Spotlight Initiative
To eliminate violence against women and girls

Ending Violence

against women and girls in Malawi

WHAT DO WE KNOW?

A literature review and assessment of the key knowledge gaps for evidence-based programming on the issues of sexual and gender-based violence and sexual and reproductive health rights in Malawi.

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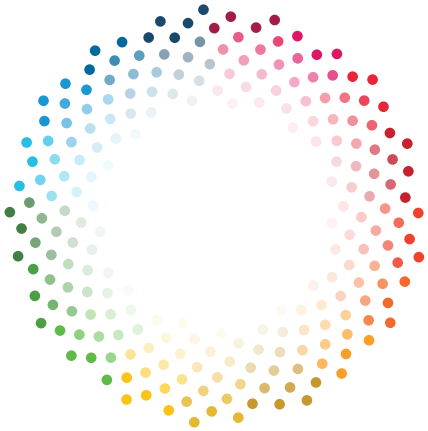

Spotlight Initiative

Ending violence against women and girls in Malawi:

WHAT DO WE KNOW?

This report was drafted by Dr Guilherme Lichand (Team Leader), Dr Alister C. Munthali, and Juliana Moura Bueno. UNICEF Malawi provided technical oversight and editorials. Technical inputs were also provided by members of the Spotlight Technical Core Team representing UNICEF, UNDP, UN Women, UNFPA and the UN Resident Coordinator's Office.

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Abbreviations

CARD	Centre for Agricultural Research and Development
CDM	Centre for Development Management
CEDEP	Centre for the Development of the People
CRH	Centre for Reproductive Health, College of Medicine
CSO	Civil Society Organization
CSR	Centre for Social Research, Chancellor College
CVSU	Community Victim Support Unit
EU	European Union
FGM/C	Female Genital Mutilation/ Cutting
FSW	Female Sex Workers
GoM	Government of Malawi
HP	Harmful Practices
IPV	Intimate Partner Violence
IPOR	Institute for Public Opinion and Research
LGBTIQ	Lesbian, Gay, Bisexual, Transgender, Intersex and Queer
LUANAR	Lilongwe University of Agriculture and Natural Resources
M&E	Monitoring and Evaluation
MDHS	Malawi Demographic and Health Survey
MICS	Mixed Indicators Cluster Survey
MoGCDSW	Ministry of Gender, Children, Disability and Social Welfare
NGO	Non-Governmental Organization
NSO	National Statistical Office
OHCHR	UN Office of the High Commissioner for Human Rights
OSC	One Stop Centres
RCT	Randomized Control Trial
SGBV	Sexual and Gender Based Violence
SRGBV	School- Related Gender Based Violence
SIGI	Social Institutions and Gender Index
SRHR	Sexual and Reproductive Health and Rights
ToR	Terms of Reference
UN	United Nations
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
UNFPA	United Nations Population Fund
VACS	Violence Against Children Survey
VAWG	Violence Against Women and Girls
VSU	Victim Support Unit

CHAPTER 1

Executive Summary

The European Union and the United Nations have embarked on a new multi-year program, entitled the Spotlight Initiative, focused on eliminating violence against women and girls and harmful practices. Malawi is one of eight countries in Africa selected to deliver this programme. This evidence review was commissioned as part of Malawi's preparatory activities to enable evidence-based refinement of programme interventions and strategies across the whole programme, and identify knowledge gaps to set the research agenda. This study critically reviews and synthesizes appropriate peer-reviewed and grey literature on Sexual and Gender Based Violence (SGBV), Harmful Practices (HP) and Sexual and Reproductive Health and Rights (SRHR) in Malawi.

Malawi is characterized by a high prevalence of violence against women and girls, from traditional practices that harm girls and teenagers (from sexual initiation rituals to child marriage) to sexual and gender-based violence and intimate partner violence. While some practices that are common elsewhere, such as Female Genital Mutilation/ Cutting (FGM/C), are low-prevalence in Malawi, related practices, such as labia stretching, as part of initiation rituals have a high prevalence in over 50%

of communities (National Statistical Office, University of Zurich, Centre for Social Research, 2019). Malawi also features among the 20 countries with the highest incidence of Intimate Partner Violence (IPV), and the prevalence of traditional practices such as child marriage and sexual initiation rituals has basically remained unchanged over the last 15 years, even though those have been falling globally at fast paces (often together with economic development) (van Eerdewijk, 2018).

In what comes to drivers, evidence from countries like Malawi point out that intrinsic motivations (such as culture and religion), extrinsic motivations (such as economic incentives and legal and social sanctions) and beliefs (about what others do and what others expect one to do) all play a role in making harmful behaviors persistent. Having said that, interventions targeting some of those drivers while not others can differ substantially in how much change those are able to effect per dollar invested. Interventions that focus on intrinsic motivations through local elites – from local chiefs and traditional authorities – have been tried for long by different international and national actors, with very limited success. By the same token, simply passing laws forbidding undesirable behaviors often does not work and makes it even harder to monitor them. In contrast, interventions focused on economic incentives and social image have been shown to have much higher potential in rapidly changing long-standing practices. Nevertheless, evidence suggests that even such interventions must take careful consideration of the local social structure: when local elites are key influencers of social norms, interventions that try to bypass them can backfire and increase support for undesirable behaviors. Lastly, recent evidence suggests that stakeholders that have often been targeted by international organizations and government are not always key influencers behind such behaviors: more often than not, girls themselves adhering to those practices. Even if this arises from the socialization process, it means those at vulnerable age should already be targeted, especially as they themselves will eventually contribute towards the socialization of the next generation.

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While, for the most part, Malawi is well served by data highlighting what the priority issues for programming and policy issues should be, there is limited evidence on how to best tackle those issues, especially if one restricts attention to rigorous quantitative studies evaluating interventions in the country. Several key knowledge gaps remain when it comes to data and research and should be an integral part of the research agenda of the institutions engaged in the topics of the Spotlight Initiative over the coming years:

- What is the prevalence of violence against specific at-risk groups, such as elderly women and persons with albinism?
- What is the share of female adolescents that access SHRH services?
- How to decrease stigma in SGBV and IPV, since it limits reporting and access to services?
- What can be done to improve access to SRHR services by vulnerable groups?
- What are the consequences of labia pulling?
- When traditional authorities and village chiefs are not the key influencers, what is the optimal approach to decrease those practices? When they are, how to replace social expectations without backfiring?
- What would a program that tries to empower girls and female adolescents in Malawi look like? Also, how to target boys and male adolescents with messages that change mindsets and gender roles?
- How to break the inter-generational transmission of negative behaviors? What are the most effective interventions to break the vicious cycle?
- How to increase female educational attainment, labor force participation, and political participation, issues that might be structurally linked to unequal opportunities for all females because of unequal participation in positions of influence in the Malawian society?

The Spotlight Initiative provides a unique opportunity to address those issues, as it entertains the possibility of a Research Observatory that would, by design, have convening power to steer the research activities towards the most important inputs required to deter violence against females and extend the access of sexual and reproductive health and rights in Malawi, especially among vulnerable populations.

CHAPTER 2

Introduction

Violence against women and girls (VAWG) is a global phenomenon and Malawi is no exception. The 2015/16 Malawi Demographic and Health Survey found that 34% of the women aged 15-49 reported experiencing physical violence, 14% experienced sexual violence while 23% experienced emotional violence within the 12 months period prior to the survey (National Statistical Office, 2017). In Malawi there are also a number of traditional practices that prevent women and girls from fully realizing their sexual and reproductive health and rights (SRHR) as well as other human rights. These traditional practices include kuchotsa fumbi, in which girls and boys are encouraged to experiment with sex after graduating from initiation ceremonies (Malawi Human Rights Commission, 2005; Kalilani-Phiri and Taulo, 2009 and Munthali and Kok, 2018); kulowa kufa, in which a woman whose husband has died is forced to have sex with the deceased husband's brother in order to cleanse her of the deceased husband's spirits (Malawi Human Rights Commission, 2005; Kalilani-Phiri and Taulo, 2009 and Kaufulu, 2016); chokolo (wife inheritance), where a widow is inherited by the younger brother of the deceased husband (Malawi Human Rights Commission, 2005); and kupimbira, where girls as young as 9 years are offered for marriage as a form of payment of debt incurred by their parents (Malawi Human Rights Commission 2006). There are also a number of sexual and reproductive health and rights (SRHR) issues affecting women and girls in Malawi: (i) HIV prevalence is higher among women and girls aged 15-49 at 10.8% than men at 6.6%; (ii) 29% of

women aged 15-19 had children or were pregnant at the time of the survey; and (iii) 47% of the women aged 25-49 were married before age of 18 (National Statistical Office, 2017).

Only 40%

of all women who had ever experienced any type of physical or sexual violence sought help to stop violence (2015-2016)

Sexual and gender-based violence (SGBV) is widespread in Malawi. The Government of Malawi (GoM) has established some structures for addressing violence and these include Victim Support Units (VSUs) based in police stations and units, the Community Victim Support Units (CVSUs) based at community level and the One Stop Centres (OSC) based in central and district hospitals. These structures have been established in order to help women and child survivors of violence. The OSCs offer health, social welfare and police services to women and child survivors of different forms of violence (Mulambia et. al., 2018 and GoM and UNICEF, 2012).

While these formal structures have been established to respond to various forms of VAWG, a good proportion of survivors of violence do not systematically utilize them. In 2015-2016, only 40% of all women who had ever experienced any type of physical or sexual violence sought help to stop violence (National Statistical Office, 2017); 49% never sought any help nor informed anyone about the violence they had experienced. Amongst those who sought help, 62% of the women reported that they sought help from their own families, 33% from their husbands' families, 10% from their friends and only 10% sought help from the police (National Statistical Office, 2017). While various efforts have been made to address VAWG in Malawi, progress has, however, been slow. More efforts are, therefore, required in order to address SGBV, harmful practices and other SRHR issues affecting women and girls. It has been argued that the elimination of VAWG can be achieved by effectively addressing the prevailing gender and socio-cultural norms in communities.

The Spotlight Initiative, a European Union/ United Nations initiative, is a multi-year programme that focuses on supporting African, South American, Caribbean, Asian and Oceania countries to address VAWG. In Africa, the initiative focuses on several issues in Malawi and seven other African countries, including SGBV, SRHR and harmful practices (HPs), and how these are linked to access to SRHR services. The elimination of VAWG in Malawi will be achieved through (i) the strengthening of policy and legislative frameworks on all forms of VAWG; (ii) the strengthening of institutions and organizations that implement policies and legislation including ensuring that adequate resources are allocated for the fight against VAWG; (iii) changing social norms that condone stereotyping harmful behaviours and practices, discrimination and violence; (iv) improving access to essential services to survivors of violence; (v) collecting, analyzing and using quality data to inform policy; and (vi) empowering women and girls to know their rights. For each of these strategies, there are specific interventions that will be implemented to contribute towards the elimination of VAWG.

The Spotlight Initiative is being implemented in six districts in Malawi and these are Mzimba and Nkhata Bay in northern Malawi; Ntchisi and Dowa in central Malawi; and Machinga and Nsanje in southern Malawi. These districts were selected for this programme largely because of high prevalence of gender-based violence, HPs and SGBV (UN, 2018). While the Spotlight Initiative will target the general population, special attention will be paid to population groups that are left further behind including persons with disabilities, persons with albinism, HIV+ persons, the LGBTIQ, refugees, prisoners and young widows. The programme will be implemented jointly by the UN and the Government of Malawi (GoM) and there will be sub-grantees including Civil Society Organizations (CSOs) who will be responsible for specific programme interventions.

2.1 Objectives

The objective of this study was to review and synthesize relevant peer-reviewed and grey literature on SGBV, HP and SRHR in Malawi, assess the quality of existing evidence, and identify gaps to set the research agenda. Specifically, the study sought to answer the following research questions:

a. What are the various forms of SGBV and HP against women and girls that exist in Malawi, and what is their prevalence?
b. What are the drivers of these practices and what are the consequences of these practices to girls and women?
c. What is known about SGBV and HP among specific marginalized populations including women and girls with disabilities, women and girls with albinism, female sex workers, LGBTIQ, and elderly and widowed women, and/or in specific settings and/or locations in Malawi?
d. What is not known or unclear about SGBV and HP against women and girls in Malawi, especially as it relates to those women and girls particularly marginalized, isolated or discriminated against?
e. What risk and protective factors are associated with SGBV and HP against women and girls in Malawi?
f. What is known or unclear about the introduction and implementation of laws and policies relating to SGBV, HP and SRH and their impact on prevalence of SGBV and HP?
g. What is the knowledge and attitudes towards SGBV, HP and SRH in Malawi, among women, men, girls and boys?
h. What is the knowledge, experiences and access to SRH services in Malawi, among women and girls, and especially among women and girls facing intersecting forms of discrimination including women and girls with disabilities, women and girls with albinism, female sex workers, LGBTIQ, and elderly and widowed women?
i. What are the intersections between knowledge, experience of and access to SRH services and forms of SGBV and HP?
j. What are the critical evidence gaps and priorities for future research?

2.2 Methodology

A comprehensive review and synthesis of relevant peer reviewed literature on SGBV, HP and SRHR in Malawi was undertaken. The quality of existing evidence was assessed, and key data and research gaps were identified to set out a research agenda for next decade within the context of the SI. Specifically, the literature review addressed the questions in Annex 1.

Several steps were followed for the literature review: (i) The identification and formulation of a problem; (ii) Conducting a literature search; (iii) Selection of relevant documents/publications; (iv) Data extraction; and (v) Writing the literature review report.

The emphasis was placed on assessing the quality of the existing evidence on both the prevalence of those behaviors and its main drivers, especially when it comes to the evidence standards of interventions meant to uncover key interventions and/or drivers in the theory of change underlying a programmatic framework to address those issues. The review organizes interventions under a theory of change for addressing each practice, highlighting evidence gaps and pointing out the key challenges and opportunities moving forward. Annex 1 maps each reference to the respective research question it helps address.

The researchers also undertook Key Informant Interviews (KII) to obtain information on gaps and priorities for the research agenda.[1] The following institutions were interviewed, via its most senior managers:

- Centre for Development Management, Private Consultancy (CDM)
- Centre for Reproductive Health, College of Medicine, University of Malawi (CRH)
- Centre for Social Research, Chancellor College, University of Malawi (CSR)
- Institute for Public Opinion and Research (IPOR)
- National Statistical Office (NSO)
- Wadonda Consult

All interviews happened between the 9th and the 13th of July 2019, and took place in the cities of Lilongwe, Zomba and Blantyre. The Centre for Agricultural Research and Development (CARD), Bunda College, Lilongwe University of Agriculture and Natural Resources (LUANAR), could not be interviewed for logistical and scheduling reasons.

1 The KIIs also looked at institutional capacity and coordination above and beyond the research agenda, with the goal of informing the broader discussion linked to the establishment of a Research Observatory in the country. This broader discussion is beyond the scope of this publication.

CHAPTER 3

Literature Review

3.1 Prevalence of sexual and gender-based violence and of harmful practices in Malawi

This literature review focuses on SGBV and IPV, as well as three important categories of HPs regarding SRHR: child marriage, initiation rituals, and FGM/C. This section starts by discussing the evidence on the prevalence of each of those issues in Malawi, and consolidates the evidence on how minorities and selected vulnerable groups experience violence and access SRHR in Malawi. Next, the literature on the consequences of each of those summarised, before turning to the evidence on the main drivers of such traditions and behaviors.[2]

The inclusion criteria for the studies reviewed in this section was scientific rigor: large sample sizes in the case of descriptive quantitative studies, randomized control trials (RCTs) in the case of evaluations, and structured interviews in the case of qualitative studies. Whenever possible, the papers and book chapters selected to be reviewed cover the prevalence, consequences and causes of the issues highlighted directly for Malawi. In some instances, however, the evidence for the country is scarce –

2 This section benefits from valuable inputs from Jiajing Feng, Simon Haenni, Qingyan Lin and Matthias Schief.

34%

of the women aged 15-49 experienced physical violence since age 15

21%

of the women aged 15-49 experienced sexual violence in their lifetime

particularly when it comes to causes, as few interventions have been rigorously evaluated in the country. For the latter, we cover evidence from other developing countries, to approximate the conditions expected to hold in Malawi.

3.1.1 SGBV

Gender-based violence (GBV) is any act of violence directed at an individual based on his or her sex, gender identity or expression of socially defined norms of masculinity and femininity (Population Services International, 2016). Men and women can both experience GBV. However, most of the victims of GBV are women and girls. SGBV is any form of sexual violence that is directed against a person based on gender (Council of Europe, 2012). The School Related Gender Based Violence (SRGBV) is also a type of GBV which includes any form of violence based on gender stereotypes or that targets students based on their sex. It includes but is not limited to rape, unwanted sexual touching, unwanted sexual comments corporal punishment, bullying and verbal harassment (Imani, 2015). Intimate Partner Violence (IPV) is sometimes included in discussion on SGBV. But in this literature review, we discuss them in two separate sections. In SGBV section, sex and gendered based violence from people other than intimate partners are discussed the IPV section, only discusses violence from intimate partners.

All the four main types of SGBV (physical, sexual, emotional and economic) are prevalent in Malawi to different degrees (Ministry of Gender and Social Welfare, 2014). Thirty four percent (34%) of the women aged 15-49 experienced physical violence since age 15 and 21% of them experienced sexual violence in their lifetime. Of the women who experienced sexual violence in their lifetime, 4% had experienced this form of violence before the age of 18 (National Statistical Office, 2017). Figures 1-12 show the prevalence of physical and sexual violence by age, residence (rural/urban), region, education, wealth status and marital status of women aged 15-49.

FIGURE 1

% of women aged 15-49 who have ever experience physical violence by age

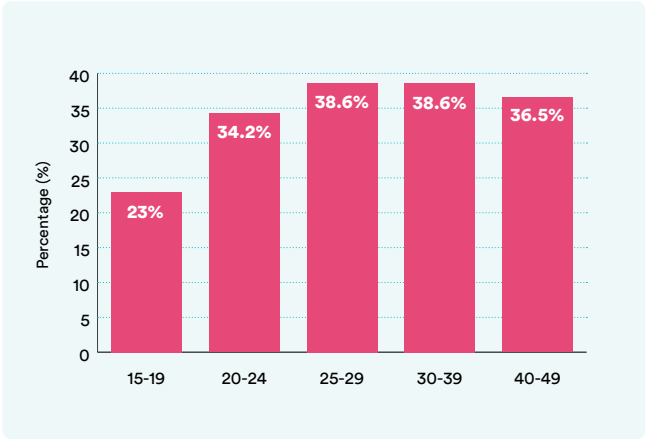


FIGURE 2

% of women aged 15-49 who have ever experienced physical violence by residence

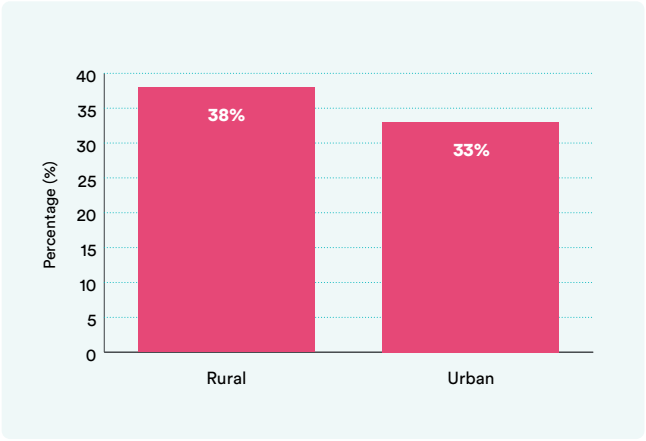


FIGURE 3

% of women aged 15-49 who have ever experienced violence by region

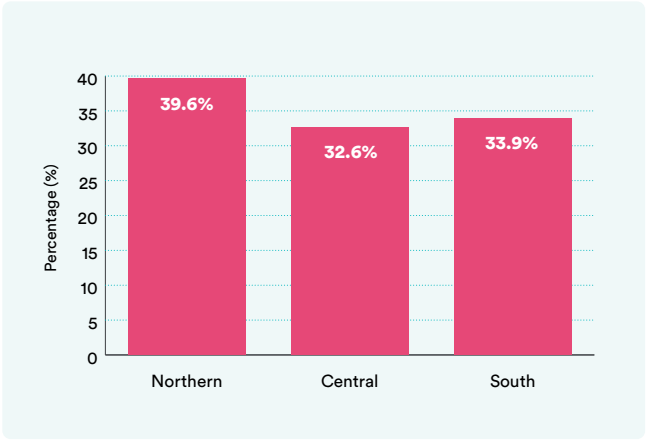


FIGURE 4

% of women aged 15-49 who have ever experienced physical violence by education

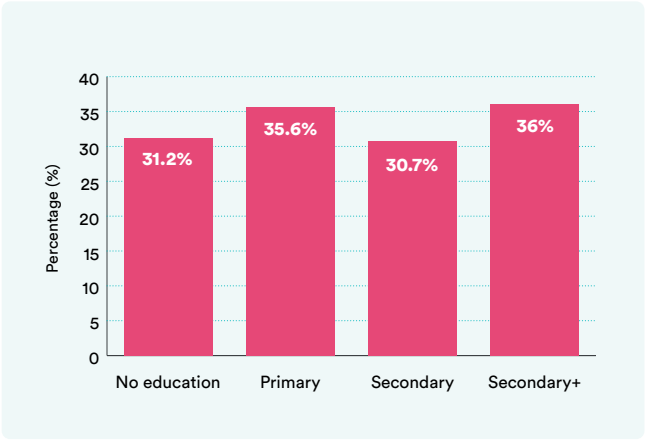


FIGURE 5

% of women aged 15-49 who have ever experienced physical violence by wealth quintile

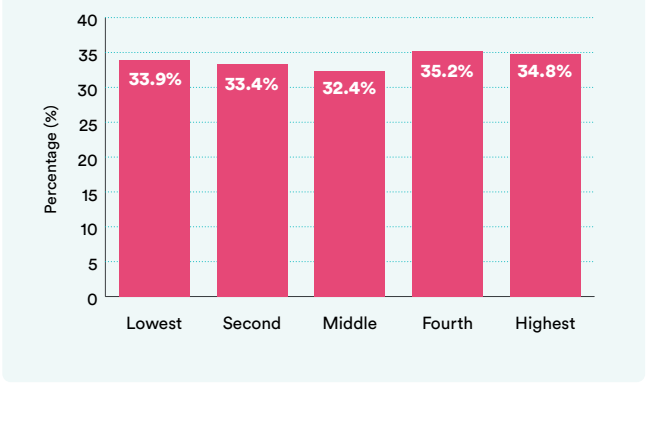


FIGURE 6

% of women aged 15-49 who have ever experienced physical violence by marital status

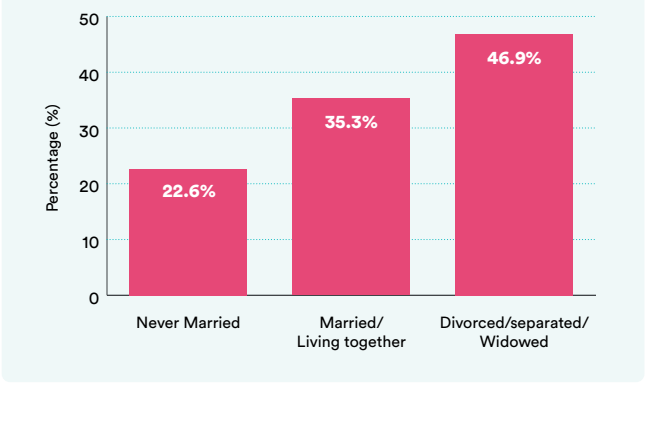


FIGURE 7
% of women aged 15-49 who have ever experienced sexual violence by age

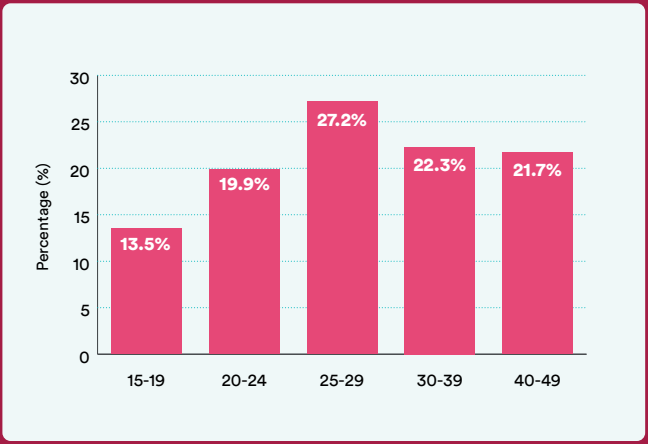


FIGURE 8
% of women aged 15-49 who have ever experienced sexual violence by residence

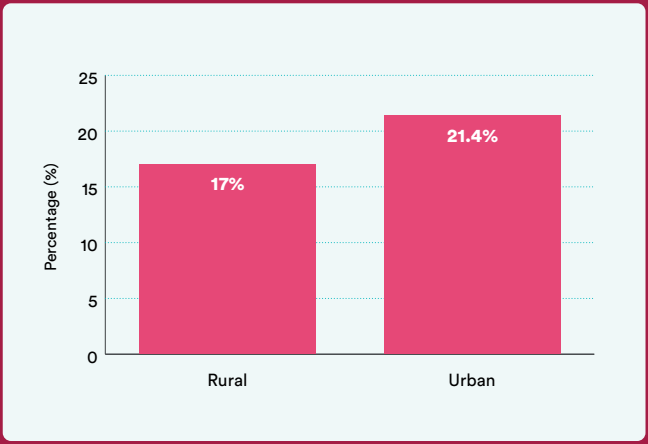


FIGURE 9
% of women aged 15-49 who have ever experienced sexual violence by region

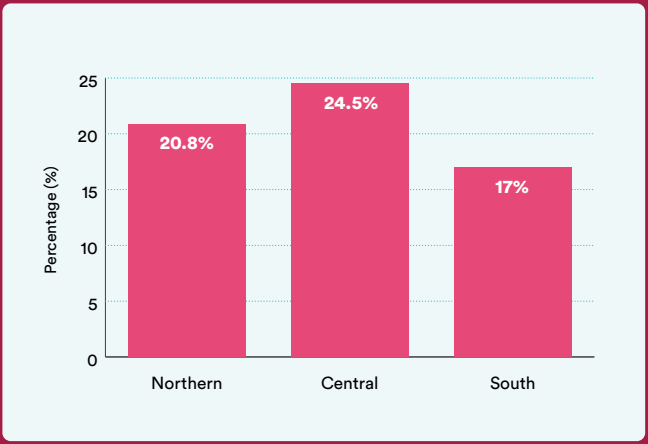


FIGURE 10
% of women aged 15-49 who have ever experienced sexual violence by education

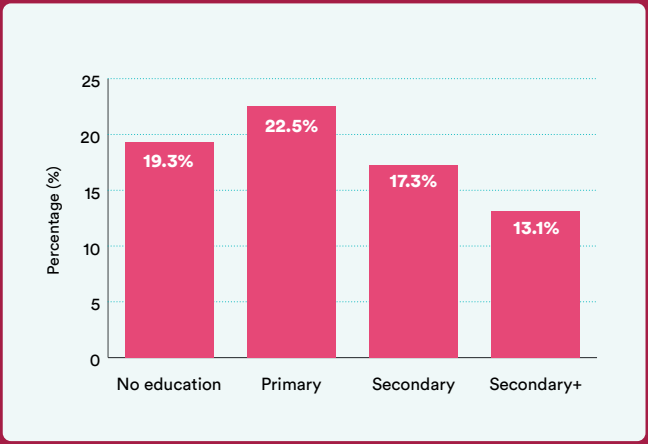


FIGURE 11
% of women aged 15-49 who have ever experienced sexual violence by wealth quintile

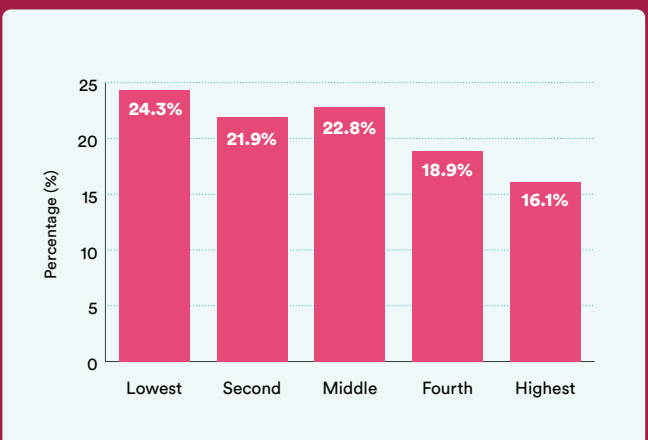
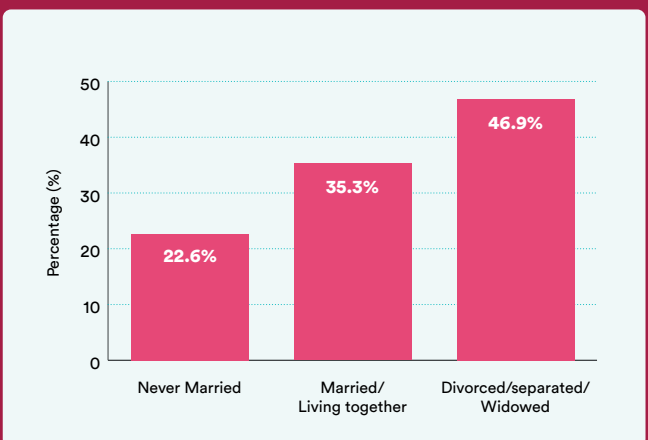


FIGURE 12
% of women aged 15-49 who have ever experienced sexual violence by marital status



The following issues can be drawn from Figure 1-12.

- The proportion of women who have ever experienced physical violence was lowest among those aged 15-19 at 23%. This proportion increases up to the age 25-30 (39%) after which it decreases (Figure 1).
- The proportion of women 15-49 who experience physical violence is higher in rural at 38% than urban areas (33%) (Figure 2).
- The proportion of women 15-49 who have ever experienced physical violence is highest in the North at 40% followed by the South at 34% and then centre at 33% (Figure 3).
- Physical violence is widespread regardless of level of education with about a third of women reporting experiencing physical violence (Figure 4).
- The proportion of women 15-49 who have ever experienced physical violence decreases the higher the wealth quintile up to the middle wealth quintile after which it increases to 35% for the fourth and highest quintiles (Figure 5).
- The proportion of women 15-49 who have ever experienced physical violence is highest among separated/divorced/widowed women at 47% and this is followed by those who are married at 35% and then those who are single at 23% (Figure 6).
- The proportion of women 15-49 who have ever experienced sexual violence increases up to the age of 25-29 after which it decreases (Figure 7).
- Sexual violence is more common in urban area with 21% of the women aged 15-49 reporting having ever experienced this than rural women (17%) (Figure 8).
- The proportion of women reporting ever experiencing sexual violence is highest in the central (25%) than the North (20.8%) and the South (17%) (Figure 9).
- For those who have ever gone to school, the proportion of those who experience sexual violence decreases the higher the educational level (Figure 10).
- The experience of sexual violence decreases the higher the wealth quintile (Figure 11).
- Just as is the case with physical violence, widowed/separated/divorced women are more likely to experience sexual violence compared to married and single women (Figure 12).

76.3%

of adolescent girls aged 13-17 years, reported experiencing multiple incidents of sexual abuse

A national survey on violence against children and young women found that 42% of the girls and 65% of the boys experienced physical violence before the age of 18 years. This study also found that 22% of the girls and 15% of the boys experienced sexual violence or abuse (Ministry of Gender, Children, Community Development and Social Welfare, 2014) . The experience of violence varies with marital status: of those who reported having ever experienced violence since the age of 15 in 2015/2016, 47% were separated or divorced, 35% were married or living together and 23% were single (National Statistical Office, 2017). Among adolescent girls and young women, 68.4% of those aged between 18-24 years and 76.3% of those aged between 13-17 years reported experiencing multiple incidents of sexual abuse before the age of 18 (Pendleton, Mellish, and Sapuwa, 2016).

Violence also occurs against pregnant women: 5% of the women aged 15-49 who have ever been pregnant reported that they have ever experienced physical violence during any pregnancy. The prevalence of physical violence is the highest in the Northern region at 40%, followed by the Southern and Central regions at 34% and 33%, respectively (National Statistical Office and ICF Macro, 2017). Other studies have also found that girls have a lot of safety concerns in their communities: just less than half of the participants felt safe to move around in their communities at night, 38.1% girls reported to having been teased or harassed by men or boys; 44.2% indicated they experienced such experiences at home or from a relative, 62.2% outside home, and 46% in school (Kelly and Daud, 2017).

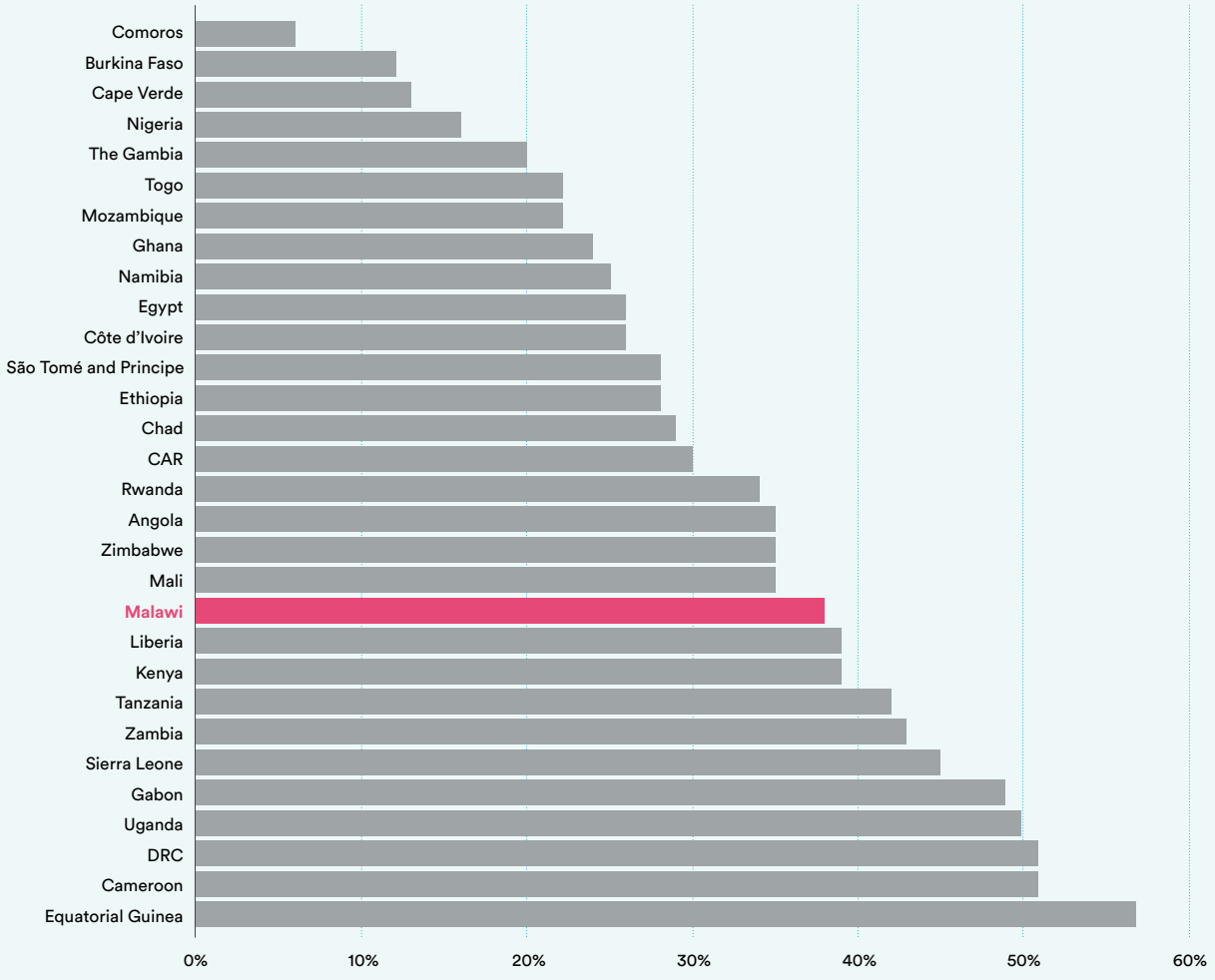
SRGBV is also prevalent in Malawi, especially in rural areas with 26.5% of the children reporting knowing someone who has a problem while walking to school and 19.4% personally have problems on the way to school. After arriving school, they still fear that they may suffer bullying, violence or unwanted sexual encounters. Twenty four percent (23.8%) of Malawian children claim they were forced to have sex against their will, and over half (54%) of them were victimized more than once (Imani, 2015). According to Munthali et. al. (2004), half of the Malawian girls in their survey experienced some form of sexual abuse in school. Every second girl said that her private parts were touched by her teacher or male classmates, and more than half of the incidents were committed by fellow students. McDermott (2016) also mentioned high SRGBV prevalence. Primary school girls were routinely subject to aggressive sexual advances including rape and sexual abuse from older male students, male teachers, and ‘sugar daddies’ who target school girls. In tertiary schools, 67% girls experienced sexual harassment and 12% had been raped.

SGBV is also highly prevalent among specific vulnerable or marginalized groups such as women and girl refugees, in prisons, among female domestic workers, among elderly women and among lesbian, bisexual or transgender women (Pendleton et al., 2016; van Eerdewijk et al., 2018), however there is limited literature on these specific groups.

3.1.2 IPV

Intimate Partner Violence or IPV, as defined by World Health Organization (2012), refers to any behavior within an intimate relationship that causes physical, psychological or sexual harm to those in the relationship. For example, acts of physical violence (slapping, hitting, kicking and beating), sexual violence (forced sexual intercourse and other forms of sexual coercion), emotional or psychological abuse (insults, belittling, constant humiliation, intimidation and threats), and controlling behaviors (isolating a person from family and friends, monitoring their movements, restricting access

FIGURE 13
Prevalence of IPV in Africa



Note: Lifetime physical and/or sexual IPV in Africa, van Eerdewijk et al. (2018).

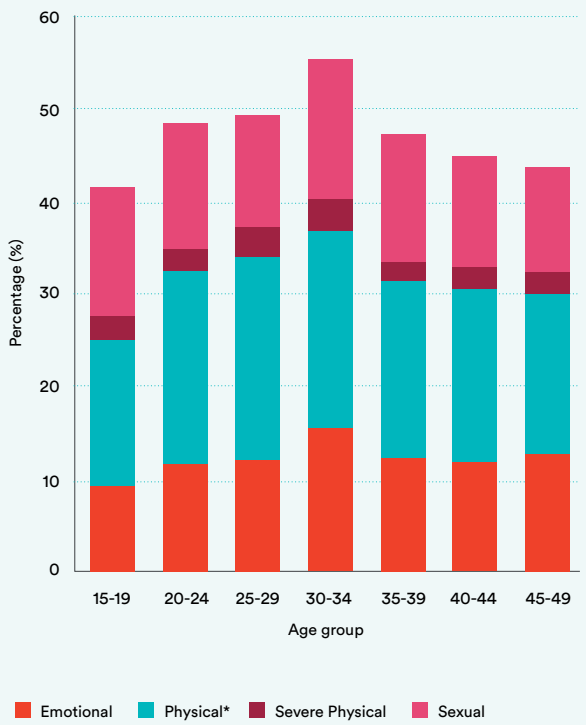
to financial resources, education or medical care). IPV is the most common type of VAWG and is less prevalent against males (Bazargan-Hejazi et al., 2013). Figure 13 shows that IPV is widespread in all countries (van Eerdewijk, 2018).

Malawi is above the African average level of IPV prevalence with 42% of ever-married women have experienced some form of physical, sexual or emotional violence perpetrated by their current or most recent spouse. In terms of individual types of violence, 53% of ever married women aged 15-49 reported their current husbands as perpetrators while 31% reported former husbands. Those figures are 63% and 31%, respectively, when it comes to sexual violence, with 5% mentioning strangers as perpetrators (National Statistical Office and ICF Macro, 2017). A recent study with a sample of 3,546 Malawi women found that physical violence is the most common type of IPV in the household, 30% of women reported physical IPV, 25% of women reported experiencing emotional violence and 18% reported sexual violence (Bazargan-Hejazi et al., 2013). Figure 14 shows the distribution of women in each age group in Malawi reporting different types of IPV.

NSO (2017) suggests that IPV is less prevalent in Malawi than other southern African countries, but it may be the result of under-reporting. Women may not disclose issues of domestic violence as it is regarded as shameful to their family (NSO, 2004). Figure 15 shows the prevalence of different types of behaviors in IPV.

FIGURE 14

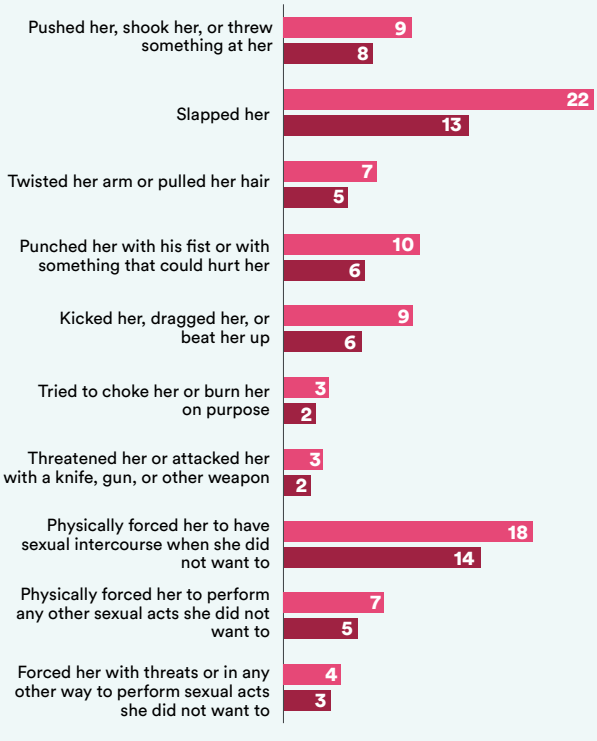
Percent of women in each age group in Malawi reporting different types of IPV



Note: Bazargan-Hejazi et al. (2013).

FIGURE 15

Percentage of ever-partnered women reporting IPV, by type



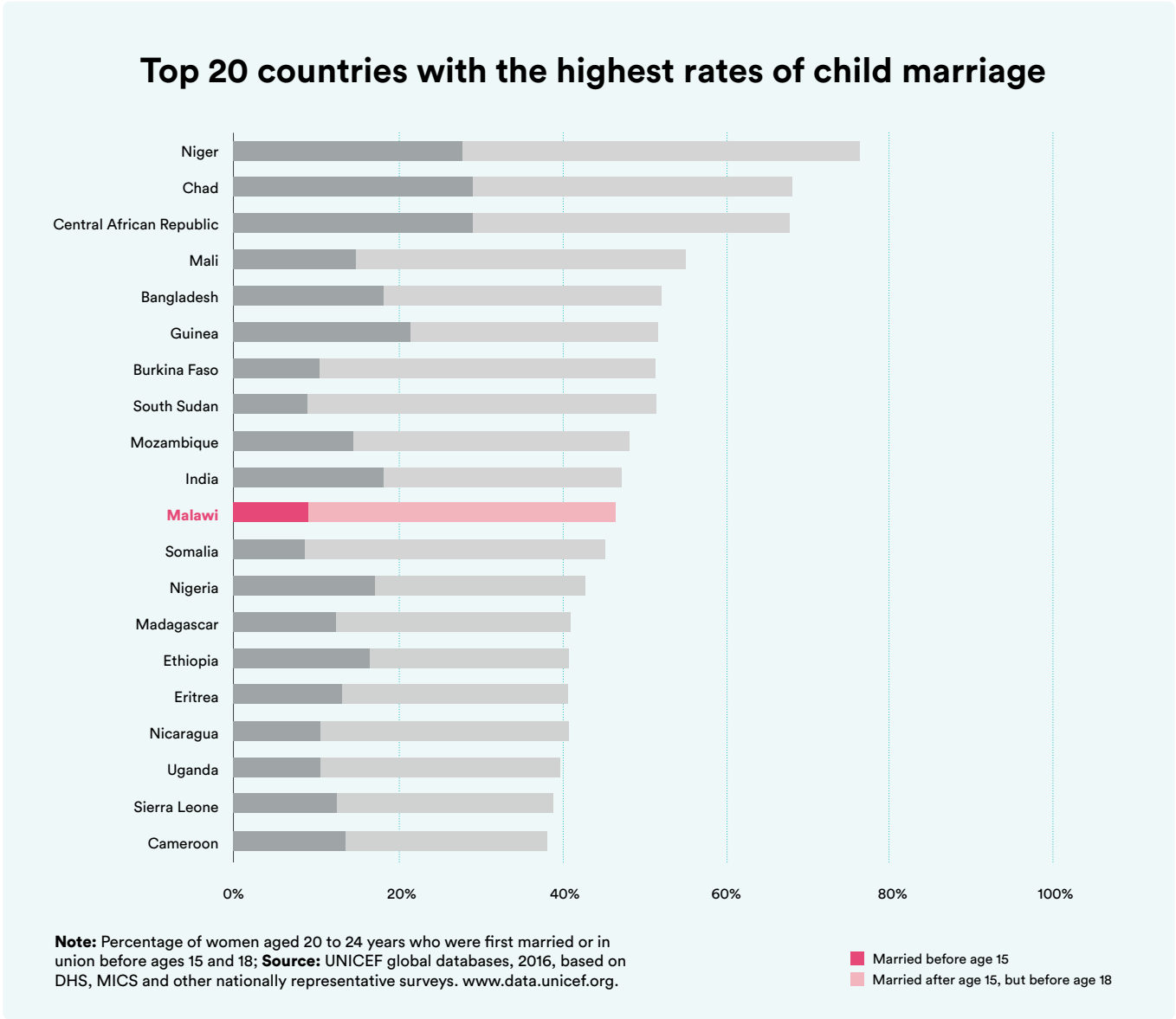
Note: Adapted from Eerdewijk et al. (2018).

IPV is also prevalent among pregnant women. Chasowa and Kambalu (2015) found that the majority (59%) of women were psychologically, physically and sexually abused by their husbands during pregnancy in a study in Southern Malawi. Mwanza (n.d.) studied IPV among people living with HIV in Malawi and found that 20% of people with HIV suffered physical violence, 50% were subjected to psychological abuse and 41% suffered from sexual abuse.

3.1.3 Child marriage

Child marriage is defined as a formal marriage or informal union entered into by an individual before the age of 18. This definition has been adopted by most countries in the world. In general, girls experience a much higher risk of child marriage compared to boys. Roughly, 700 million women alive today were married before age 18 (UNICEF, 2013a). Figure 16 shows that Malawi is among the top 20 countries with the highest percentage of women aged 20-24 who were married before they reached ages 15 and 18.

FIGURE 16
Child marriage by country



Note: Percentage of women aged 20 to 24 years who were first married or in union before ages 15 and 18; **Source:** UNICEF global databases, 2016, based on DHS, MICS and other nationally representative surveys. www.data.unicef.org.

FIGURE 17
Child marriage by country in Southern and Eastern Africa

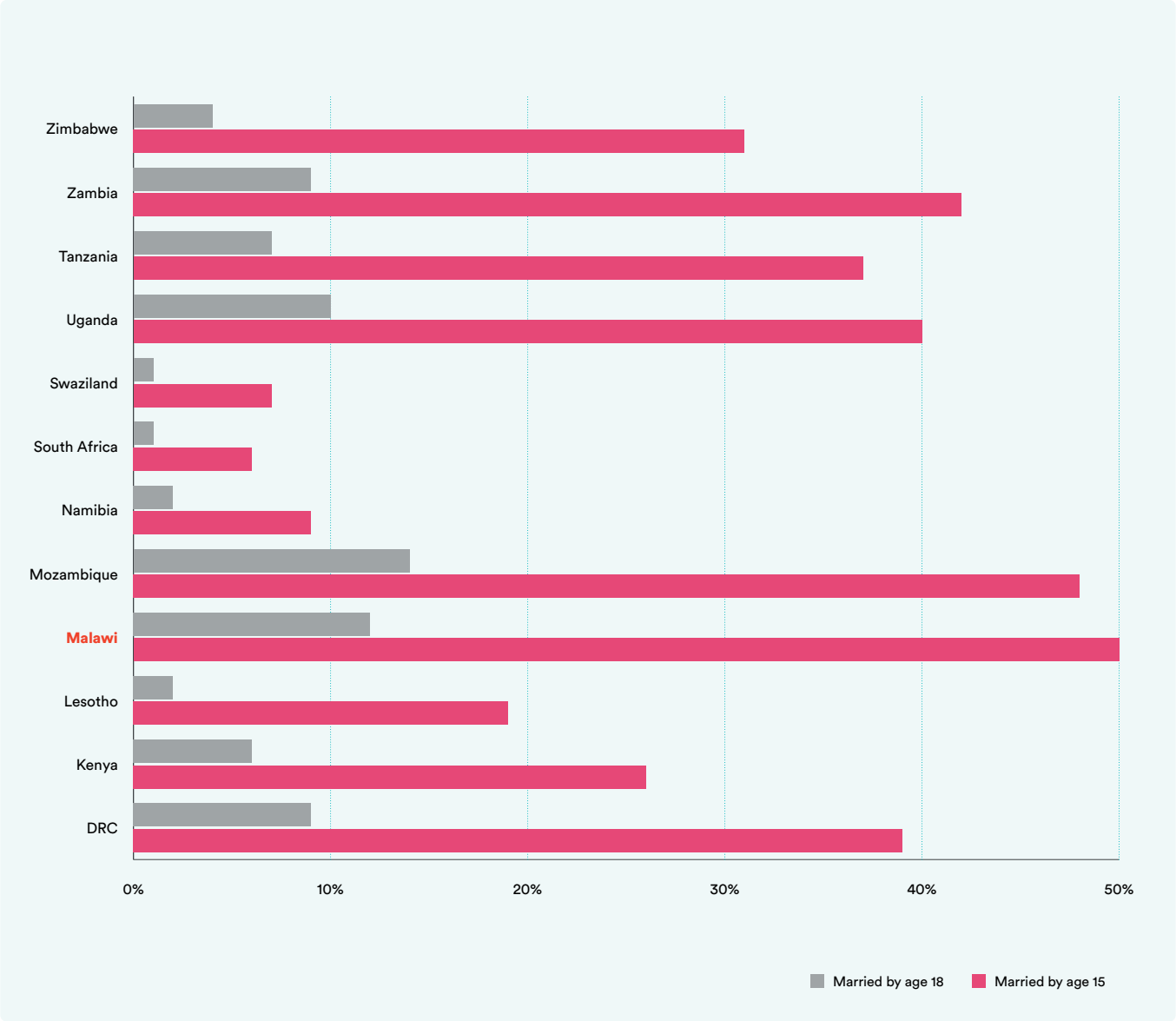


Figure 17 shows that Malawi has the highest prevalence of child marriage in Southern and Eastern Africa seconded by Mozambique.

700 million
women alive today were married before age 18

- UNICEF, 2013a

In Malawi 47% of the women aged 20-49 are married before age 18 and the proportion of men who marry at this age is at 8%. These national averages, however, mask within-country heterogeneity in the prevalence of child marriage. For example, the MDG endline survey found that while 50% of the women aged 20-49 were married before age 18, the cities of Lilongwe (26%) and Blantyre (35%) had the lowest proportion of women aged 20-49 who got married before age 18. Phalombe and Machinga had the highest proportion at 68% and 62%, respectively (NSO, 2014). While most developing countries have experienced a substantial reduction in the rate of child marriages (Mensch, Singh and Casterline, 2005; Nguyen &Wodon, 2012), in Malawi, that is not exactly the case: Figure 19 shows a reduction in marriage below 18 over the last 15 years (comparing respondents 30-45 to those 45 and above of the 2019 HTP National Survey; see NSO et al., 2019), but the reduction is only of about 2%, and concentrated on ages 16 and 17, while under-15 child marriage has remained basically the same. [3] Over the same period there has been a very substantial decrease in marriage age among males (Figure 18), suggesting that age differences between couples have decreased – a likely increase in matching quality for girls marrying under-18, even though they are still subject to the other potentially harmful issues linked to getting married at a young age.

Such change at least partially reflects changes in female attitudes across generations: 30-45 year-olds are less likely than those 45 years old and above to state that the ideal age of marriage for a female is under 18, but particularly so for females (Figure 21). For males, in turn, the ideal age distribution, if anything, seems to have shifted to the left, with a higher share of respondents in the younger cohort likely to say 18 instead of 20 years old (Figure 20).

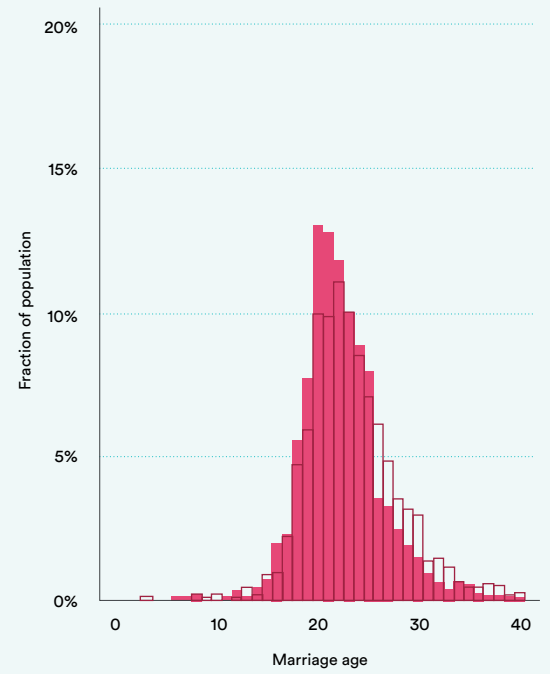
These results generally demonstrate that child marriages are quite common in Malawi. Some studies have been conducted in Malawi to explore decision making around child marriage. The 2018 traditional practices survey found that in 89% of child marriages adolescent make their own decisions to marry and parents and guardians actually force their children to marry in only about 8% of the child marriages (National Statistical Office et al., 2019). A 2016 study conducted in TA Liwonde in Machinga District found that 80% of the males and 73% of the females reported that they made decisions on their own to get married (Munthali & Kok, 2016). While parents and guardians can force their children to get married, in most cases of marriage the persons involved will make their own decisions.

3.1.4 Sexual initiation rituals

Initiation rituals or puberty rites are ceremonies of transition from childhood into adulthood, as some social recognition and in ceremonial form (Schlegel and Barry, 1979). Not every initiation ritual contains harmful practices. This literature review focuses on harmful practices during initiation rituals. These initiation ceremonies are for both boys and girls and the timing of the rituals can be before genital

3 Since the survey only interviewed households with 15-17 year-olds, it is not high-powered to make statements about the 18-29 year-old generation, as several of those individuals might have moved out of their parents' household by the time of the survey while very few of those would already be living in households with a 15-17 year-old.

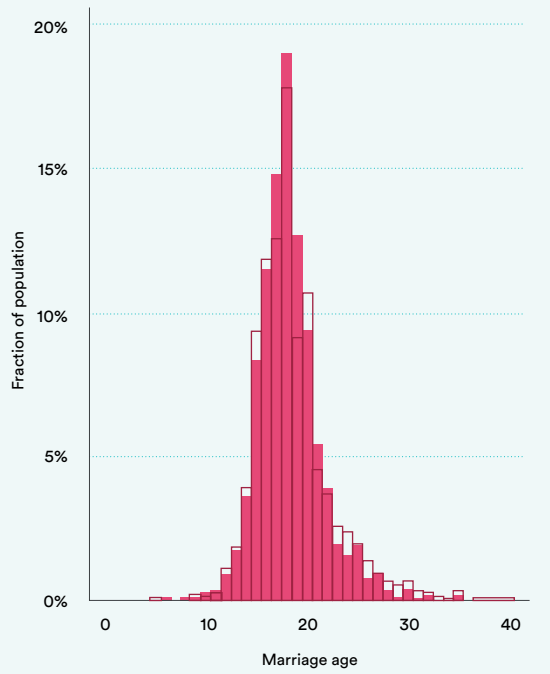
FIGURE 18
Distribution of marriage age among males



Age of respondent 30-45 Age of respondent > 45

Note: Based on 2019 HTP National Survey (NSO et al., 2019).

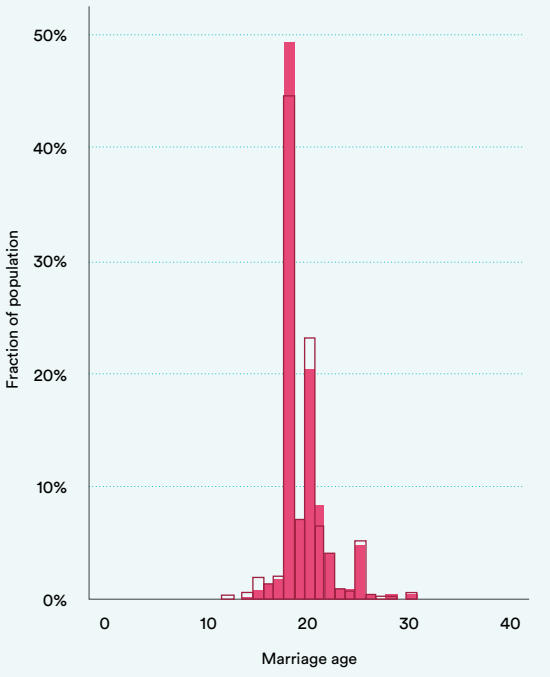
FIGURE 19
Distribution of marriage age among females



Age of respondent 30-45 Age of respondent > 45

Note: Based on 2019 HTP National Survey (NSO et al., 2019).

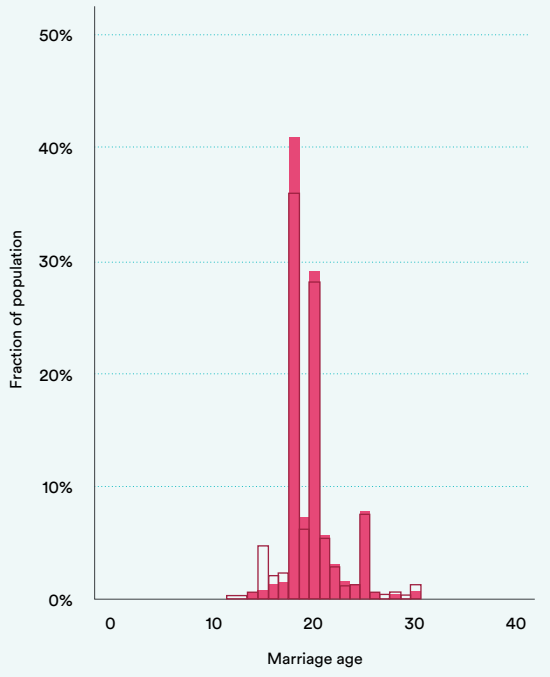
FIGURE 20
Distribution of stated ideal marriage age for females, according to males



Age of respondent 30-45 Age of respondent > 45

Note: Based on 2019 HTP National Survey (NSO et al., 2019).

FIGURE 21
Distribution of stated ideal marriage age for females, according to females



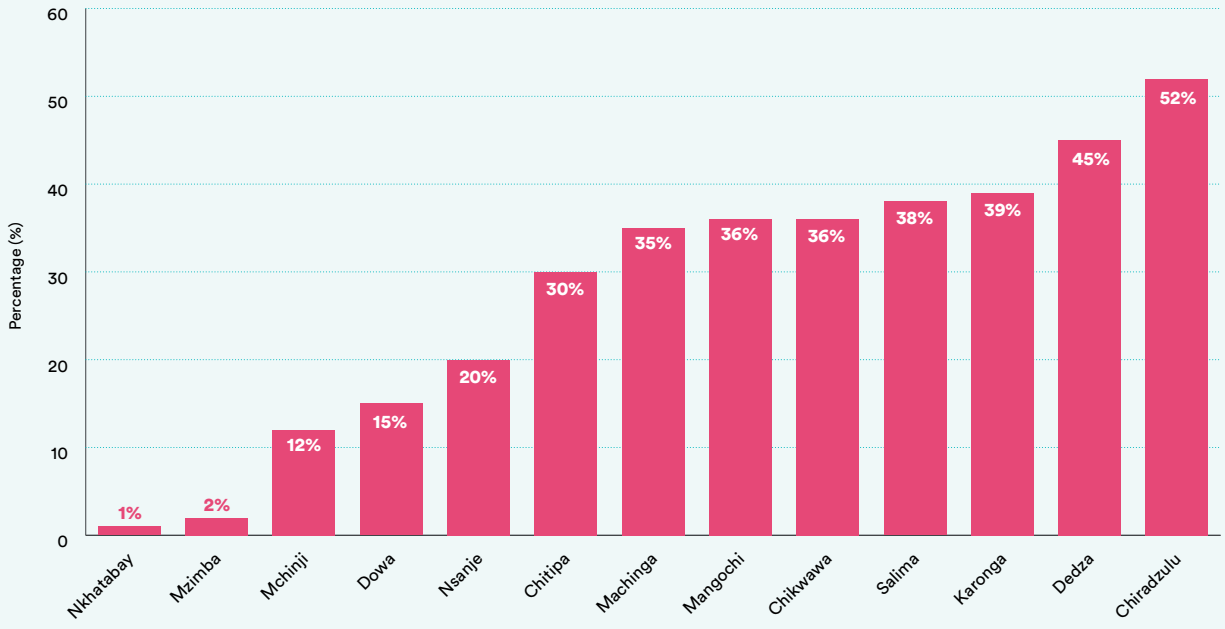
Age of respondent 30-45 Age of respondent > 45

Note: Based on 2019 HTP National Survey (NSO et al., 2019).

maturation, at first signs of genital maturation, at genital maturation, within one year after genital maturation, or even later till 18 years old. These initiation ceremonies can be individually, in small groups or in large groups. Some initiations are for both boys and girls, while most of them are exclusive to a single gender. The components of the rites differ even more significantly. There could be genital operation (for instance, FGM/C for girls, circumcision for boys), genital manipulations, learning adolescent/adulthood skills, enforcing social norms (for instance, obedience of wives to husbands), and forced or encouraged heterosexual intercourse (Schlegel and Barry, 1979).

As for Malawi, a 2018 survey of harmful practices found that in almost all villages in the southern region the majority stated that initiation rituals were practices in their villages. More than 80% of the villages in the southern region practice initiation rituals and that such rituals are rare in the central and northern regions (NSO et al., 2019). Over 45% of the population living in communities where initiations are presented have attended the rituals. The Yao ethnic group witnesses the highest proportion of population ever being initiated (93%), followed by Lomwe (55.1%), Ngoni (42.5%) and Chewa (42.2%) (see Ministry of Gender, 2013).

FIGURE 22
Initiation rituals by region in Malawi



Note: Prevalence of girl initiation ceremonies by district, National Statistical Office's 2013 GBV Baseline Survey.

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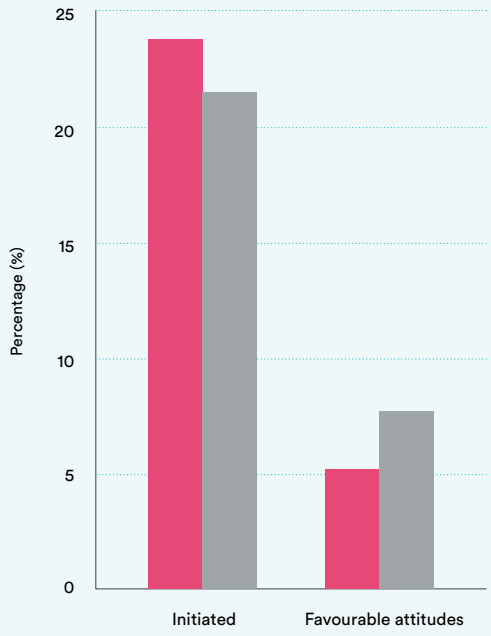
Major harmful practices during initiation rituals include participants being bullied, forced to have sex after the ceremony, and exposed to obscene language or sexual activities. In Malawi, boys participating in Jando, a circumcision ritual of the Yao people in Southern Malawi and Gule Wamkulu (big dance) of the Chewa people in Central Malawi get beaten and bullied (Invest in Knowledge, 2015). Studies have also shown that at the end of Chindakula or Maseseto initiation ceremonies in Mangochi, Nsanje and Mulanje, as an example, a male fisi (hyena) is hired to have intercourse with the newly initiated girls, as young as 10 years old, to help them practice the sex knowledge they have learned from the rituals (Ministry of Gender, 2013). Sometimes, girls may perform kutsatsa fumbi or kuchotsa fumbi (dust cleansing) instead, a practice in which both boys and girls are encouraged to experiment with sex (Silungwe, 2014; Munthali and Kok, 2018) after they graduate from the initiation camp. Boys are told that, if they do not do it, their penis will wilt or rot; girls are told that if they do not do it, they will feel a lot of pain when having sex later on (Munthali & Kok, 2018). Alternatively, in gwamula or kutsekukirana, boys invade kuka (girls' dormitory) at night and force the girls to have sex with them. Girls during some initiation ceremonies sometimes dance naked in public, a ritual which everyone in the community is welcome to watch (Ministry of Gender, 2013 & Silungwe, 2014).[4]

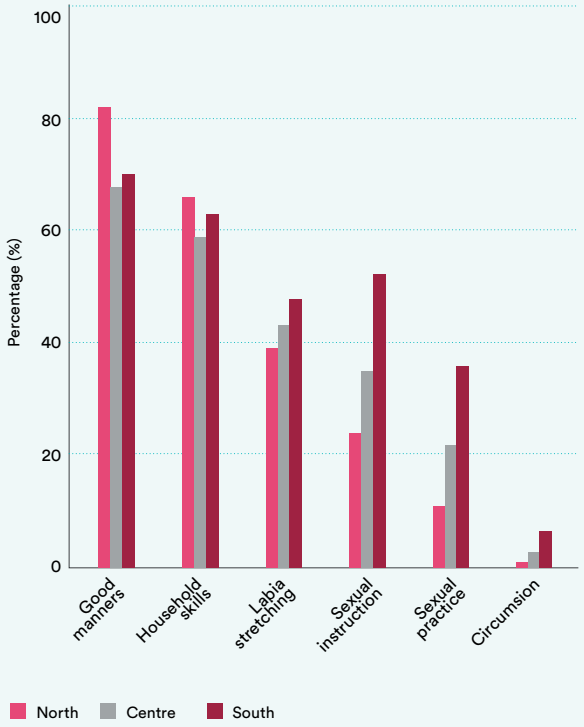
4 In some cases, traditional practices involving forced sexual relations take place outside of initiation rituals. For instance, kulowa kufa is practiced in Nsanje, in Southern Malawi, where a man has sex with a woman whose husband has died, allegedly to put to rest the spirits of the deceased husband. The cleanser can be either a relative of the husband or hired to perform the ceremony (Kalilani-Phiri and Taulo, 2009 & Malawi Human Rights Commission, 2005). Such practices have been linked to HIV transmission.

FIGURE 23
Prevalence and support of sexual initiation rituals



Note: Based on 2019 HTP National Survey (NSO et al., 2019).

FIGURE 24
Content of initiation rituals across regions in Malawi



Note: Based on 2019 HTP National Survey (NSO et al., 2019), displays frequency of typical contents at initiation rituals as stated by respondents who acknowledge that initiation rituals are performed in their village. Multiple answers are possible.

Figure 23 shows that the prevalence of sexual initiation rituals in Malawi seems to have increased over the last 15 years – despite a decrease in stated support for the continuation of those rituals among 30-45 year-olds relative to those 45 year old and above.

Figure 24 displays that sexual instruction and practice are more prevalent in the South (in about 50% and 35% of villages, respectively). Sexual practice is, however, encouraged in at least 10% of the villages across all regions.

3.1.5 FGM/C

Female genital mutilation/cutting (FGM/C), as defined by the World Health Organization (2017), comprises all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons. WHO classifies FGM/C into four major types: 1) cut but no flesh removed; 2) cut and some flesh removed; 3) sewn closed; and 4) all others. Malawi, according to UNICEF, is not classified as a country where FGM/C requires special focus. A 2018 national survey on traditional practices found a national prevalence of FGM/C of 3.5% (not inclusive labia pulling; see below), but up to 4.3% in the southern region with Phalombe having the highest concentration at 13.6%.

Despite reasonably low prevalence of cutting and mutilation, the prevalence of labia stretching (sometimes defined as female genital modification, in contrast to cutting or mutilation) as part of initiation rituals is surprisingly high in Malawi: 52% of the respondents reported that labia stretching is one of the activities that take place during initiation ceremonies. The Southern region had the highest proportion of respondents who mentioned this practice – at 55%, followed by the Central and Northern regions at 41% and 38%, respectively. An earlier study found that 5% of the respondents reported that FGM was practiced in their area and this was especially reported in Mulanje (MHRC, 2006).

3.1.6 SGBV, IPV and HTP against vulnerable populations

3.1.6.1 Women with disabilities

Several studies have been done on persons with disabilities in Malawi. Munthali et. al (2004) found that 76% of people with disabilities reported to have ever had sex; 83% of them had their first sexual encounter out of choice. People with disabilities are also very vulnerable to SGBV. Women with disabilities are twice as likely to experience IPV and other forms of SGBV as women without disabilities (Southern Africa Litigation Centre, 2017; van Eerdewijk et al., 2018). Perpetrators tend to abuse persons with disabilities more because they are easily accessible, more seldom have a close friend, and have lower self-confidence, and so less likely to tell other about the assault (Kvam and Braathen, 2008). Persons with disabilities are also at risk of sexual abuse because of beliefs that having sex with them increases wealth (Mji, 2008), helps cure HIV and that they do not have the virus (Southern Africa Litigation Centre, 2017; Mji, 2008; Munthali et al., 2004). These studies have also found that it is mainly women and girls with disabilities who are vulnerable to sexual abuse. An alternatively held belief is that persons with disabilities are all beggars. Such belief also increases the probability of contracting HIV for persons with disabilities in situations of abuse from perpetrators with HIV (Mji, 2008). Many persons with disabilities report to have been abused, but there is bound to be under-reporting (Mji, 2008). Another reason why women with disabilities are especially vulnerable to sexual abuse is poverty, inducing giving in to men in exchange for money. Lastly, the fact that some women with disabilities cannot see or move about is likely to increase the risk of sexual abuse.

Munthali et al. (2004) mention that people with hearing and visual impairments were at more risk of contracting HIV as they may not know much about AIDS. It is hard for women with disabilities to have stable marriage. Some men have the belief that women with disabilities do not have a chance of having relationships and cannot contract HIV. Then they reportedly mislead the women with disabilities to have sex with them with the promise to marry them, but they always leave the women without marrying them. Even if they do get married, the marriage may break up because the husband's family thinks the women with disabilities cannot help with household chores (Mji, 2008).

PEOPLE WITH DISABILITIES

may have problems accessing health care services because they were too far and there was no one to escort them.

SRHR of persons with disabilities often cannot be enforced because of, among other reasons, discrimination against them. When women with disabilities go to the hospital for antenatal, delivery and postnatal services, nurses reportedly treat them as if they are not supposed to give birth. Mji (2008) documents verbal abuse against those women and refusal to help them when they have trouble because of their disabilities. Their reports include even being tortured or beaten by nurses (Mji, 2008). People with disabilities may have problems accessing health care services because they were too far and there was no one to escort them (Munthali et. al., (2004). There is also significant discrimination against women with disabilities in accessing sexual and reproductive health and general health services, including lack of mobility assistance and communication for people with hearing and visual impairment. Lastly, women with disabilities are often excluded from prevention programmes, support services and access to legal redress (Southern Africa Litigation Centre, 2017).

Some women with disabilities also reported to have trouble accessing health education sessions because they are sidelined. Mji (2008) found that her participants actually knew how HIV is transmitted. Most participants have access to sexual and reproductive health care centres, but some claimed not to have enough money to pay for it. However, an earlier study found that 87% of the respondents with disabilities claimed that they had heard about HIV while 94% had heard about AIDS. But some problems were mentioned in accessing information about HIV/AIDS including the lack of radios and other materials, the need for someone to read especially for the visually impaired, and long distances to health facilities. Seventy percent (70%) of the respondents in this study knew about Voluntary Counseling and Testing (VCT), but only 10% of them had gone for VCT. The reasons for not going included thinking they were okay, fearing blood being pumped from body, and mobility problems. Ninety three percent (93%) of the respondents said that they were aware of STIs and 3% admitted having contracted an STI. This study also found that while 82% of respondents knew what a condom was, only 42% reported knowing how to use a condom, with only 27% of respondents reporting having used condoms. Some people reported to have problem using condoms because of their disabilities such as weak hands or visual impairment (Munthali et. al., 2004).

The prevalence of disability among children is lower at 2.4% than among the general population at 3.8% (National Statistical Office, 2009). A 2013 study found that children with disabilities experience difficulties in accessing health services. The problems they face include restricted mobility, communication problems due to impaired hearing and discrimination from health workers. The fact that some health education message is not provided in accessible formats (e.g. braille for

children with visual impairment) further undermines these children's health rights. Due to discrimination, the children with disabilities are always reportedly the last ones to receive treatment or are even not treated at all. Health workers in some cases inform these children that they could do nothing to help (Munthali et. al., 2013). Lastly, there are some studies which have found that girls with disabilities are vulnerable to sexual violence. For instance, Suka (2006) found that visually impaired school girls experience a wide range of challenges including threats and actual sexual abuse from for example specialist education teachers who even tell these children that no one would be interested in sexual relationships with them. Suka (2006) further argues that there are a high dropout rates among visually impaired girls because of, among other reasons, the violence perpetrated against them.

3.1.6.2 LGBTIQ

With regard to lesbian, gay, bisexual, transgender, intersex and queer (LGBTIQ), Malawi is among the nations that criminalize same-sex conduct. LGBTIQ people face routine violence and discrimination in almost all aspects of their daily lives. People who are found or presumed to be LGBTIQ are reportedly beaten, threatened, and abused in public (Human Rights Watch, 2018). Human Right Watch report that many LGBTIQ subjects are even afraid to report crimes to the police after being abused as they are also discriminated by the police. When they report a crime, Human Rights Watch document that the police not only refuse to open a case, but also arrest or beat them on homosexuality charges. LGBTIQ people report that they experience police abuse, physical assault and humiliation, arbitrary arrests and detention and are released only after paying a bribe (Human Rights Watch, 2018).

SOME PEOPLE ARE BEATEN

due to "LGBTIQ behavior"

UNAIDS reports that the prevalence of HIV among men who have sex with men (MSM) in Malawi is 17.3%, higher than adult heterosexual women at 12.8% and heterosexual men at 8.2%.[5] The discrimination and stigma have also created barriers for LGBTIQ people seeking health services. The Human Rights Watch (2018) reported that some people are beaten due to "LGBTIQ behavior" and although such people can be taken to the hospital, nurses in some cases refuse to provide treatment because they "look like LGBTIQ". Health workers also reportedly refuse to provide HIV testing services to LGBTI couples. When gay men disclose their sexual practices to health care professionals, they are often ridiculed, stigmatized and unable to get treatment. The discrimination is reportedly especially common in government hospitals. Some LGBTIQ people can get treatment at private hospitals but only when they can afford it. The discrimination against LGBTIQ people in health care settings prevents them from seeking services and this compromises their SRHR. People whose sexually transmitted infections (STI) are not treated not only

5 Different sources find lower average HIV prevalence in Malawi: according to the 2015/16 DHS, prevalence is 8.8% among 15-49 men and women, higher among women (10.8%) than men (6.4%).

have higher risk of developing complications, but also of contracting HIV. Persons who experience barriers accessing HIV testing and treatment are more likely to die of AIDS (Human Rights Watch, 2018).

Wirtz et al. (2014) specifically studied about MSM across seven districts in Malawi. MSM are a key population at risk for HIV infection. MSM constitute 1.84% of overall male population aged 20-39 in Malawi. The HIV prevalence among MSM vary from 5.4% in Mzuzu City to 24.9% in Mulanje. The percentage of MSM with HIV who do not know their status varies from 50% to 98% across the seven districts. Only a few participants in this study reported receiving information on how to prevent HIV during sex with another man. Having never received such information was associated with HIV infection among participants in Mangochi.

3.1.6.3 Elderly women

Elderly women have received very limited attention from researchers on the topics relevant to the Spotlight Initiative. Although the population profile of Malawi is becoming older, the problems of ageing tend not be viewed as a critical issue (Chilima and Ismail, 1998). Elderly people in Malawi play an important role in the society as educators and counselors, however they gradually became marginalized in modern society. Regarding HIV and the prevention of mother to child transmission of HIV (PMTCT), elderly people are rarely involved in relevant projects or services (Gombachika, 2015).

Many studies (including the DHS) typically focus on 15-49 year-olds. Studies with older subjects are rare. Freeman and Anglewicz (2012) explored the HIV prevalence and sexual behavior at older age in rural Malawi and they found that older people in Malawi are still important and relevant for studies on HIV and sexual behaviour as both sexual activities and HIV infection remained considerable in older population. Although sexual activities do decline by age, 26.7% women and 73.8% men aged 65+ reported having sex in the last year and men's average sexual partners remained above one. HIV prevalence is also significantly higher for men aged 50-64 (8.9%) than men aged 15-49 (4.1%). For women, the HIV prevalence is lower for those aged above 65 (5.4%) than those aged 15-49 (8.3%). Nonparametric analysis shows that the likelihood of HIV infection for women peaks in the early 30s and declines after that. For men, the peak is more than 10 years later and does not decline until mid-50s. But for both men and women, the likelihood of HIV infection remains considerable over age 50 (Freeman and Anglewicz (2012).

Freeman and Coast (2014) finds that many elderly people are still sexually active both in marriage and outside of marriage. Given the HIV prevalence of 8.9 % and 5.4% among men and women aged 50-65 in rural Malawi respectively, the study claims that sexual enjoyment remains absent from current policies and interventions to reduce HIV

ELDERLY WOMEN

are typically accused of being witches: such women experience physical and emotional violence

infection, which may explain barriers of condom use at older age. It suggests that the policies and interventions should also include how to have pleasurable safer sex to be more effective. Lastly, witchcraft beliefs are still strong and widespread in Malawi. Elderly women are the typical ones to be accused of being witches: such women experience physical and emotional violence such as being beaten, tortured and murdered. Their property can be vandalized or burnt and they also experience stigma and discrimination (Chilimampunga and Thindwa, 2015).

3.1.6.4 Sex workers

Current legal environment in Malawi is against sex work and there is always stigma and discrimination associated with sex work. Sex workers are difficult to study, as they are often a hidden population, hence it is extremely hard to quantify the prevalence and implement relevant interventions. Chizimba and Malera (2011) studied 950 sex workers, along with their clients and other stakeholders: they estimated that there are 19,295 sex workers in Malawi existing almost everywhere in the country. Searching for money was found to be the main reason of engaging in sex work, especially for orphaned girls and divorced women as they are unable to survive and support their dependents without doing the work, respectively.

Female sex workers are the main vulnerable group to HIV and, potentially, one of the most important for its spread, as their HIV prevalence is much higher than in the general population (NSO, 2014). The national HIV prevalence for sex workers aged 15-49 years is estimated at 62.7% (National Statistical Office, 2014), which is much higher than the national average prevalence at 8.8% (National Statistical Office, 2017). This high HIV prevalence is attributed to the high number of sexual partners, longer duration of sex, unprotected sex and high prevalence of STIs as well as the fact that sex workers are generally stigmatized and discriminated, making them fail to

access health services. Among sex workers, HIV prevention is not freely discussed. Sex workers only do HIV testing if they start falling sick or if they are pregnant and are required to do the test. One of the reasons they do not take the test is that they fear the outcome of the test and its consequences (Chizimba and Malera, 2011).

All female sex workers had heard about STIs (97%) and HIV/AIDS (99%). A majority (73%) of them knew all three methods of HIV prevention. However, comprehensive knowledge about HIV/AIDS among female sex workers is low at 50%. Over 20% of female sex workers reported having had either genital discharge or ulcers in the last 12 months, and about 20% of them tested positive for syphilis. Although 93% of sex workers reported using a condom during the last commercial sex with clients, only 60% of them reported consistent condom use with clients during the previous 12 months. While they found that over 70% of female sex workers reported to have ever turned away clients when they refused to use a condom, they also confirmed that sexual intercourse with men without a condom brings more money (National Statistical Office, 2014). Chizimba and Malera (2011) also found that condom use is generally low among sex workers with 85.5% of the sex workers had the experience where clients demanded unprotected sex and offered more money for this. The main way for sex workers to get condoms is to buy them, which causes extra financial burden. Many sex workers are also subject to different forms of abuse – including physical sexual abuse or rape. Most victims choose not to report to authorities after being abused (Roos, 2018 & National AIDS Commission, 2013). Malawi-based sex workers from other countries may face even more severe situation due to immigration status and language barrier. Chizimba and Malera (2011) also found that currently the coverage of sex work interventions is very limited in Malawi, and only in selected areas. Only 29.5% of sex workers indicated having access to HIV testing and counseling (HTC) in 12 months before the study. Interventions facilitated increase in knowledge about HIV issues among sex workers, but most respondents still have very low knowledge of laws and policies regulating sex work in Malawi. There is also limited capacity and coordination among implementers of intervention programmes in the country.

Verheijen et al. (2013) studied the prevalent “transactional sex paradigm”. This is a widespread explanation for why HIV infection rates are (sometimes much) higher among women. It claims that it is women’s economic dependence on men that drive them to risky exchanges of sex for material support. It does not necessarily only refer to sex workers, but may also refer to general sexual relationships between wives and husbands. The paper found that this paradigm is too simplified and overlooks many other important factors that lead to the outcome. The finding of this paper does not negate the important role of economic considerations in women’s decisions to engage in sexual relationships, and its potential effect on high HIV prevalence; having said that, it rules out that women involved in risky sexual practices are necessarily in acute need and have no other options to survive. First,

there are many aspects other than direct economic dependence on men that encourage women to engage in risky sexual relationships, especially those about cultural and social norms for gender roles, and the concept that regards economic support from husband as a symbol of love. Second, even if there are income-generating opportunities for women, they generally consider these as a less preferred option compared to economic dependence on men. This paper documents that women who are not economically disadvantaged also sometimes choose to engage in risky sexual relationships that expose them to HIV. The findings imply that the acclaimed solution of supporting women with income-generating activities may not be enough to affect sexual behavior if its other drivers are not addressed.

Only 29.5%

of sex workers indicated having access to HIV testing and counseling

3.1.6.5 Persons with albinism

When it comes to persons with albinism – a relatively rare, non-contagious, genetically inherited condition that affects people worldwide, resulting from a significant deficit in the production of melanin, which causes partial or complete absence of pigment in the skin, hair and eyes – there is limited information about its prevalence in Malawi. The 2018 Malawi Population and Housing Census found that there are 134,636 persons with albinism in Malawi and that 51.4% are females. People with albinism in Africa may face more problems than those on other continents , because albinism stands out in a population with dark skin, tropical climate causes severe skin problems, and the majority of those affected suffer from stigma and are precluded from accessing basic opportunities such as education (Braathen and Ingstad, 2006). Persons with albinism are marginalized and discriminated. Between 2014 and February 2018 Malawi registered 148 crimes perpetrated against people with albinism (Amnesty International, 2018). There has been a steady increase of human rights violations of people with albinism and their lives are endangered because of abductions, killings and exhumations. It is estimated that 72% of the victims of atrocities against persons with albinism are children (Government of Malawi, 2018). Misperceptions and wrong beliefs about people with albinism are prevalent. Having a child with albinism is believed to be a misfortune and connected to witchcraft. People also believe that touching the skin of a person with albinism brings bad luck. Other people hold beliefs which lead to abduction and exhumation of people with albinism. For example, some people believe that potions made from body parts of persons with albinism are so powerful that they can bring one good luck in business and protection from evil. There are also people who believe that persons with albinism can provide a cure to some chronic illnesses, e.g., having sex with a person with albinism can cure HIV and AIDS.

Ensuring basic human rights of people with albinism can be challenging. Most of them face discrimination and stigmatization, which prevent them from accessing basic social services; some parents or guardians of children with albinism also withdraw them from schools (Government of Malawi, 2018). Many people with albinism are silently abducted and killed by other citizens for the purpose of witchcraft rituals. Other people with albinism die of skin cancer and other related health problems because they are untreated and lack knowledge on these conditions. These people may even be treated as a commodity which can be used for other purposes or just sold for money. According to Braathen and Ingstad (2006), people with albinism have problem with strangers even if their own family accepts them. People spit on the floor whenever they see a person with albinism so that they will not have a child with albinism. Further, people with albinism also have difficulties finding a job because they are believed to have a short life and will die very young. A recent study found that persons with albinism, especially women and girls, are at risk of being sexually abused due to the prevailing belief that having sex with them constitutes a cure for AIDS (Amnesty International, 2016).

3.2 Consequences of SGBV, IPV and harmful practices

3.2.1 SGBV

SGBV may lead to several negative consequences for its victims. Sexual abuse often leads to mental, social, or physical problems in the victims (Kvam & Braathen, 2008). SGBV affects women and girls' health and strips them of their dignity. According to the Center for Disease Control and Prevention, et al. (2014), females aged 18 to 24 who experienced childhood sexual abuse were significantly more likely to have been drunk in the past 30 days or have ever thought of suicide compared to those who did not experience childhood sexual abuse. Malawian females aged 13 to 17 years who experienced sexual abuse were significantly more likely to have STI symptoms compared to those who didn't have such experience. Females aged 18 to 24 years who experienced physical violence were significantly more likely to have thought about suicide, to have experienced mental distress or to have reported symptoms of STI compared with those who didn't have such experience. The report also stresses that experiencing emotional violence also leads to more mental distress.

According to Malawi's Ministry of Gender and Social Welfare (2014), SGBV is also correlated with HIV and SRHR. Violence can interfere with women's ability to access treatment and care and maintain adherence to ARV treatment. On the other hand, having HIV is also a risk factor for SGBV. People report experiencing violence after disclosure of HIV. Thus, a vicious cycle of increasing HIV and SGBV is established. Sexual abuse also leads to unwanted pregnancy for more than a third of victims, and then leads to more unsafe abortions which undermines their reproductive health rights (Center for Disease Control et al., 2014; Ministry of Gender, 2014).

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In addition to negative consequences on individuals, SGBV also has negative societal consequences. The Ministry of Gender (2014) reports that SGBV drains a country's resource and prevents women from making contributions to social and economic progress. Violence not only strains on health care and judicial systems, but also lowers worker productivity, lowers rates of accumulation of human and social capital, and decreases labor market participation. Handling cases through formal courts brings high economic cost per case. Overall, the direct economic cost of handling physical domestic violence cases in 2013 in Malawi is estimated at MK 877 million or US$ 2,698,462, which could have been used for other productive uses for wealth creation (World Bank, 2018).

SRGBV can have serious negative effects on the student victims. High prevalence of violence makes children feel unsafe and unprotected, leading to absenteeism, increased school drop-outs and decreased retention rates (Imani, 2015). According to McDermott (2016), 60.9% of the girls claimed that violence at school adversely affected their performance, and 3.3% said they stopped attending school due to perpetual violence. Experiencing violence in primary school negatively affects girls' ability to access education. SGBV also often puts girls and women at higher risk of contracting HIV (McDermott, 2016).

3.2.2 IPV

IPV can cause various problems in both physical health and mental health, for both the female victims and their children. First, IPV may lead to serious physical health problems for the victims. The most obvious damage is physical injury. According to World Health Organization (2012), the injuries include bruises and welts; lacerations and abrasions; abdominal or thoracic injuries; and various damages on different

parts of the body. In the most serious situation, the violence can even lead to homicide by the perpetrator. In addition to physical damage, there are sometimes also 'functional disorders' or 'stress-related conditions', which cause different pain syndromes. Mwanza (n.d.) mentioned that IPV such as marital rape or forced sex may also cause unplanned pregnancies and may have negative consequences on women's health in a study about people living with HIV in Malawi. The Ministry of Gender (2014) also found that women experiencing IPV have more difficulty using family planning in an effective manner. They are more likely to have a partner who is not willing to use contraceptive methods and have higher rate of unintended pregnancies, and thus more unsafe abortions.

Intimate partner violence

not only affects the female victims, it also has negative consequence on their children

Besides physical violence, sexual violence also causes serious health problems, especially on SRH. The World Health Organization (2012) claims that IPV leads to negative SRH consequences including unwanted pregnancy, abortion, STIs including HIV, pregnancy complications, pelvic inflammatory disease, urinary tract infections and sexual dysfunction. IPV is also linked to mental health problems and suicide. The World Health Organization (2012) further reports that abused women are more likely to suffer from depression, anxiety and phobias than non-abused women. They also have more emotional distress, thoughts of suicide and attempted suicide.

IPV not only affects the female victims, it also has negative consequence on their children. Studies show that children from families with IPV are more likely to have anxiety, depression, poor school performance and negative health outcomes. Young participants generally regarded IPV between parents as shameful, leading to a sense of hopelessness, threatening their feelings of security at home, and social and educational development (Chepuka et al., 2014). The exposure to IPV in childhood is also shown to lead to male perpetration and female experience of IPV later in life (World Health Organization, 2012) because children may imitate parents' bad behaviors and they develop the perception that IPV is normal and should be accepted growing in such environment.

3.2.3 Harmful practices

3.2.3.1 Child marriage

The practice of child marriage has consequences both on the individual as well as the societal level. Early marriage has been found to be in many cases associated with profound psychological and physical distress due to the loss of adolescence, forced sexual relations, IPV, and early confinement to household roles (Yarrow et. al.,

2015; Erulkar, 2013; Speizer and Pearson, 2011; UNICEF, 2005, 2007). Child marriage may, moreover, be responsible for low educational attainment because young brides typically have not yet completed their education and continued school attendance after wedlock is extremely rare (Baird et. al., 2011; Duflo et al., 2015; Osili and Long, 2008; Parsons et al., 2015). In an intriguing study, Field and Ambrus (2008) document the causal effect of child marriage on educational attainment of girls in Bangladesh by exploiting variation in the age at menarche. Based on self-reported data from rural Bangladesh, the results of this study suggest that postponing marriage by 1-year increases schooling by 0.22 years.

Apart from depressing effects on educational attainment of girls, early marriage may also reinforce gender-based power inequalities among the spouses, since it is typically the bride who enters into union as a child while the groom is usually an adult (Otoo-Oyortey and Pobi, 2003). In fact, since the difference in age between the husband and the wife is in most societies inversely related to female age at marriage, child marriages are characterized by especially large spousal age gaps. Child marriage is furthermore associated with early childbearing, which in turn has been shown to cause higher maternal mortality (death) and morbidity (disability or long-run health deterioration), as well as infant mortality (Mathur et. al., 2003). Early marriage not only predicts early childbearing but is associated with poor fertility outcomes more generally. Shorter birth intervals and a higher risk of unwanted pregnancies among child brides may suggest that girls who marry young are in a worse position to defend their interests against their husbands (Raj et. al., 2009).

Finally, younger brides have also been found to be at greater risk of HIV infection compared not only to sexually inactive girls, but also relative to their sexually active unmarried peers. For example, young married girls in urban Kenya and Zambia report lower condom use than their sexually active unmarried peers while at the same time engaging in sexual relations with their husbands who are on average older and more likely to be HIV-positive compared to the boyfriends of unmarried girls at the same age (Clark, 2004).

The practice of child marriage arguably affects not only the child bride/groom and her/his immediate environment, but also produces long lasting effects at the societal level. Societal consequences from child marriage may stem from the fact that child brides are often ill-prepared for their role as mothers, which can harm the well-being of the next generation (UNICEF, 2001). Also, disempowerment of women through the practice of child marriage not only harms the girls that are being married off as children but may moreover have negative consequences for the social and economic well-being of the society as a whole. Women's empowerment has repeatedly been argued to be beneficial for the economic development of a society and to the extent that early marriage hinders girls from unleashing their full potential, reducing the prevalence of child marriage can be beneficial for the society as a whole (Duflo, 2012).

3.2.3.2 Initiation rituals

When it comes to initiation rituals, Rehema et. al. (2014) found that 13% of the girls who underwent initiation rituals in Morogoro, Tanzania expressed that attending these weeks long initiation rituals wasted their precious school time. Sixty one percent (61%) of the girls also mentioned that they dropped out of school or were absent from school because of the initiation rituals. Rehema et. al. (2014) also found that over half of the girls mentioned mistreatment during the rituals: being shouted at, beaten, slapped, and even pinched; and they felt humiliated when asked to stand nude before elderly women for "cleansing". Some girls even experienced psychological and mental trauma. Boys also experienced similar situations. Studies conducted in Malawi have also found that boys and girls experience physical violence during initiation ceremonies and Invest in Knowledge (2015) reported that over 22% of the boys and girls going through initiation rituals in Malawi have an objection against bullying and beating during the ceremony. Such mistreatment could lead to physical and psychological injury of participating boys and girls.

Halley (2012) explored the initiation rituals, both for boys and girls, in Tanzania, and concluded that the initiation rituals are a result of the socio-economic environment of the country, and in turn reinforce the socio-economic dynamics of Tanzania. The boys' rituals jando and the girls' rituals unyago mark the transition from childhood to adolescence (ukubwa), and the rituals prepare boys and girls for the transition, and communicate the traditional norms, values and expectations of the sexual roles of men and women in the society. It especially emphasises the high value of girls' reproductivity and expects girls to be economically supported by her husbands. The rituals solidify the social role of women as watu wa kupewa ("those who are given to"), and social role of men as tegemezi ("those who are depended on"). Then marriage is merely a market – men provide economic support for women, in exchange for women's reproductivity to bear children and manage the household. Such social norms are passed on through initiation rituals for generations in Tanzania.

Maambo (2007) conducted a similar research in Zambia regarding the Nkolola initiation ceremony. Girls were taught in the ceremony how to run their homes and how to satisfy their husbands during intercourses. Even though the author listed it as positive effect and praised it as "a powerful tool of bringing about unity in the society", it actually solidifies the social role of females as appendage of males and reinforces the idea of women being submissive to men. Gender inequality could gradually lead to GBV. A survey in Malawi (Bisika, 2008) shows that around 5% of the population think that initiation rituals encourage men to abuse women. As mentioned earlier initiation rituals are mostly concentrated in southern Malawi; hence considering only communities where initiation rituals are performed, increases this ratio considerably.

Some major issues raised by the Tanzanian girls interviewed by Rehema et al. (2014) relate to marriage and sex. Girls blame initiation rituals to be the cause of early engagement in sexual relations (mentioned by 54% of the interviewees), early childhood marriage (30%), and early pregnancies (39%). Maambo (2007) concluded in his study on the Zambian Nkolola initiation ceremony that young girls might want to experiment what they had learnt during the initiation as soon as possible. As a consequence, they ended up getting pregnant early, and had to enter early marriage. Some other girls, due to their zeal to experiment, go on to become exploited in prostitution. Mbozi (2000) raises a more significant consequence of initiation rituals – facilitating the wide transmission of HIV.

The author also points out that the emphasis of girls' initiation rituals on how to please their husbands in bed and meeting all the sex demand from their husbands induces submissiveness, and could disempower women to negotiate for safe sex. Under such social ideology, women insisting on safe sex could end up in divorce or being abandoned by their husbands. Activities involving sexual implications during the initiation ceremonies, for instance naked dance in public after nsondo in Malawi, are sexually exploitative and also increase the chance of girls contracting STIs including HIV. The naked dance is in public and everyone from the community is welcome to watch. Adult men, after watching the sexually implicative dance, might end up having sex with the girl dancers afterwards. Such sexual encounters can either be willingly or unwillingly and are usually unprotected hence putting girls at a high risk of getting infected with STIs (Ministry of Gender, 2013).

It is also well documented that the sexual abuse of children can lead to numerous psychological consequences, though not particularly focusing on sexual abuse during initiation rituals. Kendall-Tackett et. al. (1993) reviewed some studies and concluded that sexually abused children are more likely to suffer a variety of psychological symptoms including fears, post-traumatic stress disorder, behavior problems, sexualized behaviors and poor self-esteem. The effects could also be long-lasting with recovery taking up to 12-18 months for most victims. However, a sizeable group

of children even appeared to get worse. The scenario gets much worse when the initiation rituals include sexual intercourse. In Malawi, as part of puberty rites, a man called fisi (hyena) is hired to initiate the young girls into the sexual act and to test if they have mastered the sex lessons they learnt during the initiation ceremony. The involvement of fisi increases the risk of girls to contract STIs including HIV, as he is usually an older man who might already be infected with STIs from his frequent unprotected sexual intercourse. Munthali and Zulu (2007) draw a similar conclusion after they investigated the timing and content of initiation rituals in Malawi. They argued that boys and girls having undergone the rituals took such transition as a "permission" and implication to start having sex.

An important caveat is that all of the above consequences of initiation rituals are summarized based on interview or survey results. A statistical analysis done by Invest in Knowledge (2015) has rejected the hypotheses that initiation rituals reduce the age at sex debut, that initiation rituals increase the number of sexual partners, that initiation rituals reduce the use of condoms, and that initiation rituals increase the chance of having transactional sex. This further objects the correlation and association between initiation rituals and reproductive health practices. New causal evidence has found that rainfall shocks that decrease the probability of initiation rituals also decrease the probability of child marriage later on, above and beyond mechanical effects of getting pregnant as a result of initiation (Feng, 2019).

Secondly, a critical open question when it comes to initiation rituals is the extent to which labia stretching has harmful consequences, as its prevalence in initiation rituals in Malawi is nearly 50%, with not much variation across regions (National Statistical Office, University of Zurich, Centre for Social Research 2019). There are in general two streams of consequences. First, health problems as the ritual can result in multiple complications and physical impairments. For example, Verzin (1975) systematically documented, in professional medical terms, 5 immediate complications and 10 remote complications, both physically and psychologically. The World Health Organization (2017) summarizes the complications in a plainer language. The immediate complications (during or right after the operation) include severe pain, excessive bleeding (haemorrhage), genital tissue swelling, fever, infections (e.g. tetanus), urinary problems, wound healing problems, injury to surrounding genital tissue, shock, and death. Long-term consequences include urinary problems (painful urination, urinary tract infections), vaginal problems (discharge, itching, bacterial vaginosis and other infections), menstrual problems (painful menstruations, difficulty in passing menstrual blood, etc.), scar tissue and keloid, sexual problems (pain during intercourse, decreased satisfaction, etc.), increased risk of childbirth complications (difficult delivery, excessive bleeding, caesarean section, need to resuscitate the baby, etc.) and newborn death, need for later surgeries (e.g. deinfibulation is needed for sexual intercourse and childbirth if infibulation/type III FGM/C was performed), psychological problems (depression, anxiety, post-traumatic stress disorder, low self-esteem, etc.).

3.2.3.3 FGM/C

Lastly, issues related to understanding FGM/C as a violation of human rights. Shell-Duncan (2008) summarizes the argument. FGM/C violates the Declaration of the Rights of the Child: every child should have the opportunity "to develop physically, mentally, morally, spiritually and socially in a healthy and normal manner and in conditions of freedom and dignity" (UN General Assembly, 1959). It also violates the UN Convention on the Elimination of All Forms of Discrimination against Women (CEDAW): all states must "modify the social and cultural patterns of conduct of men and women, with a view to achieving the elimination of prejudices and customary and all other practices which are based on the idea of gender inequality" (UN General Assembly, 1979). What is more, if FGM/C is defined as a form of torture, it also breaches freedom from torture. Last, FGM/C violates the Universal Declaration of Human Rights: "everyone has the right to a standard of living adequate for the health and well-being of himself" (UN General Assembly, 1948).

3.3 Causes and drivers of SGBV, IPV and harmful practices

This literature review discusses risks and protective factors associated with SGBV, IPV and HPs within the framing of the causes and drivers of those practices. Rather than merely describing statistical associations between characteristics and the incidence of those different forms of violence or limited access to rights (which is often what is understood by risk analysis), the survey focuses on the causal drivers of their incidence. The reason is that associations are often misleading for programming and policy design: those do not provide clear guidance for action with respect to links between incidence and individual characteristics that cannot be changed, and, most importantly, those lead to mistargeting when underlying causes change — breaking down statistical associations in previous data. In contrast, causal drivers are meant to capture underlying mechanisms, pointing out clear constraints that need to be addressed by policies and programs, either in isolation or altogether to activate system's change.

3.3.1 Intrinsic motivations: values, culture and religion

Intrinsic motivations are an important driver of behavior and may be affected, among others, by religion, culture or educational attainment. However, people differ in terms of their commitment to traditional practices or their receptivity of educational messages. Hence, while traditions or education may certainly affect intrinsic motivations, their effects may not be the same for every individual.

On top of shaping an individual's private world view, religious interpretation also acts as a cultural system defining the set of approved social behaviors and practices. While personal faith can be an important source of intrinsic motivation to act according to the prescribed behavior, social sanctions associated with deviation from those norms provide additional extrinsic motivations. Efferson et al. (2017) documents that, for the case of FGM/C in Sudan, intrinsic motivations are as least as important in determining attitudes about cutting as marriageability concerns. Initiation rituals are embodied in some religions. Krige (1968) has documented a Zulu puberty rite in honor of Inkosazana or Nomkhubulwana, a maiden deity for agriculture in Zulu religions. The puberty rites serve as part of the religious ceremony. The author argued that fertility is "an important value and the object of many rituals" and is crucial to "fully understand the nature of African religion".

Above and beyond religion, other intrinsic motivations may matter for the persistence of those practices. Early marriage has been repeatedly linked to the threat of premarital sex or more vaguely the potential loss of a girl's "purity". Across many societies, a high value is placed on the virginity of the bride (Broude & Greene, 1976; Schlegel, 1991; Schneider, 1971). In societies that practice child marriage today, concerns related to the perceived threat of a daughter losing her virginity before wedlock are often cited as a motivation for parents to marry off their daughter early (Yarrow et al., 2015; Gottschalk, 2007; Jones et al., 2014; Nour, 2009). Wahhaj (2015) develops a theoretical model of early marriage, in which the bride's "purity" is considered an asset on the marriage market that cannot be observed directly. Based on the assumption that "purity" is constantly at risk and may get lost over time, agents in this model use the age of a bride as an indicator of her expected "purity". An interesting feature of this model is that it can explain how the practice of early marriage may persist even in the complete absence of any intrinsic preference for young brides. This is in sharp contrast to much of the literature on early marriage, which takes a preference for young brides as given, and motivates the question whether it is truly the bride's youth that is ultimately valued in child marriages. Furthermore, teenage pregnancies can also lead to child marriage for the same reason: the teenage pregnancy is considered legitimate and the pregnant girl is still "pure" if she marries after the pregnancy and before delivering the baby (Chilman, 1979). In Malawi, especially in the South, the co-existence (and reinforcement, according to Feng, 2019) of sexual initiation and child marriage indicates that "purity" concerns are unlikely to play an important role.

Early marriage

has been repeatedly linked to the threat of premarital sex or more vaguely the potential loss of a girl's "purity"

Last, there exists convincing evidence suggesting that higher levels of education can indeed help to delay a girl's typical age at marriage. The causal chain through which education affects the timing of marriage is, however, less clear. A large strand of the literature posits that education of girls leads to enhanced autonomy and negotiating skills as well as higher professional aspirations. A mechanistic relationship between education and the age at marriage may also account for some of the correlation. Furthermore, educational attainments in one generation may affect the age at marriage of girls in the next generation. Girls with fewer years of formal education have on average married at a younger age relative to those who achieved higher education levels (UNICEF, 2007). The most compelling source of evidence for a causal effect of educational empowerment on the typical age at marriage stems from interventions that aim at reducing the incidence of early marriage through fostering school attendance or improving the quality of education. Duflo et. al (2007) report results from a randomized controlled trial based on a large sample of 328 schools in rural Kenya involving a treatment arm that reduced the costs of education by paying for school uniforms. The authors find that the treatment significantly lowered the risk of child marriage. More precisely, girls in schools where free uniforms were provided are 2.5 percentage points (or 15%) less likely to have dropped out of school and 1.4 percentage points (or 12%) less likely to have married during the intervention period. Overall, these results may be interpreted as showing that the reduced costs of education created incentives to delay marriage.

Beyond formal schooling, the Maharashtra life skills program (Pande et al., 2006) tested the effectiveness of non-formal education and empowerment of unmarried girls on the age at marriage in a rural India in 1998-99. The intervention consisted of one-year weekly life skills classes covering civic education, sexual health, and basic literacy. Moreover, the program actively tried to involve parents and other community members through regular workshops. After one-year typical marriage timing shifted towards later ages in the programme area, while it remained constant in the control area.

Intrinsic motivations can also be important in influencing SGBV behaviors. People from different religions, with different traditions, or from different education backgrounds may have very different perceptions about gender and gender norms. It leads them to have different acceptance about SGBV and thus affecting SGBV behaviors and help seeking behaviors after experiencing SGBV. Religion can be an important source to shape people's perception about gender roles and thus affecting SGBV behaviors.

The Ministry of Gender (2014) claims that illiteracy and low educational achievement constitute one of the underlying factors of SGBV. Females with higher education level may have a different perception about gender roles and may not accept GBV against them without reporting or seeking help. For males, higher education may also change their perception about gender roles and may learn to respect females more, thus preventing them from committing SGBV against females. This is supported by findings from Munthali et al. (2018): in their baseline survey for young people in Malawi, they found that the proportion of respondents in secondary school who reported that they treated girls fairly, the proportion who think that girls are as important as boys, and the proportion who think men and women should take equal responsibility for household chores and childcare were higher than those in primary school. The study found similar results regarding attitudes towards sexual violence. Respondents in primary school were more likely to agree that "girls wearing less clothing provoke boys", and that "it is a girl's fault if she is sexually harassed" than respondents in secondary school.

3.3.2 Extrinsic motivations: economic incentives and social and legal sanctions

Extrinsic motivations – law enforcement, social sanctions and economic incentives – also affect decisions around adhering to traditional practices and prescribed gender roles. This section starts by discussing the effects of formal laws forbidding certain practices or mandating service. While there is evidence that laws establishing minimum age for marriage significantly affect reported marriage ages in Ethiopia[6], it is much less clear whether those are merely reporting effects or real behavioral

6 Jonas Hartmann (2019) "Can Access to Credit Mitigate the Effects of Liquidity Constraints on Child Marriage?", UZH Masters Thesis.

change. Many scholars claim that legally forbidding certain practices may only throw them underground – making them harder to monitor while having little effect on actual prevalence. In Malawi, analysis drawing on data from the 2018 National Survey on the Prevalence of Harmful Practices documents that establishing a minimum legal marriage rate of 18 years old in 2017 did not even significantly affect reported marriage rates (the distributions of those marrying right before and right after 2017 are statistically identical close within a close range of the 18-year threshold). Nevertheless, interventions have been shown to successfully decrease support towards early marriage (Haenni and Lichand, 2019). This suggests that legally barring certain practices is neither a necessary nor sufficient condition to deter those practices. Conversely, mandating the provision of certain services (with universal coverage or focused on vulnerable groups) is clearly insufficient to ensure that those at risk can successfully access SRHR, although it might help by creating social pressure or influencing legislative bargaining, e.g. increasing funding towards those services.

Regarding normatively prescribed behaviors, traditional practices and gender roles are embedded and rooted in various religious and other socio-cultural practices in many regions. It might seem therefore important to involve the related religions to fight child marriage. To the extent that religious leaders have some leeway in how to interpret religious precepts and provided that the community is receptive to their preaching, personal opinions of religious leaders may have a wide reach and influence the mode of conduct of many members of the community. Increasing attention and focus have been given on faith-based organizations and viewing them as "legitimate actors in the quest for development and transformation" (Haar & Wolfensohn, 2011). Leaders of religions and faith-based organizations are to some degree at grassroots level and can therefore have influence where the State cannot (UNFPA, 2005). Their influence lies in daily contacts within the communities (Greene et. al., 2015), and is, in some regions, much more intense and more influential than that from the State or other sources, especially on the aspect of daily lives within the community.

Involving religions

to fight child marriage

Having said that, the relationships between faith and initiation or child marriage is not straight forward and can vary across different communities (Gemignani & Wodon, 2015). In Malawi, a 2018 national survey has documented that village chiefs and traditional authorities are regarded as much less important stakeholders to initiation rituals and child marriage than previously thought. For initiation rituals, according to both chiefs and

villagers (independently surveyed), chiefs exercise some power – confirmed by the experiment in Haenni and Lichand (2019). This is presumably the case because such rituals occur in coordination across the whole village, once a year, and those in positions of power can charge high amounts for individual participation, sometimes as high as MK 50,000 (NSO et al., 2019). However, village elders are regarded as much more influential to that decision. For child marriage, traditional authorities are not considered (by either villages or themselves) as influential at all. The differences are confirmed by the experiment in Haenni and Lichand (2019), which randomizes whether chiefs can exercise control over a new signal introduced in their communities – donation boxes and colourful bracelets, distributed to those who donate two kilograms (2 kg) of maize to be redistributed to the poorest in the village. They find that, on average, introducing the new signal substantially decreases support towards both child marriage and sexual initiation rituals. Whether chiefs control the new signal or not makes a dramatic difference when it comes to support for the sexual component of initiation rituals: when another village is responsible for the box and bracelets, the intervention backfires as support actually increases. For child marriage, however, it makes no difference whether the chief handles the new signal or not.

The fact that chiefs and traditional authorities matter for initiation rituals suggests that targeting them might be promising not only for removing their sexual component, but also for using those to combat the spreading of STIs including HIV. The reason is that initiation rituals are, to their participants, the first and most essential channel for obtaining knowledge regarding sex. Kapungwe (2003) surveyed the initiation rituals in Zambia, where rituals are mostly conducted by professional initiators. He found out that no initiator mentioned anything about using condoms in initiation rituals they facilitated. Moreover, over half of the initiators oppose the encouragement of condom use. However, further investigation showed that this high percentage was majorly driven by initiators with no education. Furthermore, almost all initiators were willing to learn the knowledge of condom use. He, therefore, suggested interventions to educate the initiators about the advantage of using condoms, and through the initiators and initiation rituals to teach girls the importance of safe sex to fight HIV transmission. However, caution is needed as this could be against the social norms and initiators, even after being educated about condom use, could still refuse to teach the use of condom during initiation rituals. Munthali and Zulu (2007) suggest that in communities where a high proportion of adolescents go through initiation ceremonies, community leaders could be sensitized to promote abstinence and use of protective mechanisms including condoms in the ceremonies, to combat the high prevalence of HIV and teenage pregnancies.

Regarding economic incentives, Klepp et al. (2008) expressed the idea that the establishment of cash economy by the colonists in Africa had facilitated girls and boys to escape from the initiations. The logic is that the colonial regimes attract adult labors to work in cash cropping, mining and other fields other than domestic

cropping. Such work separated husbands from wives, parents from children. The younger generations gained more individual freedom from their parents and from adult authority. It became harder for parents to inculcate norms and rules into the next generations. The initiation rituals, like many other pre-colonial rituals, relied much on ideologies of inequality between the old and the young. The weakened authority of the old, as the result of the cash economy, also weakened the coerciveness of the rituals, and the young took the advantage to escape the rituals. Having said that, prevalence is still high – especially in the South of the country – and studies show that households in urban areas also send their children to initiation camps, with both boys and girls going back to their natal villages to undergo initiation ceremonies.

Bride prices are among the most often cited potential drivers of child marriage. However, the debate about the nature (and relatedly the causes) of these marriage payments is far from being settled. An important lesson from the literature is that there exists a variety of motives for marriage payments and determining the nature of the transaction at hand must be integral part of any research on bride prices and their effect on early marriage. Payments between the respective families of the bride and the groom at the time of marriage have been a cultural practice in most societies over the course of history. Bride prices have been cited as important incentives for early marriage.

In face of bride prices, poverty has been established as a typically important driver of early marriages of girls. Independent of the aggregate economic performance of a given country, girls from low-income families are more likely to be affected by child marriage than their peers growing up in wealthier families (UNICEF, 2005). In patrilineal communities as found in Nsanje and districts in northern Malawi, many children marry before the age of 18 years mainly due to poverty. Their parents and guardians may marry them off to get bride price popularly known as lobola (Munthali et al., 2017). Other factors such as negative rainfall shocks that affect income significantly increase the probability of marriage under-15 (Feng, 2019). It is often argued that daughters may be considered a financial burden to their families. Hence, parents may have incentives to marry off their daughters early, since this means both lower dowries and one less mouth to feed. Similar arguments hold for bride prices. Corno and Voena (2016) find that adverse economic shocks, including flood or drought, to the family of a young girl increase her probability of getting married, which suggests that girls may be “sold off” to overcome an unexpected financial bottleneck. At the same time, early marriage itself is believed to be a driver of poverty due to its depressing effect on educational attainment and labor force participation. Hence, poverty and early marriage may mutually reinforce each other in a vicious cycle (Handa et al., 2015; Parsons et al., 2015). See also Munthali and Kok (2016), which shows that, in Machinga, girls look forward to marrying young men who have gone to South Africa – when they come back many girls are attracted to get married to them as a way of running away from poverty.

Addressing poverty

directly could be a promising way to decrease child marriage

If that is the case, addressing poverty directly could be a promising way to decrease child marriage. Baird et. al. (2010) report the results from a large-scale cash transfer program conditional on school attendance that was conducted among girls aged 13-22 in Zomba district in southern Malawi. The conditional cash transfer was offered to all girls irrespective of whether they had attended school or not before the onset of the intervention. The study finds that girls who returned to school had a 40% lower marriage rate during the first year of the intervention relative to girls who were not offered any payment. However, no significant effect of the conditional cash transfer was found for girls who already attended school at the onset of the intervention.

The Berhane Hewan Program (Erulkar and Munthengi, 2007, 2009) was a package of interventions carried out in rural Ethiopia over the period 2004-2006 with the aim of reducing the prevalence of child marriage. The treatment comprised regular meetings of adolescent girls in groups led by female mentors, giving in-kind support (free provision of school materials worth US$ 4 over the course of a year) to girls if they stay in school, offering non-formal training in livelihoods skills, organizing community-level discussions on early marriage and reproductive health, and offering rewards (a goat worth US$ 20) for families if they do not marry off their daughter during the period of the project. Hence, the programme was both designed around strengthening girls' empowerment (assignment of female mentors, training in livelihood skills) as well as around shaping incentives for school attendance (provision of free school materials). In the treatment village, the rate of child marriages among girls aged 10-14 strongly declined over the project period, while the same change could not be observed in the control village. Interestingly, however, the data suggest that marriages in the treatment village were simply delayed into later phases of childhood and the intervention failed in pushing the typical age at marriage beyond the 18th birthday. Results suggest that a combination of interventions may effectively reduce the incidence of child marriage among young girls.

Whether or not the labor market offers young women well-paying jobs crucially shapes the incentives involved when deciding on the timing of marriage (Becker, 1981). This is especially true for contexts in which married women are expected to take on household roles, such that only premarital labor market participation may be more feasible, and marriage comes at the opportunity cost of giving up wage income. Moreover, exposure to formal work environments with personal wage payments and the mobility associated with employment outside of the home may

arguably have empowering effect on girls, which can induce them to postpone their marriage. Chowdhury and Trovato (1994) for example, studied the interaction between female premarital work histories and female age at marriage in the five Asian countries of Bangladesh, Pakistan, Nepal, Sri Lanka, and Malaysia and found that not only pre-marital work in general predicts a higher age at marriage, but also that the effect is largest for girls who worked in cash oriented jobs instead of being employed in family enterprises.

Jensen (2012) assesses the causal impact of enhanced labor market opportunities on young women's marriage and fertility decisions by conducting a randomized experiment, in which job recruiters for the business process outsourcing (BPO) industry were assigned to 80 randomly selected rural villages in India. Labor market opportunities for women in the treatment villages were enhanced through organized recruitment sessions and cost-free assistance in the application process over a period of three years. The BPO industry offers relatively well-payed jobs for women, but awareness of these opportunities is allegedly still limited. While treatment and control villages were similar at baseline in terms of labor market participation and school enrollment, in the endline survey significantly more women in the treatment villages worked away from home for pay (23.4% vs. 21%), were enrolled in vocational training (2.8% vs. 0.5%), or claimed they hoped to work before getting married (43% vs. 30%). Women (aged 15–21 at baseline) in treatment villages were 5.1 percentage points (or 17.2%) less likely to have married during the three-year intervention. Hence, the relatively moderate effect on employment was accompanied by considerable changes in human capital investment, work expectations and even marriage decisions.

Economic conditions also play a role for SGBV. Low economic status and limited economic empowerment of women are regarded as one of most important factors of SGBV. The unequal power relations between men and women ensures male dominance over females (Ministry of Gender, 2014; van Eerdewijk et al., 2018). If females are very weak in economic conditions, they sometimes must accept sexual violence against them to survive. According to Gorden and Crehan (2003), sexual violence is a gender-based issue which reflects social cultural, and economic inequalities between men and women. This is supported by the example 'fish-for sex' in Nkhotakota in central Malawi where males dominate the fish market and women have to exchange sex for fish which makes them vulnerable to HIV (Abankwah, 2017). Economic incentives are especially important for poor and young girls. Such girls may accept sexual violence from older married men just for exchange of some money (Kvam & Braathen, 2008). In some technical and vocational colleges, female students reportedly sometimes get offered transport in exchange for sex by motorbike taxis and mini-bus operators, which is a type of sexual exploitation (STEP Research Series, 2017). Extreme poverty and lack of economic opportunities may also force women into prostitution. In such relationships, women have even less power to protect themselves from sexual abuse (McDermott, 2016). Pendleton et al. (2016) also claimed that women with few employment opportunities are prevented from leaving abusive relationships. Women living in poverty are more exposed to violence, given reduced opportunities for education and employment. Men living in poverty are also more at risk of committing violence out of anger and frustration at not having an income or job (van Eerdewijk et al., 2018).

Bates et. al. (2007) tested the hypothesis that educational attainment of women in one generation affects the timing of marriage of girls in the next generation, since women of the older generation may exert considerable influence in their roles as mothers or mothers-in-law. Women who have enjoyed higher education may for example hold different views regarding the appropriate timing of marriage relative to women who did not attend school and these diverging opinions may then influence the marriage arrangements for a daughter or the search criteria regarding an appropriate bride for a son. The study is set in rural Bangladesh where, according to the authors, mothers-in-law exercise extensive informal power over their daughters-in-law. They find that mothers' education attainment positively affects their daughters' age at marriage. A similar kind of analysis is conducted with respect to the education level of the mothers-in-law. Again, mothers-in-law with more years of schooling are associated with a higher age at marriage of their daughters-in-law. Moreover, the education level of mothers-in-law is positively associated with age at first birth of their daughters-in-law when controlling for age of daughters-in-law at time of marriage, which suggests that the educational background of mothers-in-law also affects for how long the contraception of the first child is delayed after getting married. Consequently, intervention programs that aim at shaping the social

norms or economic incentives of those people who ultimately decide over a girl's initiation or marriage choice must consider the relevant decision-makers, who might be completely unrelated prior to the decision – as in the case of prospective husband's family.

Another issue related to IPV is polygamy. The odds of suffering generalised controlling behavior, moderate physical and emotional abuse, high and complete abuse are all much higher for women in polygamous marriage than women in monogamous marriage (Chikhungu et al., 2019). In polygamy family, the power relations between a man and his multiple wives can be very unequal, and the wives mostly cannot negotiate for safe sex (Ministry of Gender, 2014). In child marriage, traditional norms regarding post-marital residence may strongly affect the power relations between parents and children, as well as between the spouses. In patrilocal societies, the bride traditionally moves in with her husband's parents and is expected to take over some of the household work previously done by the mother-in-law. Hence, post-marital residence affects whether daughters-in-law become important economic assets for the groom's parents, which may in term affect the timing of marriage. For example, there is anecdotal evidence that mothers in patrilocal societies prefer younger brides for their sons because a large age gap allows them to exert more informal power over their daughters-in-law (Lowes, 2018). If this is really the case, then child marriage may reflect the mothers-in-law's desire for a young bride rather than her son's own preference.

3.3.3 Beliefs, knowledge and attitudes

This sub-section turns to beliefs about what others do or expect one to do, focusing on inaccurate knowledge and attitudes linked to social norms as drivers of violence against girls and women and disregard for women's sexual and reproductive health rights.

First, subjects may adopt a behavior simply motivated by wrong information. In the case of SGBV behaviors, Southern Africa Litigation Centre (2017) claimed that the belief that if people with HIV have sex with virgins, they can get cured of their infection has given rise to incidences of raping children or women and girls with disabilities. Another wrong belief is that a person would get rich if he raped a woman or girl with a disability and this has also led to more SGBV against females with disabilities. Beliefs also affect SGBV behaviors through the belief about the prevalence of it. Believing that SGBV is common and widely accepted may increase the probability of committing such behaviors, while believing that SGBV is not common gives people less excuse to do it.

Second, the determinants of social image – beliefs about what others do or expect one to do – might be an important driver of traditional practices that harm girls and female adolescents, or of GBV more generally in Malawi. In a 2019 national survey, 40% of respondents point out that following traditions might help build a good public reputation (Haenni and Lichand, 2019). Beliefs about the social desirability of some behavior can shape behavior by determining both the expected social sanctions from not following a given behavior and the weight assigned to them. In a large-scale experiment, Haenni and Lichand (2019) introduce a new signal in Malawian villages through which villages can build social image: donation boxes and colourful bracelets, distributed to those who donate 2kg of maize to be redistributed to the poorest in the village. Boxes increase the share of those donating and dramatically changes the profile of those who donate. Perceptions change in a way consistent with the interpretation that it becomes harder to guess who is pro-social (altruistic, reciprocal and trustworthy), and subjects believe more villagers become pro-social even though this did not happen. As a result, the signaling value of traditions such as initiation and child marriage no longer contributes to a good social image in villages where those are prevalent, and support towards those practices fall by 20-30% within 5 weeks of the experiment. What is more, the results suggest that differences in support across villages reflect entirely social image concerns. The low cost of this intervention, which is both non-invasive and community-driven, suggests a promising new approach to protecting girls and female adolescents and for improving SRHR more broadly moving forward.

Coming back to SGBV, one reason why women and girls do not seek help after experiencing violence may be due to traditional perceptions prevent them from doing so. Gender stereotypes increase women's vulnerability while reducing their ability to seek help. In Malawi, understanding of SGBV is generally poor and acceptance of SGBV is pervasive (Mellish, et al., 2015). Many forms of SGBV continue to be accepted by both females and males, owing to persisting traditional gender norms, beliefs and practices that tolerate or justify SGBV (Southern Africa Litigation Centre, 2017). Some forms of SGBV have been culturally accepted and even endorsed in Malawi, hence making it difficult for victims even to report (STEP Research Series, 2017). The Center for Disease Control and Prevention et al. (2014) reports that the most commonly cited reason for not seeking help was not seeing violence as a problem. One-third of females aged 13 to 17 years old also reported feeling that the violence was their own fault. The tradition in Malawi makes it hard for female victims to express their emotions and experience. People prefer not to discuss embarrassing situation and pretend it does not exist. People who dare to mention anything are regarded as perverts (Abankwah, 2017). According to the Center for Disease Control et al. (2014), there is stigma around violent victimization in Malawi. The stigma may prevent victims of SGBV from reporting to others and seeking for help, which may foster even more SGBV (Pendleton et al., 2016; STEP Research Series, 2017).

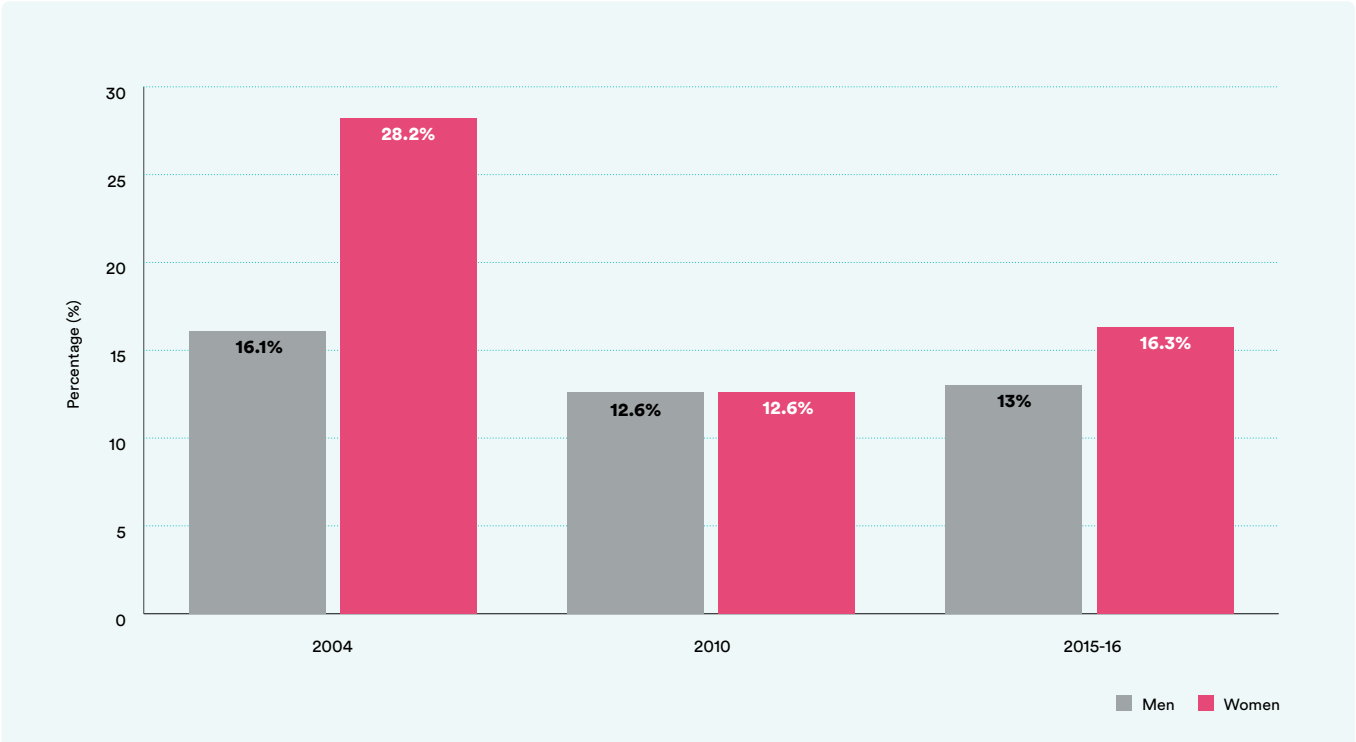
Also, when it comes to IPV, traditions shape people's perceptions. In Malawi, there is a general consensus that women do not have the right to refuse to have sex with

their husbands and IPV against wives should be accepted (Chikhungu et al., 2019). Wife battering is regarded as normal and occurs across all socio-economic and cultural backgrounds (NSO, 2004). Figure 25 shows the trends in the proportion of men and women who agree that a husband is justified in hitting or beating his wife for specific reasons.

The proportion of men who agree that a husband is justified n hitting or beating his wife for specific reasons has generally decreased over the period 2004-2015/16: it was 16.1% in 2004 and then 13% in 2010 and 2015/16. For women in 2004 28% of the women agreed that a husband is justified in hitting or beating his wife for specific reasons and this decreased to 13% in 2010 but slightly increased to 16% in 2015/16. Figure 25 also shows that the proportion of women who agree that a husband is justified in hitting or beating his wife for specific reasons is generally higher than men (National Statistical Office, 2017). In a baseline survey of two districts in Malawi (Mangochi and Nkhata Bay), 82.9% agreed that a woman should always obey her husband and 78.7% agreed that a woman should tolerate violence to keep her family together (Kelly & Daud, 2017). With this tradition, females believe that it's justifiable for their husbands to beat them or force them to have sex, and they should accept IPV without defying. There is even a so called "educational beating" where a man slaps a woman or uses a stick to beat the women as a sign of love and intended to bring about behavior change rather than divorcing the wife (Chepuka, 2013).

FIGURE 25

Proportion of men and women who agree that a husband is justified in hitting or beating his wife for specific reasons 2004-2015/16



The Center for Disease Control et al. (2014) found that 38.3% males between age 13 to 17 believe that it is acceptable for a husband to beat his wife in some situations, 44.7% believe that women should tolerate violence to keep the family together.

3.4 Key knowledge gaps

This subsection points out the key knowledge gaps with respect to SGBV, IPV and HPs in the context of Malawi, considering the literature review and of the key informant interviews (KII) with stakeholders from the main research institutions in the country.[7] The ultimate goal is to set out a research agenda to be carried forward in the country over the coming years. We divide this section into data gaps – further evidence on prevalence and incidence of SGBV, IPV and HPs, without which it is hard to set out evidence-based priorities – and research gaps – further evidence on consequences, causes and drivers of SGBV, IPV and HPs, without which it is hard to design programs and policies to protect females or extend access to rights in a cost-effective manner.

3.4.1 Data gaps

The review of the stylized facts about the prevalence of different forms of violence against females and about the access of vulnerable populations to basic sexual health and reproductive rights illustrates that Malawi is extremely well served in what comes to the quantitative assessment of the main issues, when compared to other countries of its income level or even to developing countries in general. A few gaps, however, remain, especially when it comes to the extent to which particular groups access sexual health and reproductive rights services, and the extent to which certain groups at-risk are exposed to violence.

1. What is the prevalence of violence against specific at-risk groups, such as elderly women and persons with albinism?
   According to the literature review, there is limited quantitative evidence on the extent to which elderly women are exposed to violence. The absence of precise national and regional figures makes it hard to establish priorities and mobilize resources to tackle those issues. Primary data needs to be collected, either by taking advantage of surveys already planned, or especially focused on that issue. It would be relevant to learn not only about the national prevalence, but also about whether it is particularly concentrated on certain regions.

7 The researchers also undertook KII to obtain information on institutional capacity and coordination above and beyond the research agenda, with the goal of informing the broader discussion linked to the establishment of a Research Observatory in the country. This broader discussion is not included in this report.

2. What is the share of female adolescents that access SHRH services?

According to both the literature review and KIIs, there is limited quantitative evidence on whether adolescent girls actually have access to information about their sexual health and reproductive rights, and whether they actually access the relevant services that grant them access to those rights. The absence of precise national and regional figures makes it hard to establish priorities and mobilize resources to tackle those issues. Primary data needs to be collected, either by taking advantage of surveys already planned, or especially focused on that issue. It would be relevant to learn not only about the national figures about information and access, but also about whether those are particularly low in certain regions.

3.4.2 Research gaps

In contrast to data, the summary of the literature on the consequences of and mechanisms behind the adherence to different forms of violence and to harmful practices points to important open questions. While which are the main issues comes across quite clearly from the available evidence (for the most part), the same is not true when it comes to why those issues are persistent and what are cost-effective policy instruments to tackle those.

Unfortunately, interviews with the key stakeholders in the country leave out most of the gaps identified from the literature review. The few ones that are touched upon by those interviewed are gender differences, parental engagement, and female participation in education and public spheres, all very broadly linked to drivers behind VAWG and unequal access to sexual health and reproductive rights. What is more, different interviewees referred to different gaps in research when it comes to SGBV, HP and SRHR. That indicates that even close networks and institutions that often partner and run research and consultancy work together do not have a clear picture of what are the research and evidence gaps in the country.

> **Best practices focused research;** which are usually prone from elsewhere without the full understanding of the context. There is a limited interface between practitioners and research specialists.

CENTRE FOR SOCIAL RESEARCH DIRECTOR

> **They come from a culture where there is no much space for decision-** making for girls and boys. We need to study that.

WADONDA CONSULT CO-DIRECTOR

> Two issues I would bring up are: **Participation of women in politics and gender & violence at the work place.**

NATIONAL STATISTICAL OFFICE COMMISSIONER

> **Cultural practices are a well documented issue,** but I really think there is a lack of data regarding adolescence and adolescents' issues.

CENTRE FOR DEVELOPMENT MANAGEMENT, PRIVATE CONSULTANCY (CDM) DIRECTOR

> **The gap is parental involvement.** We need more research in the household because children come from families.

CENTRE FOR REPRODUCTIVE HEALTH, COLLEGE OF MEDICINE, UNIVERSITY OF MALAWI (CRH) DIRECTOR

> **I think Education and Women.** Qualitative studies exist; but quantitative studies much less.

INSTITUTE FOR PUBLIC OPINION AND RESEARCH (IPOR) DIRECTOR

Only one of all interviewees also mentioned research about disabilities as an evidence gap, and none mentioned LGBTIQ issues or persons with albinism as part of the evidence gap.

Taking the literature review seriously points out the following research gaps:

1. ## How to decrease stigma in SGBV and IPV, since it limits reporting and access to services?

   While qualitative studies and some quantitative evidence support the claim that stigma in SGBV and IPV often limit the access to services that could prevent (further) violence against females in Malawi, there is no rigorous research piece (in the country or in a similar setting) addressing potential interventions that could decrease stigma (not to mention at low cost). This gap is critical, as removing stigma is expected to be a necessary condition in promoting access to basic services, whose impacts will, in turn, remain latent until those can actually reach their target audience. While there is research on stigma in other areas, especially in the context of social image, this literature review has not identified relevant research for the issues of interest to the Spotlight Initiative. Ideally, one or more qualitative studies should be undertaken to clarify what are promising ways forward in addressing stigma, followed by one or more RCTs to rigorously evaluate the impacts of those candidate interventions, and document the cost-effectiveness of each of them to increase access to information and demand for SHRH services.

2. ## What can be done to improve access to SHRH services by vulnerable groups (disabled women, female sex workers, LGBTIQ, elder women, and people with albinism)?

   Qualitative studies and some quantitative evidence support the claim that access to SHRH is especially low among vulnerable groups in Malawi, suggesting that those groups are especially hard to serve, above and beyond the challenges linked to stigma. Similarly, there is no rigorous research piece (in the country or in a similar setting) addressing potential interventions that could increase access to such services among vulnerable populations (not to mention at low cost). This gap is critical: extending access for the average target beneficiary can still leave behind those especially at-risk and exacerbate inequality. There is limited evidence on reaching the last mile in general, and particularly within the issues of interest to the Spotlight Initiative. Ideally, one or more qualitative studies should be undertaken to clarify what are promising ways forward in serving those groups, followed by one or more RCTs to rigorously evaluate the impacts of those candidate interventions, and document the cost-effectiveness of each of them to increase access to SHRH services among those groups.

3. What are the consequences of labia pulling?

The recent quantitative evidence on HPs in Malawi (NSO et al., 2019) documents that labia pulling is high prevalence, even though FGM/C is really not very common in the country. Whether this form of female genital modification is actually harmful is critical for programming and policy design. If so, it should be a national priority, monitored closely and subject to the same national and international efforts as those targeted at FGM/C elsewhere, where prevalence is considered to be at alarming levels. Given that the issue was under the radar until the 2019 national survey, there is no research piece assessing its potential medium- and long-term consequences for females physical and mental health. Documenting those will require one or more medical studies comparing different groups of females exposed differentially to the practice as part of initiation rituals. Ideally, such studies could leverage on natural experiments that determine some randomness on the extent to which girls in different villages participate in those rituals, such as rainfall shocks within the set of villages where those rituals are costly (see Feng, 2019). Such studies could be coupled with one or more ethnographic studies to look at this issue altogether with FGM/C (particularly high-prevalence in Phalombe, at 15%; NSO et al., 2019) to try to elucidate whether those who were exposed or who favor those practices perceive negative consequences (differentially for pulling and FGM/C).

4. When traditional authorities and village chiefs are not the key influencers, what is the optimal approach to decrease those practices? When they are, how to replace social expectations without backfiring?

The recent quantitative evidence on HPs in Malawi (NSO et al., 2019) documents that the influence of village chiefs and traditional authorities with respect to certain social norms is much more limited than previously thought. In particular, for child marriage, chiefs and villagers alike acknowledge that chiefs are not key decision-makers. In those cases, what programs and policies would have the highest potential to deter early marriages? This is a critical gap, as most international organizations have been focusing their work on those authorities for decades, with limited success. Should families be targeted directly, and if so, how? Should girls be targeted directly? If so, in isolation or altogether with the families? What is the right approach to young males likely to marry under-aged bridges? Ideally, one or more qualitative studies should be undertaken to clarify what are promising ways forward in addressing each of those stakeholders, followed by one or more RCTs to rigorously evaluate the impacts of those candidate interventions, and document the cost-effectiveness of each of them to decrease marriage under-18 and under-15. In contrast, when chiefs are deemed as important for certain social norms, such as initiation rituals, how to optimally intervene with chiefs and families/girls? To what extent

should interventions rely only on chiefs, target all stakeholders the same way, or address each stakeholder differentially? In other words, what is the most cost-effective policy-mix that targets multiple stakeholders at once when local elites play a role? Also, here, this is a critical gap: Haenni and Lichand (2019) point out that interventions that try to bypass them can backfire, and actually increase support to those practices. Ideally, one or more qualitative studies should be undertaken to clarify what are promising ways forward in addressing each of those stakeholders, followed by one or more randomized control trials (RCTs) to rigorously evaluate the impacts of those candidate interventions, and document the cost-effectiveness of each of them to decrease the harmful components of initiation rituals.

5. What would a program that tries to empower girls and female adolescents in Malawi look like? Also, how to target boys and male adolescents with messages that change mindsets and gender roles?

Recent quantitative evidence for Malawi points out that girls themselves appear as relevant decision-makers in most harmful practices (NSO et al., 2019). Having said that, little is known on what are optimal interventions to target girls directly. This is a critical gap that also shows up as a priority in the research agenda of some research institutions in the country in the KIIs. In line with evidence for Zambia from Ashraf et al. (2018), empowering girls could be a high-potential intervention to deter their exposure to harmful traditional practices. Having said that, what are cost-effective interventions that could successfully empower girls and teenagers in Malawi remains a critical research gap. What is more, should boys and male adolescents also be targeted? If so, what are the most cost-effective interventions to successfully affect traditional gender roles, inequality in access to rights and gender-based violence? Ideally, one or more qualitative studies should be undertaken to clarify what are promising ways forward in addressing each of those stakeholders, followed by one or more RCTs to rigorously evaluate the impacts of those candidate interventions, and document the cost-effectiveness of each of them to decrease self-initiated adherence to sexual initiation rituals and child marriage, as well as to decrease male support for those practices, conformity to traditional gender roles and engagement in gender-based violence.

6. How to break the inter-generational transmission of behaviors? What are the most effective interventions to break the vicious cycle?

Recent quantitative evidence for Malawi points out that families appear as relevant influencers in most harmful practices (NSO et al., 2019). Having said that, little is known on what the optimal interventions are to target parents directly.

This is a critical gap that also shows up as a priority in the research agenda of some research institutions in the country in the KIIs (parenting in particular). What are cost-effective interventions that could successfully break inter-generational transmission, with prior exposure boosting parents' promotion of harmful behaviors in the name of cultural persistence? What are the most cost-effective interventions to successfully affect parental transmission of those values and support of those behaviors? Ideally, one or more qualitative studies should be undertaken to clarify what are promising ways forward in addressing parents, followed by one or more RCTs to rigorously evaluate the impacts of those candidate interventions, and document the cost-effectiveness of each of them to decrease parental support and promotion of behaviors that harm girls and teenagers, and that decrease their opportunities to access SHRH rights.

7. How to increase female educational attainment, labor force participation, and political participation, issues that might be structurally linked to unequal opportunities for all females because of unequal participation in positions of influence in the Malawian society?

Those are issues pointed out as priorities in the research agenda of some research institutions in the country in the KIIs. While those go beyond the scope of the literature review, those issues are very plausibly linked to inequalities in treatment of females (issues which even developed countries struggle with). Ideally, a literature review of those issues and their linked to SGBV, IPV and access to SHRH services should be undertaken. Once those links have been properly documented, such findings can influence high-level discussions between different sectors or Ministries – as it will make it clear that the certain programs or policies cannot exclude a discussion of gender and violence against children. Those discussions can then provide clarity on how research institutions in Malawi active in the topics that concerns the Spotlight Initiative should be involved in the research efforts, at minimum to ensure that such links are reflected in the survey instruments designed to capture the effects of interventions targeted at improving education, employment or political participation of women. Concretely, such surveys should look beyond the immediate impacts of those interventions, to also document any potential (indirect) impacts on violence against females and access to SHRH.

CHAPTER 4

Conclusion

While Malawi is well served in what comes to the quantitative assessments of the main issues (for the most part, compared to other countries of similar development level), the ability of the relevant authorities to design programs to tackle those issues are limited by the lack of a coordinated research agenda, focused on priority issues that could inform program design. There are also challenges for Government and international organizations in taking-up evidence in program design, translating research findings into evidence-based programming to serve the population of Malawi. While this last challenge is all too common — by no means exclusive to Malawi — progress in coordinating a research agenda to inform programme design and strengthening organizational capacity of research institutions, is bound to bring benefits to the country's population.

This report has identified the following the key priority knowledge gaps:

- **What is the prevalence of violence against specific at-risk groups, such as elderly women and persons with albinism?**
- **What is the share of female adolescents that access SHRH services?**
- **How to decrease stigma in SGBV and IPV, since it limits reporting and access to services?**
- **What can be done to improve access to SHRH services by vulnerable groups?**
- **What are the health and social consequences of labia pulling?**
- **When traditional authorities and village chiefs, Nankungwis are not the key influencers, what is the optimal approach to decrease those practices? When they are, how to replace social expectations without backfiring?**
- **What would a program that tries to empower girls and female adolescents in Malawi look like? Also, how to target boys and male adolescents with messages that change mindsets and gender roles?**
- **How to break the inter-generational transmission of negative behaviors? What are the most effective interventions to break the vicious cycle?**
- **How to increase female educational attainment, labor force participation, and political participation, issues that might be structurally linked to unequal opportunities for all females because of unequal participation in positions of influence in the Malawian society?**

The Spotlight Initiative provides a unique opportunity to address those issues, as it entertains the possibility of a Research Observatory that would, by design, have convening power to steer the research activities towards the most important inputs required to deter violence against females and extend the access of sexual and reproductive health and rights in Malawi, especially among vulnerable populations.

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ANNEX 1

Guiding questions and references for the literature reviews

Question	References
a. What are the various forms of SGBV and HP against women and girls that exist in Malawi, and what is their prevalence?	Banda, F., & Kunkeyani, T. (2015). Imani Consultants. (2015). Munthali, A., & Kok, M. C. (2016). McDermont, S. (2016). GDN. (Not Dated). Human Rights Watch. (2014). Meerkotter, A. (2011). Ministry of Health. (2018). Ministry of Gender, Children, Disability and Social Welfare. (2015). Chikhugu, L. C., Amos, M., Kandala, N., & Palikadavath, S. (2018). Munthali, A., & Kok, M. (2018). Kelly, C. A., Mmelnikas, A. J., Amin, S., Mkandawire, J., & Daud, H. (2017). Ministry of Gender, Children, Disability and Social welfre. (2014). Barzargan-Hejai, S., Medeiros, S., Mohammadi, R., Lin, J., & Dalal, K. (2012). Cheputa, L., Taegtmeyer, M., Chorwe-Sungani, G., Mambulasa, J., Chirwa, E., & Tolhurst, R. (2014) Munthali, A. C., & Kok, M. C. (2018). Munthali, A., & Zulu, E. M. (2007). Munthali, A., Kok, M., & Kakal, T. (2018). National Statistical Office. (2011). World Bank. (2018). Mwanza, J. (2012). National Statistical Office. (2015). Phiri, G. R. (2006). Peser, E., Gondwe, L., Manyamba, C., Mhango, T., Phiri, W., & Burton, P. (2005). National Statistical Office. (2001). _____. (2005). _____. (2015). _____. (2017). van Eerdewijk, A., Kamunyu, M., Nyirinkindi, L., Sow, R., Visser, M., & Lodenstein, E. (2018). Ababkwah, R., Abankwah,D. (Not Dated). Wadesango, N., Rembe, S., & Chabaya, O. (2011). Chasowa, S., Kandodo, P. K., Jack, R. M., & Kambalu, R. (2015). ActionAid UK, Gender and Development Network, Womankind & IPPF. (Not Dated). Braathen, S. (2008).

Question	References
b. What are the drivers of these practices and what are the consequences of these practices to girls and women?	Munthali, A., & Kok, M. C. (2016). McDermont, S. (2016). GDN. (Not Dated). Human Rights Watch. (2014). Meerkotter, A. (2011). Ministry of Gender, Children, Disability and Social Welfare. (2015). Chikhugu, L. C., Amos, M., Kandala, N., & Palikadavath, S. (2018). Munthali, A., & Kok, M. (2018). Kelly, C. A., Mmelnikas, A. J., Amin, S., Mkandawire, J., & Daud, H. (2017). Ministry of Gender, Children, Disability and Social welfre. (2014). Peser, E., Gondwe, L., Manyamba, C., Mhango, T., Phiri, W., & Burton, P. (2005). Cheputa, L., Taegtmeyer, M., Chorwe-Sungani, G., Mambulasa, J., Chirwa, E., & Tolhurst, R. (2014) Munthali, A. C., & Kok, M. C. (2018). World Bank. (2018). Mwanza, J. (2012). Ababkwah, R., Abankwah,D. (Not Dated). Wadesango, N., Rembe, S., & Chabaya, O. (2011).
c. What is known about SGBV and HP among specific marginalized populations including women and girls with disabilities, women and girls with albinism, female sex workers, LGBTI, and elderly and widowed women, and/or in specific settings and/or locations in Malawi?	Dulani, B., Sambo, G., & Yi Donne, K. (2016). Kvam, M. H., & Braathen, S. H. (2008). Government of Malawi. (2018). Mji, G., Gcaza, S., Wazakili, M., & Skinner, D. (2008). Human Rights Watch. (2018). Mwanza, J. (2012). UNICEF, G. o. (2013). Wirtz, A., Trapence, G., Gama, V., Kamba, D., Chalera, R., Klein, L., . . . Baral, S. (2014) VIHEMA. (Not Dated). Southern African Litigation Centre. (2017). Skills and Technical Education Programme. (2017). Chasowa, S., Kandodo, P. K., Jack, R. M., & Kambalu, R. (2015). Chizimba, R., & Malera, G. (2014).
d. What is not known or unclear about SGBV and HP against women and girls in Malawi, especially as it relates to those women and girls particularly marginalized, isolated or discriminated against?	Kvam, M. H., & Braathen, S. H. (2008). Government of Malawi. (2018). Mji, G., Gcaza, S., Wazakili, M., & Skinner, D. (2008). UNICEF, G. o. (2013). Wirtz, A., Trapence, G., Gama, V., Kamba, D., Chalera, R., Klein, L., . . . Baral, S. (2014)

Question	References
e. What risk and protective factors are associated with SGBV and HP against women and girls in Malawi?	Munthali, A., & Kok, M. C. (2016). McDermont, S. (2016). GDN. (Not Dated). Chikhugu, L. C., Amos, M., Kandala, N., & Palikadavath, S. (2018). Barzargan-Hejai, S., Medeiros, S., Mohammadi, R., Lin, J., & Dalal, K. (2012). Pendleton, J., Mellish, M., & Sapuwa, H. (2016).
f. What is known or unclear about the introduction and implementation of laws and policies relating to SGBV, HP and SRH and their impact on prevalence of SGBV and HP?	Banda, J., & Atansah, P. (2016); Munthali, A. C., Chimbiri, A., & Zulu, E. (2004). ECPAT. (2016). E2A Project. (2014). Imani Consultants. (2015). Munthali, A., & Kok, M. C. (2016). Human Rights Watch. (2014). Meerkotter, A. (2011). Levandowski, B. A., Kalilani-Phiri, L., Kachale, F., Awah, P., Kangaude, G., & Mhango, C. (2012). Ministry of Gender, Children, Disability and Social welfre. (2014). Chepuka, L. (2013). Kangaude, G. D., & Mhango, C. (2018). Kailani-Phiri, L., Genresellassie, H., Levandowski, B. A., Kuchingale, E., & Kangaude, G. (2015). Human Rights Watch. (2018). Mwambene, L., & Mawodza, O. (2017). Pendleton, J., Mellish, M., Sapuwa, H., & Irani, L. (2015). Pendleton, J., Mellish, M., & Sapuwa, H. (2016). Okori, J. C., & Lansdown, G. E. (2014). Page, S. (2019). National AIDS Commission. (2014). Nash, K., O'Malley, G., Schell, E., Bvumbwe, A., & Denno, D. M. (2019). Plan International. (2016). Annan,J., Bates-Jefferys,E. (2019) Southern African Litigation Centre. (2017). Page, S. (2014). van Eerdewijk, A., Kamunyu, M., Nyirinkindi, L., Sow, R., Visser, M., & Lodenstein, E. (2018). WILSA Malawi and Faculty of Law, Chancellor College. (2015). Self, A., Chipokosa, S., Misomali, A., Aung, T., Harvey, S. A., Chimchere, M., . . . Marx, A. (2018). African Union, Economic Commission for Africa, UNICEF, UNFPA and Inter-African Committee on Traditional Practices affecting women and Children. (2013).

Question	References
g. What is the knowledge and attitudes towards SGBV, HP and SRH in Malawi, among women, men, girls and boys?	Banda, J., & Atansah, P. (2016). Munthali, A. C., Mvula, P. M., & Ali, S. (2005). Munthali, A. C., Chimbiri, A., & Zulu, E. (2004). Imani Consultants. (2015). Munthali, A., & Kok, M. C. (2016). Ministry of Gender, Children, Disability and Social Welfare. (2015). Kululanga, L., & Malata, A. (2012). Kelly, C. A., Mmelnikas, A. J., Amin, S., Mkandawire, J., & Daud, H. (2017). Ministry of Health. (2015). Consult, J. (2010). Munthali, A., Kok, M., & Kakal, T. (2018). National Statistical Office. (2011). Peser, E., Gondwe, L., Manyamba, C., Mhango, T., Phiri, W., & Burton, P. (2005). National Statistical Office. (2001) National Statistical Office. (2015). National Statistical Office. (2015). National Statistical Office. (2005). National Statistical Office. (2017). National AIDS Commission. (2014). Nash, K., O'Malley, G., Schell, E., Bvumbwe, A., & Denno, D. M. (2019).
h. What is the knowledge, experiences and access to SRH services in Malawi, among women and girls, and especially among women and girls facing intersecting forms of discrimination including women and girls with disabilities, women and girls with albinism, female sex workers, LGBTI, and elderly and widowed women?	Munthali, A. C., Mvula, P. M., & Ali, S. (2005). Guttmacher Institute. (2017). Munthali, A. C., Chimbiri, A., & Zulu, E. (2004). Levandowski, B. A., Kalilani-Phiri, L., Kachale, F., Awah, P., Kangaude, G., & Mhango, C. (2012). Munthali, A., & Kok, M. (2018). Ministry of Health. (2015). Cheputa, L., Taegtmeyer, M., Chorwe-Sungani, G., Mambulasa, J., Chirwa, E., & Tolhurst, R. (2014) Human Rights Watch. (2018). Pendleton, J., Mellish, M., & Sapuwa, H. (2016). VIHEMA. (Not Dated). National Statistical Office. (2017). Southern African Litigation Centre. (2017). van Eerdewijk, A., Kamunyu, M., Nyirinkindi, L., Sow, R., Visser, M., & Lodenstein, E. (2018). WILSA Malawi and Faculty of Law, Chancellor College. (2015). Self, A., Chipokosa, S., Misomali, A., Aung, T., Harvey, S. A., Chimchere, M., . . . Marx, A. (2018).

Question	References
i. What are the intersections between knowledge, experience of and access to SRH services and forms of SGBV and HP?	Banda, F., & Kunkeyani, T. (2015). McDermont, S. (2016). Cheputa, L., Taegtmeyer, M., Chorwe-Sungani, G., Mambulasa, J., Chirwa, E., & Tolhurst, R. (2014) Chepuka, L. (2013). Consult, J. (2010). Page, S. (2019). Page, S. (2014).
j. What are the critical evidence gaps and priorities for future research?	Munthali, A. C., Mvula, P. M., & Ali, S. (2005). Kelly, C. A., Mmelnikas, A. J., Amin, S., Mkandawire, J., & Daud, H. (2017). Pendleton, J., Mellish, M., & Sapuwa, H. (2016). Southern African Litigation Centre. (2017). van Eerdewijk, A., Kamunyu, M., Nyirinkindi, L., Sow, R., Visser, M., & Lodenstein, E. (2018).

UNICEF Malawi
PO Box 30375
Lilongwe, Malawi.
Tel: +265 (0)1 770 770
Email: lilongwe@unicef.org

www.unicef.org/malawi

@UNICEFMw @MalawiUNICEF @unicefmalawi

Spotlight Initiative
To eliminate violence against women and girls