designing policies, gender is often integrated without considering enforcement mechanisms or changes that need to be in place to support implementation. For example, Kululanga et al. (2012) found that men were encouraged to be present during childbirth as a means of promoting men's involvement in maternal and child care. However, the hospital environment was not conducive to men's participation. Often hospital gowns were unavailable and many women had to give birth naked. Privacy partitions were also not available and so the environment was not supportive of men's participation.

The men felt uncomfortable, reinforcing the notion that they did not belong in that environment. Such oversights increase men's resistance to participating in maternal and child health. While a decision may have been made to involve men more actively in maternal and child health, the infrastructure to support this initiative is often lacking. Regulations need to be put in place to ensure that a conducive environment is created for men to enable them to take a more active role in maternal and child care.

Table 2.4 highlights some of the constraints to men's involvement in maternal and child health. Limited literature exists in the area of men's involvement in maternal and child nutrition. It is also unclear what opportunities exist for nutrition policy within the context of men's involvement in maternal and child health initiatives. Similarly, men's involvement in maternal and child health initiatives have focused on the barriers to men's participation in maternal and child health. Little is known about the facilitators of men's involvement in maternal and child health.

## **2.7. Synopsis**

Gender equality is vital for improving maternal and child health outcomes. However, socially constructed gender roles and social systems deeply ingrained in social, economic, political and cultural institutions influence decisions made by policymakers. Consequently, policymakers design policies that fail to challenge systems that reinforce gender inequality. This literature review highlighted the importance of understanding interpretations of gender and the influence they have on nutrition policy.

## **CHAPTER 3 : SETTING THE SCENE – GENDER MAINSTREAMING IN MALAWI’S NUTRITION POLICY**

### **3.1. Introduction**

Malawi is a small landlocked country located in South-eastern Africa. It has a population of 17.2 million and is one of the poorest countries in the world, ranking 170 out of 188 countries on the Human Development Index (Population Reference Bureau, 2016; UNDP, 2015). Half of Malawi’s population was living below the \$1 poverty line in 2012 (WFP, 2012). Low productivity, poverty and undernutrition contribute to high levels of food insecurity. National productivity is often affected by historical rates of child stunting. In Malawi, 60% of the working-age population was reported to have been under-nourished as children in 2010, consequently, they were less productive and less able to contribute to the economy (GoM et al., 2015). While Malawi has made progress in reducing undernutrition over the past five years, it continues to have one of the highest stunting rates in the world, with 37% of children under five reported as stunted in 2015 (NSO and Macro, 2015). Gender disparities and household decision-making dynamics exacerbate undernutrition in Malawi.

Malawian women are typically responsible for household food production and consumption (Lauterbach and Matenje, 2013). However, limited access to education reduces women’s income-generating opportunities and heavy workloads constrain their ability to produce sufficient food for their households. Consequently, women are unable to provide enough food to meet their daily dietary requirements and the requirements of their families (Kerr et al., 2016). Malawian men generally play a minimal role in household food production and consumption, yet they maintain control over household income and resources (Mseu et al., 2014).

### **3.2. Gender mainstreaming and nutrition policy in Malawi**

As a signatory to the Beijing Declaration and Platform for Action (UN, 1995), Malawi has been committed to mainstreaming gender in all policies and programmes and at all levels since 1995. The Malawi government defines gender mainstreaming as, “...the process of consistently incorporating a sensitivity to gender differences/inequalities into the analysis, formulation and monitoring of strategies and activities that can address and help reduce inequalities between women and men” (GoM, 2005: 2). Coordination of all gender mainstreaming activities is the responsibility of the Ministry of Gender, Children, Disability and Social Welfare (MoGCDSW) (MoGCDSW et al., 2015). The mandate of the

MoGCDSW, is to ensure equal participation of men, women, boys and girls in national development (GoM, 2005).

The Malawi Growth and Development Strategy III (MGDS III) (2017 – 2022) is the medium-term overarching development plan that sets out Malawi’s policy priorities and objectives (GoM, 2017). There are five key priority areas included in the MGDS III. These are agriculture; water development and climate change; education and skills development; energy; industry and tourism development; transport and ICT infrastructure and health and population. The MGDS III considers gender and nutrition as ‘other development areas’, recognising that gender mainstreaming remains a challenge in Malawi’s development policies and programmes. Consequently, the MGDS III promotes gender transformative approaches, defined as approaches that challenge gender norms and create opportunities for women to influence social and political areas. In the MGDS III, gender is integrated as a cross-cutting issue in the sections related to health and education. The MGDS III aims to ensure that the nutrition and well-being of the population are improved. The strategy explicitly highlights involving men in maternal and child health and promotes gender equality in maternal and child nutrition, care and household duties.

The purpose of the National Gender Policy 2015 – 2020 is to strengthen gender mainstreaming and women’s empowerment to achieve gender equality and equity in Malawi (MoGCDSW, 2015). The policy explicitly advocates for gender mainstreaming in agriculture, food security and nutrition. It emphasises that nutrition is typically considered women’s responsibility and recognises that men’s limited participation in nutrition programmes exacerbates undernutrition. Consequently, the policy advocates for men’s involvement in food production, storage and preparation. While the policy commits to advocate for men’s participation in food security and nutrition-related activities, many of the proposed strategies remain centred on women (MoGCDSW, 2015). No clear pathway for designing men’s involvement programmes is outlined, nor is there clarity on the institutional reforms required to ensure that implementation of men’s involvement programmes is successful. The policy does not consider the impact of involving men in nutrition on gender equality.

Several challenges have contributed to the weakness in gender mainstreaming in Malawi. These challenges include delays in reviewing policies, lack of funds and weak gender mainstreaming institutional frameworks. Delays in reviewing Malawi’s 2000 National Gender Policy reflect a lack of commitment to drive the gender agenda forward. Malawi’s National Gender Policy expired in 2005 but was only passed by cabinet in 2015. Consequently, gender programmes were implemented without an overarching guiding framework (GoM, 2017). According to Mbilizi (2013), investment in mechanisms to facilitate the implementation of gender-related policies and programmes in Malawi is low. The share of the Ministry of Gender, Children, Disability and Social Welfare in the national budget was 0.9% in

2014 (MoGCDSW, 2015). Guiding documents such as the Guidelines for the preparation of the 2015/16 budget promote gender-responsive budgeting (Ministry of Finance, Economic Planning and Development (MoFEPD), 2013). However, the MoGCDSW's share of the national budget remains low, only peaking at 2.9% in the 2012/13 financial year. While the Ministry of Finance supports the MoGCDSW in the integration of a gender budget in various line ministries, weak enforcement hinders implementation efforts (Mbilizi, 2013).

### **3.3. Nutrition policy**

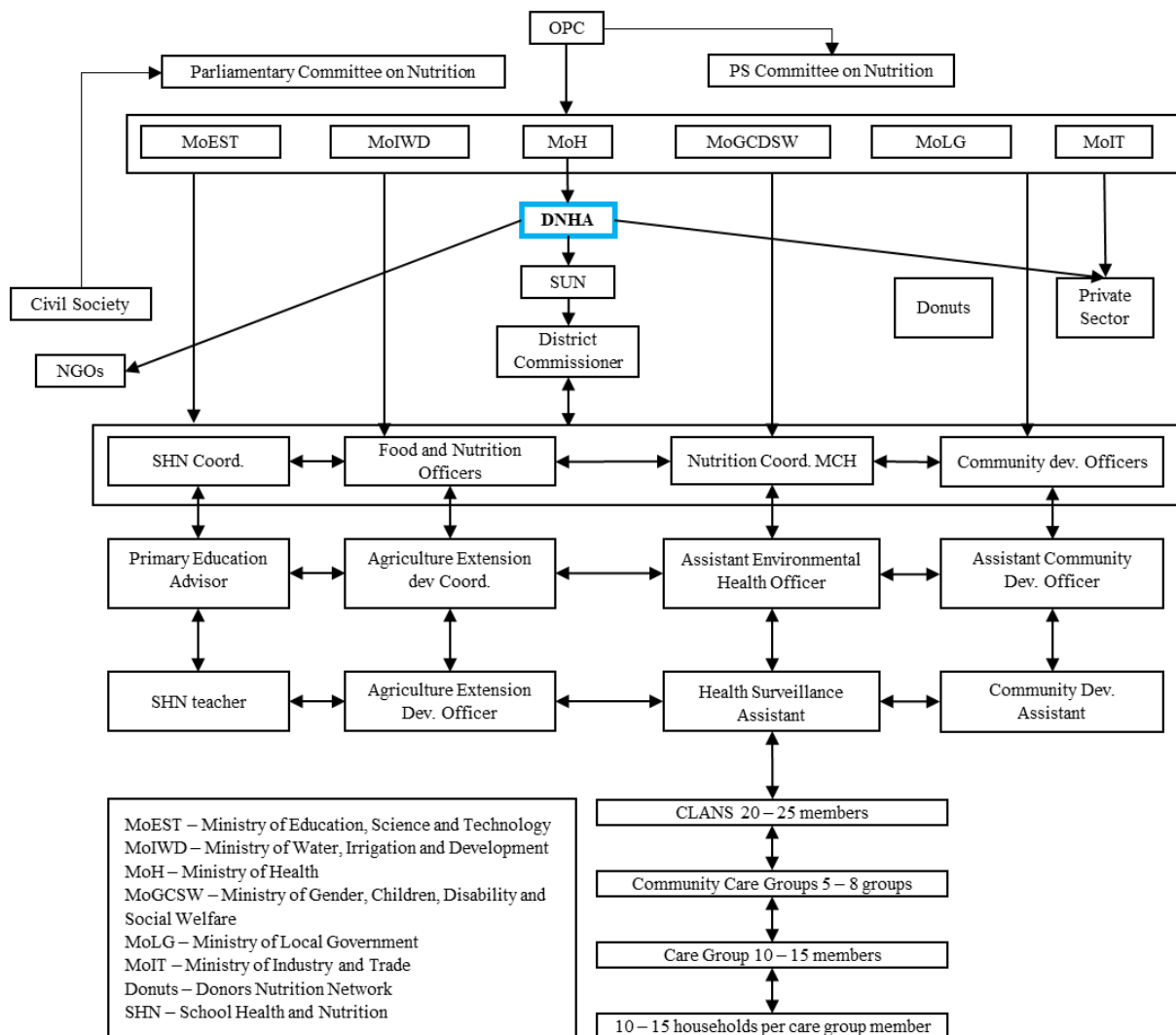
Nutrition policies in Malawi are coordinated by the Department of Nutrition, Human Immunodeficiency Virus and Acquired Immunodeficiency Syndrome (DNHA), situated in the Ministry of Health (MoH). The placement of the DNHA in the MoH occurred in 2015. Formerly in the Office of the President and Cabinet, the DNHA was moved to the MoH to decrease the number of line ministry departments with the Office of the President and Cabinet (Babu et al., 2016). The DNHA, in collaboration with a wide range of stakeholders, is responsible for setting the nutrition policy agenda, designing policies and monitoring implementation of policies.

In Malawi, nutrition policies are developed through a consultative process with the involvement of a focal person from each ministry, including the MoGCDSW. The gender focal person is responsible for ensuring that nutrition policies integrate a gender perspective. The policy process usually begins with problem identification and development of a strategy.

In the case of the forthcoming National Nutrition Policy 2016 – 2020, a local consultant was identified to draft the policy. The consultant shared the draft with various stakeholders for their input. The input was integrated into the policy and sent to the National Nutrition Committee. This consists of multiple stakeholders including Non-Government Organisations (NGO), cross-cutting ministries, donors, civil society and the private sector. The DNHA submitted the draft to the Parliamentary Committee on Nutrition. This committee was responsible for mobilising resources for implementation.

It was at this stage of the policy process that the PhD study was conducted. Research participants explained that the next step of the policy process was for the Parliamentary Committee on Nutrition to assess the draft and send it to the Permanent Secretaries' Committee on Nutrition. After that, the Cabinet Committee on Nutrition would review it. Finally, the full Cabinet would approve the policy and implementation would begin.

Figure 3.1 presents an institutional map showing how the various stakeholders interact with DNHA at a national as well as district level. Six key ministries are involved in nutrition. These ministries are the Ministry of Education, Science and Technology, the Ministry of Water, Irrigation and Development, the MoH, the MoGCDSW, the Ministry of Local Government and the Ministry of Industry and Trade. Each of these ministries hosts a nutrition focal person who is responsible for mainstreaming nutrition in the sector (Babu et al., 2016). The Scaling Up Nutrition (SUN) office in the country is located within the DNHA.



**Figure 3.1: Institutional setup map of nutrition stakeholders in Malawi (Babu et al., 2016)**

At the district level, the district commissioner coordinates nutrition activities through the District Nutrition Coordination Committee (Babu et al., 2016). This committee should ideally interact with other district-level committees and officers in different sectors. For example, the committee should cooperate with the District Community Development Committee to ensure that all community development activities integrate nutrition where possible. At the community level, care groups coordinate nutrition activities. Care groups consist of 10 – 15 community members who are responsible for delivering nutrition messages to households within the community.

The August 2016 draft of Malawi's forthcoming National Nutrition Policy 2016 – 2020 (MoH, 2016), states that women do not have the same opportunities as men in education and income-generating activities (MoH, 2016). Low levels of literacy and educational attainment decrease women's opportunities. It also mentions that women face constraints that prevent them from meeting the dietary requirements of children and other household members (MoH, 2016). For example, the policy recognises that mothers have little time and resources to provide children with optimum care and feeding. The National Nutrition Policy refers to the 2013 Gender Equality Bill, prohibiting discrimination against women because of marital status (GoM, 2013). For example, the legislation prohibits discrimination against pregnant unmarried women. The policy prioritises gender by including it as a separate priority area. Men's involvement is included as a policy statement and as a strategy (MoH, 2016).

### **3.4. Understanding how men's involvement emerged on the policy agenda in Malawi**

Table 3.1 below presents a timeline documenting international and Malawi gender and nutrition events. The purpose of the timeline is to assist in identifying key focusing events that led to policy decisions. These events are categorised as nutrition, political, health and gender events. The chronology illustrates events or actions that could have influenced gender mainstreaming. The timeline highlights efforts that have directly contributed to the emergence of men's involvement in maternal and child health.

Men's involvement emerged on the nutrition policy agenda for several reasons. As reflected in the policy chronology, international events and commitments played a fundamental role in getting men on the gender agenda. Malawi immediately operationalised these agreements by incorporating men's involvement in maternal and child health in reproductive health policies and strategies. However, it was not until 2009 when the evidence reflected a demand for men to be involved in the prevention of maternal-to-child transmission of HIV/AIDS that men's involvement in maternal and child health became a policy priority for government and other stakeholders involved in maternal and child health activities.

In 1987, African countries met in Nairobi at the Global Safe Motherhood Initiative. Recommendations were made to reduce maternal and child mortality by 50% between 1900 and 2000 (DHS, 2010). In 1994, at the International Conference on Population Development (UN, 1994), Malawi along with other countries, signed a declaration that formalised the commitment to these recommendations. Men's involvement in women's sexual and reproductive health was amongst the many approaches identified

to reduce maternal mortality. This approach was re-emphasised the following year at the 1995 Beijing Fourth Conference on Women (UN, 1995).

In response to the two declarations, Malawi began incorporating men's involvement in gender equality into the development agenda as early as 1996 with the establishment of the Malawi Platform for Action (MoCWCS, 2004). Malawi was one of two countries in the SADC region to include a chapter in the 2000 and 2004 Malawi Demographic and Health Survey (MDHS) on assessing men's participation in health care (NSO and Macro, 2000). Lesotho did likewise. The integration of men's involvement in maternal and child health approaches in Malawi's 2006 Reproductive Health Strategy continued the momentum by including men's attendance of antenatal clinics as a target.

The 2009 Second Reproductive Health Conference hosted by the Centre for Reproductive Health in collaboration with MoH and other stakeholders renewed interest in men's involvement in maternal and child health. This conference presented evidence on barriers to improving maternal and child health. Researchers highlighted that men's participation in maternal and child health was essential for achieving positive maternal and child health outcomes. The conference prompted the inclusion of men's involvement in maternal and child health as a policy priority. At this event, researchers reported that:

- The participation of traditional leaders in encouraging men to be involved in maternal and child health was important
- There was a need for clear guidelines and policy on the levels of male involvement
- There was a need for male-friendly infrastructure in labour wards where women give birth and
- There was a need to address socio-cultural myths barriers and misconceptions around men's involvement in maternal and child health (Taulo, 2008).

The lack of men's involvement in maternal and child health contributed to limited uptake of prevention of mother-to-child transmission of HIV/AIDS treatment (Nyondo et al., 2014). In 2004, mother-to-child transmission of HIV/AIDS accounted for 25% of all new HIV infections (NSO and Macro, 2004). The 2004 MDHS reported that while 53% of women received HIV counselling during antenatal visits, only 3% were tested and received the HIV test results (NSO and Macro, 2004). If found positive, women feared the responses of their partners (Aarnio et al., 2009). Consequently, women were afraid to attend voluntary counselling and testing for HIV/AIDS. It was reported that women would face abandonment by their partners, accusations of infidelity or even domestic violence if they disclosed their seropositive status to men (Nyondo et al., 2014). Women's lack of awareness of their HIV status increased the transmission to babies. Researchers recommended inviting men to attend antenatal visits to promote counselling and testing of couples so that the results would be provided to the couple while they were together (Kalembo et al., 2013; Nyondo et al., 2014; Osofi et al., 2014).



**Table 3.1: Policy chronology of nutrition, political, gender, health and international events in Malawi**

Nutrition events	Dates	Political events	Gender events	Health events	International events	Maternal and child mortality
	1974				Universal Declaration on Eradication of Hunger and Malnutrition (UN, 1974)	
Home economics approach to nutrition with focus on the family (Babu et al., <i>Forthcoming</i> )	1984					
	1985		A National Commission of Women in Development (NCWID), was established through an act of Parliament (GNGCN, 2009)			
	1986				International Convention on the Rights of the Child (UN, 1986)	
	1987				Ratified CEDAW Global Safe Motherhood Initiative (MoH, 2007)	
	1990				The World Child Summit (UN, 1990)	Maternal: 620/100,000 live births Children: 234 deaths per 1000 live births (NSO and Macro, 1992)
	1992		Renaming of Ministry of Communication to Ministry of Women and Children's Affairs, Community Development and Social Welfare (Malawi NGO Gender Coordinating Network, 2009)			
	1993		Women in Development policy and action plan (Malawi NGO Gender Coordinating Network, 2009)			
National Plan of Action for nutrition (Babu et al., <i>Forthcoming</i> )	1994	Change in constitution and government (MoGCS, 2004)			International Conference on Population and Development (UN, 1994)	
	1995				Beijing fourth conference on women and signing of Beijing Declaration and Platform for Action (UN, 1995)	
	1996	Establishment of the Malawi Human Rights Commission (Ministry of Gender and Community Services, 2004)	Malawi National platform established (Malawi NGO Gender Coordinating Network, 2009)			
	1997				The SADC Gender and Development Declaration, 1997	
	1998		Formally adopted the GAD approach (Malawi NGO Gender Coordinating Network, 2009)	Safe motherhood project commenced (Ministry of Gender and Community Services, 2004)		
Food crisis triggered need for a new food security and nutrition policy (Babu et al., <i>Forthcoming</i> )	2000		National Gender Policy (GoM, 2000)	National Reproductive Health Policy was launched (MoH, 2007) Establishment of the Men for Gender Equality Network (Ministry of Gender and Community Services, 2004)	Millennium Development Goals	Maternal: 1,120/100,000 live births Children: 234 deaths per 1000 live births (Ministry of Gender and Community Services, 2004)

Nutrition events	Dates	Political events	Gender events	Health events	International events	Maternal and child mortality
	2001		Establishment of Special Law Commission on Gender Law Reform (Malawi NGO Gender Coordinating Network, 2009)			
Nutrition was included in the Malawi Growth and Development Strategy I (Babu et al., <i>Forthcoming</i> )	2002			National Reproductive Health Policy 2002 - 2007 (GoM, 2009)		
OPC DNHA Established (Babu et al., <i>Forthcoming</i> )	2004					Maternal: 984/100,000 live births Children: 133 deaths per 1000 live births (NSO and Macro, 2004)
	2005	Bingu wa Mutharika came into power (Babu et al., <i>Forthcoming</i> )		National Reproductive Health Strategy 2006 – 2010 (MoH, 2006)	Ratified African Charter on Human Rights and People's Rights on the Rights of Women in Africa (AU, 2005)	
National food security and nutrition policy and strategic plan was finalised (Babu et al., <i>Forthcoming</i> )	2007		Revision of National Gender Policy (Malawi NGO Gender Coordinating Network, 2009)	Road Map for accelerating the reduction of Maternal and Neonatal Mortality and Morbidity in Malawi (MoH, 2007)		
	2008				Lancet Series	
	2009			Conference hosted by the Center for Reproductive Health (Taulo, 2009) Sexual and Reproductive Health and Rights Policy launched (GoM, 2009)		
Malawi signs up for SUN (Babu et al., <i>Forthcoming</i> )	2010					Maternal: 675/100,000 live births Children: 112 deaths per 1000 live births (NSO and Macro, 2004)
Launch of Nutrition Policy & Strategic Plan (2007-2012)						
	2012	Change in government (Joyce Banda) (Babu et al., 2016)			World Health Assembly Resolutions (WHO, 2012)	
Revision of the 2007 nutrition policy begins (Babu et al., <i>Forthcoming</i> )	2013		The gender equality Act was passed (GoM, 2013)			
Nutrition out of OPC and back to health (Babu et al., <i>Forthcoming</i> )	2014	Change in government (Peter Mutharika)				
	2015				Sustainable Development Goals (UN, 2016)	

In 2009, Malawi released the Sexual and Reproductive Health and Rights Policy (MoH, 2009). Men's involvement in maternal and child health was explicitly set out as a goal in this policy. The policy highlighted that Malawians consider childbearing issues as women's issues and that men's participation in this domain was limited by illiteracy, ignorance, poverty, increasing rural-urban migration and cultural beliefs (MoH, 2009). The policy stated that: 'Men's shared responsibility and active involvement in parenthood and sexual and reproductive behaviour shall be emphasised in the delivery of Sexual and Reproductive Health and Rights' (MoH, 2009:16). Given the intersections between women's reproductive health and nutrition, men's involvement in maternal and child health approaches should include nutrition.

The review of the National Nutrition Policy began in 2013 (Babu et al., 2016). However, it was not until 2016 that the draft version of Malawi's National Nutrition Policy included men's involvement in maternal and child nutrition. The 2017 MGDS III makes mention of men's involvement in nutrition. However, the timeframe in which the MGDS III and the forthcoming National Nutrition Policy were developed suggests that the 2016 draft of the National Nutrition Policy may have influenced the MGDS III. By the time the process of developing the MGDS III started in 2017, the review of the National Nutrition Policy had already made significant progress. The alignment of the two documents is out of sync. As the medium-term framework the MGDS III should ideally inform the Nutrition Policy, however, because of the weak alignment of policies, the National Nutrition Policy precedes the MGDS III.

### **3.5. Synopsis**

Malawi has signed many international commitments to address gender inequalities and several policies at national level integrate gender equality as an objective. Efforts to domesticate these international agreements have likely influenced the emergence of men's involvement on the policy agenda. The policy diffusion between the health and nutrition sectors played a role in the emergence of men's involvement in maternal and child nutrition in the forthcoming National Nutrition Policy agenda. Men's involvement in maternal and child health programmes in the health sector are designed to include nutrition education of men.

# **CHAPTER 4 : A GENDER ASSESSMENT OF MALAWI'S NATIONAL NUTRITION POLICY AND STRATEGIC PLAN 2007 – 2012<sup>1</sup>**

## **4.1. Introduction**

Over the past five years, global commitment to addressing malnutrition has increased. Following the 2014 International Conference on Nutrition Rome Declaration (FAO, 2014), UN member states committed to eradicating all forms of malnutrition. The SDGs (UN, 2016), re-affirmed this commitment, with goal two specifically dedicated to ending hunger, achieving food security and improving nutrition. At least 12 of the SDGs containing targets that are highly relevant to nutrition (International Food Policy Research Institute (IFPRI), 2016). In 2016, the UN launched the Decade of Action on Nutrition (WHO, 2016). This launch endorses the Rome Declaration and emphasises the necessity for reducing malnutrition.

Few developing countries can claim to have made as much progress as Malawi in terms of maternal and child health during the Millennium Development Goal (MDG) era. Malawi is one of a few low-income countries to have achieved MDG four on reducing child mortality (GoM, 2014). However, progress toward reducing malnutrition (MDG one) has not been as rapid. In 2010, 60% of deaths among children under five years of age in Malawi were related to undernutrition (NSO and Macro, 2010). Between 2010 and 2015, the rate of undernutrition among children under five years of age in Malawi reduced from 47% to 37% respectively (NSO and Macro, 2010 and 2016 respectively). While this reduction is significant, more rapid progress is needed if Malawi is to meet the Malabo Declaration on Accelerated Growth and Agriculture Growth and Transformation for Shared Prosperity and Improved Livelihoods target of reducing child undernutrition to 10 per cent by 2025 (AUC, 2014). Accelerated progress is also necessary to meet the Sustainable Development Target under goal two (ending all forms of malnutrition by 2030) (UN, 2016).

One of the key principles of Malawi's National Nutrition Policy and Strategic Plan (NNPSP) (GoM, 2007), is to promote gender equality. This chapter considers whether gender in Malawi's NNPSP is reduced to focussing interventions only on women or whether it is gender-responsive or gender-blind?

---

<sup>1</sup> This Chapter is based on the paper: Mkandawire, E., Hendriks, SL. and Mkandawire-Valhmu, L. 2017. A gender assessment of Malawi's National Nutrition Policy and Strategic Plan 2007–2012, Development Policy Review. doi:10.1111/dpr.12287.

The analysis considers whether policymakers' interpretations of gender are flawed and how these interpretations influence their decisions.

Gender inequality is an underlying cause of undernutrition. Gender is not defined by biological differences (sex), but rather by the social attributes with which people identify themselves as male or female and the relationships between the sexes (Moser, 1993). Applying a gender lens is important for ensuring that gender is adequately and appropriately integrated in public policies. In this study, a gender lens refers to the analysis of nutrition policy using a gender mainstreaming approach. This approach includes identifying the power relations that constrain men's and women's access to food to improve child nutrition.

Excluding men from nutrition policy perpetuates the notion that nutrition is a woman's responsibility. Public policies can make men aware of their caring responsibilities, but they can also help deconstruct systematically entrenched gender roles. Policy can assist in (re)defining roles by promoting a conducive environment for men's participation in maternal and child health. Yet, development practitioners often focus on women in the design of development programmes, overlooking the important role men can play, not only in ensuring positive child nutrition outcomes, but also in reducing gender inequality (Cornwall, 2000; Doss et al., 2018).

While policymakers recognise the importance of integrating gender into policies, the way in which this is done often reinforces systems that perpetuate gender inequalities. Policymaker's frames of reference are often informed of their own experiences of gender, which are often influenced by institutionalised gender norms. Kabeer and Subrahmanian (1996: 3), argue that because of such biases and ideologies, policymakers need to 'constantly check their assumptions and practices against the reality on the ground in order to avoid the consequences of their own preconceptions and prejudices or planning on the basis of some outmoded version of reality'.

Gender-responsive policies consider norms, roles and inequalities, ensuring that these are addressed through policies. While gender sensitive programming recognises gender issues, but only raises awareness (WHO, 2008). Gender-blind implies that gender norms are ignored and can result in perpetuating of gender stereotypes (Pederson et al., 2014). This analysis of intended gender mainstreaming in the NNPS provides insight into oversights regarding gender-responsive policy making. Gender-responsive nutrition policies could accelerate progress in meeting international commitments such as the SDGs.

## 4.2. Mainstreaming men into gender policy

Gender mainstreaming serves to ensure that both men and women's interests and concerns are an integral part of the design, implementation, monitoring and evaluation of policies and programmes. Policies and programmes integrate men and women's interests by identifying their strategic and practical needs. Strategic needs refer to men or women requirements for improving their status in society (Moser, 1993; Kabeer and Subrahmanian). For example, a strategic need may be to increase paternity leave days allocated to men, enabling them to participate more actively in the first few months of a child's life. Such policies assist in alleviating the burden of reproductive work women undertake, allowing them more time to engage in other activities. Practical needs are men and women's immediate needs. For example, women's microfinance programmes can meet women's immediate needs for cash to access food. Moser (1993) suggests that policymakers should be cautious of only addressing practical needs as these might distort the attainment of strategic needs. For example, while increasing women's income in the household may lead to improved nutrition outcomes for household members; it does not change decision-making dynamics between men and women.

Critics of gender mainstreaming argue that the concept of transforming gender relations has been 'lost in translation' (Tolhurst et al., 2012). Meier and Celis (2011), suggest that the Beijing Platform for Action (UN, 1995), failed to define a substantive goal for gender mainstreaming and transferred the responsibility of setting gender priorities to actors in various policy domains. Actors often lack the capacity to integrate gender into policy. Policymakers often overlook interrogating the gendered nature of policies.

Discourses on gender equality in nutrition policy have been for the most part rhetoric. First, the term gender is often misconstrued to mean women. Policies are often deemed to address gender if they mention women (Nyalunga, 2007). Payne (2014: 36) argues that 'the practical interpretation of gender has come to mean women'. Second, some scholars resist the idea, fearing the approach is overshadowing women's empowerment. Others are concerned that gender programmes are not only diverting resources from the women's empowerment approach but contend that proponents of gender mainstreaming shift the focus away from women to men (Samarasinghe, 2014). Third, according to Correia and Bannon (2006), the demand for addressing women's issues surpasses the demand for addressing issues of gender. Women are more adversely affected by poverty than men are; increasing their vulnerability to threats such as food insecurity. In addition, there is a perception that empowering women empowers communities. Subsequently, focusing on women is considered a development priority. Fourth, in low-income countries, programme designers often work around cultural norms. In doing so, they accommodate gender inequalities and avoid addressing structural inequalities,

perpetuating the status quo. For example, pregnancy and childcare are traditionally associated with women. Consequently, men are often excluded from maternal and child health programmes (Greene et al., 2006).

Harnessing the complementary role of men in child nutrition can improve relationships between men and women. Including men as equal partners in reproductive work positions men in a supportive role and deconstructs the notion that men are only perpetrators of injustices against women. In the past, this notion served to increase tensions between men and women (Okali, 2011). Engaging men as allies and recognising their capacity to provide care and support to women could strengthen relationships between men and women.

### **4.3. Food security and nutrition with regards to women in Malawi**

The 2015 Global Nutrition Report states that in Malawi, only 29% of infants between six and 23 months consumed diets of at least four food groups (IFPRI, 2015). Malawian diets consist primarily of two food groups: cereals or grains (mainly as *nsima*, a stiff maize-meal porridge) and vegetables. WHO (2010) recommends a diverse diet, including foods from at least four food groups four times a week.

Malawian men have greater control over household income. Women earn 70% less than their partners and are less involved in deciding how earnings are used (NSO and Macro, 2015). The 2016 Malawi Demographic and Health Survey (NSO and Macro, 2016) reports that while joint control is exercised over women's earnings (42%), women often have no say regarding men's earnings (47%). Men also often make decisions on resource allocation for transport to health facilities. Women may walk long distances to attend antenatal care or ask their partners for money for transportation (Geoffrey et al. 2014). Accordingly, 56% of women reported that the distance to health facilities constrained access in 2015 (NSO and Macro, 2016).

Considering the critical role men play in decision-making and allocation of resources, this study analysed Malawi's NNPS to determine if it responds to such gender dynamics. While Malawi appears to be responsive to international agreements like the Beijing Platform for Action, it is unclear whether commitments have reshaped policymaker's gender normative assumptions in the context of nutrition policy. This study assesses Malawi's NNPS to understand if the policy is gender-responsive or if gender normative biases and ideologies influenced policy choices.

## **4.4. Research methodology**

Several tools have been developed to guide policymakers in gender mainstreaming (Overholt et al., 1985; Anderson and Woodrow, 1989; Moser, 1993; Parker, 1993; Williams, 1994; Kabeer and Subrahmanian, 1996). No tools could be found in the available literature that were designed specifically for determining the gender-responsiveness of nutrition policy, including the identification of gender biases that may influence policy choices.

Considering the paucity of appropriate tools, the researchers developed an analytical tool to assess Malawi's NNPS. The desk study analysis tool combined three existing tools: the WHO Gender Assessment Tool, the FAO Gender Mainstreaming in Nutrition Framework and a policy chronology (adapted from Babu et al., 2016, Haggblade et al., 2016 and Hendriks et al., 2016). In the interest of space, these tools, although described in the following section, will be presented in the results section with the exception of the FAO Gender Mainstreaming in Nutrition Framework. The limitations of a desk study are acknowledged, recognising that a natural next step of this study will be an active validation engagement with in-country stakeholders. However, there is merit in detailing the process and findings of the desk review at this stage for the benefit of on-going policy reform in Malawi and for others to learn from the process.

### **4.4.1. WHO Gender Assessment Tool**

The WHO Gender Assessment Tool (WHO, 2011), was integrated into this study. It provides criteria for assessing whether a policy or programme is gender-responsive or gender-blind. A gender-responsive policy reflects commitment of decision-makers to achieving gender equality. The tool forms part of a manual developed, applied and refined through workshops in 23 WHO countries in the context of gender analysis within the health sector (WHO, 2011). The tool asks 23 'yes' or 'no' questions. The scorecard for this tool is presented in Table 4.2. If the responses are predominantly affirmative in the first section of questions (1 – 18), then a policy is considered gender-responsive. If questions are predominantly affirmative in the second section of questions (19 – 23), then a policy is considered gender-blind.

The researchers felt that some of the questions could be collapsed. For example, 'Does the policy or programme consider life conditions and opportunities of women and men?' was collapsed with the question 'Does the policy consider and include men and women's practical needs'.



#### **4.4.2. FAO Gender Mainstreaming and Nutrition Framework**

The Food and Agriculture Organization (FAO) Gender Mainstreaming and Nutrition Framework (FAO, 2012), is referred to as the FAO framework in this paper. This tool combines issues of both nutrition and gender (Table 4.1). The FAO framework focuses on gender both in terms of agriculture, food security and health. It highlights gender issues related to nutrition and the life cycle, agriculture extension and technology, socio-cultural issues and distribution, rights-based approaches and nutrition and allocation of income toward nutritious food. It also promotes policies that foster partnerships between men and women by including men as targets of policy interventions. It proposes seven key areas for nutrition policies. These key areas can strengthen men's and women's capacity to access nutritious food for their families. The key areas were identified through a comprehensive review of international literature on nutrition and gender.

#### **4.4.3. Policy chronology**

The third tool used was a policy chronology (Babu et al., 2016; Haggblade et al., 2016; Hendriks et al., 2016) which is presented in Table 4.3. This documented the events that influenced policy choices, including nutrition events in Malawi as well as political, gender and relevant international development events. The policy chronology assists in identifying binding and non-binding international commitments. These commitments provide an indication of Malawi's commitments and the progress it has made in terms of gender mainstreaming and nutrition.

#### **4.5. Applying the integrated framework for gender analysis in nutrition policy**

In an attempt to present a simplified and holistic outlook of the findings, the three tools were integrated into a consolidated and condensed tool. The integrated tool adopts six of the most pertinent questions from the WHO Gender Assessment Tool. While this tool is useful in determining what types of questions should be asked to discern if a policy is gender-responsive, it is not specific to nutrition.

The FAO framework (FAO, 2012), was adopted as options that policymakers could choose to guide them in developing gender-sensitive policies. These options are referred to as policy instruments. Policy instruments, in this case, referred to gendered actions that can be taken to improve nutrition outcomes. While the FAO framework provides possible areas for mainstreaming gender in nutrition policy, it does not provide criteria for assessing whether the policy is gender-responsive or gender-blind.

**Table 4.1: FAO Gender Mainstreaming in Nutrition Framework (Mkandawire et al., 2017)**

<b>Gender and nutrition in ag extension</b>	<b>Income generating activities and spending income on nutrition</b>	<b>Local food culture and gender</b>	<b>Nutrition and the life cycle</b>	<b>Obesity and nutrition</b>	<b>Rights based perspective related to gender and nutrition</b>	<b>Targeting in nutrition</b>
Men are often favoured in both food and resource distribution, typically at the expense of women and children.	Efforts shall be devoted to improving women's socio-economic status relative to that of men in all aspects of nutrition.	Men are often favoured in both food and resource distribution, typically at the expense of women and children.	Promotion of women's nutritional status among the general public.	Controlling of nutrition related non-communicable and other diseases.	The right of all people to have access to safe and nutritious diets shall be observed in accordance with the fundamental basic rights of citizens to be free from malnutrition and related disorders.	Most nutrition education programmes have been targeting women, yet household-level decisions are mostly done by men. Gender roles further skew the distribution of nutritious diets within a household.
Empowerment of communities with adequate nutrition knowledge, skills and resources will be prioritised for the successful implementation of the policy.	Promotion of practices that promote healthy life styles, food availability, diversity, access, proper storage, preparation, utilisation, the consumption of a variety of foods from the six food groups every day, safety and quality in the general population.	-	Promotion of optimal feeding practices for children 6-24 months or beyond to sustain breast feeding while giving appropriate complementary feeds with emphasis on feeding frequency, amount, energy and nutrient density and diversity based on the six food groups. Strengthening of optimal feeding of a sick child during and after illness.	-	-	-
-	Strengthening capacities for households and communities to attain adequate nutrition for their families with emphasis on socio-economically deprived persons.	-	Prevention and control of micronutrient deficiency disorders with emphasis on Vitamin A Deficiency, anemia and iodine deficiency disorders.	-	-	-

Gender and nutrition in ag extension	Income generating activities and spending on income on nutrition	Local food culture and gender	Nutrition and the life cycle	Obesity and nutrition	Rights based perspective related to gender and nutrition	Targeting in nutrition
-	-	-	Promotion of optimal breastfeeding practices for children 0-6 months in the context of HIV and AIDS at facility, community and household level.	-	-	-

To ensure that each policy instrument was rigorously interrogated, the policy instruments were cross-referenced with the WHO questions (WHO, 2011), to determine whether the policy instrument reflects an understanding of gender issues. Aligning the questions and instruments ensured careful interrogation of each policy instrument using a gender lens, assessing if the policy elements are gender-blind or gender-responsive.

The framework enabled reflection on assumptions that may have influenced policy decisions. The shading in Table 4.4, reflects the level of biased assumptions in the policy. The lighter shade of grey suggests that the question is of mild relevance to bias and ideologies.

Medium shading suggests a moderate relevance and the darker shade of grey suggests strong relevance. For example, if the question ‘Does the policy avoid considering men and women as homogenous groups?’ is not satisfied, it is possible that the policymaker not considered the different characteristics of different groups, including adolescent girls who have different dietary needs compared to older women. This suggests that the policy may have been significantly influenced by institutionalised gender normative biases and ideologies. Some examples of what a gender-responsive policy would look like are presented in Table 4.4.

#### **4.5.1. An overview of Malawi’s NNPS**

The NNPS is guided by the WHO’s seven Essential Nutrition Actions (ENAs) (WHO, 2007). These are a set of actions that can be taken during the first thousand days of a child’s life (from conception to two years of age) to reduce maternal and child mortality, morbidity and under-nutrition. These are women's nutrition, breastfeeding, complementary feeding, care of sick and malnourished children, prevention and control of anaemia, prevention and the control of vitamin A and iodine deficiencies (WHO, 2007).

The NNPSPP has three main objectives: prevention of common nutrition disorders; increasing timely and effective management of the most common nutrition disorders and creating an enabling environment for effective implementation of nutrition interventions. The first two objectives focus primarily on integrating the ENAs into strategic objectives. The third objective focuses on improving multisectoral coordination of nutrition with the Department of Nutrition, HIV and AIDS taking responsibility for oversight. It promotes the establishment of a harmonised, decentralised nutrition sector.

The policy targets pregnant and lactating women, children between birth and two years of age, children under five years of age, school-aged children, people living with HIV and people in emergencies. Six strategic objectives are presented. The policy sets out a range of strategies and expected results. Strategic outcomes are stated and specific annual targets and outputs are set out.

## **4.6. Results and discussion**

The results of the analysis are presented in the sections that follow. First, some preliminary observations are presented. Second, the results of the WHO tool and the policy chronology are presented. Third, the results of the FAO Framework assessment are presented along with the integrated framework for gender analysis of nutrition policy. The results are presented in two steps, the first identifies the policy instrument and the second interrogates the policy instrument.

### **4.6.1. Preliminary observations**

The researchers first conducted a universal search of the words gender, women and men in the NNPSPP (GoM, 2007). Gender appears eight times in the document. The word ‘women’ appears 94 times and the word ‘men’ appears 30 times. The word ‘men’ often appears in a situation where women, men, boys and girls were listed as beneficiaries. The word ‘women’ appears in relation to pregnant and/or lactating women, or with reference to improving women and adolescent girls’ nutrition. The use of the word ‘women’ in this context could suggest that nutrition in Malawi, specifically maternal and child nutrition, was still predominantly considered women's responsibility. Although the focus on women is aligned with literature that recommends focusing on the first thousand days, the NNPSPP perpetuates the stereotype that maternal and child health and nutrition are primarily women's responsibility.

#### **4.6.2. Findings from the individual tools**

The application of the WHO tool found that the NNPS was not gender-responsive (Table 4.2). The assessment of questions one to 18 were primarily negative, with 12 negative and only four affirmative responses. According to the guidelines, the number of negative responses suggests that the policy is gender-blind. It must be noted that questions five, six, seven and fourteen (Table 4.2) were eliminated as they could not be answered without consulting the stakeholders involved in the development of the policy. Assessment of questions 19 to 23 found that three of the five questions were affirmative. This suggests that the policy may be gender-blind.

The policy chronology provided the context in which the NNPS was developed (Table 4.3). Malawi's international binding agreements include the Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW) (UN, 1979) and the African Charter on Human Rights and People's Rights on the Rights of Women in Africa (AUC, 2005). The non-binding agreements include the Beijing Declaration and Platform for Action (UN, 1995), the SADC Gender and Development Declaration (SADC, 1997) and the SDGs (UN,2016). Malawi's NNPS does not comply with commitments made in Beijing to mainstream gender. The policy chronology provided reference to other policies in Malawi that may intersect with the NNPS. Notably, the Sexual and Reproductive Health and Rights Policy (SRHRP) provided some interesting insights.

Although NNPS focuses considerably on coordination, there appears to be a disconnect between nutrition and health policies. Malawi's Sexual and Reproductive Health and Rights (SRHR) Policy explicitly recognises that: 'Men's shared responsibility and active involvement in parenthood and reproductive behaviour shall be emphasised in the delivery of SRHR services' (MoH, 2009: 16).

The SRHR Policy recognises that men have an important role to play in health because they are typically the main decision-makers in the household. The SRHR Policy sets out specific strategic objectives to promote men's involvement in SRHR matters, including maternal and child health. Targets are defined for achieving men's involvement in maternal and child health. Guidance is provided on who should be responsible for achieving these objectives. In all these objectives, the DNHA is not mentioned in the SRHR, yet the DNHA plays an important role in promoting and coordinating activities related to maternal and child nutrition which is intrinsic to maternal and child health.

It was not until 2009 that the aspect of men's involvement was integrated into Malawi's Sexual and Reproductive Health and Rights Policy (SRHRP). According to Taulo (2010), men's involvement in maternal and child health emerged on the sexual reproductive health agenda in Malawi in 2009. Men's

involvement was advocated for by the University of Malawi's College of Medicine who provided evidence on the importance of including men in maternal and child health at a multi-stakeholder conference where key decision-makers were present.

### **4.6.3 Outcomes of the analysis of the integrated framework**

Only one key area of the FAO framework could be identified in the NNPS. Nutrition and the life-cycle is the only focus of the NNPS. Emphasis is placed on women's nutrition before, during and after pregnancy. The policy makes explicit commitments to improving maternal and child health and lists strategies for doing so. However, it provides no clarity on how the underlying constraints to women's nutrition will be addressed. For example, the policy sets targets to increase the number of pregnant women receiving iron supplements. However, evidence suggests that women face geographical constraints accessing clinics where these supplements are distributed (NSO and Macro, 2010). The NNPS provided no indication of how such constraints are addressed.

The other policy instruments in the FAO framework (Table 4.2) are mentioned in the background of the NNPS. At no point does the policy provide guidance on how these key areas will be addressed. For example, the policy states: 'Men are often favoured in both food and resource distribution, typically at the expense of women and children.' NNPS (GoM, 2007: 36), acknowledging some understanding of the gender context.

Although the NNPS acknowledges that men are favoured in terms of food and resource distribution, it makes no attempt to address women's limited access to agricultural resources in a predominantly agricultural society. The policy mentions that actions will be taken to facilitate empowerment activities for improved nutrition, but no specific group of beneficiaries is identified.

Both sexes have specific nutritional needs, which are not mentioned or indicated in the policy. Similarly, the elderly and people with disabilities have specific dietary requirements. The policy does not define 'deprived persons'. Conflating these groups does not consider the specific needs of each group. While the policy mentions non-communicable diseases, there is no indication of key actions or programmes to address non-communicable diseases. The policy states that: 'Gender roles further skew the distribution of nutritious diets within the household' (GoM, 2007: 36), alluding to the notion that the food culture and gender may threaten women's nutrition. However, it does not mention how socio-cultural constraints will be addressed.

**Table 4.2: WHO Gender Assessment Tool (Analysis of NNPS) (Mkandawire et al., 2017)**

Question	Yes	No
1. Do the vision, goals or principles have an explicit commitment to promoting or achieving gender equality? Scoring hints: 'No' may indicate gender-blindness. 'Yes' may indicate that the programme is gender-sensitive, gender-specific or gender-transformative.	✓	
2. Does the policy or programme include sex as a selection criterion for the target population?		✓
3. Does the policy or programme clearly understand the difference between sex and gender?	✓	
4. Does the target population purposely include both women and men?	✓	
5. Have women and men participated in the following stages?		
6. Have steps been taken to ensure equal participation of women and men?		
7. Do both male and female team members have an equal role in decision-making?		
8. Does the policy or programme consider life conditions and opportunities of women and men?		✓
9. Does the policy or programme consider and include women's practical and strategic needs?		✓
10. Have the methods or tools been piloted with both sexes?		✓
11. Does the policy or programme consider family or household dynamics, including different effects and opportunities for individual members, such as the allocation of resources or decision-making power within the household?		✓
12. Does the policy or programme include a range of stakeholders with gender expertise as partners, such as government affiliated bodies, national or international non-governmental organizations or community organizations?	✓	
13. Does the policy or programme collect and report evidence by sex?		✓
14. Is the evidence generated by or informing the policy or programme based on gender analysis?		
15. Does the policy or programme consider different health needs for women and men?		✓
16. Does the policy or programme include quantitative and qualitative indicators to monitor women's and men's participation?		✓
17. Does the policy or programme consider gender-based divisions of labour (paid versus unpaid and productive versus reproductive)?		✓
18. Does the policy or programme address gender norms, roles and relations?		✓
19. Does the policy or programme exclude (intentionally or not) one sex but assume that the conclusions apply to both sexes? Scoring hints: 'No' may indicate that the programme is gender-sensitive, gender-specific or gender-transformative. 'Yes' may indicate that the programme is gender-blind or gender-unequal.	✓	
20. Does the policy or programme exclude one sex in areas that are traditionally thought of as relevant only for the other sex, such as maternal health or occupational health?	✓	
21. Does the policy or programme treat women and men as homogeneous groups when there are foreseeable, different outcomes for subgroups, such as low-income versus high-income women or employed versus unemployed men?	✓	
22. Do materials or publications portray men and women based on gender-based stereotypes?		✓
23. Does the language exclude or privilege one sex?		✓

Reference is made to the right to food, which is included in Malawi's Constitution (Article 30.2) (GoM, 1994). The policy refers to the 'right to safe and nutritious diets' and the 'right of all citizens to be free from malnutrition'. However, nutrition is only recognised as a Constitutional principle and not

necessarily a right. The policy misinterprets the 1948 Universal Declaration of Human Rights (UN, 1948), by stating that nutrition is a right. The 1948 Declaration only refers to the right to food and not nutrition. The policy provides no guidance on how people can realise the Constitutional principle related to nutrition. In 2014, de Schutter, the United Nations special rapporteur on the right to food, recommended the drafting of a national food security bill in Malawi. Such a bill could offer more specific binding rights and obligations, assisting in the realisation of the Constitutional principle related to nutrition. To date, no legislation exists to support the policy's commitment to enforcing people's right to nutritious food.

In terms of targeting, the policy states that: 'Most nutrition education programmes have been targeting women, yet household-level decisions are mostly done by men' (GoM, 2007: 36) The policy focuses primarily on pregnant and lactating women. No mention of men's role in nutrition or men's dietary requirements is made. The NNPSPP provides no guidance as to how to re-negotiate programmes so that men are involved as allies in improving nutrition outcomes of women and children. The policy also does not consider how gender relations can be improved to increase women's agency with regard to decision-making for nutrition. Although not explicitly, it conforms to traditional role allocations through neglect of men's participation in maternal and child health and nutrition. It perpetuates the notion that men should not be involved in 'women's work'. Although the policy refers to behaviour change, which may have provided opportunities for introducing men's involvement, the concept of behaviour change is not defined and little clarity is given as to how or even what behaviours should change.

Next the analysis interrogated the policy's elements related to nutrition and the life-cycle, using the questions in the top row of Table 4.4 The NNPSPP outlines several guiding principles and strategic objectives. One guiding principle specifically relates to gender equality: 'Gender equality and equity will be enhanced in all nutrition initiatives to ensure improved nutritional status of women, men, boys and girls. Efforts shall be devoted to improving women's socio-economic status relative to that of men's in all aspects of nutrition' (GoM, 2007: 67). This statement satisfies the question 1 in the top row of Table 4.4: 'Do the vision, goals or principles have an explicit commitment to promoting or achieving gender equality?', but not in relation to nutrition and the life-cycle policy interventions. It is unclear how gender equality will be enhanced through the nutrition and the life-cycle. The word 'women' appears often, but no mention is made of gender relations or what actions will be taken to increase equity. No indicators are included that would determine if gender equality has been met in the context of nutrition.



**Table 4.3: Chronology of international, African and national events and documents (Mkandawire et al., 2017)**

Nutrition events	Dates	Political events	Gender events	International events
	1985		A National Commission of Women in Development was established through an act of Parliament (Women and Law in Southern Africa Research and Educational Trust (WLSA Malawi) and Malawi NGO Gender Coordinating Network (MNGCN, 2009).	
	1987			Ratified CEDAW.
	1992		Renaming of Ministry of Communication to Ministry of Women and Children's Affairs, Community Development and Social Welfare (WLSA and MNGCN, 2009).	
	1993		Women in Development policy and action plan (WLSA and MNGCN, 2009).	
National Plan of Action for Nutrition.	1994	Change in constitution and government.		ICPD (UN, 1994).
	1995			Beijing Fourth Conference on Women and signing of Beijing Declaration and Platform for Action.
	1996		Malawi National Platform established (WLSA and MNGCN, 2009).	
	1997			The SADC Gender and Development Declaration, 1997.
	1998		Formally adopted the 'Gender and Development' approach (WLSA and MNGCN, 2009).	
	2001		Establishment of Special Law Commission on Gender Law Reform (WLSA and MNGCN, 2009).	
Food crisis triggered need for a new food security and nutrition policy.	2000		National Gender Policy (Ministry of Gender, Children and Community Development, 2000).	Millennium Development Goals.
Nutrition was included in the Malawi Growth and Development Strategy I.	2002			
DNHA Established.	2004			
	2005	Bingu came into power.		Ratified African Charter on Human Rights and People's Rights on the Rights of Women (AUC, 2005).
National food security and nutrition policy and strategic plan was finalized.	2007		Revision of National Gender Policy (WLSA and MNGCN, 2009).	
Sexual and Reproductive Health and Rights Policy.	2009			
Malawi signs up for SUN.	2010			
Revision of the 2007 nutrition policy begins.	2013		The gender equality Act was passed.	
Nutrition out of OPC and back to health.	2014	Change in government (Peter Mutharika).		

The NNPS does not satisfy question 2 concerning whether the policy considered and included men and women's practical needs. Women's practical needs in terms access to resources and decision-making power for nutrition are not taken into account, neither are men's practical needs considered. The policy reflects a limited understanding of the constraints that women face and does not consider what actions could be taken to support men's participation in maternal and child health. For example, one of the strategic outputs to promoting women's nutrition is to increase the number of women eating a variety of food from the six food groups with the appropriate number of meals according to their physiological status (GoM, 2007:81). The six food groups refer to: animal foods, fats, fruits, legumes and nuts, staples and vegetables (MoH, 2007). While accessing six food groups per day is important for dietary diversity, expecting communities (and women in particular) to access six food groups per day does not seem practical in a country where a 39% of the population is reported to be food insecure. Simply 'promoting women's nutrition before, during and after pregnancy' (GoM, 2007: 81) does not address women's resource constraints or decision-making challenges mentioned in the background section of the NNPS. The policy is not explicit in its description of how women's access to diverse diets (six food groups) can be achieved.

Question 4 queries whether the policy considers gender norms, roles and relations. The NNPS does not consider gender norms or relations. It fails to deconstruct socially prescribed gender norms that allocate the responsibility for maternal and child health and nutrition to women. It does not cater for gender norms that may have a negative impact on policy outcomes. For example, as mentioned above, men are typically responsible for resource allocation for food and antenatal care, but the policy does not mention how men will be engaged to improve women's access to diverse food and antenatal care. Neglecting gender norms constrains women's ability to meet their dietary requirements. Instead, the policy reinforces stereotypical gender roles by excluding men, potentially perpetuating gender inequalities. By excluding men, the NNPS overlooks men's right to provide care and nutrition for children. It condones social stigmatisation, discouraging opportunities for men's active participation in maternal and child health and nutrition.

Question five from Table 4.4, asks if the policy avoids considering men and women as homogenous groups. With the exception of pregnant and lactating women, beneficiaries are referred to using gender-neutral language. The NNPS often conflates beneficiaries by using the phrase 'women, men, boys and girls'. This lack of distinction presumes equal decision-making power, access to resources and similar dietary requirements. The term 'caregiver' is used often. While this term is internationally recognised as gender-neutral, in this context, it reinforces the gender status quo. Malawian women are typically responsible for providing care. Consequently, the gender-neutral language can be said to automatically presume that caregivers are women. In this case, the use of gender-neutral language has no purpose.

The NNPSF does not clearly differentiate between sex and gender, failing to satisfy question six from Table 4.4. While the NNPSF recognises that both sexes are allocated gender-stereotyped roles, it perpetuates the notion that only women can be responsible for nutrition. The NNPSF places emphasis on women, overlooking the supportive role men can play in improving nutrition. This focus on women suggests that the policy drafters were indeed influenced by gender normative biases and ideologies. Men are not included as targets for the NNPSF, consequently perpetuating the notion that men do not have a role to play in reproductive work.

Several deficiencies and gaps were identified in the NNPSF. The lack of affirmative responses to the questions in Table 4.4, suggests that the drafters of the policy lacked understanding of how to mainstream gender. The NNPSF interprets gender as women. While the policy makes reference to gender and even includes a principle on gender, it fails to include measures to ensure that gender inequalities in the context of nutrition will be addressed. The focus on women suggests that the policy decisions were influenced by gender-normative biases and ideologies regarding the allocation of reproductive work. Therefore, the policy is not gender-responsive.

While the policy focuses on women's access to nutritious food, it overlooks the means through which women can access nutritious food, demonstrating a limited understanding of the relationships between the sexes and how these relationships hinder or facilitate improved access to nutritious food. Women have limited control over resources and decision-making, often preventing access to nutritious food during the first thousand days of a child's life

. The policy overlooks the importance of creating a conducive environment for men's participation in child nutrition. Redistribution of women's work could free up women's time, enabling them to pursue other activities. Creating a conducive environment for men to participate in maternal and child health can deconstruct institutionalised norms that prevent men from participating in maternal and child health and increase the work burden on women. However, this would require understanding men's needs in order for them to be involved.

**Table 4.4: Integrated framework for gender analysis of nutrition policy (Mkandawire et al., 2017)**

Policy instruments	1. Do the vision, goals or principles have an explicit commitment to promoting or achieving gender equality?	2. Does the policy consider and include men and women's practical needs?	3. Does the policy include men and women's strategic needs?	4. Does the policy consider gender norms, roles and relations?	5. Does the policy avoid considering men and women as homogenous groups?	6. Does the policy clearly differentiate between sex and gender?
Agricultural extension and nutrition.	Commitment to equitable access to agriculture extension.	Promoting training of male and female extension workers.	Establishing legislation supporting 50/50 representation of extension workers.	Promoting women's decision-making and control over agriculture resources.	Promoting youth involvement in agriculture through extension worker education	Promoting men's agriculture extension for improved nutrition.
Local food culture and gender.	Commitment to addressing cultural and gender norms.	Promoting men's nutrition education at antenatal clinics.	Establishing legislation to give traditional authorities the power to enforce legislation related to food.	Promoting men and women's cooking groups to promote sharing of household responsibilities.	Promoting male youth champions to support changes in local food cultures that favour men at the expense of women.	
Nutrition and the life cycle.	Commitment to addressing gender inequalities pertaining to nutrition and the life cycle.	Promoting individual and joint counselling for men and women before, during and after pregnancy.	Establishing policies to incentivise men's attendance of antenatal visits.	Promoting the integration of nutrition in the school curriculum.	Promoting different types of awareness campaigns targeted towards men and women on nutrition before, during and after pregnancy.	
Gender, obesity and non-communicable diseases.	Commitment to addressing gender inequalities related to obesity and non-communicable diseases.	Creating a conducive environment for men's behaviour change in eating habits given men's predisposing to NCDs.	Establishing policies/legislation to support men's behaviour change in relation to eating habits.	Promoting men's uptake of health care services, given that most health initiatives are directed towards women.	Promoting sensitisation campaigns targeted towards women to raise awareness of the importance of men's nutrition.	Promoting the re-socialisation of men to improve their consumption of nutritious food.
Spending income on nutrition.	Commitment related to inequalities in terms of access to income, opportunities and equal decision-making.	Promoting joint decision-making regarding food choices.	Establish policies that promote joint decision-making programmes.	Promoting joint decision-making.	Promoting men's nutrition education for increased allocation of resources for nutrition.	Promoting men's increased contribution toward spending on food.

Policy instruments	1. Do the vision, goals or principles have an explicit commitment to promoting or achieving gender equality?	2. Does the policy consider and include men and women's practical needs?	3. Does the policy include men and women's strategic needs?	4. Does the policy consider gender norms, roles and relations?	5. Does the policy avoid considering men and women as homogenous groups?	6. Does the policy clearly differentiate between sex and gender?
Rights based approach to nutrition.	Commitment to improved legislation on gender and nutrition e.g. land rights.	Promoting the establishment of legal support services at community level.	Strengthen legislation related to gender and nutrition.		Promoting both women and in particular men's rights with relation to maternal and child health as often only women's rights are highlighted.	Establishing regulatory frameworks that support participation of men in antenatal clinics.
Targeting in nutrition policy.	Commitment to involving <i>men in particular</i> as well as other vulnerable groups (these must be clearly defined).	Promoting men's maternal and child health clubs.	Strengthen or develop maternity and paternity leave legislation.	Ensuring all media and promotion material supports men's participation in maternal and child health.	Promoting awareness raising on the importance of men's participation in maternal and child health.	Promoting improved participation of men in maternal and child health.

## 4.7. Conclusion and policy recommendations

While Malawi has made much progress in reducing undernutrition, gender-responsive policies could accelerate progress with regard to nutrition and gender equality. The policy has failed to meet Malawi's commitments to the Beijing Platform for Action. Gender is included in the text, but there are no explicit actions stated to achieve gender equality without the creation of an environment that fosters gender equality. The policy is not gender-responsive. The policy does not challenge institutionalised gender norms. It accommodates existing societal gender roles by focusing only on women and young children and their immediate nutritional needs. However, even in focusing on women, the NNPS fails to recognise women's constraints in accessing nutritious food and health care services.

The analysis suggests that although focusing on the first thousand days is important, it disproportionately increased the focus on women. While the recommendations that follow can apply to Malawi's review of the NNPS, they are also more generally applicable. Women alone cannot reduce undernutrition because they face several constraints in accessing nutritious food. Men have a shared interest in reducing maternal and child mortality. Therefore, their participation as partners is warranted. Moreover, men have a right to participate in maternal and child health and nutrition and it is important for policymakers to recognise the gender norms that constrain men from becoming involved. Such an approach could accelerate progress towards reducing malnutrition and improve gender equality. Involving men would reduce women's work burdens and increase women's opportunities to pursue other activities.

While mainstreaming gender in public policy is important, policymakers should be cognisant that gender includes both men and women. In the interest of enhancing partnerships between men and women to improve gender equality, both men's and women's needs should be addressed. Involving men can indeed reduce women's work burdens but it is not sufficient for changing the gender dynamics that prevent women from accessing nutritious food. Concerted effort is needed to increase women's control over resources and promote joint household decision-making. Men are integral to strengthening these efforts and incentives for men's involvement in maternal and child health should be provided.

Policy makers should consider both men and women's practical needs. Measures should be put in place to support men's involvement in maternal and child health, such as the identification of male champions to advocate for men's involvement in maternal and child health. Similarly, men's strategic needs could be addressed by, for example, establishing paternity leave policies.

Insights from the analysis on Malawi can be applied in other countries. At a continental level, more gender-responsive approaches to nutrition policies could accelerate progress in meeting the Malabo Declaration on Accelerated Growth and Agriculture Growth and Transformation for Shared Prosperity and Improved Livelihoods targets. Gender-responsive nutrition policies could also accelerate progress in meeting not only SDG two, but also meeting the nutrition related targets identified in the SDGs.

# **CHAPTER 5 : A QUALITATIVE ANALYSIS OF MEN'S INVOLVEMENT IN MATERNAL AND CHILD HEALTH AS A POLICY INTERVENTION IN RURAL CENTRAL MALAWI<sup>2</sup>**

## **5.1. Background**

Men's involvement in maternal and child health has been on the development agenda for over two decades. However, in policy practice, it has for the most part been overlooked and excluded from policy design. Nutrition policies place significant emphasis on women, particularly pregnant and lactating women. Drawing from evidence indicating that empowering women can lead to improved child nutrition outcomes and in recognising the importance of addressing gender inequality, nutrition policymakers have often targeted women as beneficiaries of such policy interventions (Bellows et al., 2011). Recent policy initiatives, for example, have been directed to the first thousand days of a child's life wherein women have been the primary focus of policy interventions. Proponents of this development approach posit that if women and children consume the necessary dietary requirements from conception up until a child's second birthday, undernutrition can be reduced (Save the Children, 2012). While empowering women is indeed crucial, the narrow focus on women (Yeboah et al., 2015), overlooks women's limited decision-making power (Ganle and Dery, 2015) and the gendered dynamics of resource allocation (Yargawa and Leonardi-Bee, 2015).

International agreements such as the Beijing Declaration and Platform for Action (UN, 1995) and the Rome Declaration (UN, 2014) require states to ensure that both gender and nutrition respectively, be mainstreamed into all policies. Gender mainstreaming refers to the integration of men and women's concerns in the design and implementation of policies and programmes at all levels. Gender power relations are often overlooked in the design of policies, leading to a narrow focus on women because of the genuinely urgent need to address women's issues (Greene et al., 2006). In the case of nutrition policy, emphasis is placed on women and men continue to be excluded owing to socio-cultural determinants dictating that pregnancy, child care and nutrition are the realm of women (Kululanga et al., 2011; Aarnio et al., 2009). When men are excluded, women may face challenges in negotiating for resources to purchase food that is nutritious. A study by Singh et al. (2014) found that when men are involved in maternal and child health, one of the roles they identify with is ensuring that their partners

---

<sup>2</sup> This study is based on the paper: Mkandawire, E. and Hendriks, S.L. 2018. A qualitative analysis of the conceptualisation of men's involvement in maternal and child health in rural Central Malawi. *BMC Pregnancy and Childbirth*, 18(37): 1 – 12.



are eating properly. In this current study, we analyse how gender normative assumptions, such as nutrition being women's responsibility, have shaped policies and how these assumptions have been deconstructed by the emergence of the men's involvement agenda. The study contributes to literature that informs the integration of gender in nutrition policies. In reporting our findings, we highlight the implications of including men when integrating gender into nutrition policy.

### **5.1.1. Men's involvement in maternal and child health**

The definition of men's involvement varies depending on the context in which it is applied. According to Ditekemena et al. (2012), men's involvement is considered to be men's participation in HIV testing during pregnancy. Alio et al. (2013), offer a different perspective from the Western context, by suggesting that men's involvement is "...being accessible (e.g. present, available), engaged (e.g. cares about the pregnancy and the coming child, wants to learn more about the process), responsible (e.g., is a caregiver, provider, protector), and maintaining a relationship with the woman carrying the child regardless of their own partnership status."

The literature on men's involvement in maternal and child health suggests that men's involvement in antenatal clinics results in positive maternal and child health outcomes (Singh et al., 2014) For example, it increases women's attendance of antenatal clinics, compliance with breastfeeding, family planning and the uptake of Prevention of Mother-to-Child-Transmission of HIV/AIDS (PMTCT) (Mangeni et al., 2012; Kalembo et al., 2013; Susin and Guigliani, 2008). In their study Kalembo et al. (2013) found that women who attended antenatal care were more likely to agree to an HIV test, deliver their babies at the hospital and complete postnatal follow-up treatment. Kululanga et al. (2011), highlight how the use of incentives, male peer initiatives and sensitisation campaigns served as tools for encouraging men to participate in antenatal clinics.

Socio-cultural institutions that prescribe gender roles to men and women create barriers to men's involvement in maternal and child health and nutrition (Kululanga et al., 2011; van den Berg et al., 2015) Men who divert from socio-culturally prescribed gender roles by, for example engaging in child care or cooking, are often stigmatised and sanctioned by their fellow men (Ganle and Dery, 2015; Osman et al., 2014). Food and nutrition are typically considered women's responsibility, subsequently men do not realise that they have a role to play in nutrition and thus may not be involved (Audet et al., 2015; Mohlala et al., 2012).

In low-income countries, men's involvement has focused on men's involvement in PMTCT (Audet et al., 2015; Ditekemena et al., 2012; Ganle and Dery, 2015; Kalembo et al., 2013; Mohlala et al., 2012;

Susin and Guigliani, 2008, van den Berg et al., 2015). Less attention has been paid to men's involvement in maternal and child nutrition, where men's decision-making role has significant implications for maternal and child health outcomes. This study explores the implications of men's involvement for integrating gender in nutrition policy. The specific aims of the study were to develop an understanding of how men's involvement is defined in rural Central Malawi and what hinders and facilitates men's involvement.

### **5.1.2. The role of tradition leaders in safe motherhood in Malawi**

Safe motherhood initiatives were introduced in Malawi in 2000 to reduce the incidence of maternal mortality which was 984 per 100,000 live births in 2004 and 675 per 100,000 live births in 2010 (NSO and ICF Macro, 2010). An important part of this initiative is to involve men, given their household decision-making role in relation to women's access to healthcare. In some cases, women not only need to obtain resources but also permission from their husbands in order to access healthcare (Mseu et al., 2014).

As part of the Malawi safe motherhood initiative, maternity waiting homes (MWH) were established as a way of increasing women's access to trained health care professionals at a health facility for delivery. Maternity waiting homes are built in close proximity to a health facility. These waiting homes help to reduce the risk of giving birth at home and increase the likelihood of delivery by a qualified health care professional (van Lonkhuijzen, 2012). In Ntcheu, the Traditional Authorities have established bylaws that prevent women from giving birth outside of a health facility. If women contravene these bylaws, they are subject to paying a fine (Butrick et al., 2014). Bylaws on safe motherhood have increased the number of women giving birth at health facilities at the hands of a skilled birth attendant. In Ntcheu, the 2016 Malawi Demographic and Health Survey reported that 91% of women gave birth at a health facility (NSO and Macro, 2016), compared to 37% in the Central Region in 2004 (NSO and Macro, 2010). The bylaws established by Traditional Authorities are communicated to people in the community by word of mouth but also through other media channels like the radio.

While policies are established at the national and government level, bylaws are often established at the local level by community leaders in the form of Traditional Authorities or village headmen or headwomen. However, the Constitution does not bestow legislative power on Traditional Authorities. Therefore, these bylaws are not legally binding. Traditional leaders vary in their level of involvement on issues pertaining to the health and nutritional well-being of the communities they oversee. A number of noteworthy traditional leaders are well known for developing bylaws that have had a positive impact on maternal child health and nutrition well-being in their communities. For example, Chief Kwataine,

a renowned chief from Ntcheu district at the Traditional Authority level, has become a champion of safe motherhood in recent years (Yang, 2014).

### **5.1.3. Study location**

This study was conducted in one Traditional Authority in Ntcheu, a district located in the Central Region of Malawi. This region was selected because the policymakers interviewed mentioned that communities in this District were successfully encouraging men to participate in maternal and child health. With a population of 499,936 (GoM, 2012), 88% of households in Ntcheu engage in subsistence farming, with only five percent earning wages through formal employment. Most households (61%) consume the food that they produce (WFP, 2012).

Malawi is located in sub-Saharan Africa, south of the equator. The country is divided into three regions, the North, South and Central region. Within these three regions, there are 28 districts, which are further sub-divided into Traditional Authorities, a customary form of leadership responsible for oversight of several villages. The villages are in turn governed by village headmen or headwomen who are under the leadership of the Traditional Authority. The village is the smallest administrative unit (Chirwa, 2014). Traditional Authorities are managers of customary land, custodians of customary law and guardians of tradition and culture.

Although the main road through Ntcheu is tarred, most communities are far removed from the main road. Ewing et al. (2011) suggest that communities living in hard to reach areas do not access health care facilities frequently because of the financial costs associated with transportation. Also, for rural dwellers involved in subsistence farming, access to healthcare often involves long distance travel. Consequently, they lose a whole day of farm work, which has important implications for crop production. In Ntcheu, 60% of the population reported that distance to the health facility constrained access to health care services (NSO and Macro, 2016).

Health Surveillance Assistants (HSA) were first introduced in 1973 as cholera assistants to mediate the cholera outbreak. In 1998, the government recognised the need to bring health services closer to the community. Cholera assistants were renamed HSA and their work was broadened to include a range of health care services such as conducting bi-monthly mobile clinics for postnatal health checks and child immunisations. In the study area, approximately eight HSAs are available for a population of 8,715.

## **5.2. Methodology**

### **5.2.1. Study design**

Focus groups and individual interviews were conducted. The use of these two methods, along with the use of two different sample populations – informants and community members – provided a deeper understanding of men’s involvement in maternal and child health. To create a distinction between the two groups of participants, the non-state and state actors were referred to as the informants and the target population for policy implementation was referred to as community members. The data from the individual interviews was used to corroborate the data from the focus group discussions.

Ethical clearance to conduct research on human subjects was obtained from the Institutional Review Board at Michigan State University, see Appendix A. Permission to conduct research in Ntcheu was obtained from the District Commissioner. A letter introducing the researchers was drafted for each traditional authority in the district, see Appendix B. This letter was presented to the traditional authority, who then gave permission to the researchers to conduct interviews with consenting participants in their villages. The chiefs of each village were also visited to request permission even though the traditional authority had already given his consent.

The informants all signed written consent forms prior to participating in the interviews or focus groups, see Appendix C. Given the limitations in formal education in the community, consent to participate was recorded digitally by voice recording. A tape recorder was used capture each participant’s consent. Participants were given a number which they would state and then confirm that they consented to be part of the study. For example, ‘I am number ... and I consent to participate in the study’. At the start of the session, the researchers emphasised that participation was voluntary and participants were not obliged to participate and could withdraw from the discussion at any time should they wish to do so, without any penalty.

### **5.2.2. Focus group discussions**

Focus group discussions were used to obtain perspectives of how men’s involvement in maternal and child health was understood in Malawi. Liamputtong (2011) suggests that focus group discussions are valuable for eliciting community perspectives on various issues. The interactive nature of the focus group discussions enabled participants to challenge each other or present different personal experiences of men’s involvement in maternal and child health. This offered validation on the extent of convergence or divergence of themes related to men’s involvement. Discussions lasted for an hour to two hours. All

focus group discussions were conducted in the communities from which the participants came and were held at the health centre or at a local community gathering place. The discussions were conducted once large groups had dispersed at the clinic to reduce distractions. The HSAs, nurses and a community contact person ensured that discussions were not interrupted by making the community aware of our presence and the purpose of our visit. They were also intercepted curious individuals who may have interfered with the discussions.

The community members were initially selected through purposive and then through convenience sampling, dependent on their availability at the time of the focus group discussion. The HSAs were referred to us by the District Health Office. All eight HSAs were interviewed. They assisted us in selecting focus group discussion participants at the clinic. At the maternity waiting homes, the nurses helped identify participants. In the community, the Traditional Authority identified a key informant to assist us during our field work. She helped to select men and women from the community to participate in the focus group discussions. A total of 63 participants were interviewed, 26 were informants and 37 were community members. The majority of participants were women (N = 44).

Seven focus group discussions were conducted with informants and community members. Three mixed-sex focus group discussions were conducted with the informants: one with eight HSAs, another with six village headmen and women and the third with five officials from an NGO. Four focus group discussions were conducted with community members from three communities in rural Central Malawi. Two of these focus group discussions were conducted with women, one was conducted with men and one combined both women and men.

The discussions were facilitated in the local language, Chichewa by one of the female authors of this article and an experienced female facilitator who are both fluent in Chichewa. The facilitator is an experienced qualitative researcher and skilled at minimising participant bias during interviews. She was able to create trust and rapport amongst the participants, providing a conducive environment for open discussion. The other facilitator provided support and moderated the discussion. The lack of a male facilitator for the men's focus group discussions is recognised as a limitation. The researchers counted the number of times men and women spoke during the focus group discussions to determine if men and women's participation was hindered by this. In all of the interviews women were slightly more vocal than men. The exception was the interview with eight HSAs, where men responded 31 times compared to 21 responses from women. The composition of this group was skewed in favour of men because of the limited number of female HSAs in the area. Men were engaged in the discussion and the researchers had no reason to believe that the lack of a male facilitator hindered or biased the open discussions.

While we recognise that there are constraints in conducting mixed-sex focus group discussions, these focus groups were useful to investigate gender perspectives. Having separate groups might have created a situation where men say one thing and women say another. But having men and women in the same group helped each group reach a consensus on the probable pathways to shift gender dynamics in favour of men's increased involvement in maternal and child nutrition. Having separate gender discussion would be gender accommodating rather than transformative in nature (Pederson et al., 2014).

We recognise that women can be marginalised in mixed sex focus group discussions. The power dynamics existent in society wherein men have more power over women can sometimes create a situation where women defer to men's opinions. We took measures to ensure that women participated freely in the discussions. First, unlike much research into gender dynamics, the focus groups for this study did not analyse gender dynamics. Where current gender power dynamics would constrain honest discussions in mixed groups, these discussions sought to identify and negotiate pathways to change dynamics through reaching a consensus between the sexes. Second, three single-sex focus group discussions were conducted and the mixed-sex focus group discussions were used to triangulate the data from these discussions. Third, both men and women were consulted on participating in these mixed groups prior to participation. They had no concern about participating. Fourth, the ratio of women to men in these mixed-group discussions was deliberately skewed, with higher participation of women. Fifth, in all but one group, the participants were of an equal professional level. Sixth, participants were not asked to reflect on their personal experiences but discussed possible pathways to change gender dynamics.

The mixed-sex focus group discussions converged with the single-sex focus group discussions, leading us to believe that mixed-sex focus group discussions did not hinder the study. There is an added benefit of corroborating the findings of the single-sex groups with a mixed group discussion. We also used the discussion as an opportunity to observe gender dynamics between professionals who are responsible for implementing gender policies. Understanding these interactions has implications for the development of policy.

### **5.2.3. Individual interviews**

Eighteen individual interviews were conducted with informants using an interview guide (available in Appendix D) which outlined the key research issues and topics to be explored. Individual interviews were conducted for some of the informants' group because it was difficult to schedule their participation in the focus groups, but we needed their perspectives on the topic. Participants in the informants' group were initially selected through purposive sampling following a stakeholder mapping process.

Stakeholders in the DNHA were identified. These informants referred the researchers to other stakeholders. As a result, snowball sampling was used.

These individual interviews included discussions with the District Health Officer; the Environmental Health officer; officers from the MoGCDSW, the Ministry of Education, Science and Technology and the DNHA as well as representatives from donor agencies, NGO and community members. Engaging with various groups and using a variety of research approaches such as focus group discussions and individual interviews enabled corroboration of data.

#### **5.2.4. Data analysis**

All interviews were transcribed, and Chichewa transcripts were translated into English. The transcripts were reviewed, and notes were made for each transcript. The data analysis included manually organising the data into the three core themes of facilitators, barriers and limitations of men's involvement. A table was developed of the sub-themes in each of the core themes (see Table 5.1). Once all the transcribed data were categorised into themes, the information was again reviewed, taking note of the frequency with which a certain theme occurred. The authors made sure to reflect on data that did not converge. For example, not all participants agreed that men were involved in maternal and child health. These opinions were taken into consideration in reporting the results. Quotations from the transcripts have been used to illustrate the sub-themes identified during the analysis. The informants' and community members' responses were analysed separately.

### **5.3. Results**

Demographic data were collected for the community members' group, see Appendix E. Most participants in this group engaged in subsistence farming and *ganyu* to sustain their livelihoods. The mean age of participants was 37 with ages of participants ranging from 19 – 80 years. The average education of the participating community members was seven completed years of schooling, ranging from those with no education to participants who had obtained a secondary school certificate. Except for one woman who was pregnant with her first child, all the community members had children.

We identified five main facilitators of men's involvement: (i) men's recognition of the benefits of participation; (ii) pride; (iii) advocacy; (iv) incentives and disincentives as provided by health care providers and Traditional Authorities; and (v) encouragement from male champions. We identified facilitators as factors that led to the renegotiation of socio-cultural barriers that have prevented men's participation. Three barriers to men's involvement were identified, including: (i) socio-cultural beliefs;

(ii) stigmatisation and (iii) opportunity costs. Two limitations were identified in terms of men’s involvement including: (i) discriminating against women and (ii) reinforcing men’s decision-making power. The table below presents the main themes and sub-themes that were identified in the analysis.

**Table 5.1: Themes and sub-themes (own analysis)**

Themes	Facilitators	Barriers	Limitations
Sub-themes	Men’s recognition of the benefits of participation.	Socio-cultural beliefs.	Discriminating against women.
	Pride.	Stigmatisation.	Reinforcing men’s decision-making power.
	Advocacy.	Opportunity costs.	
	Incentives and disincentives as provided by health care providers and Traditional Authorities.		
	Encouragement from male champions.		

### 5.3.1. Facilitators of men’s involvement

Facilitators of men’s involvement refer to the various factors that reinforce men’s involvement in maternal and child health.

#### Recognition of impact of men’s involvement in maternal and child health

One of the main facilitators of men’s involvement in maternal and child health was men’s recognition of the benefits of their involvement. Men themselves expressed that their participation was important because they were provided with information that would help them protect the baby from contracting HIV, encourage women to eat food that would promote the health of the unborn child and recognise signs that could lead to maternal mortality. One man in an all-male focus group discussion said:

*P: When it is the first time, we learn together with them. They tell us that expectant women are not supposed to do very tiresome work. They need to eat different food groups and they mention those food groups like meat, eggs, beans, vegetable and fruits like bananas, mangoes and papayas.*

It was clear from the findings that when men received information on nutrition during their partner’s pregnancy, they tried to ensure that their partners accessed the necessary food for the growth and development of the baby. Men mentioned that the hospitals encourage them to provide milk to women milk when they are pregnant. Man in a focus group discussion said:



*P: Then we try as much as possible to give her milk at home. We get milk on loan from fellow villagers and the debt is paid on monthly basis. A bottle of coca cola is worth MWK300<sup>3</sup>, so we buy every day and at the end of the month we pay MWK 3000. It is very helpful.*

### **Pride**

Pride was another factor that facilitated men's participation. The men took pride in identifying their own community as the 'number one village in terms of safe motherhood'. One man said:

*P: When people from the government are coming to research on safe motherhood, they come to this community.*

Women also mentioned that when men attended antenatal care, they had the opportunity to see other healthy children. This motivated them to try to make sure that they too provided their wives with the necessary resources to ensure a healthy pregnancy outcome.

### **Advocacy**

Another facilitator of men's involvement in maternal and child health was advocacy. Both informants and community members mentioned that NGO advocacy and messaging played an important role in encouraging men to participate in maternal and child health. Women mentioned that radio messages helped to motivate men to participate in maternal and child health. One man in a focus group discussion said:

*P: The gender issue is triggering these acts. Before, when we went to the farm with our parents after farming our mother would carry a lot of things while our father would carry nothing. But these days, because of advocacy, we have realised that we were not treating women [sic] nicely. So, we help with the household chores, but before, that was not happening.*

Gender messaging also made men realise that men needed to take a more active role in the household and assist their wives with cooking, cleaning and child care. Concern (men's involvement in gender equality), Care Universal Malawi (community governance project), Catholic Relief Services (men's involvement in maternal and child health) and The Hunger Project (sustainable development in rural communities) were mentioned by men and women participants as playing a particularly important role in advocating and providing messaging for men's involvement.

---

<sup>3</sup> A bottle of coca-cola is used to measure the amount of milk. A full bottle of coca-cola is purchased at MWK300.

### **Incentives and disincentives**

A further facilitator of men's participation in maternal and child health that was identified was incentives and disincentives that either encourage men's involvement in maternal and child health or dissuade them from acts that were detrimental to maternal child health respectively. Incentives and disincentives were reinforced by both hospitals and Traditional Authorities. Clinics in Malawi have developed an incentive and disincentive system to motivate men to attend antenatal care along with their partners. Women attending antenatal care with their partners are attended to first. For women who have travelled a great distance to get to the clinic and have left fields unattended to make their clinic appointment, being attended to in a timely manner is important. Many women lose an entire day's work in order to access healthcare, which for a small holder subsistence farmer is considered a great loss. The order in which women are served at the antenatal clinic should thus be understood within this context. One woman said:

*P: Let's say you reach your fourth month and you tell your husband that you should go to antenatal clinic. You are at an advantage because even if you get there late, you are given place at the front of the queue. You end up finishing quickly. I'm talking from experience because when I went to the clinic with my husband we were fourth in the queue and they moved us up.*

Another woman said:

*P: The first thing is that a woman who has gone with the husband is attended to first. The other women seeing that plead with their husbands to go with them the next time so that they too are attended to quickly.*

If women attend antenatal care without their partners, they are either served last or not provided with services until they return with their partner. In support of the clinics, Traditional Authorities have also developed a set of bylaws to reinforce the incentives and disincentives. If a woman was abandoned by her partner, her family serves as witness to the chief who will then provide her with a letter excusing her from attending antenatal care with a partner. This letter is taken by the women to the clinic.

### **Male champions**

Male champions are responsible for delivering messages of safe motherhood to other men within a community. Secret men or lead fathers in care groups also facilitate men's involvement. Secret men and secret women travel from house to house discretely encouraging men to be involved in maternal and child health and to attend antenatal care. In Malawi, issues of sexual and reproductive health have traditionally been considered taboo to discuss in public. Also, the sensitivity of some of the issues discussed requires that conversations be conducted discretely. Secrecy is observed because, in many cases, secret men and in particular secret women, discuss issues sensitive topics around sexual and reproductive health, which may include family planning, HIV and unwanted pregnancy. Both

informants and community members suggested that male champions played an important role in facilitating men's participation in maternal and child health. One woman said:

*P: The nurses are the ones that write a letter to the chief to say that the woman is not being escorted to antenatal clinics by her husband. That means the chief will go and speak to the husband. But there are also secret men who can go and visit them.*

Lead fathers in care groups also assist in encouraging men to get involved in maternal and child health. Care groups are committees that are setup to provide maternal and child health, nutrition and care information to households. They consist of 6 – 15 participants. Men have been integrated into this system to encourage other men to attend antenatal care and to support their wives during pregnancy. In both the case of the secret men and the care groups, it was felt by the men that they would be in a better position to motivate other men to be involved in maternal and child health, taking into account gendered social dynamics that cause men to be more apt to listen to other men than to women.

### **5.3.2. Barriers to men's involvement**

Although men's involvement in maternal and child health has seen some success in the Traditional Authority where the study was conducted, not all men are willing to participate in maternal and child health. Barriers to men's involvement refer to the various factors that prevent men from being involved in maternal and child health. Some women participants expressed that their partners were not involved in their pregnancy. Some informants offered different perspectives as to why men were constrained to participate in maternal and child health. These constraints included; socio-cultural beliefs, stigmatisation of men involved in maternal and child health and opportunity costs associated with attending antenatal care.

#### **Socio-cultural beliefs**

Regardless of the involvement of the Traditional Authorities, socio-cultural beliefs that prevent men from participating in maternal and child health were prevalent. Female participants expressed that not all men were able to understand the importance of men's participation in maternal and child health and continued to see pregnancy as a woman's responsibility.

The male participants expressed that men who are not able to appreciate the importance of participating in maternal and child health are likely still being influenced by traditional beliefs. Informants expressed that women too are influenced by socio-cultural beliefs that prevent them from allowing the men to perform typically 'female-related' tasks. For example, one informant said:

*P: Because in the village, they don't allow a man to cook. Even if the woman is sick, they will invite someone to come and cook. Even that woman will not be very free to have her man come and cook. So, when you talk of behavioural change, it has to be both men and women.*

### **Stigmatisation of men involved in maternal and child health**

Stigmatisation is another barrier closely related to socio-cultural beliefs. According to the female participants, stigmatisation of men who participated in what they considered to be typically 'female activities' endures. The women expressed that even in situations where their partners wanted to be involved in maternal and child health, men were ridiculed or mocked for engaging in 'women's work'. A woman in a focus group discussion said,

*P: There are those who understand, but because of chatting with their friends when they see them doing these things, they tell them, you are weak. They have given you medicine<sup>4</sup>. You're helping carry the garden tools and sweeping? That is a woman's job. Instead of continuing to do what he has learned, he becomes embarrassed and says, I shouldn't do this. My friends will laugh at me.*

### **Opportunity costs associated with attending antenatal care**

Another barrier that was expressed mainly by the informants was that there were high opportunity costs associated with men's involvement in antenatal clinics. The time spent travelling to and from the health centre could have been used for farm work, or other income generating activities. The lack of a conducive environment for men's participation further exacerbated men's frustration with the time lost. Information presented at the health facilities, for example, was often targeted at women and the songs sung as part of the education sessions might be offensive to men. An excerpt from one of the songs sung at one of the health care centres visited is translated as:

*He has drunk tameki<sup>5</sup>,*

*He has drunk tameki,*

*Because of having too many children.*

*He has gone to South Africa,*

---

<sup>4</sup> In rural communities in Malawi, it is common for people to be superstitious about certain behaviours that appear uncommon. As such, people often make the assumption that when a man is engaging in work that is typically considered women's responsibility, he has either been bewitched or has been given some potion to change his behaviour.

<sup>5</sup> *Tameki* is the brand name of a rat poison in Malawi

*He has gone to South Africa,  
Because of having too many children.*

Some informants mentioned that at some health facilities, there are no activities to keep men occupied while women receive attention. Some informants were also concerned that when men were present, women were not able to speak freely during HIV testing and counselling sessions and that men's involvement might prevent women from disclosing information vital to the growth and development of the baby.

### **5.3.3. Limitations to men's involvement**

Besides these barriers, there are also some limitations to the way in which interventions for men's involvement in maternal and child health were designed in Malawi. Limitations to men's involvement in maternal and child health referred to factors that may have unintended consequences on the desired outcome of programmes.

#### **Discriminating against women**

There were some mixed responses to the incentives and disincentives used to encourage men to participate in maternal and child health. Although some of the informants and community members alike felt that withholding services from women who attended antenatal care without a partner was important because it forced men to attend antenatal care, others felt that women were being punished for offences that were not within their control. A female informant in an individual interview said,

*P: Now they have shifted blame on women. Now they are saying that whoever does not bring their husbands must be punished. That is what is happening. That policy or bylaw punishes women. It puts the responsibility of involving men on the women. It punishes women.*

Even in cases where treatment was not withheld, there was some concern that bylaws gave preferential treatment to women with husbands and discriminated against women who did not have partners with whom to attend antenatal care. One woman said:

*P: So, when they go there they ask, "those who have come with their husbands come first". Then those who are pregnant but didn't have husbands, even though they came early, stay behind.*

Another woman said:

*P: So, if you come with a spouse at whatever time, you will be the first to be attended to. Women felt that it was not good for them because they would wake up early in the morning, they would come to*

*the clinic and stand in the queue, and then someone comes with a spouse and they are attended to, it was very unfair.*

Unmarried women were further marginalised by these bylaws because they are expected to pay a fine to the chief. Women who had been abandoned by their partners or fell pregnant out of wedlock were fined. It was reported during the discussions that some women have found ways around paying these fines. Informants reported that some women replicated letters from the chief that exempted women from attending antenatal clinics with their partners, although the chiefs insisted that they write the letter in such a way that it is not replicable. Others noted that some women pay men who they find loitering around the clinic to pose as their partners, negating the intended benefit of men's attendance of antenatal clinics.

### **Reinforcing men's decision-making power**

Men's involvement in the area where the study was conducted does not appear to always have an impact on gender equality. The findings suggest that in areas where men's involvement programmes are not complemented by gender equality activities, such as joint family planning counselling, men's involvement is used as a tool to bypass gender norms. For example, although men attend antenatal care because of the pressure that they received from the Traditional Authorities and the clinics, there was not necessarily equal decision-making in the home. Some men still refrain from helping with housework – which they consider to be 'women's work'. Although men were encouraged to attend antenatal care, some men continued to regard child care as 'women's work'.

In some areas where gender sensitisation campaigns have been complemented with advocacy on men's involvement, men have been able to apply lessons to other aspects of life. A man in a focus group discussion said,

*P: These days, because of advocacy, we have realised that we are not treating women [sic] nicely. They are also the same as us...so we help them with the household chores. But initially, this was not happening.*

Another woman in a focus group discussion said:

*P: It is now when they brought in gender to say that when coming from the field, the man has to carry his hoe. When they get home, the man has to be doing other work like sweeping the surrounding while the woman is cooking. This time, things are just ok. You just make sure that you cook relish when you are going out and he will cook nsima.*

However, in most cases, men's involvement does not go beyond men's attendance of antenatal clinics. The bylaws were limited to only incentivising attendance of antenatal clinics. Socio-cultural beliefs related to inequality and stereotyping with regard to gender roles and responsibilities remained prevalent, regardless of men's participation in antenatal clinic visits.

Although attendance of antenatal clinics was deemed important for maternal and child health, once the child is born the responsibility of child care and housework often reverts to women. For example, one woman in a focus group explained that men were forced to go to antenatal clinics because they have to be tested for HIV, but they do not attend postnatal clinics.

#### **5.4. Discussion**

While men's involvement in maternal and child health in Malawi has been often understood to mean men's involvement in antenatal clinics to reinforce PMTCT, this study found that men's involvement in maternal and child health in rural Central Malawi also includes men's active roles in nutrition, child care and other household responsibilities. Often men's involvement occurs when women are pregnant or ill, but in some instances, men's involvement remained consistent, adopting more equitable roles. Men expressed that their involvement protected their unborn child by encouraging mothers to attend antenatal clinics and meeting their dietary requirements. Their involvement also included providing emotional support to women and recognising signs that could lead to maternal and child mortality. Men expressed that they were also responsible for providing financial support to acquire food and other necessities required during the delivery.

Advocacy from NGOs, media, male champions as well as traditional leaders plays a critical role; not only facilitating men's involvement but also in overcoming gender stereotypes and reinforcing gender equality. The continuous messaging on men's involvement in gender equality in conjunction with the bylaws, created an environment where stigmatisation was reduced, and men were free to actively be involved in maternal and child health. However, in cases where the bylaws and d/incentives were applied without supporting activities from the NGOs and male champions, men's involvement was limited to attending antenatal care. This suggests that men's participation in antenatal care alone is not sufficient for addressing institutionalised gender inequalities. The study findings are consistent with August et al. (2016) who suggested that when men's involvement programmes are implemented without complementary activities such as decision-making and gender equality sensitisation programmes, men's involvement simply reinforces gender inequalities.

The role of the traditional leaders in enforcing men's involvement is a notable finding for facilitating policy implementation, particularly regarding behaviour change. Although much controversy surrounds traditional leaders in Malawi because of nepotism in resource allocation, their role in the context of men's involvement in maternal and child health has been important in influencing adherence to attendance of antenatal clinics. Their commitment to improving maternal and child health is evident through the bylaws established. While the bylaws enable traditional leaders to take advantage of unmarried women who are subjected to paying fines, the involvement of traditional leaders has advanced the agenda of proponents of men's involvement in maternal and child health. This finding emphasised the need for healthcare and nutrition practitioners and policymakers to involve traditional leaders strategically in the development of policy and implementation.

It is important to note that the bylaws created by traditional leaders, although not legally binding, infringe upon women's constitutional and human rights. The Constitution of Malawi (GoM, 1994) states that all people have the right to health services. Therefore, when health care facilities withhold services because women have come without their partners, they are in breach of the Constitution. Furthermore, women travel long distances to attend antenatal care and serving them last could serve as a disincentive for their continued attendance of antenatal clinics.

The findings of our research are consistent with literature that suggests that socially constructed norms around gender continue to hinder men's involvement in maternal and child health. For example, both Kululanga et al. (2011) and Aarnio et al. (2009) suggest that pregnancy is typically a woman's domain and that men do not feel that they should be involved. However, our findings differ slightly in that undertones of change are evident. For example, some men are gradually becoming active in nutrition activities relating to maternal and child health, another domain which was previously associated with women. In situations where men's involvement programmes have been implemented with complementary gender equality activities in Malawi, men were often responsible for providing food and in some cases even preparing food.

Although there is a need for joint counselling sessions for couples, there is also clearly a need for separate activities for men and women during antenatal clinic visits. Women have historically owned the antenatal care domain and the environment is one in which they have space to share and express themselves. The design of men's involvement programmes should consider this need and provide a safe space for couples to engage but also provided separate spaces for each of the sexes to express themselves. For example, men could have separate spaces where they could engage with one another on their role in the household.



Men's involvement in maternal and child health has implications for maternal and child nutrition. When men attend antenatal clinics, they are provided with information that encourages them to appreciate the importance of their participation in maternal and child nutrition. They are also able to recognise the importance of allocating resources to diverse foods and as this study showed, even go out of their way to obtain loans to ensure their partners meet their dietary requirements. Men's attendance of antenatal clinics provides an opportunity for exposure to messages that enable men to make more informed decisions on food choices, food purchases, food production and allocation of resources toward food. Men's involvement in child care activities, as well as household activities, suggests that messaging on food preparation and infant and young child feeding need to be gender sensitive with particular attention to how men receive messages. Similarly, images in the media and other public messages need to be gender sensitive and consider men's involvement in the presentation. Policymakers often make the assumption that only women are and can be involved in nutrition. As a result, they too may perpetuate socially proscribed gender roles. Based on our study findings, we suggest that not only are there benefits to involving men, but men are already getting involved in nutrition. Therefore, policymakers need to be aware of men's involvement in maternal and child nutrition and promote an environment that is conducive for and facilitates men's involvement.

## **5.5. Conclusion and recommendations**

This study is one of the few to have focused on analysing men's involvement in maternal and child health interventions, with specific attention to the implications of men's involvement in maternal and child health for nutrition policy. The study findings identify several facilitators of men's involvement in maternal and child health. Although socio-cultural barriers remain, evidence of change is clear. However, limitations need to be addressed to ensure that men's involvement activities do not infringe upon women's human rights.

Policymakers need to ensure that they create a conducive environment for men's involvement in maternal and child health by providing support services that motivate men to want to be involved. Interventions that support men's involvement in maternal and child health should not undermine women in decision-making but rather enhance equitable decision making in the household. Policymakers should recognise that gender dynamics at community level are changing and that policies should be respond to these changing gender dynamics.

The study concludes that stakeholders involved in maternal and child health did not respond to emerging gender concerns that arose from the men's involvement in maternal and child health approaches. For example, bylaws intended to motivate men to attend antenatal care by withholding services from women

who did not attend antenatal care with their partners discriminated against women. Service providers cannot withhold critical treatment. Policymakers in Malawi should ensure that men and women have the knowledge and the capacity to demand their rights in non-confrontational ways as partners and stakeholders in their own treatment.

While men's involvement interventions are important for maternal and child nutrition, the design of these interventions undermine gender equality. Consequently, the real constraints that confront men and women in terms of accessing nutritious food are not addressed. More supportive programmes are needed in all districts in Malawi to promote men as agents of change. Nutrition policy interventions need to complement activities in health by providing information on joint decision-making in resource allocation for food and food production choices.

# **CHAPTER 6 : VALIDATION OF RESEARCH FINDINGS USING A POLICY DIALOGUE**

## **6.1. Introduction**

The Sustainable Development Goals reiterate the importance of gender with SDG five explicitly focusing on gender equality (UN, 2016). Malawi's Growth and Development Strategy III (MGDS III) singles out gender as a development priority. The MGDS III recognises that gender is a cross-cutting issue that needs to be integrated into all sectors, including nutrition. Chapter 4 identified weaknesses in the integration of gender in Malawi's former NNPS 2007 – 2012. The workshop presented in this chapter took the form of a policy dialogue, sharing research findings from Chapters 4 and 5. These findings were used to reflect on the integration of gender in the August 2016 Draft of Malawi's National Nutrition Policy. The dialogue process generated recommendations for improving the integration of gender in the forthcoming National Nutrition Policy and obtained Input on the usability of the integrated framework from the participants.

## **6.2. Validating the research findings**

Validation of research is the process of verifying the reliability of qualitative and quantitative research findings. This study applies two methods of validation. The first is triangulation, which involves the use of different sources to confirm and clarify research findings. The second is member or respondent validation, which entails returning to the research participants or a similar group to confirm the interpretation of the research findings (Lewis et al., 2014).

As discussed in Chapter 5, the study applied triangulation but also used member validation to improve the credibility of the research findings. This approach was used to ensure, active participation of communities, which is essential for sustainable development. Local ownership of solutions to problems is important for sustained action (Heritage and Dooris, 2009).

The researcher chose the policy dialogue as a vehicle for delivering the research findings for three reasons. First, it provided an opportunity to share the results off the case study. The in-country fieldwork set out to conceptualise men's involvement in Malawi and identify opportunities for nutrition within this context. Through the dialogue, the researcher could verify if the barriers, facilitators and limitations to men's involvement in maternal and child health were, in fact, accurate. The dialogue presented an

opportunity to ascertain if there were any further opportunities for nutrition within the context of men's involvement in maternal and child health that may have been overlooked by the researcher.

Second, the dialogue provided a platform through which various stakeholders and rural community members could participate in the critique of the National Nutrition Policy. Irvin and Stansbury (2004) suggest that citizen participation in the policy process might result in policies that echo the preferences of communities. They may also result in citizens being less critical of government decisions. When the public is involved in the decision-making process, the likelihood that they will understand the reasons why the government made specific choices is greater. According to the Committee of Experts on Public Administration (2007) involving citizens in decision-making about their communities and broader social issues has social economic and political benefits. They also argue that for accountability purposes, the involvement of all stakeholders is essential.

Third, the policy dialogue approach also provided an opportunity for rural communities to engage with policymakers in the form of an intergroup dialogue. Inter-group dialogues bring together people from diverse backgrounds and facilitate learning about others. These interactions can assist in changing the negative views of one group on another. Often the purpose of intergroup dialogues is to strengthen community partnerships (Wheatley et al., 2012). The policy dialogue aimed to increase collaboration and improve relationships between policymakers, stakeholders and community members.

### **6.3. Validation method**

The policy dialogue had four objectives. The first was to present findings on the assessment of the NNPS 2007 – 2012 from Chapter 4. The second was to share the research findings from the field research in Chapter 5. The third was to provide recommendations to the DNHA and the MoGCDSW for the forthcoming National Nutrition Policy. The final purpose was to provide an opportunity for policymakers to engage with rural community members for mutual learning. Table 6.1 lists institutions represented in the policy dialogue.

The programme for the policy dialogue is available in Appendix F. The dialogue was divided into two sessions. In the first session, the researcher presented the findings from Chapter 4. The researcher explained that the integrated framework was developed to fill a gap identified through the research. The researcher was unable to find a tool that assessed the gender-responsiveness of nutrition policies.

**Table 6.1: Policy dialogue participants 19<sup>th</sup> August 2016**

Angel Gender Coordination.	Network for Youth.
CARE Malawi.	Ntcheu Nutrition Platform.
Civil Society Organisation Nutrition Alliance.	Nutrition Diet Society.
Concern Worldwide.	Nyasa Times.
Department of Nutrition, HIV and AIDS.	Power 101.
International Potato Center (CIP).	Three Community members.
Livingstonia Radio.	Traditional authority: Chief Kwataine.
Maravi Post.	University of Pretoria.
Ministry of Gender, Children, Disability and Social Welfare.	USAID.
Mothers to Mothers.	Zomba Nutrition Platform.

The participants were asked to consider the weaknesses of the former NNPS and apply the integrated framework in assessing the extent to which the draft National Nutrition Policy integrated gender. There were eight priority areas in the version of the draft National Nutrition Policy (MoH, 2016) assessed.

These were:

- i. Prevention of undernutrition,
- ii. Gender, equality, protection, participation and empowerment,
- iii. Treatment and control of acute malnutrition,
- iv. Prevention and management of over-nutrition and non-communicable diseases,
- v. Nutrition education, social mobilisation and positive behaviour change,
- vi. Nutrition during emergency situations,
- vii. Creating an enabling environment,
- viii. Nutrition monitoring and evaluation, research and surveillance.

The participants were divided into four groups and allocated two priority areas to each group. Participants assessed the draft policy using the following approach:

- i. Determine the policy instruments selected.
- ii. Assess if these instruments were gendered, if not explain why they were not gendered.
- iii. Make recommendations to improve the gendered aspects of the policy.

In the second session, four research participants from the rural community shared their experiences of men's involvement in maternal and child nutrition. Two men, one woman and one male traditional authority, related their experiences. This specific traditional authority was selected to participate in the

policy dialogue because of his reputation as a champion of safe motherhood. These corroborated the research findings. The relating of their experiences provided clarity and verified the extent to which the themes identified in Chapter 5 were exhaustive. The researcher then presented the findings from Chapter 5. Although the members of the rural community were conversant with English, a translator sat with the rural community members to explain the presentations. Box 1, 2 and 3 summarise the experiences shared by two community members and the traditional authority. Only two community members experiences are captured to avoid repetition.

All policy dialogue participants signed a consent form from the University of Pretoria's Department of University Relations, Communication and Marketing permitting the researcher to use photographs and videos taken during the policy dialogue. This form, available in Appendix G, was translated into Chichewa for the rural community members.

#### **6.4. Validating research findings from Chapter 4 and assessing gender in the forthcoming National Nutrition Policy**

The results are divided into three sections. The first presents the validation of findings from Chapter 4. The second section discusses the validation of research findings from Chapter 5. The third section consolidates the recommendations that came from the dialogue. The fourth section sets out participants' comments and suggestions on applying and improving the integrated framework. The fifth section presents insights on the August 2016 draft National Nutrition Policy and the policy dialogue conducted through this workshop.

The researcher presented the research findings from Chapter 4 in the first Workshop session. Participants were encouraged to comment and share any further insights from the presentation. Participants agreed with the results and were able to use them in assessing Malawi's forthcoming National Nutrition Policy. The participants noted that Malawi's draft National Nutrition Policy integrates a gender perspective more appropriately than its predecessor. However, this policy focuses on involving men and improving women's control and access to resources for improved nutrition outcomes. Like the NNPS, this policy perpetuates the notion that nutrition and childcare are women's responsibility. Although the draft policy promotes men's participation in childcare and household duties, men's involvement restricted as a means to ensure that women have more time to provide optimal care for children.

The participants expressed that the draft policy, like the former NNPS, appears to prioritise gender equality. The draft policy has a priority area specifically dedicated to gender. However, the NNPS only focused on positive nutrition outcomes and overlooked the gender constraints that hinder men and

women’s access to nutritious food. The draft policy proposed no actions to address gender inequalities. It did not consider socio-cultural factors that prevent men from being involved in nutrition and children’s lives, overlooking the practical needs of men and women. The draft policy also neglects men’s nutrition interests.

Table 6.2 presents the consolidated assessment of the integration of gender in the draft policy by the four groups using the integrated framework. Only five boxes out of twenty-four are ticked in the darker section of the integrated framework suggesting that although the policy appears to make an explicit commitment to promoting gender equality, it does not challenge structural inequalities such as socially determined gender roles. The un-ticked boxes in the dark grey section of Table 6.2 suggest that there are gaps in the policy. Policymakers need to review these gaps and interrogate why these boxes were not ticked. They would then need to identify the best approaches to address these gaps.

**Table 6.2: Consolidated assessment of the four groups using the integrated framework (Mkandawire et al., 2017)**

Policy instruments (may not be exhaustive)	Do the vision, goals or principles have an explicit commitment to promoting or achieving gender equality?	Does the policy consider and include men and women’s practical and strategic needs?	Does the policy consider gender norms, roles and relations?	Does the policy avoid considering men and women as homogenous groups?	Does the policy clearly differentiate between sex and gender?
Agriculture extension and nutrition	✓		✓	✓	✓
Local food culture and gender					✓
Nutrition and the life cycle		✓			
Gender and obesity					
Spending income on nutrition					
Rights-based approach to nutrition	✓	✓		✓	
Targeting in nutrition policy	✓				

## 6.5. Validating the research findings from Chapter 5

In the second session of the workshop, three rural community members and the traditional authority shared their experiences of men's involvement in maternal and child health, focusing specifically on nutrition. They confirmed the facilitators and barriers to men's participation in maternal and child health discussed in Chapter 5. In Box 2 and 3, the shared experiences of Lesten Nyangulu and Chief Kwataine referred to the critical role that male champions play in encouraging men to become involved in maternal and child health. Chief Kwataine also validated that men are indeed playing a role in nutrition and that nutrition is no longer solely the domain of women. The perspectives presented in Box 1, 2 and 3 reflect that men play an important role in women's access to diverse foods during pregnancy. Group discussions verified the other facilitators (Table 5.1) of men's participation in maternal and child health, including recognition by men of the impact of involvement, pride, advocacy and incentives and disincentives.

### **Box 1: Lesten Nyangulu shares his experience of men's involvement in maternal and child health**



Lesten Nyangulu stated that men are embarrassed to go to antenatal care. However, in Champiti, community, male champions and the chiefs are encouraging men to attend prenatal care with their partners. The men try to ensure that women eat food from the six food groups recommended by the Malawi dietary guidelines. These foods are not always available in the village. 'If a woman tells a man that she wants to eat from six food groups, he might say that she is greedy but in Champiti, men's committees explain the value of diverse diets. People can eat mice and grasshoppers to compensate for the lack of availability of meat or fish'.

In response to a question regarding gender divisions of labour, Lesten responded, 'These days' men and women are doing the same work. There is nothing stopping men from attending antenatal care.'



Participants involved in men's involvement in maternal and child health programmes confirmed that 'opportunity costs' were a constraint to men's participation. Men lose productive time by attending antenatal visits. Consequently, they are not motivated to accompany their partners to prenatal clinics. Participants felt that stakeholders (e.g. policymakers, traditional leaders, NGOs) could provide incentives for men to become involved in maternal and child health. Participants explained that for men to appreciate the value of attending antenatal clinics, they would need to receive some benefit. If men could be tested for non-communicable diseases and provided with nutrition information on how to manage these diseases, men would be incentivised to attend antenatal visits. Men might be motivated to attend antenatal clinics if they received information that directly targeted to them.

For example, providing men with information on how to improve energy and productivity, might motivate men to attend antenatal visits. One policymaker shared that when she explained the linkage between vitamin A and virility, male parliamentarians showed interest in Vitamin A fortification. Over the past few decades, the health sector has neglected paying attention to men's health (Garfield and Rogers, 2008).

**Box 2: Lucy Kayenga shares her experience of men's involvement in maternal and child health**

Lucy Kayenga expressed how issues of safe motherhood are progressing in traditional authority Champiti. She explained that in the past men were not taking any responsibility when women became pregnant. Women went to antenatal care by themselves. Now because of safe motherhood, women are attending prenatal care from when they are three months pregnant. 'In Champiti when women go to antenatal care, they must go with the baby's father. Men receive information that is important for the baby to be born healthy. The couple also gets tested to ensure that if any of the parents are HIV positive, they can protect the baby from contracting HIV. The nurses also tell the woman that she needs a healthy diet while she is pregnant. Men are responsible for ensuring that women have healthy diets and don't struggle to find six food groups so that the baby is not born under-nourished. Eating from these six food groups every day ensures that a person has a diverse diet.'



During the group discussions participants confirmed that socio-cultural beliefs and stigmatisation are barriers to men's involvement in maternal and child health. Participants noted that it is not considered the norm for men to participate in maternal and child health and to assist in housework. They expressed that men who are involved in child care, cooking and cleaning might be mocked by other men in the community. They felt that measures to support men's participation in maternal and child health are needed.

**Box 3: Chief Kwataine shares his experiences of men's involvement in maternal and child health**

Chief Kwataine from Ntcheu spoke about the male champions in the local communities, highlighting the value of male motivators and male role models. He explained the role of Growth Monitors who are responsible for registering undernourished children. They record changes in child mass and other information including the number of pregnancies and deliveries a woman has had. They share this information with the traditional authority. As such, Chief Kwataine is aware of how many women are pregnant in his community, how many will give birth the following month, how many children are under-nourished and the progress of these children once they begin receiving treatment.

He mentioned that bylaws had been established to encourage men to attend antenatal care with their partners. 'Men who

participate in prenatal care can understand that women need to eat well because they hear it directly from the nurses or doctors. They recognise that the woman needs to eat as if she is eating medicine so that the baby can grow and be



healthy. When men attend antenatal care, they are also able to learn about family planning and child spacing. Men's attendance at prenatal care involves them in the pregnancy. They too become expectant of the child and they begin to understand what the woman requires during pregnancy. Similarly, when a child is undernourished, men recognise that a child needs food the same way they would need medicine. Men are motivated to take extra measures to ensure that his child gets the food they need.'

Participants acknowledged that men's involvement in maternal and child health could help achieve gender equality and not only positive nutrition outcomes. One participant from the MoGCDSW expressed that because Malawi is a signatory to the Beijing Platform for Action, the nutrition policy should aim to reduce malnutrition as well as gender inequality. Participants emphasised that men's gender equity should not be overlooked as it is an essential component of gender equality. One participant mentioned that the neglect of men by the health and nutrition sectors was an example of gender discrimination against men.

### **6.5.1. Recommendations for the draft policy**

From the consultative dialogue and assessment of the forthcoming National Nutrition Policy, recommendations were put forward by the participants. These recommendations were grouped into themes and consolidated, see Appendix H. The researcher provided recommendations to the MoGCDSW in the form of a policy brief, see Appendix I. The policy brief integrated participant recommendations as well as insights from the researcher.

Nutrition policies tend to focus on women and children as targeted beneficiaries. Likewise, the forthcoming Malawi National Nutrition Policy concentrates on women and children. However, Malawi is a signatory to international instruments such as the 1974 Universal Declaration on Eradication of Hunger and Malnutrition and the UN General Assembly Resolution 67/174 on the Right to Food. Consequently, Malawi has committed to addressing the neglect of the nutritional requirements of women and children, but also men, the elderly, people undergoing palliative care and other vulnerable groups. However, the draft policy refers to all these groups as 'vulnerable groups' without differentiating their needs. Participants suggested that these groups should be defined to ensure that government and other stakeholders address the nutritional requirements of all the different vulnerable groups.

Although the policy includes gender as a separate priority area, participants suggested that all priority areas need to incorporate gender. Each priority area should be assessed using a gender lens and each priority area should consider gender norms, roles and relations that undermine men and women's ability to access nutritious food. For example, priority area eight in the forthcoming National Nutrition Policy on nutrition monitoring and evaluation, research and surveillance does not include an indicator on gender and should do. The SDGs emphasise the need for indicators to monitor progress towards gender equity and equality (UN, 2016).

Similarly, the priority area on non-communicable diseases does not consider men's specific needs. Men's nutritional requirements are neglected. The policy perpetuates the notion that men and women's needs are the same. Gender norms relating to the enactment of masculinity prevent men from fully realising their nutrition and health rights. For example, health-seeking behaviour amongst men is not considered masculine (Mróz et al., 2011).

As a signatory to the Beijing Platform for Action, Malawi is committed to ensuring that policies and programmes at all levels integrate gender and also promote gender equality. Nutrition policies need to provide guidance on nutrition messaging that targets both men and women. The health sector in Malawi is particularly active in motivating men to participate in maternal and child health. Participants suggested combining nutrition messages with messages on safe motherhood. The participants felt that community leaders, such as traditional authorities and faith-based leaders should be involved in the dissemination of nutrition messages, particularly concerning behaviour change and men's involvement in maternal and child health. Nutrition messages could promote gender equality. Messages should be constructed with care to ensure that they do not perpetuate inequality. For example, posters and other media should not have images of women only but also include men.

The researcher noted that the community's participation in the dialogue was valuable and recommended the inclusion of community members in the development of policies and strategies essential. When policymakers do not align policies with the needs of communities, implementation can be constrained. Including traditional authorities and communities in the development of policies and strategies provides policymakers with an accurate picture of what is feasible to implement based on the community's knowledge and experiences. Traditional authorities - as the custodians of culture - can identify how to negotiate socio-cultural barriers to men and women's access to nutritious food. In Box 3, Chief Kwataine reflects the meaningful role that traditional authorities can and are playing in reducing maternal and child undernutrition. Chief Kwataine has been able to develop strategies to encourage to participate in antenatal clinics because he understood the benefits of men playing an active role in pregnancy. With the right training, traditional authorities can be the bridge between policymakers and communities, facilitating implementation as well as providing input for policy evaluation and reform based on evidence of successful approaches and interventions.

The researcher recommended that decisive action is required to involve men as partners in addressing systematically embedded inequalities, such as prescribed gender roles, in Malawi. Nutrition stakeholders need to discuss and explore the specific contexts of Malawian men and women. The nutritional and social needs of men and women are different. Social factors may prevent both men and women from accessing nutritious food. People-centred policy development requires direct engagement

with the beneficiaries of public policies. Involving communities in the design and validation of policies ensures coherence between the needs of the rural community and the policy.

## **6.6. Participants' comments on the integrated framework for gender analysis of nutrition policy**

The participants provided critique and recommendations for improving the integrated framework. Appendix J presents a revised version of the tool, incorporating the comments of the participants, highlighting revisions to the tool in white. They were able to apply the tool in identifying gaps and biases in the policy. For example, three groups felt that the policy assumes that men and women's needs are the same. They expressed that the beneficiaries in the draft policy were very narrowly defined and excluded several 'vulnerable groups', such as the elderly, men and people with disabilities. The participants felt that the tool provided a lens through which they could make such determinations. One group expressed that:

*'The tool was useful, but it has some limitations'*

Another group felt:

*'The tool was useful. It helped identify some of the elements that policymakers need to consider.'*

A third group commented that:

*'The tool is useful, but it would be better if it related to health, education and other social sectors.'*

The groups found the integrated framework useful, but not very user-friendly. Recommendations were provided to improve the tool. Appendix J presents the revised integrated framework. One group appeared to struggle in their application of the tool. One participant from this group commented that the draft policy should be analysed in its entirety and not by priority areas. Therefore, this groups analysis focused on the policy priority areas allocated to them, as well as other areas. Some groups experienced challenges in applying the tool and needed support from the facilitators. However, the groups were eventually able to understand how the tool should be used and commented on its usability. Three central themes emerged from the assessment of the integrated framework: (i) the need for a user's guide to applying the tool; (ii) the seven policy instruments are not exhaustive and (iii) participants felt the phrasing of questions in the top row of the integrated framework inadequate such as neglect of men.

Three groups expressed concern that the integrated framework required expert knowledge to understand the terms and concepts. The groups recommended that a guide is developed to assist users in applying the integrated framework for gender analysis of nutrition policy. Two groups mentioned that the colour

coding in the legend of the framework is misleading. The legend was revised to clarify the colour coding and give clarity on how the tool provides conclusions on the extent to which a policy is gendered based.

One group mentioned that the seven policy instruments in the first column of the integrated framework were not exhaustive. For example, during the dialogue, the researcher recognised that men, women and children's nutrition in emergency situations requires particular attention, especially in a country like Malawi which is vulnerable to climatic shocks. Policymakers need to consider these situations and outline contingencies in nutrition policies.

Another priority area, women and nutrition in emergency situations, was added to the framework. A caveat was also added to the tool to note that the list of policy instruments is not exhaustive and that users of the integrated framework may include other instruments should the need arise. However, any additional instruments should still be interrogated using the selected WHO questions in the top row of the integrated framework for gender analysis of nutrition policy. The questions in the top row of the framework ensure rigorous questioning of the policy instruments and expose possible biases.

Three groups were concerned with the phrasing of the first row of questions in the framework. One group felt that the questions only focussed on women. The question 'Does the policy consider and include women's practical and strategic needs' was revised to include both men and women. Another group felt that strategic and practical needs should be separated. The participants felt that these two needs were different and could not be conflated. Therefore, the question was separated in the revised integrated framework in Appendix J to read 'Does the policy consider and include men and women's practical needs?' and 'Does the policy consider and include men and women's strategic needs?'

Finally, one group was concerned that the tool only catered for affirmative and negative responses to the questions in the first row of the framework. The researcher explained that the questions in the top row of the framework in Appendix J were intended to stimulate debate. The questions force the assessor of the policy to question the extent to which a policy instrument meets the criteria for a gender-responsive policy. In doing so, it forces the policymaker to interrogate the policy instrument.

## **6.7. Researcher insights from the policy dialogue**

The policy dialogue presented an opportunity for the researcher to assess the forthcoming Malawi National Nutrition Policy and determine the extent to which the gender-responsiveness of nutrition

policies in Malawi have improved. It was found that the draft policy reflected biases. For example, the National Nutrition Policy includes the following priority statement:

*'The policy shall ensure an increase in men's shared responsibility for child care and household duties to enable women to have more time to provide optimal child care.'* (MoH, forthcoming:17)

Another priority statement notes:

*'The policy shall ensure sustained livelihoods for women and child headed households to increase access and control of resources for improving nutrition.'* (MoH, forthcoming:17)

The first statement suggests that the only reason that men should be involved in child care and household duties is to enable women to increase time allocated to child care. Policymakers did not understand that the purpose of redistributing reproductive work was to ensure that women had more time to pursue other activities, such as farm work. Redistributing reproductive work is an approach to empowering women. Women's reproductive roles are reinforced through this statement. The statement contradicts other policy statements contained within the National Nutrition Policy that seek to empower women. The failure to recognise the policymakers' gender role bias in these statements suggests that either the policy did not undergo rigorous interrogation during the broader consultative process or that those consulted were unable to disassociate personal biases.

The policy does integrate gender more adequately than the former NNPS. It highlights the importance of renegotiating gender norms, roles and responsibilities by promoting men's involvement in reproductive work. However, the policy perpetuates the notion that only women can be responsible for nutrition and child care. Such oversights suggest patriarchal bias. The objective of the policy is only to improve child nutrition. Therefore, while the policy is not entirely gender-blind, it is also not gender-responsive. The policy does not articulate that men's involvement as an approach to achieving gender equality. As such, nutrition and health programmes and strategies only involve men to meet sectoral objectives. In this case, improved child nutrition. Policymakers continue to overlook gender equality.

Two insights were observed from the policy dialogue. First, promotion of reflexivity amongst policymakers and communities is needed to ensure that the policies, by-laws and activities implemented have not been influenced by personal biases. Often policymakers do not realise the unintended consequences that prejudices policy choices. The policy dialogue stimulated a process of reflexivity amongst policymakers, stakeholders and community members. Through supported discussions, policymakers and stakeholders were able to recognise how their interpretations of gender may perpetuate gender inequality and reinforce bias in policy documents.

The policy dialogue provided an opportunity for stakeholders, policymakers and community members to interact. The second insight was that dialogue between policymakers, stakeholders and communities can strengthen relationships, bringing about mutual respect and collaboration amongst the three groups. Many of the policymakers stated that they were happy to have been able to engage with the rural community members. They expressed that such forums were necessary and should be regularly conducted. The members of the rural community were also pleased to have been invited and given an opportunity to share their experiences and participate in generating solutions. The policy dialogue strengthened the relationship between the two groups. Some of the policymakers planned on further interaction and collaboration with the members of the rural community. One of the stakeholders invited the community members to help his organisation develop men's involvement in maternal and child health interventions in the communities in which they worked.

Many participants expressed that it is common to think that rural communities do not have solutions to the challenges they face. Very often, development approaches are top-down and governments, NGOs and donors often tell communities how to resolve problems without consultation. Policymakers and stakeholders emphasised that the bottom-up approach is crucial to development and that from the dialogue, they were able to recognise that communities were innovative and could generate solutions to problems that governments had been unable to tackle.

One policymaker participant said:

*'It was very useful to have them around. The larger population in Malawi is rural, so we need things that work for them. We need to know what works for them because in implementing things like the nutrition policy, we need the community involved because we are going to implement this thing on the community. So, to then have them here and tell us what has worked for them, and what strategies they have used to make this thing work, would help inform policy.'*

Policymakers emphasised that solutions generated by the rural communities can be applied broadly across Malawian communities. One policymaker participant said:

*'We have people from the community also coming in to give us their view, which is very important. My understanding is that if it can work for the rural areas, it can also work for the urban areas. It's all about how we are going to bring them together.'*

## **6.8. Synopsis**

The policy dialogue provided an opportunity for validating the study findings and reinforced the trustworthiness of the study. The policymakers were able to reflect on how their gender biases had



influenced policy decisions. They were able to identify the changes necessary to ensure that policies are gender-responsive. The dialogue was an opportunity to strengthen the relationship between policymakers, community members and other stakeholders. Policymakers were able to appreciate the value of community members input in the policy. They were also able to identify opportunities for collaborating with communities in rolling out men's involvement in maternal and child nutrition programmes.

## **CHAPTER 7 : CONCLUSIONS AND RECOMMENDATIONS**

### **7.1. Synopsis**

The purpose of this study was to explore how interpretations of gender influence nutrition policy in Malawi. This study addressed three sub-objectives. First, a desk review determined how adequately Malawi's NNPS (2007 -2012) integrated gender. Second, the study explored how men's involvement in maternal and child health is defined in rural Central Malawi and what hinders and facilitates men's involvement. Finally, the implications of men's involvement in maternal and child health for gender mainstreaming in nutrition policy were explored.

The desk study included a review Malawi policies, strategies, legislation and international agreements. The qualitative fieldwork applied focus group discussions and in-depth interviews to generate data from both study informants and community members. A policy dialogue was used to present feedback to the research participants and to validate research findings. This dialogue was a unique opportunity to facilitate discussions between policymakers, stakeholders and community members. It was also an opportunity to provide recommendations for Malawi's forthcoming National Nutrition Policy. The study set out to generate a hypothesis as opposed to testing one. Three propositions were made. These propositions were:

1. Policy-makers gendered frames of reference influence their gender perspective.
2. It is possible to influence gender roles even in the most traditional rural communities.
3. Gender equality was not the goal of men's involvement in maternal and child health approaches in the nutrition and health sectors.

These propositions are discussed below in relation to the objectives and research findings.

A review was conducted of existing gender assessment tools. A list of tools included in this review is available in appendix K. No tools were identified that assessed the integration of gender in nutrition policy. Consequently, an integrated framework was developed to evaluate the first proposition. The tool exposed policymaker's biases and ideologies that may have influenced policy decisions. This tool was used to analyse Malawi's NNPS. While the NNPS referred to women, it did not adequately incorporate gender. The policy did not consider the practical and strategic needs of women or men or the gender relations that constrain women's access to nutritious food. The integrated framework indicated that the policy was not gender-responsive but in fact gender-blind. The NNPS made no attempts to improve gender relations between men and women. Instead, it was focused narrowly on

improving child nutrition. The policy reinforced the role of women in nutrition, suggesting that traditional gender divisions of labour influenced policymakers.

This finding relates to the second proposition, emphasising how it is possible to influence gender roles even in the most traditional rural communities. Community members' interpretations of gender differed significantly from that of policymakers. The discussions at community level showed that men are increasingly taking responsibility for reproductive work that was previously associated with women. Consequently, gender divisions of labour at the community level are changing. This finding concurred with the literature on barriers to men's involvement in maternal and child health. Like other research, this study found that socio-cultural beliefs, stigmatisation and opportunity costs are all barriers to men's participation in maternal and child health. However, this study extended beyond the identification of obstacles to also identifying facilitators of and limitations to men's involvement in maternal and child nutrition. The facilitators included: men's recognition of the benefits of participation; advocacy; incentives and disincentives provided by health care providers and traditional leaders and encouragement from male champions. The limitations included: discrimination against women and reinforcing men's decision-making power. Men's involvement in maternal and child health approaches were not integrated with a gender equality objective in mind. The implications for integrating men in nutrition policy interventions can result in positive maternal and child nutrition outcomes. However, policies should ensure that men's involvement improves nutrition outcomes and also reduces women's work burden to enable women to pursue other activities, such as adult basic education and training programmes. Men's involvement in maternal and child health can indeed be strategic in advancing nutrition as well as gender-related objectives.

This finding concurs with the third proposition, suggesting that gender equality was not at the centre of men's involvement initiatives. The study found that in Malawi's draft National Nutrition Policy men's involvement in maternal and child nutrition was only applied to achieve positive nutrition outcomes. The policy did not address gender dynamics that undermine men and women's access to nutritious food. In fact, some of the approaches to involving men in maternal and child health infringed on women's human rights which likely widened the gender gap as opposed to bridging it. When policymakers fail to address gender dynamics, unintended consequences often result. For example, concerning the bylaws on partners attending antenatal clinics, women who were not accompanied to antenatal clinics by their partners were attended to only after those who were. Considering the productive time women lose waiting in queues at prenatal visits, this approach served as a disincentive for some women to attend antenatal visits. Other methods were counterintuitive because assets used for improving nutrition, such as goats and chickens, were payable as fines when men did not attend antenatal care sessions with their partner. Limited interaction between policymakers and communities constrains the development of policies that address the weaknesses in the design of men's involvement programmes. Policymakers

were unaware of the changing gender dynamics at the community level and were unable to identify emerging gender issues, such as the discrimination that women face because of the flawed design of men's involvement initiatives.

During the study period, Malawi was reviewing the NNPS. The policy dialogue offered a platform through which policymakers and communities shared perspectives and experiences of gender and explored how to apply these perspectives to the design of nutrition policies. The researcher obtained a copy of the revised draft policy and worked with participants to use the integrated framework for gender analysis in nutrition policy to assess whether gender was adequately integrated into the draft National Nutrition Policy. The assessment suggested that while the policy incorporated gender more adequately compared to its predecessor, it failed to prioritise gender equality. The policy focused mostly on re-organising gender roles by promoting men's involvement in housework and childcare: activities traditionally associated with women. The policy appeared to include men to ensure that women had more time to provide care for children, reinforcing traditional interpretations of gender that associate reproductive work with women. This finding relates to both the first and the third proposition.

Policymakers' gender biases and ideologies continue to influence policy decisions. Traditional perspectives on gender amongst policymakers results in policies that are gender-tepid. Also, the design of men's involvement approaches fails to address constraints to women's empowerment. The dialogue provided an opportunity for policymakers to reflect on their own gender biases and ideologies. It also encouraged policymakers to acknowledge the changing gender dynamics that communities were experiencing.

## **7.2. Conclusions**

The study drew three conclusions. The first conclusion relating to the first proposition was that while Malawi's first NNPS did not adequately integrate gender, the forthcoming National Nutrition Policy pays some attention to gender issues. However, neither policy was gender-responsive. Unlike its predecessor, the draft National Nutrition Policy was not gender-blind but gender-tepid. The term 'gender-tepid' is coined to describe the level to which the policy integrated gender. The NNPS did not address systematic inequalities that undermine gender equality. For example, the draft policy promoted sustained livelihoods for women but did not consider household gender dynamics that constrain women's control over resources. The policy did not address the causes of inequality. The intent and effort to integrate gender was evident. There were clear efforts to apply emerging approaches, such as involving men in care activities, to integrating gender in nutrition policy. However, policymakers'

gender biases and ideologies prevented them from recognising how their gender perspectives were perpetuated through the policy.

Varying perspectives on gendered policy exist amongst stakeholders in Malawi. However, lack of engagement between policymakers and communities prevented policymakers from recognising changes in gender dynamics and incorporating them in policy, resulting in policies that did not respond to emerging gender concerns (proposition two). For example, bylaws intended to motivate men to attend antenatal care by withholding services from women who were not accompanied by their partners discriminated against women. These bylaws were contrary to the Constitution. While men's involvement interventions are essential for maternal and child nutrition, the design of these interventions unintentionally undermines gender equality. Policymakers did not recognise unintentional consequences as new and emerging gender issues. Subsequently, policymaker's stereotypical interpretations of gender are reflected in the policy, failing to address the real constraints that confront men and women regarding accessing nutritious food. For example, the policy does not address socio-cultural norms that hinder joint decision-making at the household level to increase women's participation in resource allocation.

The third conclusion (relating to the third proposition) is that men's involvement efforts in maternal and child health and nutrition have applied an 'add men and stir' approach. The designers of the NNPSF did not fully grasp the concept of gender. This lack of understanding resulted in a policy that was gender-tepid as opposed to gender-responsive. While the draft policy recognises that men should play a role in nutrition, it fails to harness men's roles as an approach to gender equality. The policy is only concerned with its core mandate, which is to address maternal and child nutrition. It reproduces these stereotypes and only addresses the immediate gender barriers to maternal and child nutrition that constrain women and children's dietary adequacy such as women's limited time to provide adequate childcare. But this is only a short-term solution and does not address inequalities embedded in society. The policy does not challenge gender stereotypes associated with women. Policymakers are unable to understand that men's involvement in reproductive work should enable women to pursue other activities. Even when policymakers recognised the need to challenge stereotypical gender roles by involving men, the policymakers still interpreted the role of women as the primary caregiver by asserting that men should participate in care work so that women have more time to provide optimal care for children. The policymakers do not address the underlying gender inequalities that perpetuate undernutrition.

### 7.3. Recommendations

This study makes four recommendations. While some of these recommendations relate to Malawi, they have implications for policymakers in many low-income countries. First, there is need to strengthen the institutional capacity to integrate gender in nutrition policy in Malawi. Policymakers can be provided with gender training before revising policies. This approach can equip policymakers with the tools needed to integrate gender appropriately. Such an approach is required at all levels of planning from national, district, traditional authority and chiefs. This approach would assist in ensuring compliance with the Beijing Declaration and Platform for Action by integrating gender at all levels of policymaking.

Second, gender training should include reflection on personal biases and ideologies that may influence the design of policies, programmes, interventions and bylaws. Policymakers should reflect on their own experiences and interpretations of gender to ensure that these do not affect policy decisions or prevent them from recognising gender flaws in the design of policies. Male policy champions committed to redistributing gender roles could motivate policymakers as well as the general public to revisit how they interpret gender. Gender training should also include the critical evaluation of how new approaches, such as men's involvement, might be re-shaping gender dynamics at the community level. An understanding of the implications of these changes for gender equality is also imperative.

Policymakers in low-income countries should be more proactive in engaging communities in the formulation of policies, particularly in generating an understanding of emerging gender issues. Many international commitments such as the World Declaration and Plan of Action for Nutrition and the Voluntary Guidelines on the Right to Food advocate for the involvement of communities in development planning. NGOs can play a particularly important role in bridging the gap between communities and policymakers and create a space for engagement between these two groups. NGOs are also powerful advocates who can lobby the government to engage communities more effectively in the policy process.

Finally, when policymakers are designing nutrition policies, the fundamental role of men in nutrition should be acknowledged. In complying with the Beijing Declaration and Platform for Action, policymakers should ensure that legislation, such as paternity leave and other incentives, encourage men to share equal responsibility for the family. The role of men should not be regarded only as a means to alleviate women's time constraints so that women can provide optimal care to children, but also as an opportunity to empower women. Policymakers should consider how men's involvement presents opportunities for gender equality as well as improved nutrition outcomes. Involving men in nutrition

presents opportunities for sensitising men on the benefits of gender equality for them as well as society as a whole.

#### **7.4. Contribution to knowledge**

This study contributes four novel ideas, some of which have already influenced policy. It also provides a tool for analysing the extent to which a policy is gender-responsive. The first contribution to knowledge is that increasing policymaker's awareness of gender biases that influence their decisions could improve the gender-responsiveness of policies and accelerate progress toward reducing malnutrition as well as advancing gender equality. The nutrition domain, in particular, offers various opportunities for negotiating how gender roles and responsibilities are distributed. Involving men in food choices, food preparation, child and maternal care challenges gender stereotypes. Also, including men in maternal and child nutrition creates opportunities for balancing the workload in the household.

The second contribution to knowledge is that the study identified facilitators of men's involvement, highlighting limitations of men's participation in maternal and child health interventions. Gender power relations and women's empowerment are inextricably linked and addressing the systematically embedded constraints to women's empowerment is critical to its success. Where most studies on men's involvement in maternal and child health have focused on the barriers to men's participation in maternal and child health, this study focused on men's involvement in maternal and child nutrition. The inclusion of traditional leaders in men's involvement initiatives was one of the most critical facilitators identified in this study. As the custodians of culture, traditional authorities can negotiate barriers to men's participation in maternal and child health and influence positive behaviour change amongst men. While some of the approaches applied by the traditional authorities are limited, in that they discriminate against women, the influence of the community leaders on men's behaviour has powerful implications for policy and policy interventions.

The third contribution to knowledge is an integrated framework which offers policymakers a lens which they could use to better integrate gender in nutrition policy. The tool enables policymakers to reflect on personal biases and ideologies reflected in the decisions they have made. It also assists policymakers in identifying gender gaps in nutrition policies. In Malawi, the integrated framework assisted decision-makers in identifying gender weaknesses in the policy. Policymakers in the policy dialogue reflected on how gender stereotypes had been perpetuated in the phrasing of one policy statement, suggesting that they can recognise and address flaws in the way the policy interprets gender. The policy brief and dialogue report were shared with the MoGDSCSW and the DNHA. Although no further advocacy efforts were made, one of the recommendations was taken up by the policy drafting team and adopted in the

final policy. The policy was launched June 2018. The policy statement: ‘The policy shall ensure an increase in men’s shared responsibility for child care and household duties to enable women to have more time to provide optimal child care.’ (MoH, 2016:17) was amended to read, ‘Men’s shared responsibility for child care and household duties to enable women participation in social and economic activities is increased.’ (GoM, 2017: 12)

The fourth contribution to knowledge was the identification of the potential role of policy dialogues in strengthening community participation in policy. The policy dialogue emphasised the valuable contribution communities can make in informing policy. The policy dialogue also provided a platform where decision-makers, stakeholders and community members could reflect on how the forthcoming National Nutrition Policy portrays gender. This dialogue generated consensus regarding how gender is interpreted by different stakeholders. Relationships between NGOs, government and community members were strengthened, increasing the potential for continued collaboration. Decision-makers recognised the capacity of communities to innovate and improve nutrition in their areas. Community members were also made aware of the meaningful contribution they can make to policy.

## **7.5. Recommendations for improvement of the study**

Several limitations of the study were noted. This section provides recommendations to overcome these. More time could have been allocated to conduct the focus group discussions in the community. We underestimated how much valuable information the participants had to share with us and how much they had to say on issues relating to men’s involvement in maternal and child nutrition. More time spent with the communities would have enabled them to share more information that may have added value to the study.

A champion from within the system could have been identified to increase participation of policymakers. It is also always challenging to meet with policymakers, who have limited time to participate in research. While many of the policymakers approached were able to make time to meet with us, we were unable to engage them in focus group discussions as their time limitations posed a constraint to scheduled group meetings. The methodology was being formulated at the time the study was conducted and in retrospect, it might have been useful to develop a brief to convince policymakers of the value of participating in the study.

More communities should be sampled to understand how other communities apply different strategies to involve men in maternal and child nutrition. Sampling several communities would enable researcher



to compare the approaches used to include men in maternal and child health across different communities.

## **7.6. Recommendations for further research**

This study did not directly explore policymakers' perceptions of gender. However, research is needed to understand what these perceptions are. Understanding how policymakers interpret gender can assist researcher in determining how to re-shape the way in which policymakers make gendered decisions. It can also help in improving how policymakers integrate gender in nutrition policy.

Understanding whether policymaker's capacity to integrate gender in nutrition policies would improve the gender-responsive of nutrition policies is important. This study suggests that policymakers in the nutrition domain have limited ability to incorporate gender in nutrition policy. Building the institutional capacity to integrate gender in nutrition policy may not necessarily make policymakers aware of how their personal experiences of gender may affect the decisions that they make.

Further research is needed to understand if the term 'gender' is no longer relevant and to determine if there is a need to for a new term to coin the inequalities still existent between men and women. Misconceptions around the term 'gender' have influenced the design of policies and interventions. Perhaps a shift from the term 'gender' to 'social inclusion' decrease the influence of biases and ideologies on policy choices?

Studies are needed to determine how policymakers can identify changes in gender dynamics. The concept of gender is not static and with new approaches to addressing issues of gender inequality, such as men's involvement approaches, a range of new concerns arise. It is crucial to understand how policymakers can be made aware of these emerging issues and how they can be equipped with the tools necessary to respond to these issues.

## References

Aarnio, P., Olsson, P., Chimbiri, A. and Kulmala, T. 2009. Male involvement in antenatal HIV counseling and testing: Exploring men's perceptions in rural Malawi. *Acquired Immunodeficiency Syndrome (AIDS) Care*, 21(12): 1537-1546.

Aguair, C. and Jennings, L. 2015. Impact of male partner antenatal accompaniment on perinatal health outcomes in developing countries: A systematic literature review. *Maternal and Child Health Journal*, 19(9): 2012 – 2019.

Akintola, O. 2008. Towards equal sharing of AIDS caring responsibilities: Learning from Africa. Paper prepared for the Expert Group Meeting on 'The equal sharing of responsibilities between women and men, including caregiving in the context of Human Immunodeficiency Virus (HIV)/AIDS' organized by the Division for the Advancement of Women, Geneva, Switzerland, from 6-9 October 2008 (EGM/ESOR/2008/EP.5).

Alio, A. P., Lewis, C.A., Scarborough, K., Harris, K. and Fiscella K. 2013. A community perspective on the role of fathers during pregnancy: a qualitative study. *BMC Pregnancy and Childbirth*, 13(60): 1-11.

Anderson, M.B. And Woodrow, P.J. *Rising from the Ashes: Development strategies in times of disaster*. London: Intermediate Technology Publications.

African Union/New Partnership for Africa's Development. 2009. *The Comprehensive Africa Agriculture Development Plan Framework for African Food Security*. Midrand: New Partnership for Africa's Development.

African Union Commission (AUC). 2003. *Maputo Declaration on Agriculture and Food Security*. Addis Ababa: African Union Commission.

AUC. 2005. *African Charter on Human Rights and People's Rights on the Rights of Women in Africa*. Addis Ababa: African Union Commission.

AUC. 2014a. *The Malabo Declaration on Nutrition Security for Inclusive Economic Growth and Sustainable Development in Africa*. Addis Ababa: African Union Commission.

AUC. 2014b. Malabo Declaration of Accelerated Agricultural Growth and Transformation for Shared Prosperity and Improved Livelihoods. Addis Ababa: African Union Commission.

AUC. 2014c. Malabo Declaration on Ending Preventable Child and Maternal Deaths in Africa. Addis Ababa: African Union Commission.

Audet, C.M., Chire, Y.M., Vaz, L.M.E., Bechtel, R., Carlson Bremer, D., Wester, W. Amico, K.R., and Gonzalez-Calvo, L. 2015. Barriers to male involvement in antenatal care in rural Mozambique. *Qualitative Health Research*, 26(12): 1 – 11.

August, F., Pembe, A.B., Mpembeni, R., Axemo, P. and Darj, E. 2016. Community health workers can improve male involvement in maternal and child health: evidence from rural Tanzania. *Global Health Action*, 18(9): 1 - 10.

Ayuko, B. and Chopra, T. 2008. The illusion of inclusion: Women's access to rights in Northern Kenya. Research Report. Nairobi: Legal Resources Foundation Trust.

Babu, S.C., Haggblade, S., Mkandawire, E., Nankhuni, F. and Hendriks, S.L. 2016. Micronutrient Policy Processes in Malawi. Discussion Paper 01568. Washington, DC: International Food Policy Research Institute.

Barandiaran, X., Di Paolo, E. and Rohde, M. 2009. Defining Agency. individuality, normativity, asymmetry and spatio-temporality in action. *Journal of Adaptive Behavior*, 15(5): 1 – 13.

Barker, G., and Ricardo, C. 2010. Young Men and the Construction of Masculinity in Sub-Saharan Africa. *Social Development Papers, Conflict Prevention & Reconstruction* 26. Washington, DC: World Bank.

Bellows, A.C., Scherbaum, V., Lemke, S., Jenderedjian, A. and do Socorro Gonçalves, V.R. Gender-specific risks and accountability: women, nutrition and the right to food. 2011. Available: <http://www.icco-international.com/int/linkservid/EE74AFE2-0F41-9373-86C974611E0042AC/showMeta/0/> (Accessed 12 Nov 2016).

Benson, T. and Shekar, M. 2006. Trends and issues in child undernutrition. [eBook]. Available: <http://www.ncbi.nlm.nih.gov/books/NBK2301/> (Accessed 19 Nov. 2014).

Bhutta, Z., Tahmeed, A., Black, R.E., Cousens, S., Dewey, K., Giugliani, E., Haider, B., Kirkwood, B., Morris, S., Sachdev, H.P.S. and Shekar, M. 2008. What Works? Interventions for Maternal and Child Undernutrition and Survival. *Lancet Series*, 371 (9610): 417-440.

Black, R.E., Vitora, C.G., Walker, S.P., Bhutta, Z.A., Christian, P. and de Onis, M. 2013. Maternal and child undernutrition and overweight in low-income and middle-income countries. *Lancet Series*, 382 (9890): 427–451.

Boserup, E. 1989. *Woman's Role in Economic Development*. London: Cromwell Press.

Brubaker, K., Nelson, B.D., McPherson, H., and Ahn, R. 2016. Qualitative study of the role of men in maternal health in resource-limited communities in western Kenya. *International Journal of Gynecology and Obstetrics*, 135(3): 245 – 249.

Bradshaw, S., Caselin, J. and Diop, B. Women's role in economic development: Overcoming the constraints Background paper for the High-Level Panel of Eminent Persons on the Post-2015 Development Agenda. New York: Sustainable Solutions Development Network.

Bryce, J., Coitinho, D.; Darnton-Hill, I., Pelletier, D. and Pinstrup-Andersen, P. 2008. Maternal and child under-nutrition: Effective action at national level. *Lancet Series*, 371 (9611): 510 – 526.

Butrick, E., Diamond-Smith, N., Beyeler, N., Montagu, D. and Sundinaraset, M. 2014. Strategies to increase health facility deliveries: three case studies. Available: <https://globalhealthsciences.ucsf.edu/sites/globalhealthsciences.ucsf.edu/files/pub/pshi-strategies-to-increase-health-facility-deliveries.pdf> (Accessed 28 Jul 2016).

Case, A. and Mendez, A. 2009. Sex differences in obesity rates in poor countries: Evidence from South Africa. *Economic Human Biology*, 7(3): 271–282.

Chant, S. and Gutmann, M.C. 2002. 'Men-streaming' gender? Questions for gender and development policy in the twenty-first century. *Progress in Development Studies*, 2(4), 269–282.

Committee of Experts on Public Administration. 2007. *Participatory Governance and Citizens' Engagement in Policy Development, Service Delivery and Budgeting*. New York: United Nations Economic and Social Council.

Committee on World Food Security. 2011. Policy Roundtable Gender, Food Security and Nutrition. Thirty-Seventh Session, 17 – 22 October, 2011. Rome: Food and Agriculture Organisation.

Committee on World Food Security. 2012. Coming to Terms with Terminology. Rome: Food and Agriculture Organization.

Connell, R.W. 2003. The role of men and boys in achieving gender equality. Prepared for the Expert Group Meeting on “The role of men and boys in achieving gender equality” 21 to 24 October 2003 Brasilia, Brazil. New York: United Nations.

Cornwall, A. 2000. Missing men? Reflections on men, masculinities and gender in GAD. *IDS Bulletin*, 31(2): 18 – 27.

Cornwall, A and Rivas, A.M. 2015. From ‘gender equality’ and ‘women’s empowerment’ to global justice: Reclaiming a transformative agenda for gender and development. *Third World Quarterly*, 36 (2) 396 – 415.

Correia, M. and Bannon, I. 2006. *The Other Half of Gender*. Washington, DC: World Bank.

Covic, N. and Hendriks, S.L. 2016. ‘Introduction’. (Eds). N. Covic and S.L. Hendriks. (In). *Achieving a Nutrition Revolution for Africa: The Road to Healthier Diets and Optimal Nutrition*. ReSAKSS Annual Trends and Outlook Report 2015. International Food Policy Research Institute (IFPRI). pp 1 – 5.

Davids, T. van Driel, F and Parren, F. 2014. Feminist change revisited: Gender mainstreaming as a slow revolution. *Journal of International Development*, 26, 396 – 408.

de Schutter, O. 2014. Report of the Special Rapporteur on the right to food: Mission to Malawi. New York: United Nations Human Rights Council.

Doss, C. Meinzen-Dick, R., Quisumbing, A and Theis, S. 2018. Women in agriculture: Four myths. *Global Food Security*, 16: 69 – 74.

DFID. 2013. G8 Nutrition for Growth Commitments. Executive summary of the Nutrition for Growth Commitments for 2020 made at the G8 Summit. London: Department for International Development of the UK Government.

Ditekemena, J., Koole, O., Engmann, C., Matendo, R., Tsehfu, A., Ryder, R. and Colebunders, R. 2012. Determinants of male involvement in maternal and child health services in sub-Saharan Africa: A review. *BMC Reproductive Health*, 9(32): 1-8.

Eckert, P. and Mc Connell-Ginet, S. 2003. *Language and Gender*. New York: Cambridge University Press.

Eisenhardt, K.M. and Graebner, M.E. 2007. Theory building from cases: opportunities and challenges. *Academy of Management Journal*, 50(1): 25 – 32.

Ellemers, N. 2018. Gender stereotypes. *Annual Review of Psychology*, 69(1): 275 – 298.

Ewing, V.L., Lalloo, D.G., Phiri, K. S., Roca-Feltre, A., Mangham, L.J. and Sanjoaquin, N.A. 2011. Seasonal and geographical differences in treatment-seeking and household costs of febrile illness among children in Malawi. *Malaria Journal*, 10(32): 1-8.

Food and Agriculture Organisation (FAO) and World Health Organisation. 2014. *The Rome Declaration on Nutrition*. Rome: FAO.

FAO. 1992a. *International Conference on Nutrition Final Report of the Conference Rome, December 1992*. Rome: FAO.

FAO. 1992b. *World Declaration and Plan of Action for Nutrition*. Rome: FAO.

FAO. 2004. *Implementation of the CAADP of NEPAD Progress Review. Twenty-third regional conference for Africa Johannesburg, South Africa, 1-5 March 2004* Rome: FAO.

FAO. 2004. *Voluntary Guidelines on the Right to Food*. Rome: FAO.

FAO. 2008. *The State of Food Insecurity in the World, 2008: High Food Prices and Food Security, Threats and Opportunities*. Rome: FAO.

FAO. 2011. *Gender inequalities in rural employment in Malawi. Country Profile*. Rome: FAO.

FAO. 2012. *Gender mainstreaming and nutrition. Prepared by FAO for submission to and discussion within the UNSCN with a view to developing consensual briefs for non-specialists on cross-cutting issues impacting food and nutrition security*. Rome: FAO.

FAO. 2014. Rome Declaration on Nutrition. Rome: FAO.

FAO. 2016. United Nations Decade of Action on Nutrition. Rome: FAO.

Ferrant, G., Pesand, L.M. and Nowacka, K. 2014. Unpaid Care Work: The missing link in the analysis of gender gaps in labour outcomes. Boulogne Billancourt: OECD Development Center.

Flood, M. 2007. Involving men in gender policy and practice. Engaging men in “women’s issues”: Inclusive approaches to gender and development. *Critical Half*, 5:8–13.

Fransisco, V.T. and Butterfoss, F.D. 2007. Social validation of goals, procedures and effects in public health. *Health Promotion Practice*, 8(2): 128 - 133.

Ganle, J.K. and Dery, I. 2015. ‘What men don’t know can hurt women’s health’: A qualitative study of the barriers to and opportunities for men’s involvement in Ghana. *Reproductive Health*, 12 (93): 1 -13.

Garfield, C.F. and Rogers, T.E. 2008. A review of men’s health and masculinity. *American Journal of Lifestyle Medicine*, 2(6): 474 – 487.

Geoffrey, E.; Harries, A.D.; Bissell, K.; Schell, E.; Bvumbwe, A.; Tayler-Smith, K. and Kizito, W. 2014. Bringing care to the community: expanding access to health care in rural Malawi through mobile health clinics. *Public Healthcare Action*, 4(4): 252 -258.

Government of Malawi (GoM) and Malawi Vulnerability Assessment Committee (MVAC). 2015. National Food Security Forecast April 2015 to March 2016. Lilongwe: Government of Malawi.

GoM and MVAC. 2016. National Food Security Forecast April 2016 to March 2017. Lilongwe: Government of Malawi.

GoM, AU, NEPAD, World Food Programme (WFP) and United Nations Economic Commission for Africa (UNECA). 2015. The Cost of hunger in Malawi: Social and economic impacts of child undernutrition in Malawi implications on national development and Vision 2020. Lilongwe: Government of Malawi.

GoM. 1994. Constitution of the Republic of Malawi. Lilongwe, Malawi: Government of Malawi.

GoM. 2007. National Nutrition Policy and Strategic Plan 2007 – 2012. Lilongwe: Government of Malawi, Office of the President and Cabinet.

GoM. 2011. Malawi Growth and Development Strategy II. Lilongwe: Government of Malawi, Ministry of Finance, Economic Planning and Development (MoFEPD).

GoM. 2012. Malawi's Third Integrated Household Survey. Lilongwe: Government of Malawi.

GoM. 2013. Gender Equality Act. Number 49 of 2012. Lilongwe: Government of Malawi, Ministry of Justice and Constitutional Affairs.

GoM. 2014. Malawi Millennium Development Goals Endline Report. Lilongwe: Government of Malawi, MoFEPD).

GoM. 2017. Malawi Growth and Development Strategy II Review and Country Situation Analysis. Lilongwe: Government of Malawi.

Grantham-McGregor, S., Yin Bun, C., Santiago, C., Glewwe, P., Richter, L. and Strupp, B. 2008. Development Potential for the First 5 Years for Children in Developing Countries. *Lancet Series*, 369(9555): 60-70.

Greene, M.E., Mehta, M., Pulerwitz, J., Wulf, D., Bankole, A. and Singh, S. 2006. Involving Men in Reproductive Health: Contributions to Development. Background paper prepared at the request of the United Nations Millennium Project to contribute to the report *Public Choices, Private Decisions: Sexual and Reproductive Health and the Millennium Development Goals*. New York: United Nations Development Programme.

Haddad, L. and Bouis, H. 1991. The impact of nutritional status on agricultural productivity: Wage evidence from the Philippines. *Oxford Bulletin of Economics and Statistics*, 53 (1): 5–68.

Haggblade, S. and Babu, S. C. 2017. A user's guide to the Kaleidoscope Model. Practical tools for understanding policy change. Feed the Future Innovation Lab for Food Security Paper 46. Michigan State University, IFPRI and University of Pretoria, East Lansing, Washington DC and Pretoria.

Hendriks, S.L., Mkandawire, E., Hall, N., Olivier, N.J.J., Schönfeldt, H.C., Randall, P., Morgan, S., Olivier, N.J.J., Haggblade, S. and Babu, S.C. 2016. Micronutrient policy change in South Africa:



Implications for the kaleidoscope model for Food security policy change, Research paper 18. East Lansing: Feed the Future Innovation Lab for Food Security.

Heritage, Z. and Dooris, M. 2009. Community participation and empowerment in health cities. *Health Promotion International*, 24(S1): 45 – 55.

High Level Panel of Experts. 2017. Nutrition and food systems. A report by the High-Level Panel of Experts on Food Security and Nutrition of the Committee on World Food Security, Rome.

Hoddinott, J. 2016. The economics of reducing malnutrition in Sub-Saharan Africa. Global Panel on Agriculture and Food Systems for Nutrition Working Paper. London: Global Panel on Agriculture and Food Systems for Nutrition.

Hoddinott, J., Alderman, H., Behrman, F.R., Haddad, L. and Horton, S. 2013. The economic rationale for investing in stunting reduction. *Maternal and Child Nutrition*, 9(2): 69 – 82.

Hoddinott, J., Maluccio, J., Behrman, J., Flores, R. and Martorell, R. 2008. Effect of a Nutrition Intervention During Early Childhood on Economic Productivity in Guatemalan Adults. *Lancet Series*, 371(9610): 411 – 416.

International Food Policy Research Institute (IFPRI). 2015. Global Nutrition Report. Washington, DC: IFPRI.

IFPRI. 2016. Global Nutrition Report. Washington, DC: IFPRI.

Irvin, A.R. and Stanbury, J. 2004. Citizen participation in decision-making: Is it worth the effort? *Public Administration Review*, 64(1): 55 – 65.

Izugbara, C. and Ngliangwa, D. 2010. Women, poverty and adverse maternal outcomes in Nairobi, Kenya. *BMC Women's Health*, 10(33): 2 – 8.

Jones, H. 2009. Equity in Development: Why it is Important and How to Achieve it? Working Paper 311. Results of ODI research presented in preliminary form for discussion and critical comment. London: Overseas Development Institute.

Kabeer, N. 2003. *Gender Mainstreaming in Poverty Eradication and the Millenium Development Goals: A Handbook for policymakers and other stakeholders*. London: Commonwealth Secretariat, CIDA, IDRC.

Kabeer, N. and Subrahmanian, R. 1996. *Institutions, Relations and Outcomes: Framework and Tools for Gender-Aware Planning*. Discussion Paper 357. Brighton: Institute of Development Studies.

Kalembo, F.W., Zgambo, M., Mulaga, A.N, Yukai, D. and Ahmed, N.I. 2013. Association between male partner involvement and the uptake of prevention of mother-to-child transmission of HIV (PMTCT) interventions in Mwanza District, Malawi: A retrospective cohort study. *PLoS One*, 8(6): 1 – 7.

Kerr, R.B. 2005. Food security in Northern Malawi: Gender, kinship relations and entitlements in historical context. *Journal of Southern African Studies*, 31(1):52 – 74.

Kerr, R.B., Chilanga, E., Nyantakyi-Frimpong, H., Luginaah, I. and Lupafya, E. 2016. Integrated agriculture programs to address malnutrition in northern Malawi. *BMC Public Health*, 16(1197): 1 - 14.

Kretchmar, J. 2009. *Gender Socialization*. Massachusetts: EBSCO Publishing.

Kululanga, L.I. Sundby, J. Chirwa, E., Malata, A. and Maluwa, A. 2012. Barriers to husband's involvement in maternal health care in a rural setting in Malawi: a qualitative study. *Journal of Nursing and Midwifery*, 1 (1): 1 – 10.

Kululanga, L.I., Sundby, J., Malata, M. and Chirwa, E. 2011. Striving to promote male involvement in maternal health care in rural and urban settings in Malawi – A qualitative study. *BMC Reproductive Health*, 8(36): 1-12.

Lauterbach, C. and Matenje, I. 2013. *Gender, International Financial Institutions and Food Insecurity Case Study: Malawi*. Available: <http://www.genderraction.org/publications/malawifoodsecurity.pdf> (Accessed November 6 2014).

Levtov, R., van der Gaag, N., Greene, M., Kaufman, M., and Barker, G. 2015. *State of the World's Fathers: A MenCare Advocacy Publication*. Washington, DC: Promundo, Rutgers, Save the Children, Sonke Gender Justice, and the MenEngage Alliance.

Levy, C. Taher, N. and Vouhe, C. 2000. Men and masculinities in Gender and Development. *International Development Studies Bulletin*, 31(2): 86 – 96.

Lewis, J. Ritchie, J., Ormston, R. and Morrell, G. 2014. Generalising from qualitative research. (Eds). J. Ritchie, J. Lewis, C. M. Nicholls and R. Ormston. (In). *Qualitative Research Practice*. London: Sage Publications.

Liamputtong, P. 2011. *Focus group methodology: Principle and practice*. London: Sage Publications Ltd.

Maine, D. and Rosenfield, A. 1999. The Safe Motherhood Initiative: Why has it stalled? *American Journal of Public Health*, 89(4): 480 – 482.

Mangeni, J.N., Mwangi, A., Mbuga, S. and Mukthar, V. 2013. Male Involvement in Maternal Health Care as a Determinant of Utilization of Skilled Birth Attendants in Kenya. *East African Medical Journal*, 89(11): 372 – 383.

Mbilizi, M.A. 2013. When a woman becomes president: Implications for gender policy and planning in Malawi. *Journal of International Women's Studies*, 14(3): 148 – 162.

Meier, P. and Celis, K. 2011. Sowing the seeds of its own failure: Implementing the concept of gender mainstreaming. *Social Politics*, 0(0): 1 – 21.

Merchant, K.M. 2013. Women's nutrition through the life cycle. In: N. P. Stromquist (ed.) *Women in the third world: and encyclopaedia of contemporary issues*. New York: Routledge.

Meinzen-Dick, R., Behrman, J., Menon, P. and Quisumbing, A. 2012. Gender a key dimension linking agricultural programmes to improved nutrition and health. (Eds) Fan, S. and Pandya-Lorch, R. (In). *Reshaping Agriculture for Nutrition and Health*. International Food Policy Research Institute, Washington DC, pp 135 – 144.

Ministry of Gender, Women and Community Development (MoGWCD). 2000. *National Gender Policy*. Lilongwe: Government of Malawi, MoGWCD.

MoGWCD. 2005. *Guidelines in Gender Mainstreaming*. Lilongwe: Government of Malawi, MoGWCD.

Mitchell, S. 2004. What lies at the heart of the failure of gender mainstreaming: The strategy or the implementation?. Development Bulletin 64. Aotearoa: Development Studies Network.

Mkandawire, E. 2012. Socialisation of Malawian Women and the Negotiation of Safe Sex. Published Dissertation. Pretoria: University of Pretoria, Department of Sociology.

Mkandawire, E. and Hendriks, S.L. 2018. A qualitative analysis of the conceptualisation of men's involvement in maternal and child health in rural Central Malawi. BMC Pregnancy and Childbirth, 18(37): 1 – 12.

Mkandawire, E., Hendriks, S.L. and Mkandawire-Valhmu, L. 2017. A gender assessment of Malawi's National Nutrition Policy and Strategic Plan 2007–2012, Development Policy Review. doi:10.1111/dpr.12287.

Ministry of Finance Economic Planning and Development (MoFEPD). 2013. Guidelines for the preparation of the 2015/16 budget. Lilongwe: MoFEPD.

Ministry of Gender, Children, Disability and Social Welfare (MoGCDSW). 2004. Malawi country report: Implementation of the Beijing Declaration and Platform for Action (1995) and the outcomes of the Twenty Third Special session of the General Assembly (2000) in the context of the of the twentieth anniversary of the Fourth World Conference on Women and the adoption of the Beijing Declaration and Platform for Action 2015. Lilongwe: Government of Malawi, MoGCDSW.

MoGCDSW. 2015. Malawi's National Gender Policy. Lilongwe: Government of Malawi.

Ministry of Health (MoH). 2007. National Nutrition Guidelines for Malawi. Lilongwe: Government of Malawi, MoH.

MoH. 2009. National Sexual and Reproductive Health and Rights Policy. Lilongwe: Government of Malawi, MoH.

MoH. 2016. National Nutrition Policy. Lilongwe: Government of Malawi, MoH.

Mohlala, B.K.F., Gregson, S and Boily, M. 2012. Barriers to men's involvement in antenatal clinics and Voluntary Counselling and Testing (VCT) in Khayelitsha, South Africa. AIDS Care, 24(8): 927 – 977.

Moser, C. 1993. *Gender Planning and Development: Theory, Practice, and Training*. London: Routledge.

Mróz, L.W., Chapman, G. E., Oliffe, J.L. and Bottroff, J.L. 2011. Men, food and prostate cancer: Gender influences on men's diets. *American Journal of Men's Health*, 5 (2): 177 – 187.

Mseu, D., Nyasulu, B. M. and Muheriwa, S.R. 2014. Evaluation of a safe motherhood project in Ntcheu district, Malawi. *International Journal of Women's Health*, 6: 1045 – 1055.

NEPAD. 2003. *Comprehensive African Agricultural Development Programme*. Midrand: New Partnership for Africa's Development.

NEPAD. 2009. *Comprehensive Africa Agriculture Development Programme (CAADP)*. Midrand: NEPAD.

National Statistics Office (NSO) and Macro. 2000. *Malawi Demographic and Health Survey*. Zomba: Government of Malawi, National Statistics Office; Calverton: ICF Macro.

NSO and Macro. 2004. *Malawi Demographic and Health Survey*. Zomba: Government of Malawi, National Statistics Office; Calverton: ICF Macro.

NSO and Macro. 2010. *Malawi Demographic and Health Survey*. Zomba: Government of Malawi, National Statistics Office; Calverton: ICF Macro.

NSO and Macro. 2016. *Malawi Demographic and Health Survey*. Zomba: Government of Malawi, National Statistics Office; Calverton: ICF Macro.

Nyalunga, D. 2007. Dispelling the misconceptions and myths about gender. *International NGO Journal*, 2 (1): 1 – 5.

Nyondo, L.A., Chimwaza, A.F. and Muula, A.S. 2014. Exploring the relevance of male involvement in the prevention of mother to child transmission of HIV services in Blantyre, Malawi. *BMC International Health and Human Rights*, 14(30): 1 - 12.

Okali C. 2011. *Achieving Transformative Change for Rural Women's Empowerment*. Paper prepared for the Expert Group Meeting on Enabling Rural Women's Economic Empowerment: Institutions, Opportunities and Participation, Accra, Ghana, 20–23 September. New York: UN Women.

Osman, J.R., Unkels, R., Aliyu, U., Musa, H.A., and Matthew. O.K. 2014. Barriers to male involvement in uptake of prevention of mother-to-child-transmission (PMTCT) of HIV in Sub-Saharan Africa. *Journal of Nursing and Health Services*, 3(1): 1 – 7.

Osmani, S. and Sen, A. 2003. The hidden penalties of gender inequality: Fetal origins of ill-health. *Economics and Human Biology* 1(1): 105–121.

Osofi, A., Han, H., Kinuthia, J. and Farquhar, C. Role of male partners in the prevention of mother-to-child HIV transmission. *Research and Reports in Neonatology*, 4: 131 – 138.

Overholt, C., Anderson, M., Austin, K. and Cloud, J. 1985. *Gender Roles in Development Projects*. Connecticut: Kumarian Press Inc.

Oxfam. 2016. *WeCare Malawi Programme report: Linking unpaid care work and mobile value-added services in Malawi*. Lilongwe: Oxfam.

Parker, A.R. 1993. *Another Point of View: A Manual on Gender Analysis Training for Grassroots Workers*. New York: Women, Ink. Publishers.

Parpart, J.L. 2014. Exploring the transformative potential of gender mainstreaming in international development institutions. *Journal of International Development* 26(3): 382 -395.

Payne, S. 2011. Beijing fifteen years on: The persistence of barriers to gender mainstreaming in health. *Policy Social Politics*, 18 (4): 515-542.

Payne, S. 2014. Gender mainstreaming as a global policy paradigm: barriers to gender justice in health. *Journal of International and Comparative Social Policy*, 30(1): 28 – 40.

Pederson, A., Greaves, L. and Poole, N. 2014. Gender-transformative health promotion for women: a framework for action. *Health Promotion International*, 30(1): 140 – 150.

Population Reference Bureau. 2016. *2016 world population data sheet with a special focus on human needs and sustainable resources*. Washington, DC: Population Reference Bureau.

Rae, I. 2008. *Women and the right to food, international law and state practice*. Rome: FAO.

Rao, A. and Kellner, D. 2003. Institutions, organisations and gender in an era of globalisation. *Gender and Development*, 11(1): 142 – 149.

Razavi, S. and Miller, C. 1995. *From Women in Development to Gender in Development: Conceptual shifts in the women and development discourse*. New York: United Nations Research Institute for Social Development.

Ravindran, T.K.S. and Kelkar-Khambete, R. 2008. Gender mainstreaming in health: Looking back, looking forward. *Global Public Health. An International Journal of Research, Policy and Practice*, 3(S1), 121-142.

Reeves, H. and Baden, S. 2000. *Gender and Development. Concepts and definitions*. Prepared for the Department for International Development (DFID) for its gender mainstreaming intranet resource. Brighton: Institute of Development Studies.

Richards, E., Theobald, S., George, A., Kim, J.C., Rudert, C., Jehan, K., Tolhurst, R. 2013. Going beyond the surface: Gendered intra-household bargaining as a social determinant of child health and nutrition in low and middle-income countries. *Social Science and Medicine*, 95: 24 -33.

Ruel, M.T., Alderman, H. and the Maternal and Child Nutrition Study Group. 2013. Nutrition-sensitive interventions and programmes: How can they help to accelerate progress in improving maternal and child nutrition? *Lancet Series*, 382(9891): 536 – 551.

SADC. 1997. *Gender and Development*. Gaborone: Southern African Development Community.

Samarasinghe, V. 2014. Lost in translation?: Keeping women's issues alive. *Development in Practice*, 2(1): 30 – 38.

Singh, D. Lample, M. and Earnest, J. 2014. The involvement of men in maternal healthcare: Cross-sectional, pilot case studies from Maligita and Kibibi, Uganda. *Reproductive Health*, 11 (68): 1 – 8.

Save the Children. 2012. *Nutrition in the first 1,000 days: State of the world's mothers*. Available: <http://www.savethechildren.org/atf/cf/%7B9def2ebe-10ae-432c-9bd0-df91d2eba74a%7D/STATE-OF-THE-WORLDS-MOTHERS-REPORT-2012-FINAL.PDF> (Accessed 24 Jun 2016).

Sheeran, J. 2008. The challenge of hunger. *Lancet Series*, 371: 180 – 181.

Smith, L.C. and Haddad, L. 2015. Reducing child undernutrition: Past drivers and priorities for the post-MDG era. *World Development*, 68, 180 – 204.

Sternberg, P. and Hubley, J. 2004. Evaluating men's involvement as a strategy in sexual and reproductive health promotion. *Health Promotion International*, 19(3): 389-396.

Strauss, J. and Thomas, D. 1997. Health and wages: Evidence on men and women in urban Brazil. *Journal of Econometrics*, 77(1): 159-185.

Sultana, A.M. 2011. Factors effect on women autonomy and decision-making power within the household in rural communities. *Journal of Applied Sciences Research*, 7(1): 18-22.

Sun Movement Secreteriat. 2012. Sun movement progress report 2011-2012. New York: Sun Movement Secretariat.

Susin, L.R. O. and Giugliani, E.R.J. 2008. Inclusion of fathers in an intervention to promote breastfeeding: impact on breastfeeding rates. *Journal of Human Lactation*, 24(4): 386-392.

Taulo, F. 2010. Centre for reproductive health, 2nd reproductive health conference, Lilongwe, Malawi. *Malawi Medical Journal*, 22(1): 2 – 4.

Te Lintelo, D.J.H., Haddad, L.J., Lakshman, R. Gatellier, K. 2017. Reducing Hunger and Nutrition: The Hunger and Nutrition Commitment Index (HANCI 2013). Evidence Report Number 78. Institute for Development Studies.

Tolhurst, R., Leach, B., Price, J., Robinson, J., Ettore, E., Scott-Samuel, A., Kilonzo, N., Sabuni, L. P., Robertson, S., Kapilashrami, A., Bristwo, K., Lang, R., Ramao, F. and Theobald, S. 2012. Intersectionality and gender mainstreaming in international health: Using feminist participatory action research process to analyse voices and debates from the global south and north. *Social Science and Medicine*, 74: 1825 – 1832.

United Nations (UN). 1948. Universal Declaration of Human Rights. New York: United Nations.

UN. 1974. Universal Declaration on Eradication of Hunger and Malnutrition. New York: United Nations.

UN. 1976. International Covenant on Economic, Social and Cultural Rights. New York: United Nations.



UN. 1979. Convention of the Elimination of all Forms of Discrimination Against Women. New York: United Nations.

UN. 1989. Convention on the Rights of the Child, 20 November 1989. New York: United Nations.

UN. 1990. World Declaration on the Survival, Protection and Development of Children. New York: United Nations.

UN. 1994. International Conference on Population Development. New York: United Nations.

UN. 1995. Beijing Declaration and Platform for Action. New York: United Nations.

UN. 1995. Report of the Fourth World Conference on Women. Beijing, 4-15 September 1995. New York: United Nations.

UN. 2000. Millennium Development Goals. New York: United Nations.

United Nations Development Programme. 2016. Sustainable Development Goals. New York: UNDP.

UNDP. 2015. Human development report: Human development for everyone. Washington, DC: UNDP.

United Nations Educational, Scientific and Cultural Organisation (UNESCO). 1997. Gender Mainstreaming. Report of the Secretary General. Geneva, 30 June-25 July 1997. Vienna: Division for Advancement of Women. UN Department of Economic and Social Affairs.

UN, Department of Public Information. 1997. World Child Summit. Available: <http://www.un.org/geninfo/bp/child.html> (Accessed 21 May 2018).

Unger, R.K. 1979. Toward a redefinition of sex and gender. *American Psychologist*, 34(11), 1085-1094.

United Nations High Commission for Refugees. 1995. Preliminary report of the special rapporteur on traditional practices affecting the health of women and children. New York: United Nations High Commission for Refugees.

United Nations Children's Fund. 2013. Improving Child Nutrition: The achievable imperative for global progress. New York: UNICEF.

United Nations Standing Committee on Nutrition (UNSCN). 2004. Nutrition and the Millennium Development Goals. Lavenham: Lavenham Press.

Van den Berg, W. Bittan, K., Mercer, G., Peacock., Stinson, K., Janson, H. and Dubula, V. 2015. Improving men's participation preventing mother-to-child transmission of HIV as a maternal, neonatal and child health priority in South Africa. *PLoS Med*, 12(4): 1 – 8.

Van den Bold, M., Quisumbing, A., Gillespie S. 2013. Women Empowerment and Nutrition: An evidence review. Washington, DC: International Food Policy Research Institute.

Van Eerdewijk, A and Davids, T. 2014. Escaping the mythical beast: Gender mainstreaming reconceptualised. *Journal of International Development*, 26(3): 303 – 316.

van Lonkhuijzen, L., Stekelenburg, J. and van Roosmalen, J. 2012. Maternity waiting facilities for improving maternal and neonatal outcome in low-resource countries (review). *Cochrane Database of Systems*, 8(3): 1 – 11.

Veerle, M. 2011. Cooking, caring and volunteering: Unpaid work around the world. social, employment and migration. Working papers number 116. Paris: Organisation for Economic Co-operation and Development.

Vitora, C.G., Adair L, Fall, C. for the Maternal and Child Undernutrition Group. 2008. Maternal and child undernutrition: Consequences for adult health and human capital. *Lancet Series*, 371(9609): 340–57.

Wanner, T. and Wadham, B. 2015. Men and masculinities in international development: 'Men-streaming' gender and development? *Development Policy Review*, 33 (1): 15-32.

World Food Programme (WFP). 2012. Comprehensive Food Security and Vulnerability Analysis. Lilongwe: United Nations World Food Programme.

WFP. 2007. HIV and Food Security: Conceptual and Institutional Framework. New York: WFP.

Wheatley, A. Christman, S.T. and Nicolas, G. 2012. Walking the talk: Reflections from a community-focussed dialogue series. *Journal for Social Action in Counselling and Psychology*, 4(1): 1 - 17.

WHO. 2010. Indicators for Assessing Infant and Young Child Feeding Practices. Part II: Measurement. Geneva: World Health Organisation.

WHO. 2011. Gender Mainstreaming for Health Managers: A Practical Approach. Geneva: World Health Organisation.

WHO. 2012. Global Targets 2025: To improve maternal, infant and young child nutrition. Geneva: World Health Organisation.

WHO. 2016. United Nations Decade of Action on Nutrition. Available: <http://www.who.int/nutrition/decade-of-action/en/> (Accessed 18 March 2017).

Williams, S. 1994. Oxfam Gender Training Manual. Oxford: Oxfam.

Women's Commission for Refugee Women and Children. 2005. Masculinities: Male roles and male involvement in the promotion of gender equality: A Resource Packet. New York: Women's Commission for Refugee Women and Children.

Yang, J. 2014. Malawi's child brides: Married at 15. *The Star*. Available at: [https://www.thestar.com/news/world/2014/03/03/malawis\\_child\\_brides\\_married\\_at\\_15.html](https://www.thestar.com/news/world/2014/03/03/malawis_child_brides_married_at_15.html), Accessed 23 August, 2018.

Yargawa, J. and Leonard-Bee, J. 2015. Male involvement and maternal health outcomes: systematic review and meta-analysis. *Journal of Epidemiology and Community Health*, 13(1):1-9.

Yeboah, T., Serbah, R. and Bembir, P. 2015. Omission of men from gender-development theory and praxis: A pathway for addressing the plights of women. *Journal of Social Science*, 11(1): 7-19.

Zimmerman, M. and Snow, B. 2012. *An Introduction to Nutrition*. Boston: Flat World Knowledge.

Zosuls, K.M., Miller, C.F., Ruble, D.N. Martin, C.L and Richard A. Fabes. 2011. Gender development research in sex roles: Historical trends and future directions. *Sex Roles*, 64 (11-12): 826 – 842.

## Appendix A: Ethics clearance for the Food Security Policy Innovation Lab



### Initial IRB Application Determination **\*Exempt\***

February 12, 2015

To: Steve Longabaugh  
5918 Beuna Parkway  
Haslett MI 48840

Re: IRB# x13-635e Category: Exempt 5  
Approval Date: February 12, 2015

Title: Feed the Future Innovation Lab for Food Security Policy (FSP) (CGA129523, RC102750)

The Institutional Review Board has completed their review of your project. I am pleased to advise you that your project has been deemed as exempt in accordance with federal regulations.

This approval includes a RENEWAL of the 45 CFR 46.118 designation.

The IRB has found that your research project meets the criteria for exempt status and the criteria for the protection of human subjects in exempt research. Under our exempt policy the Principal Investigator assumes the responsibilities for the protection of human subjects in this project as outlined in the assurance letter and exempt educational material. The IRB office has received your signed assurance for exempt research. A copy of this signed agreement is appended for your information and records.

**Renewals:** Exempt protocols do not need to be renewed. If the project is completed, please submit an *Application for Permanent Closure*.

**Revisions:** Exempt protocols do not require revisions. However, if changes are made to a protocol that may no longer meet the exempt criteria, a new initial application will be required.

**Problems:** If issues should arise during the conduct of the research, such as unanticipated problems, adverse events, or any problem that may increase the risk to the human subjects and change the category of review, notify the IRB office promptly. Any complaints from participants regarding the risk and benefits of the project must be reported to the IRB.

**Follow-up:** If your exempt project is not completed and closed after three years, the IRB office will contact you regarding the status of the project and to verify that no changes have occurred that may affect exempt status.

Please use the IRB number listed above on any forms submitted which relate to this project, or on any correspondence with the IRB office.

Good luck in your research. If we can be of further assistance, please contact us at 517-355-2180 or via email at IRB@msu.edu. Thank you for your cooperation.

Sincerely,

Harry McGee, MPH  
SIRB Chair

c: Duncan Boughton, Eric Crawford, Steven Haggblade, Thomas Jayne, Steve Longabaugh, David Mather, David Tschirley, Mywish Maredia, Veronique Theriault, Nicholas Sitko



Office of Regulatory Affairs  
Human Research  
Protection Programs

Biomedical & Health  
Institutional Review Board  
(BIRB)

Community Research  
Institutional Review Board  
(CRIRB)

Social Science  
Behavioral/Education  
Institutional Review Board  
(SIRB)

Olds Hall  
408 West Circle Drive, #207  
East Lansing, MI 48824  
(517) 355-2180  
Fax: (517) 432-4503  
Email: irb@msu.edu  
www.humanresearch.msu.edu

## Appendix B: Letter of introduction from the District Commissioner

Telephone: (265) 01 235 431  
(265) 01 235 519  
Fax: (265) 01 235 462  
All correspondence should be addressed to  
The District Commissioner



Ntcheu District Council  
Private Bag 1  
Ntcheu  
Malawi  
4<sup>th</sup> August 2015

District Health Officer

Senior Chief Makwangwala

Senior Chief Kwataine

Inkosi Chakhumbira

Ms Elizabeth Mkandawire, Ms Lucy Mkandawire and Mr Jimmy Mkandawire are conducting a research on nutrition in Ntcheu District. They would like to meet you and other people in your areas concerning the research.

I am therefore requesting you to assist them accordingly.

For any further details please contact the undersigned.

Yours sincerely,

  
Chikhawo L.K. Mbewe

CHIEF ADMINISTRATION OFFICER

FOR DISTRICT COMMISSIONER

## Appendix C: Informed consent form

### Feed the Future Innovation Lab for Food Security Policy

#### Informed consent for personal interview

##### Introduction

Thank you for taking time to talk to us. This consent form contains information about the above-named study. To ensure that you are adequately informed about your possible participation in this study, we are asking you to read (or have read to) this consent form.

##### Reason for the study

The goal of the Food Security Policy Programme is to promote gender and youth inclusive agricultural productivity growth, improved nutritional outcomes and enhanced livelihood resilience through improved policy environments.

##### Participation in the study

You are being asked to take part on this study because of the work you do related to food policy. We will need about 60 minutes of your time.

##### Possible risks

The study involves minimal possibilities for risk, stress and discomfort in a discussion.

##### Possible Benefits

The study intends to inform future case studies for this programme that intend to produce tools and products to support policy making in Africa on agriculture and food security.

##### Confidentiality

If you decide to participate, your participation and any and all information you provide is completely confidential and will be treated as anonymous. You will not be identified nor named in any reports.

Signing this consent form signifies agreement to participate in the study. You can withdraw from the study at any time you feel like and you will receive no penalties.

If you have any questions regarding your experience in this study, please feel free to contact:

Prof Sheryl Hendriks (+27 12 420 3811).

\_\_\_\_\_  
Signature of the participant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of the interviewer

\_\_\_\_\_  
Date

## **Appendix D: Semi-structured interview guide (adapted from kaleidoscope model for agriculture and food security policy stakeholder mapping table)**

My name is Elizabeth Mkandawire. I am from the University of Pretoria in South Africa. The purpose of this study is to understand interpretations of gender and how they influence nutrition policy. The information gathered is for my studies and will also be used to develop research policy briefs to improve nutrition policies. The questions I will ask relate to your knowledge in the area of nutrition/gender. You have been selected because you are in a position to provide information that is valuable to the study. Your participation in this study is voluntary and you may choose to withdraw at any time.

### **Name of respondent:**

#### **1. Agenda-setting**

How are men involved in maternal and child health?

Do men help with cooking?

Do they help with any other domestic duties?

How did this policy get on the agenda?

What was the trigger for this change?

#### **2. Design**

What motivates men to participate in maternal and child health?

How have socio-cultural barriers been negotiated?

What is gender?

#### **3. Decision making**

How have the traditional authorities assisted in getting men to be involved in maternal and child health?

#### **4. Implementation**

Who have been the main advocates of men's involvement?

Is this happening in other areas?

#### **5. Evaluation and reform**

What do you think about the by-laws that are passed by the traditional authorities?

Any other relevant research bearing on this policy?

### **Other noteworthy insights:**

**Appendix E: Demographic data of focus group discussion participants (own work)**

	<b>Female</b>	<b>Male</b>	<b>Average</b>
<b>Age</b>	37	35	37
<b>Range</b>		30 - 81	
<b>Education</b>	Standard 7	Form 2	Standard 7
<b>Marital status</b>	<b>Female</b>	<b>Male</b>	<b>Total</b>
<b>Married</b>	24	9	33
<b>Divorced</b>	1	0	1
<b>Widowed</b>	2	0	2
<b>Abandoned</b>	1	0	1



## Appendix F: Policy Dialogue Programme

### Policy Dialogue: Gendering Malawi's National Nutrition Policy

19<sup>th</sup> August 2016, Capital Hotel Lilongwe

TIME	ACTIVITY	OFFICIAL
08:00 – 08:30	Registration	
08:30 – 08:45	Welcome and introductions: Outline the purpose of the workshop, context and background	Elizabeth Mkandawire, Charles Mazinga, Lucy Mkandawire-Valhmu
08:45 – 09:15	Looking back: An analysis of Malawi's National Nutrition Policy and Strategic Plan 2007 – 2012 using the Integrated Framework for Gender Analysis in Nutrition Policy	Elizabeth Mkandawire
09:15 – 10:15	<b>TEA</b>	
10:30 – 12:00	Group work	Facilitated by team
12:00 – 12:30	Report back	Lucy Mkandawire-Valhmu
12:30 – 13:30	<b>LUNCH</b>	
13:30 – 14:00	Men's involvement: Barriers, facilitators and limitations	Elizabeth Mkandawire
14:00 – 15:00	Group work/discussion: Opportunities for nutrition	Facilitated by team
15:00 – 15:30	Report back	Lucy Mkandawire-Valhmu
15:30 – 15:45	<b>TEA</b>	
15:45 – 16:00	Wrap-up	Tisugeni Zimpita



## Department of University Relations Communication and Marketing

Filming and/or taking photographs on Campus

### Appendix G: Department of University Relations Communication and Marketing Consent Form

I hereby give consent to the University of Pretoria, through its Department of University Relations (DUR), to use my image, likeness and/or sound of my voice as recorded in any photograph, photographic image and/or video, in DUR publications, including but not limited to training materials, websites, newsletters, pamphlets and marketing materials.

I hereby grant to the University of Pretoria the irrevocable and unrestricted right and permission to copyright, in its own name or otherwise, and to use, re-use, publish or re-publish the photograph, photographic image or video recording taken of me or in which I may be included, as described hereinbefore, in whole or in part, or composite or distorted in character or form, without restriction as to changes or alterations, or reproductions thereof in colour or otherwise, in conjunction with my own or a fictitious name, made through any medium at the DUR's studios or elsewhere, and in any and all media now or hereafter known for illustration, promotion, art editorial, advertising, trade, or any other purpose whatsoever. Additionally, I waive any right to royalties or other compensation arising from or related to the use of my image, likeness and/or sound of my voice as recorded in any photograph, photographic image and/or video.

The DUR may sell, assign, license or otherwise transfer all rights granted to it hereunder. This authorisation shall also inure to the benefit of the legal representatives, licensees and assigns of the DUR.

I hereby agree to release, defend and hold harmless the University of Pretoria, its legal representatives, licensees and assigns and all persons acting under its permission or authority, from and against any claims, damages or liability arising from or related to the use of my image, likeness and/or sound of my voice as recorded in any photograph, photographic image and/or video, or by virtue of any alteration, processing or use thereof in composite form, whether intentional or otherwise, as well as any publication or distribution thereof.

I am 18 (eighteen) years of age and am competent to contract in my own name. I have read this release before signing below and fully understand the contents, meaning and impact of this release.

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Printed Name)

If the person signing is under 18 (eighteen) years of age, there must be consent by a parent or guardian, as follows:

I hereby certify that I am the parent or guardian of \_\_\_\_\_, named above, and do hereby give my consent without reservation to the foregoing on behalf of this person.

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Printed Name)

## Appendix H: Thematic grouping of recommendations from policy dialogue

<b>Broadening target groups</b>	<b>Include gender in all priority areas</b>	<b>Nutrition messaging</b>	<b>Engagement of community leaders and communities in the development of policies and strategies</b>
<p>The policy does not look at other gender groups, it only looks at children, adolescents and adults in these policy areas.</p>	<p>There needs to be a strategy on gender on each of the priority areas.</p>	<p>Combine nutrition messages with messages of safe motherhood. There are men who are involved in safe motherhood, but not necessarily nutrition. These messages need to be promoted at areas like antenatal clinics or other meetings in the communities.</p>	<p>Don't under estimate the knowledge of the community. There are reasons that communities don't always apply the lessons that are taught to them by advocacy groups. A bottom up approach to developing policies needs to be applied. When coming up with strategies and interventions, communities should be involved because they are the ones who understand their needs. If communities are involved in developing policies and strategies, it will be easier for them to implement.</p>
<p>Vulnerable groups must be clearly defined. They may include the following, women, children, people living with HIV and people with disabilities. Also, gender roles and norms must be clearly defined. What are these gender roles and norms</p>	<p>Many of the concerns that the group had in Priority 1 were addressed under this section, but these have not been incorporated into other sections. This policy priority needs to be mainstreamed into the other policy priorities.</p>	<p>Use technologies to disseminate nutrition information. Work with telecommunications networks to disseminate nutrition messages.</p>	<p>If nutrition committees can be set up at community level, these committees can be the bridge between hospitals and households.</p>

<b>Broadening target groups</b>	<b>Include gender in all priority areas</b>	<b>Nutrition messaging</b>	<b>Engagement of community leaders and communities in the development of policies and strategies</b>
and the linkages between them?			
	Although it is important to have a gender priority, gender needs to be incorporated into all policy statements. The nutrition policy statements need to be carefully constructed so that they don't infringe upon human rights.	Incorporate community leaders like chiefs, in the dissemination of nutrition messages as well as messages of men's involvement in nutrition. Faith-based leaders are another group that can be used to promote nutrition messages.	
	All the priority areas need to apply a gender lens even though there is a priority area that looks at gender.	The messages that are promoted should target both men and women. Men should also know that they have a role to play in nutrition. It should be clear that both men and women have a role to play in nutrition.	
		Nutrition messages and interventions need to be designed keeping in mind gender equality. Nutrition messages should target	

<b>Broadening target groups</b>	<b>Include gender in all priority areas</b>	<b>Nutrition messaging</b>	<b>Engagement of community leaders and communities in the development of policies and strategies</b>
		the family, including both men and women. Messages should not be targeted at women only, or men only. They should be targeted at families.	
		Nutrition messages also need to be gender sensitive	
		In health, service providers provide pregnancy education even before pregnancy. This can also be applied to nutrition. Nutrition education shouldn't only be provided when women are pregnant. Infant and young child feeding education shouldn't only be provided when women are pregnant. By the time a woman gets pregnant, both men and women should know what food is required, because they have been prepared.	

### Appendix I: Policy Brief

## Gendering Malawi's National Nutrition Policy using the integrated framework for gender analysis in nutrition policy

Elizabeth Mkandawire, Sheryl L Hendriks and Lucy Mkandawire

### Introduction

The Sustainable Development Goals (SDGs) demonstrate the importance of integrating a gender equality perspective into all areas of development work. With the exception of goal five, which specifically focuses on gender, eight of the SDGs include gender and gender equality.

For over two decades' gender discourse has been dominated by a focus on women, overlooking opportunities to engage men as partners in achieving gender equity. Achieving gender equity requires acknowledging dynamics in the relationships between men and women that lead to the differentiated allocation of resources, programmes and decisions based on gender. Equality cannot be achieved by excluding men from development programmes and focusing solely on women. Nutrition policies offer opportunities to progress towards long-term equality development goals.

Policies provide an overarching framework for comprehensive and aligned strategies and programme implementation. As part of the Feed the Future Innovation Lab for Food Security Policy (FSP), the University of Pretoria, in collaboration with the Civil Society Organisation Nutrition Alliance (CSONA) and the Ministry of Gender, Children, Disability and Social Welfare conducted an assessment of the extent to which Malawi's forthcoming National Nutrition Policy (2016 – 2020) incorporates gender. This assessment reflected on the policy's application of gender and identified possible areas of gender bias, focusing on the extent to which men and women's interests were considered.

### Embedded gender biases hinder access to nutritious food for mothers and children

In the past, nutrition policies have focused narrowly on women. As a result, structural inequalities (or inherent biases) that limit women's ability to access nutritious food are perpetuated. In many developing countries, men are the key decision-makers, making critical decisions related to women's sexual and reproductive health, resource allocation and food consumption. Men's role as decision-makers is reinforced through socio-cultural prohibitions and taboos. Nutrition policies typically target women as beneficiaries. Evidence suggests that improving women's nutritional status before, during and after childbirth can reduce child under-nutrition. While women often allocate more resources to children's nutrition and education, women in developing countries face constraints regarding accessing this essential income.

### Terms and definitions

**Gender equality** is when men and women enjoy the same rights across all aspects of society including decision-making and economic participation and when the different aspirations, behaviours and needs are equally favoured.

**Gender equity** refers to the allocation of resources, programmes and decisions based on the needs and requirements of specific gender groups.

**Structural inequalities** are biases that are embedded in organisations, institutions, governments or social networks that present obstacles to progressing equality.



Although men’s involvement in maternal and child health is important for achieving positive maternal and child health outcomes, policies need to be designed with caution. Men’s involvement in maternal and child health interventions are generally implemented to achieve positive maternal and child health outcomes. Gender equality is often forgotten, resulting in unintended outcomes.

For example, instead of enlisting men’s involvement to address issues of unequal decision-making dynamics in the household, many interventions only focus on involving men in maternal and child health so that men make better decisions on behalf of women as opposed to making better decisions with women. Involving men in maternal and child health can reinforce men’s decision-making power, perpetuating the status quo.

Therefore, policies that apply the men’s involvement in maternal and child health approach need to prioritise the objective of engaging men as partners in achieving gender equality in order to avoid unintended negative consequences.

### Introducing the integrated framework for gender analysis in nutrition policy

To support the incorporation of gender in nutrition policy, an integrated framework for assessing the extent

to which a policy integrates gender was developed. This framework combines the [WHO gender assessment tool](#) and [the FAO gender mainstreaming in nutrition guidelines](#). The new integrated framework for gender analysis in nutrition policy bridges insights from the agriculture and health sectors. The framework is a tool through which nutrition policies can be assessed with a gender lens.

There are three main benefits to using the integrated framework for gender analysis in nutrition policy. First, it helps policymakers identify policy options for incorporating a gender perspective into nutrition policies. Second, it provides guidance on the determination of biases and ideologies that may be reflected in the policy. Third, the colour coding provides policymakers with an indication of where efforts should be focused to more adequately incorporate gender.

### Applying the integrated framework for gender analysis in nutrition policy

The framework was used to assess the extent to which Malawi’s National Nutrition Policy and Strategic Plan 2007 -2012 incorporated essential gender components. The findings were presented at a policy dialogue in Lilongwe. The participants included 36 people from Civil Society Organisations, government, donors, NGOs and research institutions. Three community

Policy instruments	Do the vision, goals or principles have an explicit commitment to promoting or achieving gender equality?	Does the policy consider and include women’s practical and strategic needs?	Does the policy consider gender norms, roles and relations?	Does the policy avoid considering men and women as homogenous groups?	Does the policy clearly differentiate between sex and gender?
Agriculture extension and nutrition	✓		✓	✓	✓
Local food culture and gender					✓
Nutrition and the life cycle		✓			
Gender and obesity					
Spending income on nutrition					
Rights based approach to nutrition	✓	✓		✓	
Targeting in nutrition policy	✓				

members and one Traditional Authority participated in the discussions, particularly with regard to involving men as partners in achieving positive maternal and child health outcomes as well as gender equality. Participants were afforded the opportunity to apply the framework to assess the forthcoming National Nutrition Policy.

## Findings

Malawi's forthcoming National Nutrition Policy integrates a gender perspective more appropriately than its predecessor. The policy focuses significantly on involving men and improving women's control and access to resources for improved nutrition outcomes. However, the policy perpetuates the notion that nutrition and child care are women's responsibility. Although it includes men's involvement in child care and household duties, the condition is that men should be involved so that women have more time to provide optimal care for children. While the policy appears to promote gender equality, because it has a priority area specifically dedicated to gender, it is only promoting nutrition. In fact, it is perpetuating the notion that only women can be responsible for nutrition. It does not consider socio-cultural factors that prevent men from being involved in nutrition and children's lives. The policy also overlooks the practical needs of men and women and neglects to consider men's nutrition interests. The lack of ticks in the red section of the framework suggests that although the policy appears to make an explicit commitment to promoting gender equality, the policy does not challenge structural inequalities such as socially determined gender roles.

## Recommendations for the Department of Nutrition, HIV and AIDS and the Ministry of Gender, Children, Disability and Social Welfare

Decisive action is required to involve men as partners in addressing structural inequalities in Malawi. Further deliberation regarding the specific context of men and women in Malawi is necessary to understand how best to involve men in maternal and child nutrition. The nutritional and social needs of men and women are different. Social factors may prevent both men and women from accessing nutritious food. People-centred policy development requires direct engagement with the beneficiaries of public policies. Involving communities in the design and validation of policies ensures coherence between the needs of the community and the policy.

From the consultative dialogue and assessment of the forthcoming National Nutrition Policy, the following recommendations are put forward:

### 1. Broadening the beneficiaries of the policy

Nutrition policies generally tend to focus on women and children as targeted beneficiaries. Likewise, the forthcoming Malawi National Nutrition Policy targets women and children. However, as a signatory to international instruments such as the 1974 Universal Declaration on Eradication of Hunger and Malnutrition and the UN General Assembly Resolution 67/174 on the Right to Food, Malawi has committed to addressing the neglect of the nutritional requirements of women and children, but also men, the elderly, people under-going palliative care and other vulnerable groups. The National Nutrition Policy homogenises these groups by referring to 'vulnerable groups'. These groups should be defined to ensure that the nutritional requirements of all the varied vulnerable groups are specifically addressed.

### 2. Include gender in all priority areas

Although a separate priority area has been included for gender, all priority areas need to incorporate gender. Each priority area should be assessed using a gender lens and each priority area should consider gender norms, roles and relations that undermine men and women's ability to access nutritious food. For example, priority area eight on nutrition monitoring and evaluation, research and surveillance does not include an indicator on gender. The SDGs emphasise the need for indicators to monitor progress towards gender equity and equality. This data should also provide evidence of how these actions are improving maternal and child nutrition. Similarly, the priority area on non-communicable diseases does not consider men's specific needs. Men's nutritional requirements are neglected, yet evidence suggests that men are more predisposed to non-communicable diseases, many of which are related to nutrition. In this example, the policy is perpetuating the notion that men and women's needs are the same. Gender norms relating to the enactment of masculinity (such as excessive alcohol consumption) prevent men from fully realising their nutrition and health rights.

### 3. Inclusive nutrition messaging

As a signatory to the Beijing Platform for Action, Malawi is committed to ensuring that policies and programmes at all levels not only integrate gender but



that they also promote gender equality. Nutrition policies need to provide guidance on nutrition messaging that targets both men and women. The health sector in Malawi is particularly active in terms of promoting men's involvement in maternal and child health. Therefore, nutrition messages should be combined with messages on safe motherhood. Community leaders, such as traditional authorities and faith-based leaders should be involved in the dissemination of nutrition messages, particularly with regard to behaviour change and men's involvement in maternal and child health. Nutrition messages should also promote gender equality. Messages should be constructed with care to ensure that they do not perpetuate inequality. For example, posters and other paraphernalia should not only have images of women, but also include men.

#### 4. Engagement of community leaders and communities in the development of policies and strategies

Community members need to be included in the development of policies and strategies. Implementation failure results because policies are not aligned with the needs of communities. Including Traditional Authorities and communities in the development of policies and strategies provides policymakers with a true picture of what is feasible to implement based on the community's knowledge and experiences. Traditional Authorities - as the custodians of culture - are able to identify how to navigating socio-cultural barriers to men and women's access to nutritious food. With the right training, Traditional Authorities can be the bridge between policy makers and communities, facilitating implementation as well as providing input for policy evaluation and reform based on evidence of success.

## Conclusions

Men's involvement in maternal and child health is important for achieving positive nutrition outcomes. However, men's involvement in maternal and child health should be carefully designed to ensure that it does not perpetuate or reinforce gender inequalities. Men's gender equity too should not be overlooked as it is an essential component of gender equality. By involving men in nutrition it is possible to break the vicious cycle of under-nutrition that undermines development efforts.

Elizabeth Mkandawire – Research Assistant at the Institute for Food, Nutrition and Well-being, University of Pretoria.

Sheryl L Hendriks – Professor and Director of the Institute for Food, Nutrition and Well-being, University of Pretoria.

Lucy Mkandawire-Valhmu – Associate Professor at the College of Nursing, University of Wisconsin Milwaukee

e-mail: [elimka23@gmail.com](mailto:elimka23@gmail.com)

We thank all colleagues who participated in the policy dialogue. In particular, we acknowledge the participation of local community members from Ntcheu, including Traditional Authority Kwataine.

*This research is made possible by the generous support of the American people through the United States Agency for International Development (USAID) under the Feed the Future initiative. The contents are the responsibility study authors and do not necessarily reflect the views of USAID or the United States Government*

**Copyright © 2016, Michigan State University and University of Pretoria. All rights reserved. This material may be reproduced for personal and not-for-profit use without permission from but with acknowledgement to MSU and University of Pretoria.**

**Published by the Department of Agricultural, Food, and Resource Economics, Michigan State University, Justin S. Morrill Hall of Agriculture, 446 West Circle Dr., Room 202, East Lansing, Michigan 48824**

## Appendix J: Revised integrated framework for gender analysis in nutrition

Policy instruments (may not be exhaustive)	Do the vision, goals or principles have an explicit commitment to promoting or achieving gender equality?	Does the policy consider men and women's practical needs?	Does the policy consider and include men and women's strategic needs?	Does the policy consider gender norms, roles and relations?	Does the policy avoid considering men and women as homogenous groups?	Does the policy clearly differentiate between sex and gender?
Agriculture extension and nutrition						
Local food culture and gender						
Nutrition and the life cycle						
Gender and obesity						
Spending income on nutrition						
Rights based approach to nutrition						
Targeting in nutrition policy						
Gender and nutrition in emergency situations						

## Appendix K: Gender mainstreaming tools reviewed

<b>Gender mainstreaming tools</b>
WHO Gender Assessment Tool (WHO, 2011)
FAO gender mainstreaming in nutrition guidelines (FAO, 2012)
Socio-Economic and Gender Analysis (SEAGA) (FAO and WFP, 2005)
Guide for Conducting and Managing Gender Assessments in the Health Sector (Greene, 2013)
USAID Guide to Gender Integration and Analysis, Gender integration in Monitoring and Evaluation in agriculture toolkit (World Bank, 2005)
Bill and Melinda Gates Gender Toolkits and Checklist.
Gender mainstreaming and 4R method in local governance (UNDP,
GENDER IMPACT ASSESSMENT: Gender Mainstreaming Toolkit (European Union, 2016)
Harvard Analytic Framework (March, 1999)
Moser Gender Analysis Framework (March, 1999)
Social Relations Framework (ILO, 1994)