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Socio-cultural factors influencing male involvement in reproductive health during pregnancy, childbirth and the postnatal period in rural districts of Malawi

Jane Dzumbila-Namasasu
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**Socio-Cultural Factors Influencing Male Involvement in
Reproductive Health during Pregnancy, Childbirth and the
Postnatal Period in Rural Districts of Malawi**

Jane Dzumbila-Namasasu

**This thesis is presented in fulfilment of the requirements for the degree of
Doctor of Philosophy**

**Faculty of Computing Health and Sciences
Edith Cowan University**

August 2010

USE OF THESIS

The Use of Thesis statement is not included in this version of the thesis.

Abstract

This thesis focuses on socio cultural factors influencing male involvement in reproductive health during pregnancy, childbirth and the postnatal period in rural districts of Malawi. This research stems from my fourteen years of experience in designing and overseeing the implementation of reproductive health services in Malawi, which led me to question why men as partners/husbands are not considered in the design and implementation of such services. Men as partners/husbands bear witness to most of the reproductive health problems that women go through and they are in a position of power, making decisions for their families' welfare. In addition to men's lack of inclusion, the high maternal mortality further provides the impetus to identify reproductive health interventions that will improve maternal and neonatal outcomes. Several reports have shown that involving men in matters of fertility regulation and HIV prevention have yielded positive results; however involving men in pregnancy, childbirth and the postnatal period have not been explored, particularly in developing countries like Malawi.

Thus, from a public health point of view, determining why men are not currently involved and how they may become involved in reproductive health during pregnancy, childbirth and the postnatal period are central to this analysis. To answer these questions, exploratory qualitative research was undertaken between February and July of 2008 with key stakeholders in four rural and two urban districts of Malawi. Data were collected from eight focus groups of men and women who are citizens of Malawi; additional data came from twenty eight in-depth interviews with Traditional Chiefs, Traditional Birth Attendants, health professionals, civil society groups, and Ministry of Health officials. Participants were asked about the meanings of male involvement and reproductive health, barriers to male involvement and ways to overcome barriers. Gender similarities and differences in the perceptions and attitudes of men and women about men's involvement during pregnancy, childbirth and the postnatal period were identified.

Participants suggested that men should be involved during pregnancy by accompanying pregnant women to the hospital, attending health education talks, and providing nutritious food. However, mixed support was given for male involvement during childbirth. Women in three districts said men should not be *present* during

childbirth, although they were of open mind about men being *involved* during childbirth in other ways. Women from the fourth district were more conservative in their support of men's involvement during childbirth and expressed stronger opposition to male involvement. Men in all districts were cautiously interested in being involved during childbirth, if requested by health workers. Older men were the most resistant to the idea of male involvement during childbirth, particularly in Mangochi, which is predominantly a Muslim district. Civil society representatives, health workers and Traditional Birth Attendants were of the view that men should be involved during childbirth.

Recommendations for promoting male involvement during pregnancy, childbirth and the postnatal period address both short and long term objectives. One short term objective is to promote a favourable policy environment by allowing men's involvement during pregnancy, childbirth, and the postnatal period. Another is to design culturally sensitive information, education, and communication materials for behavioural change which reflect the differing needs of Malawian communities. Consideration of specific socio-cultural differences among Malawians will also be important.

The long term objectives include the enactment of legislation that enables men to be involved and the establishment of services that responds to men's needs. Information, education, communication, and advocacy for male involvement should continue to raise awareness and address emerging issues in male involvement. The results of this research will inform policy makers, politicians, non-governmental organisations/activists, and the community in order to support the deployment of resources to promote and facilitate male involvement in pregnancy, childbirth and the postnatal period. In turn, this will help Malawians better understand the benefits of male involvement in reproductive health and lead to the improvement of reproductive health outcomes for women and their families.

Declaration

I certify that this thesis does not, to the best of my knowledge and belief:

- (i) incorporate without acknowledgement any material previously submitted for a degree or diploma in any institution of higher education;
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Table of Contents

USE OF THESIS	I
ABSTRACT	III
DECLARATION	V
ACKNOWLEDGEMENTS	VII
TABLE OF CONTENTS	IX
LIST OF TABLES	XIV
LIST OF FIGURES	XV
VOCABULARY	XVI
ACRONYMS	XVIII
CHAPTER ONE: INTRODUCTION	1
1. INTRODUCTION	1
1.1 Statement of the Problem	2
1.2 The Purpose for the Research.....	3
1.3 Research Questions	3
1.4 Research Approach.....	4
1.5 Significance of the Study.....	4
1.6 Expected Outcomes	5
1.7 Theoretical Framework	6
1.8 The Research Sites	10
1.9 Family Structure	12
1.9.1..... <i>Mzimba District</i>	13
1.9.2..... <i>Dowa District</i>	14
1.9.3..... <i>Mangochi District</i>	14
1.9.4..... <i>Nsanje District</i>	14
1.9.5..... <i>Lilongwe District</i>	14
1.9.6..... <i>Blantyre District</i>	14
1.10 The Organisation Structure of the Thesis	17
CHAPTER TWO: LITERATURE REVIEW	18
2. INTRODUCTION	18
2.1 Purpose of the Literature Review	20
2.2 Reproductive Health in the Malawi Context	20
2.3 Definition of Male Involvement	24
2.4 Why Male Involvement?	25

2.5	Programmes that Involve Men in Reproductive Health Issues	28
2.5.1	..... <i>Male Involvement in Family Planning</i>	29
2.5.2	..... <i>Involving Men in Prevention of Gender Based Violence</i>	31
2.5.3	..... <i>Male Involvement in Prevention of STIs/HIV/AIDS</i>	34
2.6	Factors to be Considered When Involving Men in Reproductive Health	37
2.6.1	..... <i>Socio-cultural Constructions of Masculinities</i>	37
2.6.2	..... <i>Gender Inequality</i>	38
2.6.3	..... <i>Socio-cultural Factors in Pregnancy and Childbirth</i>	39
2.6.4	..... <i>Gender Roles and Norms</i>	40
2.6.5	..... <i>Women's Empowerment and Autonomy</i>	41
2.6.6	..... <i>Reproductive Health Rights</i>	44
2.7	Chapter Summary	45
CHAPTER THREE: METHODOLOGY		47
3.	INTRODUCTION	47
3.1	Research Design	48
3.2	Preparation for Research.....	50
3.3	Gaining Access to the Field	51
3.4	Recruitment of the Research Team.....	51
3.5	Translation of the Interview Guide	52
3.6	Training of the Research Team.....	53
3.7	Planning the Logistics.....	55
3.8	Researchers as Human Instrument.....	55
3.9	Purposive Sampling	56
3.10	Study Participants	57
3.10.1	... <i>In-depth Interview Participants</i>	57
3.10.2	... <i>Focus Group Participants</i>	60
3.11	Data Collection Methods	62
3.11.1	... <i>In-depth Interview</i>	62
3.11.2	... <i>Focus Group Discussions</i>	63
3.12	Culture Sensitivities.....	65
3.13	After the Interviews	66
3.14	Audio Recording.....	66
3.15	Transcribing Interviews	67
3.16	Data Analysis.....	69
3.16.1	... <i>Thematic Analysis</i>	69
3.16.2	... <i>Immersion of Data</i>	69
3.16.3	... <i>Coding</i>	69
3.16.4	... <i>Cases and Attributes</i>	70
3.16.5	... <i>Development of Themes</i>	70
3.16.6	... <i>Data Queries</i>	71
3.16.7	... <i>Rigour Procedures</i>	72
3.17	Chapter Summary	72

CHAPTER FOUR: RESEARCH FINDINGS.....	74
4. INTRODUCTION	74
4.1 Background of Female Participants.....	74
4.2 Background of Male Participants	76
4.3 Research Context.....	78
4.3.1.....Dowa District.....	78
4.3.2.....Mzimba District	79
4.3.3.....Mangochi District	79
4.3.4.....Nsanje District	80
4.4 Work for Women and Men.....	81
4.4.1.....Men Should Help with Household Chores	83
4.5 FAMILY PLANNING	85
4.6 Men’s Roles in Pregnancy, Childbirth and the Postnatal Period.....	88
4.6.1.....Providing Nutritious Food during Pregnancy	88
4.6.2.....Escorting Women to the Antenatal Clinic and Delivery	90
4.7 Men Should be Present in the Labour Ward	92
4.8 Benefits of Male Involvement during Childbirth	93
4.8.1.....Psychological Bond and Support	94
4.8.2.....Emotional and Physical Support.....	96
4.8.3.....Reduction of Maternal Deaths	99
4.9 Taking Care of Mother and Baby after Birth	100
4.9.1.....Transport Women Home from the Hospital	102
4.10 Chapter Summary.....	103
CHAPTER FIVE: GENDER DIFFERENCES.....	104
5. INTRODUCTION	104
5.1 Avoiding Violence against Women.....	104
5.2 Compatibility of Blood.....	107
5.3 Love the Family.....	108
5.4 Reproductive Health Problems.....	110
5.5 Women’s Views of Reproductive Health Issues	111
5.5.1.....Teenage Pregnancy.....	111
5.5.2.....Promiscuity	112
5.5.3.....Lack of Blood during Pregnancy and Blood loss during Childbirth.....	114
5.5.4.....Malposition of the Baby	114
5.6 Men’s Views of Reproductive Health Problems	116
5.6.1.....Deliver without Problems	116
5.6.2.....Men to get involved in Safe motherhood Activities	118
5.6.3.....Perinatal Deaths	119
5.6.4.....Maternal Deaths	120
5.7 Opposition to male involvement during childbirth.....	121
5.8 Opposition to Men’s Presence during Childbirth	121
5.8.1.....Marriage Will End	121

5.9	Disadvantages to Male Involvement.....	125
5.9.1	..... <i>Men Feel Guilty</i>	125
5.9.2	..... <i>Emotional Involvement of the Husband</i>	126
5.9.3	..... <i>Working Men/paternal leave</i>	128
5.9	Chapter Summary	129
CHAPTER SIX: BARRIERS TO MALE INVOLVEMENT		131
6.	INTRODUCTION	131
6.1	Cultural Barriers to Male Involvement.....	131
6.1.1	..... <i>Abstinence</i>	132
6.1.2	..... <i>Baby Cleansing</i>	134
6.2	Gender Segregation.....	136
6.2.1	..... <i>Lack of Respect</i>	139
6.3	Attitude of Health Workers towards Men.....	141
6.4	Infrastructure Barriers.....	144
6.4.1	..... <i>Lack of Privacy</i>	144
6.4.2	..... <i>Non-accessibility to the Hospitals</i>	145
6.4.3	..... <i>Shortage of Personnel</i>	146
6.4.4	..... <i>Hospital Policy</i>	147
6.5	Financial Barriers.....	149
6.5.1	..... <i>Poverty</i>	149
6.5.2	..... <i>Utilisation of Finances</i>	151
6.6	Chapter Summary	152
CHAPTER SEVEN: OVERCOMING BARRIERS AND MOTIVATIONAL FACTORS TO MALE INVOLVEMENT		153
7.	INTRODUCTION	153
7.1	Engaging with Community Leaders	154
7.2	Education	156
7.3	Community Sensitisation and Civic Education	159
7.4	Change Policy	161
7.5	Motivational Factors for Male Involvement.....	164
7.5.1	..... <i>Abstinence Period Should be Reduced</i>	165
7.5.2	..... <i>We are Expecting a Baby</i>	167
7.5.3	..... <i>Love and Trust</i>	168
7.5.4	..... <i>Personal Hygiene</i>	168
7.5.5	..... <i>Communication/Information</i>	169
7.6	Chapter Summary	171
CHAPTER EIGHT: INFORMATION AND SUPPORT		172
8.	INTRODUCTION	172
8.1	Early Antenatal Care.....	172
8.2	Birth Preparedness	174
8.3	Deliver at the Hospital	175
8.4	Contraceptive Methods	178

8.5	Support that Women Need	180
8.5.1	.....<i>Neighbour's Instrumental Support of Household Labour</i>	180
8.5.2	.....<i>Neighbour's Support with Caring for the Baby</i>	182
8.6	Chapter Summary	185
CHAPTER NINE: SUMMARY OF RESEARCH, RECOMMENDATIONS AND CONCLUSIONS.....		186
9.	INTRODUCTION	186
9.1	Summary of Research	186
9.2	General Recommendations for Male Involvement during Pregnancy, Childbirth and Postnatal Period	190
9.3	Gender Inequality in Pregnancy, Childbirth, and Postnatal Period	193
9.4	Cultural Factors Hindering Male Involvement.....	195
9.5	Policy Change for Male Involvement.....	197
9.6	Achieving Reproductive Health Rights	199
9.7	Implementation to Overcome Barriers	202
9.7.1	.....<i>Policy Environment</i>	202
9.7.2	.....<i>Information, Education and Communication (I E C)</i>	202
9.8	Study Limitations and Future Research	203
REFERENCES.....		205
APPENDIX A: FOCUS GROUP INTERVIEW GUIDE – WOMEN		228
APPENDIX B: FOCUS GROUP INTERVIEW GUIDE – FOR MEN		230
APPENDIX C: IN-DEPTH INTERVIEWS		232
APPENDIX D: CONSENT FORM		233
APPENDIX E: PARTICIPANTS INFORMATION		234

List of Tables

Table 1: Research Sites Population, Languages, Religion and Family Structure	11
Table 2: Sample of Coded Data	70
Table 3: Demographic Characteristics of Women Interviewed	75
Table 4: Demographic Characteristics of Men	77

List of Figures

Figure 1: Map of Malawi showing the Location of Research Sites	16
Figure 2: Overcoming Barriers	154
Figure 3: Motivation Factors.....	165
Figure 4: Conceptual Framework for Male Involvement	201

Vocabulary

Bzyade	A woman who is still bleeding after delivery and has not yet resumed sexual intercourse. She is considered unclean and may infect a man during sexual intercourse and cause hydrocele.
Bumphu (Sissy)	A weak man controlled by his partner or wife
Chisuwila	Getting pregnant before menses resumes after giving birth
Cold	Someone who has not had sex is said to be “cold” and it is only this person who can touch the baby
Chiberita	Tetanus
Dawale	Water that is given to the baby after it is born. It is believed that it is healthy to just give plain water or traditionally medicated water for the first three to four months
Dziwi	Transverse lie
Face	A polite way of mentioning the vagina
Hot	Someone who has had sex is said to be “hot” will not touch the baby because it is feared the baby will get sick and will show signs of “Tsempho” (see below). If these signs appear it means the baby has been “jumped”
Juju	A love concoction given to the husband to prevent him from having affairs; also used to reinforce the love relationship especially where the husband shows signs of disinterest with his wife
Kakolekole	Retained membranes
Kutengera mwana kumphasa	The end of abstinence period symbolising the beginning of permitted sexual intercourse
Kudumula or Kulumula	Sexual intercourse after delivery before the accepted period by the elders
Mwikho	Something that is forbidden or restricted area
Nsima	Traditional meal made from maize meal flour
Phudzi	If a man has sexual intercourse with a woman who is still bleeding after delivery, it is believed that the man is

	infected and he shows by swelling of the scrotum.
Staying together (Kukhala malo amodzi)	Refers to sexual intercourse
Taking care of the thing	This phrase has two meanings. The first meaning refers to providing the baby with basic needs for example clothes, food etc. The second meaning refers to abstaining from copulation.
“Thing”	Refers to the foetus as long as it is unborn; it will be called a baby only when it is born and it is breathing
Tsempho	Signs and symptoms such as malnutrition arising from copulation with a woman who is still bleeding after giving birth
When a woman is sick	When a woman is pregnant
Wachitanga chikoko mwana	The baby is epileptic
Vimbuza	A traditional cult dance practiced among Tumbuka in the Northern Region of Malawi

Acronyms

ANC	Antenatal Care
AVSCI	Association of Voluntary Surgical Contraception International
BEOC	Basic Essential Obstetric Care
BLM	Banja La Mtsogolo
CEDAW	Convention on Elimination of all forms of Discrimination against Women
CILIC	Civil Liberties
CSR	Centre for Social Research
DALYS	Disability Adjusted Life Years
DHS	Demographic Health Survey
FWCW	Fourth World Conference on Women
ICPD/POA	International Conference on Population and Development/Programme of Action
IEC	Information Education and Communication
MAP	Men as Partners
MCH	Maternal and Child Health
MDG	Millennium Development Goals
MHRRC	Malawi Human Rights Resource Centre
PMTCT	Prevention of Mother to Child Transmission
SAW	Society of Advancement of Women
SRH/RH	Sexual and Reproductive Health/Reproductive Health
STAFH	Support to AIDS and Family Health
STI	Sexually Transmitted Infections
TA	Traditional Authorities
TBA	Traditional Birth Attendants
UNFPA	United Nations Population Fund
USAID	United States of America International Development
WHO	World Health Organization

CHAPTER ONE: INTRODUCTION

1. INTRODUCTION

Male involvement in reproductive health has received growing global attention (Walston, 2005), especially after the Cairo International Conference on Population and Development (1994) where countries were encouraged to provide holistic reproductive health care for both men and women (Barker & Das, 2004; Family Care International, 2006; Wang, 2000). In Malawi, men often act as gatekeepers to their wives' health-seeking behaviours and families' use of health services (Matinga, 1998). While men's roles in family planning, STI/HIV/AIDS and gender based violence are known to be substantial, their involvement during pregnancy, childbirth and postnatal care in Malawi and other developing countries is largely unexplored.

Analyses of literature indicates that family members, including husbands, bear witness to complications of pregnancy and maternal death (Coombes, 2001). Men affect outcomes of obstetric emergency in their role as partners or husbands, yet studies have not addressed the roles that men play during these emergencies or their experiences of obstetric emergencies. This information is usually only collected from women (Dudgeon & Inhorn, 2004). Further, communities have not focused sufficiently on reproductive health issues, existing reproductive health services are not male friendly, and men are not aware of the dangerous signs in pregnancy. For example, Malawi reported that men lack information about the importance of care during the antenatal, delivery and the postnatal period (National Statistics Office, 2004) and this is the main reason why women are not receiving care. The report further indicates that 65 percent of men have no knowledge of any signs or symptoms that show that a woman's pregnancy is in danger. There is little awareness about women's physiological body changes during pregnancy and delivery (Matinga, 1998). The high rates of maternal deaths in Malawi (984 per 100,000 live births) further underscore the need to focus attention on male involvement during pregnancy, childbirth and the postnatal period.

1.1 Statement of the Problem

Several researchers have attested that aspects of reproductive health such as pregnancy and childbirth remain an unexplored area (Coombes, 2001; Ntabona, 2002; Wang, 2000) despite the high maternal mortality rate in Malawi. Little research has been conducted on the role that husbands can play in reducing maternal mortality (Shefner-Rogers & Sood, 2004). The reproductive health policy of Malawi clearly stipulates that “male involvement in sexual and reproductive health shall be encouraged at all levels including pregnancy, childbirth, and postnatal care” (Ministry of Health, 2002, p. 11). The “Malawi Road Map,” a maternal mortality reduction strategy developed following the Emergency Obstetric Care Assessment in 2005, has as one of its strategies, “empowering communities to ensure continuum of care between households and health facility by strengthening the capacity of women and their partners to ensure self care in the home and to seek and reach health care facilities in a timely manner for improved pregnancy outcomes” (Ministry of Health, 2005c, p. 18). Despite these government health policies, there is a lack of research about the perceptions, preferences, and determinants of male involvement, partly due to the fact that discussions of issues related to sex are taboo within communities across Malawi.

Social and cultural norms and practices that undermine the health of women and men in Malawi have not yet been fully addressed either. To date, efforts have been directed solely at increasing men’s use of contraceptives (Greene et al., 2006). Furthermore, information on men’s intentions and practices related to pregnancy and childbirth is scarce (Dudgeon & Inhorn, 2004). Little is known about men’s attitudes about their presence at delivery, their participation in childbirth, and their lack of involvement during antenatal and the postnatal periods in developing countries like Malawi (Mullany, 2005). This is in sharp contrast to the developed world where maternity care is family-centered (Mardorossian, 2003), and where the presence of husbands or male partners during childbirth is well accepted (Semper, n.d.). In developed countries, couples are encouraged to participate from antenatal to childbirth (Early, 2001).

A workshop organised in Zimbabwe in April 1999 by the United Nations Population Fund Country Support Team (UNFPA/CST), focused on priority areas of research in Sub-Saharan countries. A presentation from Malawi indicated that

antenatal coverage was very high and yet maternal mortality and morbidity were still high. The presentation also indicated that the lack of follow-up with mothers at one week and six weeks after delivery poses serious challenges as postpartum problems such as haemorrhage and infections may occur (Gjerdingen & Bruce, 2003). Male involvement in reproductive health was non-existent. As a result of these issues, the United Nations Population Fund (UNFPA) was requested to support the design and delivery of a safe motherhood programme and undertake a reproductive health operational research programme (Gijima, 1999).

It is in the context of this lack of research despite government policy calling for increased male involvement and raising awareness to maternal and neonatal health issues that this study explores support for involving men during pregnancy, childbirth and the postnatal period in Malawi. Additionally, this research identifies cultural and structural barriers to men's involvement and provides suggestions for overcoming these obstacles in order to improve the health outcomes of pregnant women, their babies, and Malawian families in general.

1.2 The Purpose for the Research

The purpose of this study is to understand the perceptions and attitudes of men and women of reproductive age and over, including those perceptions of health workers and civil society groups about male involvement in reproductive health during pregnancy, childbirth and the postnatal period in Malawi. (Postnatal period and postnatal care are used interchangeably in this thesis.) Male involvement in this thesis means men's presence, support, and assistance with women's antenatal care, childbirth and postnatal care. Involvement is based on men's emotional and financial support and their physical care of women before, during and after pregnancy. Involvement includes supporting women in a variety of ways by taking part in multiple gender roles, such as being the household breadwinner while doing household chores and caring for baby.

1.3 Research Questions

To address the role that men play in women's reproductive health before, during, and after pregnancy, this research considered:

- What are the attitudes and beliefs of women about involving men during pregnancy, childbirth and the postnatal period?

- What are the attitudes and beliefs of men about being involved during pregnancy, childbirth and the postnatal period?
- What are the cultural and systemic barriers in involving men in reproductive health during pregnancy, childbirth and the postnatal period?
- What are the cultural and systemic barriers in men caring for women and their babies after delivery?

1.4 Research Approach

The paradigm that guides this research is symbolic interactionism, within a social constructionist framework. This approach is one that privileges the perceptions and views of the participants in this research and takes into account how their views are created, institutionalised, and made into traditions (Crotty, 1998). My role as the Director of Reproductive Health Services in Malawi, as a policy maker and planner of reproductive health services, afforded me the opportunity to interact with people that play an important role in creating and maintaining health policy in Malawi including various health workers, village Chiefs and other civil servants. In addition, my position enabled me to consider the varied beliefs, problems, and responses of the Malawi government in meeting the human rights of women within the realm of reproductive health. At the same time, as a citizen of Malawi, as a woman and a mother, I was in a unique position to be able to privilege the experiences of other women, mothers, and their partners.

This study uses a strategic sampling strategy to conduct in-depth interviews and focus group discussions with Malawians in order to gain rich qualitative data on views about sensitive and cultural taboo issues. Data were collected from male and female Malawian citizens of reproductive age and older and from government health workers in order to create social, cultural, and government sponsored change to promote women's reproductive health. By engaging citizens and health workers, this research uses a community empowerment model to facilitate change in improving the public health of families in Malawi.

1.5 Significance of the Study

“State of the World Population” estimates that 99 percent of the approximately 500,000 maternal deaths occurring around the world each year are in

developing countries (Yerudian, 2004) where complications of pregnancy and childbirth take the life of about one out of every 48 women. Available information shows that of women who die of pregnancy related conditions, 24% die during pregnancy, while 16% die during delivery and 61% after delivery (Gay, Hardee, Judice, Agarwal, Fleming, Hairston, et al., 2003). The latter statistic highlights the importance of postnatal care, which is often neglected or non-existent in most developing countries including Malawi (World Health Organisation, 2005). The first week of the postpartum period is prone to risk. The World Health Organisation (2005) indicates that almost 45% of postpartum maternal deaths occur during the first 24 hours and more than two-thirds during the first week. Moreover, the death of the mother almost always accompanies the death of the baby.

It has been shown in developing countries that men make decisions about when their wives should seek obstetric care and yet they lack specific knowledge about why such care is necessary (Shefner-Rogers & Sood, 2004). This lack of knowledge is potentially dangerous since it may cause husbands to downplay their wives' need for timely care, especially when financial resources are strained (Shefner-Rogers & Sood, 2004). Therefore, interventions beyond information, such as education and communication, are potentially important ways of reducing the incidence and severity of major complications of pregnancy and childbirth (Karim, 2003). Despite this, efforts to involve men at the time of pregnancy, childbirth and postnatal care are virtually nonexistent (Kamal, 2002; Ntabona, 2002) especially in Malawi.

This exploratory research, therefore, is the first of its kind to be conducted in Malawi and will broaden the scientific body of knowledge currently available in reproductive health in developing countries. The findings of this research will specify ways to involve men during pregnancy, childbirth and postnatal care and it will provide policy direction in Malawi on male involvement in reproductive health. Finally, the qualitative aspects of this research will help to inform the formulation of culturally sensitive and appropriate reproductive health interventions.

1.6 Expected Outcomes

It is hoped that this research provides:

- A deep understanding of socio-cultural factors that shape any future male involvement in reproductive health during pregnancy, childbirth and the postnatal period.
- An analysis of structural factors in health care and health policy in order to make recommendations for male involvement in reproductive health programmes related to pregnancy, childbirth and the postnatal period in Malawi.
- Recommendations for practical implementation of gender sensitive programmes that meet the needs of women and men in relation to pregnancy, childbirth and the postnatal period.

1.7 Theoretical Framework

This section outlines the theoretical frameworks used to inform socio-cultural factors influencing male involvement in reproductive health during pregnancy, childbirth and the postnatal period for this study. The frameworks of women's human rights and public health guided this study. Both frameworks are internationally recognised as foundations for advancing the rights, health and well-being of men and women. In addition, these frameworks involve making connections between social, cultural, and economic environment to facilitate social change and improve the conditions in which people live for the benefit of health of individuals and health of communities. Unique and contributive aspects of each framework for the current study are discussed below.

Under a public health framework, health is understood as a social phenomenon rather than an individual one. That is, a public health framework broadens health care from a model based on the treatment of individual persons' illnesses and diseases to a model whereby *prevention* and *treatment* are aimed at *groups* and *society* in order to prevent diseases, illnesses and deaths before they occur (Petersen & Lupton, 1996). This framework encompasses the economic and physical environments in which people live, requires complex forms of inter-sectoral policy action, and is often linked to a broader social justice agenda (Solar & Irwin, 2007). It focuses on, the aetiology of problems, disease prevention, prolonging life, and health promotion and wellbeing. These goals are achieved by addressing the social, economic, political and environmental determinants of health through

community development and capacity building in sanitation of the environment, control of communicable diseases, the organisation of medical and nursing services for early diagnosis and prevention of disease, and the education of individuals in personal health (Petersen & Lupton, 1996). These strategies are in place to assure everyone in the community has a healthy standard of living (L. W. Green & Ottoson, 1994).

Baum (2008) argues that contemporary public health research uses a range of methods from a variety of social science disciplines and epidemiology. She contends that public health research aims to “understand and use that understanding to bring about change” (Baum, 2008, p. 142) which she sees primarily a political activity. The World Health Organization’s 1948 Constitution clearly acknowledges the impact of social and political conditions termed “social determinants” of health. This social model of health was amplified in the 1978 Alma-Ata Declaration on Primary Health care by reasserting the need to address social conditions impacting health. The General Comment on the Human Right to Health released in 2000 by the UN Committee on Economic, Social and Cultural Rights, explicitly affirms that the right to health must be interpreted broadly to embrace key health determinants.

The other framework guiding this study is that of human rights. A human rights framework is appropriate for advancing health (Solar & Irwin, 2007) and challenging injustice and discrimination, particularly against women in varied locations and settings (Sheans, 2007). Such a framework is based on the 1948 Universal Declaration of Human Rights. The human rights aspects of health, and in particular the connections between the right to health and social and economic conditions, were clarified in the 1966 International Covenant on Economic, Social and Cultural Rights. Article 12 of this Covenant acknowledges, “The right of everyone to the enjoyment of the highest attainable standard of physical and mental health.” Several regional human rights instruments also recognise the right to health, such as the African Charter on Human People’s Rights (United Nations Economic and Social Council, 2000). The right to health includes freedoms and entitlements. These freedoms are directly pertinent to women in developing countries like Malawi and include women’s right to control their bodies and health, especially sexual and reproductive health (United Nations Economic and Social Council, 2000). Arguably they are not just rights to be healthy, but also include rights to access a variety of

services, facilities, and conditions that promote and protect the highest attainable standard of health (University of Essex, 2008). In this respect, these human rights may require adjusting policies and expanding resources to ensure equal access to and equity in a health care system for pregnant women and women with children.

The landmark was the International Conference on Population and Development in 1994 which recognized that “sexual and reproductive health is integral elements of the right of everyone to the enjoyment of the highest standard of physical and mental health” (United Nations Population Fund, 1994). The Programme of Action arising from the conference called for the inclusion of men in sexual and reproductive health through the promotion and encouragement of equal participation of women and men in all areas of family, household, and child rearing including family planning (Food Agriculture Organisation of the United Nations, 1998).

The Programme of Action further emphasised that men should share responsibility and promote their active involvement in responsible parenthood in all elements of sexual and reproductive health for example sexual and reproductive health services, family planning, antenatal care, maternal and child health, and unwanted and high risk pregnancies (Food Agriculture Organisation of the United Nations, 1998). Male involvement was identified as central to improving reproductive health and gender equity. The Millennium Development Goals agreed to by United Nations member states and international organizations in 2000 set goals, targets and indicators for combating poverty among other inequities (World Health Organisation, 2003). These goals affirm that gender equality and empowering women cannot be achieved without the guarantee of sexual and reproductive health and rights of girls and women (Greene, et al., 2006). Reproductive health rights and responsibilities can only be realised if states comply with programmatic statements of international conventions they have signed, and if they are held accountable to the communities they serve (Dudgeon & Inhorn, 2004).

Bunch & Fried (1996) argue that the Beijing Conference held in 1995 was a significant event in so far as it strengthened international commitment to women’s human rights. The conference buttressed the concept of human rights as it applies to women. Some of the rights debated at this conference included, the right to education, health and freedom from violence and the right to information (United

Nations Population Fund, 2005). Such commitment has been important in translating international and national rights to on-the-ground practice, for example in legal literacy and reproductive health initiatives (Cornwall & Molynux, 2006). Thus, a women's human rights framework has provided a language with which to articulate claims (Sheans, 2007) based on human rights principles such as non-discrimination, participation and obligation (Cornwall & Molynux, 2006).

This discourse has been embraced in a variety of national and cultural contexts to challenge discrimination, persecution or harm perpetuated and legitimised by ideologies of gender that naturalise inequality and that reinforce the inferior/subordinate status of women (Afsharipour, 1999; Bunch, 1995). Thus, the language of rights has the potential to challenge gender structures and injustice (Guerrina & Zalewski, 2007). In this process, the political art of taking an existing discourse (human rights) that has currency in the practice of international politics is infused with new meanings (Sheans, 2007).

Given that in many parts of the world, including Malawi, women experience the consequences of a lack of equal rights through continuing gender-based discrimination, they arguably have the most to gain from a rights based approach (Cornwall & Molynux, 2006). This is particularly so given that the meaning of women's rights is not exclusively legal but can be invoked as moral authority and as an advocacy tool (Thomas, 2000). The rights based approach invaluablely requires programmes, for example, to encourage shared responsibilities for reproductive health; and to mobilize communities to recognise the dangers in delaying seeking care during pregnancy and the risks of too early and poorly spaced pregnancies (United Nations Population Fund, 2005).

That is not to say, however, that there is consensus on the saliency of a rights-based approach to women's health. Specifically, arguments have been advanced against the implementation of a Universalist framework for women's human rights on the grounds that gender and gender structures emerge from cultural norms and cannot therefore be essentialized and applied to all women in the same way (Guerrina & Zalewski, 2007). This argument is prominent in the literature (see for example, Lloyd, 2007; Zerilli, 1998) but is countered by the UN framework for women's rights, which promotes the rights of women above those of cultural groups.

Indeed, culture cannot be cited as an excuse and/or justification for discrimination and discriminatory practices (Merry, 2003).

Thus the dual frameworks of public health and women's human rights provide a holistic way of conceptualizing male involvement in reproductive health during pregnancy, childbirth and the postnatal period in Malawi in this thesis. Together, research informed by these frameworks can address the needs of Malawian women in general and offer ways of implementing specific policies that are culturally sensitive and beneficial to communities in particular ways.

1.8 The Research Sites

Malawi, generally known as “the warm heart of Africa,” is a land locked country south of the equator in Sub-Saharan Africa (Zanera, 2004). It is bordered by the United Republic of Tanzania in the North and North East, Mozambique to the East, South and Southwest, and Zambia to the west and Northwest. The country is 901 km long and varies in width from 80 to 161 km. It has a total area of 118,464 sq km of which 94,276 sq km is land area. Lake Malawi which is about 475 km long occupies the remaining area (Zanera, 2004).

According to the National Statistics Office, the total population of Malawi is 13,077,160. Females comprise 51% of the total population and about 42% are in the reproductive age group of 15-49 years (National Statistics Office, 2008). The report further indicates that 85% of the population live in the rural areas (National Statistics Office, 2008). Adult literacy for women is 69% compared to 79% for men (Zanera, 2004). Although the literacy levels have increased for women, their lower level vis-à-vis that of men is a result of inequality in access to education. This has an impact on the health of the family, particularly the children, as evidence shows that female education is linked with better health for women and their children and lower fertility (Kasanda, 2005).

The major provider of formal health services in Malawi is the Ministry of Health (MOH) which provides 60% of all services; the Christian Health Association of Malawi (CHAM) provides 37%. The Ministry of Local Government, the Police Force, the Defence Force and other not-for-profit organisations provide two percent of the services, while the remaining one percent is provided by the private sector (National Statistics Office, 2004). However, access to some health services is limited

due to the high cost of services, long distances to facilities, and lack of adequate transport (Coombes, 2001).

The country is divided into three regions and districts. The Northern Region contains six districts. The Central Region contains nine districts and the Southern Region 13 districts. For ease of administration, the districts are subdivided into Traditional Authorities (TAs) presided over by the Chiefs. Each Traditional Authority is composed of villages which are the smallest administrative units. These units are presided over by Village Headmen. Each region is unique because of the cultural diversity of Malawi (National Statistics Office, 2004). Key similarities and differences in each region are discussed below and summarised in table one.

Table 1: Research Sites Population, Languages, Religion and Family Structure

District	Total Population	Males	Females	Language	Religion	Marriage system
Mzimba	727,931	350,956	376,975	Tumbuka	Christians dominated	Patrilineal
Dowa	558,478	274,192	284,278	Chichewa	Christian dominated	Matrilineal
Lilongwe <i>urban</i>	674,448	344,890	329,558	Several languages	Mixed	Mixed marriage systems
Mangochi	797,061	380,175	416,886	Yao	Muslim dominated	Matrilineal
Blantyre <i>urban</i>	661,256	336,234	325,022	Several languages	Mixed	Mixed marriage systems
Nsanje	238,103	115,219	122,884	Sena	Christian dominated	Patrilineal

1.9 Family Structure

Two family systems exist in Malawi: patrilineal and matrilineal. In the patrilineal system of marriage, descent is traced in the father's line and the child takes the father's family name. The child usually becomes associated with the father's family and clan (Matinga & McConville, 2003). Conversely, the woman normally leaves her family, joins the family of her husband and removes herself from being under the responsibility of the male members of her own lineage. However, she is still considered an outsider at her husband's place. In a patrilineal family, the paternal grandfather and the grandmother, sons, aunts and sisters have very powerful influence on decision making with regard to health and illness (Matinga & McConville, 2003).

In addition, polygyny is more profound in this family system than in a matrilineal system. A man customarily pays a bride price or dowry to a girl's family in exchange for a life time of productive and reproductive labour. This "gives the husband the right to take his wife to his natal village and to have children inherit his property" (Mandala, 1990). In the event that a husband dies, the widow can be inherited by her deceased husband's brother. Basu and Gupta (2001) observe that inheritance and marriage rules are heavily weighted in favour of men as women have little economic independence or autonomy. Therefore, patriarchal relations do affect women's reproductive health and this type of a marriage system may perpetuate the dominant role of men deciding what is best for women or ignoring their needs (Dudgeon & Inhorn, 2004).

In contrast, in matrilineal marriage, the family descent is traced in the mother's family name and is customarily more closely associated with her blood than with the father's (Matinga & McConville, 2003). The husband relocates to the local group of the wife. In this type of marriage, authority over the members of the family is in the hands of the mother or her relatives. According to Matinga & McConville (2003), the custodian of the family unit is the elder brother on the maternal side. This elder brother is responsible for the entire family's well being and is the legitimate owner of the children and not their biological or marital father. In addition, the maternal uncle (mother's brother) is the ultimate decision maker in matters related to child care, education and health. Even though the mother may have considerable

power over the children, it is argued that more power is with the family than the woman alone (Matinga & McConville, 2003).

Recognizing this diversity in marriage and family systems can contribute to an understanding of the potential barriers to male involvement in women's reproductive health during pregnancy, childbirth, and postnatal care. Additionally, an awareness of culturally specific beliefs may also be useful in designing interventions that will be accepted and implemented by families, Traditional Leaders, health workers and civil society groups across Malawi. To capture and reflect the diversity of family structure and gender relations within the household, language, and religious practice among men and women, this research was conducted in four rural districts and two urban districts in Malawi. The rural districts were: Mzimba in the Northern Region, Dowa in the Central Region, Mangochi and Nsanje in the Southern Region. These districts were purposively selected based on deep rooted traditions that vary between tribal and religious groups. Mzimba and Nsanje districts are both rigidly patrilineal and residents speak different dialects, while Dowa and Mangochi districts are matrilineal. Mangochi is a predominately Muslim community while the other districts are primarily dominated by Christians. The urban districts included in this study are Lilongwe and Blantyre. Key demographic characteristics of each region are described below.

1.9.1 Mzimba District

Mzimba is the third largest district with a population of 727,931; almost 52 percent are female. It is situated in the northern region of Malawi, about 578 km from Lilongwe. Mzimba follows a rigidly patrilineal system of marriage and their language of communication is Tumbuka. Mzuzu city is located in Mzimba district and has a population of 133,968 with a female population of 49.9 percent (National Statistics Office, 2008). One of the referral hospitals participating in this study is located in this city. In contrast to the city, the rural population contains more women than men. The reason for these differences may be due to the fact that most men are moving into the urban setting for work while women stay at home rearing children. This trend is similar in all the districts and cities in this study.

1.9.2 Dowa District

Dowa is located in the central region about 53 km from the capital city of Lilongwe. Dowa, unlike Mzimba, follows a matrilineal system of marriage. It has a population of 558,478; 51 percent are women (National Statistics Office, 2008) and Chichewa is the language spoken in this district. One interesting aspect about Dowa that separates it from the other districts in this study is that, according to local politicians, it is considered politically conservative. In the past, it has resisted moves to a national self-government and from a one party to a multiparty system of government.

1.9.3 Mangochi District

Mangochi is the second largest district with a population of 797,061 of which 48 percent are men. Mangochi is located in the southern part of Malawi along Lake Malawi (National Statistics Office, 2008), about 344 km from Lilongwe and is a Muslim dominated district. Residents speak Yao as the main language. Like Dowa, Mangochi follows a matrilineal system of marriage.

1.9.4 Nsanje District

This district is located in the southern part of Malawi, 752 km from Lilongwe. Nsanje has a population of 238,103, of which almost 52 percent are women (National Statistics Office, 2008). The language spoken is Sena and like Mzimba, Nsanje follows a patrilineal system of marriage.

1.9.5 Lilongwe District

Lilongwe is located in the central region of Malawi. The rural population surrounding it is 1,230,834. Women constitute fifty-one percent of the population. The capital city of Malawi is located in this district and has a population of 674,448. Like the other cities mentioned above, the population of men is larger than the population of women (National Statistics Office, 2008). Apart from the government offices, the main training Colleges of Nursing and the referral hospital are located in this district.

1.9.6 Blantyre District

Blantyre is located in the southern part of Malawi and is one of the major commercial cities. The rural has a population of 340,728, of which almost 52 percent

are women (National Statistics Office, 2008). There are several different languages spoken in the district including Chichewa, Nyanja, Yao, and Mang'anja. The city's population is 661,256. Men make up almost 51 percent. The biggest hospital in Malawi; the College of Medicine, and the second largest College of Nursing are located in this district.

Figure 1 provides a map of Malawi showing the location of the research sites.

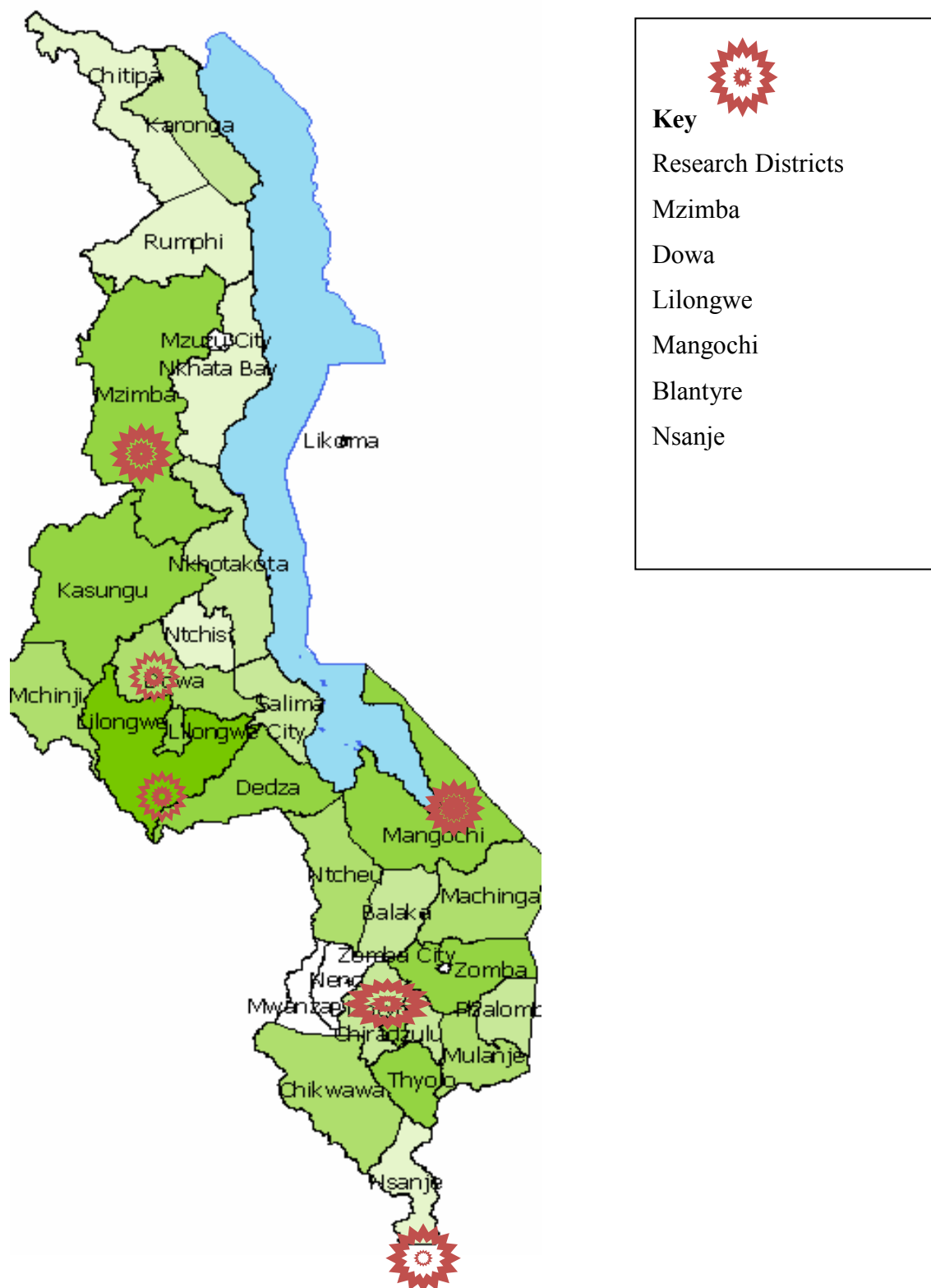


Figure 1: Map of Malawi showing the Location of Research Sites

1.10 The Organisation Structure of the Thesis

Chapter one sets the scene to the reader about why this research was undertaken, where it was undertaken and theoretical framework guiding the research.

Chapter two reviews pertinent literature and links it to the research questions and the conceptual framework discussed in chapter one. The literature helped to bring the problem into focus, added the breadth of knowledge to the study, and guided the development of questions and the building of the conceptual framework. It also provided a framework through which to identify factors that may be associated with positive outcomes of male involvement during pregnancy, childbirth and the postnatal period based on previous research in other cultural contexts.

Chapter three presents a detailed discussion of how the study was conducted. It summarizes the methods used to collect data in order to answer the research questions, the theoretical perspectives underpinning the research, and data analysis of issues related to socio-cultural factors influencing male involvement in reproductive health during pregnancy, childbirth and the postnatal period.

Chapter four discusses gender similarities in men and women's perceptions about reproductive health problems and their views of the benefits of men becoming involved during pregnancy, childbirth and the postnatal period. Chapter five examines gender differences between men and women's conceptions of reproductive health problems, and their perceptions and attitudes about male involvement during pregnancy, childbirth and the postnatal period.

The barriers to male involvement during pregnancy, childbirth and the postnatal period are presented in chapter six. This chapter also discusses cultural factors and beliefs, health workers' attitudes, infrastructure, policy and systemic barriers to male involvement. The succeeding chapter (seven) examines how these barriers may be overcome and the motivating or enabling factors for men to get involved in reproductive health issues.

Chapter eight discusses the information, support, and services that women need when they are pregnant and after childbirth. Chapter nine summarizes the results of this study, draws recommendations for change, identifies limitations of this study and suggests future research questions.

CHAPTER TWO: LITERATURE REVIEW

2. INTRODUCTION

In 1994, the International Conference on Population and Development's Programme of Action (ICPD/POA) emphasised the need for men to take greater responsibility for their sexual and reproductive behaviour, to promote their active involvement in sexual and reproductive health including: family planning, prenatal, maternal and child health, and the prevention of unwanted and high risk pregnancies. It is argued that for the desired behaviour to be achieved, men's knowledge, attitude and behaviour change are prerequisites to establish a harmonious relationship (United Nations Population Fund, 1994) in their roles as fathers, husbands and brothers (Sonfield, 2004; Ubaidur, 2000, United Nations Fund, 1994). The enabling factors that contribute to how individuals make choices and exercise their sexual and reproductive rights are also identified (Greene, 2000). It was at this ICPD meeting where governments agreed to provide universal access to sexual and reproductive health by 2015 as part of a package to improve the health of the people, reduce population growth and promote sustainable development (Glasier, Gulmezoglu, Schmid, Moreno, & Van Look, 2006).

A year later, the Fourth World Conference on Women (FWCW) held in Beijing further reaffirmed areas of concern for women. These included poverty, education, and health, violence against women, gender equality and human rights. Six years after the ICPD, the United Nations Agencies Heads of State and other international organizations defined a set of goals and indicators known as the Millennium Development Goals (MDGs) for combating poverty, hunger, disease, illiteracy, maternal and child mortality, environmental degradation and discrimination against women (Department of Women's Health, 2003; Singh, Darroch, Vlassoff, & Nadeau, 2003). However, the MDGs are silent on sexual and reproductive health. To some commentators, the exclusion of sexual and reproductive health (SRH) in the MDGs signifies the declining priority of SRH (United Nations, 2005).

Realising this oversight, world leaders at the UN Summit in 2005 responded to this call by adding another target under MDG 5: To achieve universal access to reproductive health. Achieving this goal is central to achieving other MDGs that relate to poverty, child mortality, HIV/AIDs, gender equality and ensuring adequate food (United Nations Population Fund, 2009). Some commentators have questioned whether indeed the Millennium Development Goals will be achieved at all in the face of dwindling financial resources from donor commitments to sexual and reproductive health (Fathalla et al., 2006; see also Glasier et al., 2006; and Women Deliver, 2009), by the global economic crisis, and the effects of climate change (United Nations, 2009). UN Secretary General Ban Ki-moon observes that many countries in Sub-Saharan African and Asia have shown slow progress if the MDGs target of 2015 is to be achieved. For example, the death rate from pregnancy and childbirth has declined only by 1% per year between 1990 and 2005 in developing countries (Women Deliver, 2009). Ban Ki-moon notes that if the MDG 5 (improve maternal health) is to be realised, a 5.5% annual rate of decline is needed. This requires more concerted efforts from all donor communities to address maternal health needs in developing countries by increasing funding levels (ibid).

Historically, most reproductive health programmes have primarily focused on women and children (Food Agriculture Organisation of the United Nations, 1998; Ghorayeb, Ladjali, & Villarreal, 1998; United Nations Population Fund, 2005), especially with regard to family planning, immunisation, unwanted pregnancy and safe motherhood (World Health Organisation, 2002). Past and most current programme planners view women as the target group (Reproductive Health Outlook, 2006) and assume that contraception, childbirth and sexually transmitted infections (STIs) are exclusively women's concerns. Programmes have paid very little attention to the roles that men might have with respect to women's sexual and reproductive health decisions (Barker & Das, 2004; Liow, 2002; Reproductive Health Outlook, 2006). Similarly, research in the area of reproductive health has mainly concentrated on understanding the perspectives and needs of women. This has reinforced men's lack of involvement in safeguarding reproductive health, both their own and that of their partner (Reproductive Health Outlook, 2006; United Nations Population Fund, 2000). Review of the literature indicates that where men are involved, it is to a lesser extent in and with issues such as contraceptive continuation, and acceptability, or to

promote the diagnosis and treatment of sexually transmitted diseases (Greene, et al., 2006).

This female focus is changing. Since the ICPD conference in 1994, relevant programmes have paid increasing attention to male involvement in reproductive health (Liow, 2002) after realising the strong influence that men have on women's health and their access to care (Y. M. Kim & Kols, 2002). As Sharma (2003) notes, however, male involvement in reproductive health including pregnancy, childbirth and postnatal care, is not straightforward and requires complex social and behaviour changes for men. Such involvement requires that men change their attitude and behaviour towards women's health, become more supportive of women using health care services and share child rearing activities (Clift, 1997).

2.1 Purpose of the Literature Review

This review of the literature provides an understanding of male involvement: what male involvement means in terms of reproductive health generally; why male involvement is important in reproductive health; and the extent of current male involvement. The current situation in Malawi, the focus of this research, in respect to reproductive health will be addressed first.

2.2 Reproductive Health in the Malawi Context

In line with the WHO definition of health, ICPD (United Nations Population Fund, 1994) has defined reproductive health as:

A state of complete physical, mental and social well-being and not merely the absence of disease and infirmity in all matters related to the reproductive system and its functions and processes (United Population Fund, 1994, paragraph 7.2).

Reproductive health means that people are able to have a satisfying and safe sexual life and that they have the capability to reproduce and the freedom to decide if, when, and how often they do so. It means that women, men, and youth should have the knowledge and the motivation to access services and other essential supplies so that they are able to make safe and responsible decisions, and they should have the right to access appropriate health care that will allow women to go through pregnancy, childbirth, and postnatal care safely (Glasier, et al., 2006). Reproductive health encompasses concepts that are very important to the well-being of the women,

men, and children including the right to access appropriate information and services that will empower women to have a healthy pregnancy, childbirth, and postnatal period and enhance their lives and personal relations (United Nations Population Fund, 1999). The concept of reproductive health (henceforth RH) is underpinned by the principles of gender equity and human rights (World Health Organisation, 2005).

The current implementation of comprehensive reproductive health in Malawi is in line with the recommendations of the ICPD held in 1994, which emphasised the need to integrate reproductive health into existing health services. This involves discontinuing the use of the vertical programme of services such as Family Planning and Safe Motherhood and integrating the services by providing family planning at Sexually Transmitted Infections (STI) Services. That is, a range of services are provided at the same facility during the same operating hours with same provider (Shears, 2004).

In response to ICPD and the Fourth World Conference on Women in Beijing, the Ministry of Health in Malawi, following recommendations by the Ministry's delegate who attended the two conferences, established the Reproductive Health Unit in 1997, with the mandate to:

1. Coordinate the integration of reproductive health services at all levels.
2. Develop reproductive health policy, strategy and guidelines.
3. Guide implementation of reproductive health.
4. Monitor and evaluate reproductive health services.

In February of 2002, the Minister of Health launched a new National Reproductive Health Programme. The purpose of the programme was to promote, through informed choice, safer reproductive health practices by men, women and young people. The programme was further required to increase use of high quality, accessible reproductive health services. In addition, it was required to enable men, women and youth to access reproductive health services. These reproductive health services are delivered through the public sector, the Christian Hospital Association of Malawi (CHAM), various facilities, and private providers as part and parcel of the nation's primary health care system (Ministry of Health, 2005b). In Malawi, the components of reproductive health are stipulated in the POA (United Nations Population Fund, 1994) and are as follows:

- Family planning;
- Safe motherhood;
- Prevention and management of STIs including HIV/AIDS;
- Management of unsafe abortions;
- Management of cancers of the cervix, breast and prostate;
- Infertility;
- Prevention of harmful practices and female genital mutilation.

However, Malawi added adolescent health to the above list as a priority area to be addressed (Ministry of Health, 2002) because of the many problems that adolescents face such as unintended pregnancy and sexually transmitted infections (United Nations Population Fund, 2009).

According to recent surveys in Malawi, (National Statistics Office, 2004) the status of reproductive health of Malawians ranks among the lowest in Sub-Saharan Africa, which reinforces the urgency of addressing issues relating to pregnancy, childbirth and the postnatal period. The total fertility rate remains elevated at 6.0 (Namasasu, 2004). The maternal mortality ratio of 984 per 100,000 live births is one of the highest in the world (Poedjastoeti & Phoya, 2004). Equally high is the neonatal mortality rate which stands at 27 per 1000. Childhood mortality rates are also unacceptably high, under-five mortality is 133 per 1,000 and infant mortality is 76 per 1,000 excluding neonatal mortality (Mwale, 2004) despite the good health infrastructure. The rate of skilled attendance at delivery is relatively low at 57 percent (Poedjastoeti & Phoya 2004). Other statistics reflecting the poor reproductive health status of Malawians include the estimated STI prevalence rate of 1.9 percent, (Ministry of Health, 2005a) with available literature suggesting that STIs facilitate acquisition and spread of HIV (Ministry of Health, 2005a).

Of great concern is the HIV prevalence rate among those of reproductive age (15-49 years) which stands at 14 percent and the HIV prevalence rate among pregnant women estimated at 16-30 percent (Zanera & Miteka, 2004). Various reports have also shown that in the absence of any intervention, the mother to child transmission rate of HIV can vary from 15-30 percent (Ministry of Health, 2005a). In addition, there are certain Malawian cultural practices which predispose a woman to

the risk of infection. For example, (Coombes, 2001) reports that exchanging husbands or wives is a practice that contributes to the spread of HIV. The Demographic Health Survey (DHS) shows that 12 percent of the population in Malawi is living with HIV and that HIV prevalence is higher in women than men (Zanera & Miteka, 2004). In addition, women who are in a polygamous union, a practice associated with specific ethnic groups and cultures within Malawi, have higher HIV prevalence at 16 percent than those in a monogamous union (12 percent) (Zanera & Miteka, 2004).

Other cultural practices impact on a woman's reproductive health during pregnancy and childbirth. For example, it is believed in Blantyre and Nsanje districts that women who experience prolonged labour while delivering at home must confess to infidelity to facilitate labour. Similarly, in the Muslim community of Mangochi, the husband's family encourages the woman to deliver at home, particularly with the first pregnancy, due to the belief that infidelity of the woman leads to a difficult birth. In the same district, it is believed that if a pregnant woman delivers by caesarean section, it means the husband or the wife had extramarital sexual relationships (Matinga, 1998). When birth complications are experienced, these cultural beliefs often mean that referral to a health facility is delayed which has resulted in maternal deaths (Coombes, 2001).

As a way forward, (Coombes, 2001) suggests the need to emphasise men for greater involvement in, and responsibility for, women's reproductive health, and that every man should monitor the health and progress of his partner's pregnancy, delivery, and post delivery care. She further recommends every man support his pregnant partner and accompanies her to her first antenatal clinic and to the delivery of the baby. This sentiment is echoed in other literature with Bloom et al (2000) also emphasising the need for men to be involved with women's reproductive health during pregnancy, childbirth and postnatal care.

These multiple calls for men to be involved in women's reproductive health are evident. The task then is to examine why male involvement is important in reproductive health and the extent of men's current involvement. First, an explanation of what constitutes male involvement is provided.

2.3 Definition of Male Involvement

There is no clear-cut definition for male involvement in the research literature as it has been conceptualized and operationalised a number of different ways. Researchers and programmers have defined male involvement differently based on what they intend to achieve. For example, at one end of the continuum, Family Care International (2006) observes that male involvement is an ambiguous term. It may range from “setting out a bowl of condoms in the family planning clinic waiting rooms to educating men about women’s health and gender roles” (Family Care International, 2006, p. 1). A more holistic and encompassing definition is given by UNFPA and defines male involvement as: “an umbrella term to encompass the various ways in which men relate to reproductive health problems and programmes, reproductive rights and reproductive behaviour” (C. P. Green, Cohen, & El-Ghouayel, 1995, p. 8). According to Green et al. (1995), male involvement has two key features. Firstly, it refers to the way men accept and indicate support for their partners’ needs, choices and rights in reproductive health. Secondly, it refers to men’s own reproductive and sexual behaviour. Clark et al., (2008) contend that male involvement should be more encompassing. They argue that it should include men’s knowledge of family planning and reproductive health, men’s attitudes about the use of contraception, communication with their partners about family planning, choices about contraceptives, and emotional and behavioural participation in their partner’s contraceptive use.

The use of the term “*male involvement*” is also contested. Other terms used synonymously with male involvement that are worth noting are “*male responsibility*” and “*male participation*” (C. P. Green, et al., 1995). Ghorayeb et al.(1998) argue that the term “*responsibility*” stresses the need for men to assume responsibility for the consequences of their sexual and reproductive health outcomes. Marsiglio (n.d.) argues that “*responsibility*” refers largely to the role the father takes in ascertaining that the child is taken care of and that the resources are available for the child both inside and outside the home (Carlson, 2006). Thus, Marsiglio’s definition reflects the role of the male as breadwinner and head of the household. Food Agriculture Organization of the United Nations (1998) argues that both terms “*male responsibility*” and “*male involvement*” are judgmental for they infer that men are irresponsible and uninvolved. Family Care International (2006) considers that many

men may well be irresponsible, but assert that this may not form the basis for a positive reproductive health programme that involves men and women in a transformative way.

Thus, male involvement reflects the widespread belief that it is now time for men to take their fair share of responsibility in reproductive health (Family Care International, 2006). Many take the view that “male involvement” is a useful term that can encompass many kinds of involvement (Ghorayeb, et al., 1998). Similarly, “male participation” is viewed broadly as it implies participation in reproductive health services for women (Family Care International, 2006). “Participation” indeed is seen by some authors as a term that allows agency, in that men can take a more active role in decision making and behaviours (C. P. Green, et al., 1995).

There is no consensus in the literature about which term best describes the place for men in women’s reproductive health. What is important, however, are the programme implications (Ghorayeb, et al., 1998). What is needed is an understanding of the complex process of social and behaviour change for men to play a more responsible role in reproductive health (Drennan, 1998) including during pregnancy, childbirth and postnatal care. Drawing from the idea that gender is a relational aspect of men and women’s relationships, it is argued that if men are involved in supporting women, it makes them conscious of gender as a social determinant of health and as something that affects their lives as well as women’s lives (Women's Commission for Refugee Women and Children, 2005). The first step towards challenging gender inequalities is the realisation that men need to be part of the solution in efforts to improve women’s health (Wang, 2000) including their reproductive health during pregnancy, childbirth and in the postnatal period. For example, a study in the United States showed that men who were educated about reproductive health issues were more likely to support their partners in contraceptive use, use contraceptives themselves and demonstrated greater responsibility for their children (Bernal & Mehta, 2002). Not only did education change men’s behaviour, it led to men’s support of women engaging in healthy sexual behaviours.

2.4 Why Male Involvement?

It is only in recent years that male involvement in reproductive health has attracted attention in the international public health community. Some authors

believe that this is mostly due to the HIV/AIDS epidemic, which has reinforced the urgency of encouraging men to take more responsibility for their own and their partners' sexual health (Drennan, 1998; Mullany, Becker, & Hindin, 2006; Wegner, Landry, Wilkinson, & Tzanis, 1998). Considering that HIV is spreading more quickly among women than men in some regions, the AIDS epidemic has forced attention on the consequences of men's sexual behaviour.

Review of the literature also suggests that the slow progress in meeting the fifth Millennium goal of reducing maternal mortality in third world countries has compelled countries like Malawi to look for new strategies to maternal and newborn health interventions (Mullany, et al., 2006). Studies have further shown that men's involvement in reproductive health results in better reproductive health outcomes for men, women and their families (Bernal & Mehta, 2002).

The international community, policy makers, programmers and health planners have recognised other compelling reasons to include men in reproductive health programmes (Clift, 1997). Considering that men may control women's sexuality, focusing only on females misses important perspectives that could change behaviour and enhance reproductive health for both men and women (Clift, 1997). For a long time, policy makers have ignored the influential role that men play in sexual and reproductive health. Pan American Health Organization, (n.d.) asserts that failure to incorporate men in sexual and reproductive health has resulted in serious health impacts for themselves and their partners.

It was only after the International Conference on Population and Development that husbands, fathers, brothers, male clinicians and researchers have recognised male involvement as having a positive effect on women's health (Reproductive Health Outlook, 2006). They are leaders and decision makers at the household level, in the community and in organisations that manage reproductive health (Berer, 1996; C. P. Green, et al., 1995; Ntabona, 2002; Piet-Pelon & Ubaidur, 1998). Because men and women reference one another from their perceived social positions vis-à-vis culturally constructed systems of gender, an approach in reproductive health requires the integration of social and sexual roles as part of a dynamic system of relationships (Greene, 2000).

Gender equality may not be possible without the active involvement and support of men because as Walston (2005) notes, opposition to male involvement often comes from women themselves. It is further argued that men need to be reached and included so that interventions for women and girls are not “derailed by male resistance” (Women's Commission for Refugee Women and Children, 2005, p. 2).

Men may enforce cultural practices, often to the detriment of women's reproductive health (Greene, et al., 2006), and still play a dominant role in reproductive health-related decisions and outcomes (Drennan, 1998; Mehta, 2002; Ntabona, 2002; Pantelides, 2002; Sonfield, 2004) in many countries including Malawi. They make decisions about women's contraceptive use and impose conditions in which women exercise their sexuality, sometimes through violent means (Sciortino, 1998). Even in modern societies, women still find it difficult to make decisions about their own lives, restrained by customs and laws that give men the power to authorise or prevent women from seeking sterilisation, or using other contraceptives (Drennan, 1998). Drennan (1998) points out this dominant role for men in reproductive health-related decisions and outcomes continues despite unintended pregnancies, the many thousands of women who die as a result of these pregnancies (Mehta, 2002; Ntabona, 2002), and the women who die from illegal abortions. Review of the literature further suggests that women themselves have requested the incorporation of men into sexual and reproductive health particularly during pregnancy and childbirth (Pan American Health Organization, n.d.). It is time that men play a positive role in women's reproductive health to benefit women, men, their children, and their communities.

Researchers, policy developers and programmers, need to understand male behaviour and attitudes as they may affect reproductive health through the timing and characteristics of sexual initiation, contraceptive use and resources for abortion, prevention and treatment of STIs including HIV, sexual abuse and sexual coercion (Pantelides, 2002). Analytical approaches need to be identified to situate men within the reproductive health processes. While other commentators acknowledge the possibility of exploring these relationships, and potential areas of conflict in sexual and reproductive health (Dudgeon & Inhorn, 2004), attention should be paid also to how different groups of men and women understand, define and experience

reproductive health problems. Because reproductive health depends upon more than one person, it is important that men who also experience reproductive health problems be allowed to explain how they interpret these problems for their own sexual and reproductive wellbeing (Dudgeon & Inhorn, 2004).

To facilitate the positive involvement and engagement of men, Women's Commission for Refugee Women and Children (2005) argues that health programmes need to be multi-layered and address men's behaviour through their multiple roles as sexual partners, husbands, fathers, family household members, community leaders and gatekeepers to health information and services (see also (C. P. Green, et al., 1995). It is important for men to understand that they are necessary partners to reducing maternal deaths and other reproductive health problems affecting themselves and their families (Women's Commission for Refugee Women and Children, 2005). Thus, programmes should be based on the understanding of gender dynamics, on how decisions are made and implemented, on the changing needs of both genders and their interaction. According to Food Agriculture Organization of the United Nations (1998), involving men through the provision of reproductive health information, in a timely and culturally appropriate manner, should lead to more support for women's reproductive health issues.

2.5 Programmes that Involve Men in Reproductive Health Issues

There are several examples from developing countries that attest to the importance of male involvement (Dangor, 2006; Furuta & Salway, 2006; Y. M. Kim & Kols, 2002). In some countries innovative programmes have been successful in involving men in sexual and reproductive health. In Latin America and the Caribbean, they have incorporated gender and life cycle into SRH programmes, creating opportunities for discussion about masculinities and gender equality among men and women, providing services for men beyond contraceptives and reaching men in work places (Pan American Health Organization, n.d.). These programmes provide evidence of the saliency of and support for male involvement and are instructive for exploring male involvement during pregnancy, childbirth and the postnatal period. Specific examples include male involvement in family planning, gender based violence, gender equality and STI/HIV/AIDS and are discussed below.

2.5.1 Male Involvement in Family Planning

Potts (2002) refers to the twentieth century as being the period of increased global population and massive change in the distribution and age structure of the population. He notes that differences in birth rates in the second half of the century were a dividing factor between developed and developing countries and evidence that, globally, most couples all over the world wanted fewer children. Countries with high birth rates responded by establishing family planning programmes (Potts, 2002).

In Malawi, family planning was first introduced in the early 1960s, but was discontinued from 1968 to 1982 because the approach and rationale of the programme was not clearly articulated. As a result, this led to misunderstandings and misconceptions on the part of the general public and policy makers about the intent of the programme (Ministry of Health & National Family Planning Council, 1996). Some people believed that the government was planning to limit the size of the population while others believed that the government wanted to sterilize everybody (Ministry of Health & Chancellor College, 1986). In addition, part of the problem may have been the top down approach where communities were not involved in the planning of the programme. The government continued its effort to re-introduce the programme.

These efforts were realised in 1980 when child spacing was introduced. Since then, child spacing has been an integral part of the Maternal and Child Health (MCH) programme with the number of relevant clinics increasing from 2 to 326 during 1983-1994 (Ministry of Health & National Family Planning Council of Malawi, 1996). The overall objective of the programme was to reduce infant and maternal morbidity and mortality by lengthening the intervals between births so that women could recover from the effects of pregnancy and childbirth and to look after the nutritional and health needs of children (Ministry of Health & National Family Planning Council of Malawi, 1996). Since 1982, Malawi's contraceptive prevalence rate has increased from one percent to 28 percent (Namasasu, 2004). Family planning programmes have been well integrated into service delivery and are perceived to have driven the fertility decline (Namasasu, 2004).

Family planning programmes were offered within the Maternal and Child Health (Toure, 1996) programme and initially catered to women only (Haile, du Guerny, & Shoukal, 2000). Toure (1996) observes this female-only focus reflected a

need to free women from excessive child bearing and to reduce maternal and infant mortality through use of modern contraceptives. Food Agriculture Organization of the United Nations (1998) argues that this approach barred men from accessing services and from exercising a number of responsibilities in the area of reproductive health of their wives as well as the health of their children.

Despite the situation, initially in Malawi many programmes involving males were subsequently established in relation to family planning. Examples include: Banja La Mtsogolo (BLM which means future family); United States Agency for International Development (USAID) Support to AIDS and Family Health (STAFH) project; Association for Voluntary Surgical Contraception International (AVSCI); Johns Hopkins Program for International Education in Gynaecology and Obstetrics (JHPIEGO); National Family Planning Council; Family Planning Association of Malawi; the World Bank's funded Population Family Planning Project; and Family Federation of Finland's project on family planning (Family Planning/Sexually Transmitted Infection Project 1997-2000). Unfortunately, systematic evaluations of these projects have not yet been undertaken. However, the National Statistics Office (2004) reports an increase in the contraceptive prevalence rate from one to 28 percent and that 72 percent of couples discussed family planning. These changes may be attributed to men's knowledge about family planning and changes in the attitudes of men in supporting women's use of contraception (National Statistics Office, 2004).

Available literature also indicates that men have been involved in family planning in other countries. For example, there have been successful programmes for men in family planning in the Agra district in India (Khan & Patel, 1997), counseling and communicating with men to promote family planning in Kenya and Zimbabwe (Y. M. Kim & Kols, 2002), and the Planned Parenthood Association of Ghana's family planning project. A study in Madagascar examined the impact of male involvement in Norplant counseling, decision making and follow up processes and found that women whose husbands were involved had lower discontinuation rates and their rate of satisfaction was higher with the method in comparison to those husbands that were not involved (Blanc, 2001). Analyses of male involvement in family planning in Mali (United Nations Population Fund, 1999) and Bangladesh found that in order for programmes to promote male involvement, they need to provide a conducive environment in which men's contribution to decisions about

family planning are valued and desired. They also found that educating men about contraceptive choices can provide them with the tools to make informed decisions about their own and their wives' contraceptive use (Clark, et al., 2008). In the Men as Partners (MAP) project in South Africa, the programme succeeded in changing men's attitudes by working with men in the delivery of family planning services, making it easier for men to access reproductive health and family planning services and support their partner's access of services (Mehta, Peacock, & Bernal, n.d.).

As a result of men's increased participation, family planning adoption by many women in developing countries has reduced the maternal mortality rate just by reducing the number of unwanted pregnancies among the women of reproductive age (Murphy, 2003). According to the Millennium Development Goal's report of 2009, it is claimed that increased contraceptive use has reduced fertility rates. Thus, male involvement in reproductive health can lead to better outcomes for women, their children, and families overall.

2.5.2 Involving Men in Prevention of Gender Based Violence

In planning for ways to implement successful programmes that involve men in reproductive health, important insights can be made by examining other gender based programmes aimed at improving the health and well-being of women via the inclusion of men. For example, a vast literature on gender-based violence addresses the need to involve men in preventing intimate partner violence and identifies ways to do so. This literature is outlined below.

A review of the literature describes gender-based violence to include sexual abuse (ranging from sexual harassment to insertion of objects into the vagina and rape), domestic violence (Osakue & Van Beelen, 2006), threatening with a weapon and strangling. It also includes harmful practices such as early marriage, female genital mutilation and wife inheritance which cannot be overlooked nor justified on the grounds of tradition, culture or social conformity (United Nations Population Fund, 1999). Violence against women is worldwide and is still a hidden problem even though in recent years women have shared their stories when interviewed (The Johns Hopkins School of Public Health, 1999). It is a violation of a woman's self-esteem and human rights and puts the woman at greater risk of various mental health problems (The Johns Hopkins School of Public Health, 1999).

Globally, women are subjected to violence from intimate partners and sexual violence from strangers and people they know (Murphy, 2003). A survey conducted by World Health Organisation in 10 countries representing different geographic and cultural traditions such as Japan, Peru, Bangladesh and Namibia found that between one eighth and two thirds of women have experienced physical abuse, sexual abuse, or both (United Nations Population Fund, 2009). The study found that younger women were more likely than older women to experience gender based violence (United Nations Population Fund, 2009). Despite being abused, most women remain in abusive relationships without telling anyone for fear of being stigmatised, retribution from their partner, and lack of support from friends and families (The Johns Hopkins School of Public Health, 1999). In fact as one researcher attests, many women are encouraged by their families to stay and not leave violent relationships to preserve culture (Kasturirangan, Krishnan, & Riger, 2004). Several authors have acknowledged that cultural beliefs perpetuate violence against women and reinforce masculinity. Masculinity is a socially constructed concept based on the shared cultural belief that being a “real man” involves men being tough, violent, able to control women (Women's Commission for Refugee Women and Children, 2005), and tolerant of physical punishment as a means to settle disputes. Where dowry is practised, a wife is regarded as a property owned by the man (The Johns Hopkins School of Public Health, 1999). These events illustrate how women are vulnerable to these acts of violence at the mercy of an intimate partner.

Gender based violence predisposes a woman to many sexual and reproductive health problems (Glasier, et al., 2006) including physical and emotional horrors of sexual violation, unwanted pregnancy, exposure to STIs including HIV/AIDS (International Population Centre, n.d.), pregnancy complications (Population Council, n.d.), cruel forms of communication which are psychologically corrosive to relationships and to personal wellbeing (Johnson, 2005), and broken bones (Chakwana, 2004) among others. According to Webster et al. (2001), women experience physical illness resulting from violence including urinary tract infection, asthma, epilepsy, gastro intestinal disorders, severe depressions, suicidal and somatic disorders. In developing countries, it is estimated that rape and domestic violence account for five percent of healthy years of life lost to women of reproductive age (International Population Centre, n.d.).

In spite of the violence that women experience, they often do not report victimisation unless asked (Webster, et al., 2001). For instance, in Malawi, a study conducted by Save the Children Fund (Coombes, 2001) found that community members were reluctant to disclose the identity of the abuser if he was known. Reporting may well depend on public tolerance of whether or not gender based violence is seen as a problem, and if the victim can trust the authorities (Gracia & Herrero, 2006). However, most often, it is kept a secret because of feelings of shame and fears of rejection by the community, husbands or partners, families and neighbours (Interactive Population Center, n.d.).

Internationally, violence against women is a major concern – it is at the heart of human rights issues (The Johns Hopkins School of Public Health, 1999). As a result, the United Nations General Assembly adopted the Convention on Elimination of all forms of Discrimination Against Women (CEDAW), maintaining an international Bill of Rights of women that provides a basis for realising equality between men and women (United Nations Economic and Social Council, 2000). Another milestone, in 1993, was the passing of the Declaration on the Elimination of Violence Against Women, UN Resolution 48/104 (444). This declaration was followed by the Beijing Declaration and Platform for Action providing global direction to further the implementation of human rights and social justice for women. Most countries are signatory to these international legal and human rights instruments and some have even gone further to create new laws to assist women to exercise their rights, but these laws have not translated into action (United Nations Population Fund, 2005). UNFPA claims that law enforcement agents such as the police and the judiciary are not aware of women's rights and their impact on gender based violence, and customary laws often fail to recognise women's rights, particularly in Africa (United Nations Population Fund, 2005).

Countries have established a wide array of initiatives and programmes worldwide in response to gender based violence; some involve men. For example, Punto de Encuentro of Nicaragua involves men in a communication for social change media campaign to reduce intimate partner violence (Greene, et al., 2006). In South Africa, EngenderHealth and Planned Parenthood Association of South Africa have initiated the Men as Partners (MAP) programme to promote sexual and reproductive health (Mehta, et al., n.d.). This programme encourages men to become actively

involved in preventing gender based violence as well as HIV/AIDS (Greene, et al., 2006). EngenderHealth teaches men to examine aspects of gender norms that drive men to engage in risky behaviour. Raising awareness about gender issues is one strategy used to encourage men to develop alternative ways of defining and enacting their masculinity (Mehta, et al., n.d.). The Men as Partners (MAP) approach has resulted in a change in the attitudes and practices of men regarding issues of violence (ibid). In another programme in the United States, a Nurse-family Partnership Programme was developed to teach first time, low income mothers how to establish healthy relationships so that children grow up in environments without violence (Olds, Kitzman, Cole, & Robnson, 1997). This has been among the most successful of programmes in preventing and lowering partner violence; however, only recently the programme began to incorporate male involvement into curriculum (Olds 1997). These new components of the programme have not yet been evaluated in their effectiveness of reducing intimate partner violence, but they emphasise men and women working together to raise their children in households and communities without violence.

2.5.3 Male Involvement in Prevention of STIs/HIV/AIDS

Another public health issue from which insights may be gleaned regarding the inclusion of men to promote women's reproductive health and well-being concerns programmes aimed at preventing sexually transmitted infections, HIV and AIDS. The prevalence of these diseases, their impact on communities, and specific programmes aimed at disease prevention through men's engagement and involvement are outlined below.

Many reports indicate that Sub-Saharan Africa is the worst affected region in the world with 70 percent of adults and 80 percent of children living with HIV (Mocumbi & Amaral, 2006; World Bank, 2004). Other reports have indicated that other regions affected, apart from Africa, include Latin America and the Caribbean (Greene, et al., 2006). Reports indicate that HIV has leveled globally since 2000; however, in Sub-Saharan Africa, HIV still accounts for 67% of all people living with AIDS and for 75% deaths in 2007 (United Nations AIDS, 2008). Even though the trend of HIV is falling, there is still need for effective policy and comprehensive implementation of programmes (United Nations AIDS, 2008).

Many programmes exist that minimize sources of HIV risks and vulnerability and create an enabling environment for all people, and those at risk of exposure (United Nations AIDS, 2008). Lack of information and services contribute to the spread of HIV and STIs (United Nations Population Fund, 2002). Influencing men's sexual behaviour is essential if the number of new infections is to be reduced and this can be achieved by devoting greater attention to the prevention needs of heterosexual men. Such programmes may yield useful results which may empower women and girls to prevent HIV transmission (United Nations AIDS, 2008).

Women and adolescents are at special risk of contracting HIV because sexual behaviour may be unplanned and sometimes a result of force (Karim, 2003). According to Mocumbi and Amaral (2006), economic disparities, social discrimination and unequal roles predispose women to the risk of acquiring the virus. In addition, sexual violence, harassment and exploitation are some of the factors that increase the spread of the disease (Gable, Gostin, & Hodge, 2008). Although the epidemic affects people worldwide, its disproportionate concentration among the poor is well documented (Mocumbi & Amaral, 2006). The general lack of prevention methods that target women suggests that there is also need to promote safer sex and responsible sexual behaviour among men (United Nations AIDS, 2008).

At a macro level, HIV/AIDS has a significant impact on communities. HIV/AIDS contributes to high morbidity and mortality that erode socioeconomic gains. For example, life expectancy has dropped to 40 years in Botswana, Central African Republic, Lesotho, Malawi, Mozambique, Rwanda, Swaziland, Zambia and Zimbabwe (Mocumbi & Amaral, 2006). Worse still is the stigma attached to HIV/AIDS and the abandonment and death that often accompany it (United Nations Population Fund, 2002). Furthermore, evidence suggests that HIV infection results in additional expenses such as user fees and transport costs which poor families cannot afford (United Nations AIDS, 2008). Providing micro finance has been shown to empower women, particularly in low income countries like in Africa (United Nations AIDS, 2008). As Drennan (1998) notes, new studies of men and couples with creative interventions and extensive HIV/AIDS prevention outreach efforts have yielded a number of lessons that can help programmes communicate with male audiences and encourage men's positive behaviour change.

Involving men in reproductive health is central to addressing STIs including HIV/AIDS. Innovative programmes have been initiated to involve men on a broad range of issues relating to HIV and STI prevention. In Ukraine, UNFPA is supporting HIV/AIDS/STI prevention in the armed forces through two projects. The first project was a baseline information survey to assess awareness of HIV/AIDS/STI in the military. The second project involved design of HIV/AIDS/STI prevention education curriculum and relevant education materials (Cohen, Gudkovsky, & Poshtaruk, 2003). The results showed that the impact of the project on knowledge and behaviour was positive with regard to sexual behaviour, use of condoms with casual partners and use of condoms under the influence of alcohol and drugs (Cohen, et al., 2003).

In South Africa several projects have been established, one of which raises the awareness of the interface between gender based violence and HIV/AIDS (Dangor, 2006). Youth sexual health and HIV is a focus of programmes in the Balkans, Bosnia and Herzegovina, Kosovo, Macedonia, Serbia and Montenegro (International Planned Parenthood Federation, 2004). Other projects include a dialogue strategy with truck drivers and their wives and HIV/AIDS prevention among the male population in the Philippines (Morisky, Nguyen, Ang, & Tiglaio, 2005). In this project, peer educators were recruited from taxicab and tricycle drivers to train their peers in different sites using information education materials (IEM) about prevention of HIV, educating and reinforcing safe sexual practices and promoting use of condoms. The results showed that peer education was relatively effective for taxi and tricycle drivers with regard to knowledge, attitude and condom use (Morisky, et al., 2005). Programmes like these that involve men in HIV/AIDS prevention may achieve greater results than those that involving women only. Encouraging men to avoid risky sexual behaviours would play a vital role in preventing new HIV infections in women, motivate men to openly discuss sex and HIV and encourage them to take care of themselves and their families (United Nations AIDS, 2008). As noted, there is considerable variation across different programmes in terms of what they have achieved and what lessons can be learned.

2.6 Factors to be Considered When Involving Men in Reproductive Health

Engaging men to be knowledgeable about and involved in programmes aimed at improving the conditions of women is an important strategy for advancing reproductive health. However, various socio-cultural issues need to be considered to facilitate their involvement (Liow, 2002).

2.6.1 *Socio-cultural Constructions of Masculinities*

Male's attitudes and behaviours, especially regarding health, are influenced by societal expectations about what it means to be a man (United Nations Population Fund, 2000). Definitions about what it means to be a man come from gender socialisation, in which men learn society's standards and internalise these gender standards through culture (Lupton, Short, & Whip, 1992). Socio-cultural definitions of masculinity, however, vary across cultures and so challenges brought about by constructions of masculinity require understanding and adapting to local customs and norms (Hoga, Alcantara, & de Lima, 2001). For example, a study in Brazil found that men who wish to limit their family size face gender norms that equate number of children with virility and discourage men from using reproductive health services of any kind (Hoga, et al., 2001).

Available research suggests that in Africa, the dominant construction of masculinity values virility, strength and control in heterosexual relationships as well as valuing the role of economic provider for the family (Reeve, 1998). Essentially, a man must be a fierce competitor (including for women), be physically strong, sexually successful, a risk taker and able to provide financial support for his family (ibid). A study in Nigeria found that men decide on matters such as family size, when to have sex, and how long periods of sexual abstinence should last (Drennan, 1998), which renders women as objects for husbands to use as they please. Similarly, a study conducted in Chile found that men considered women as sex objects for satisfaction (Hoga, et al., 2001). A study in Malawi conducted by Save Children Fund found that Malawian men initiate sex in 92 percent of relationships and women feel powerless to refuse sex (Coombes, 2001). In the West African context, a pregnancy caused by an adolescent boy is evidence of his reproductive and sexual performance. Similarly, early marriage and early pregnancy are encouraged to ensure continuity of lineage in West Africa (Toro, Jato, & Baro, 1998a).

These features of dominant constructions of masculinity seem to be common across developing countries such as Brazil, India, the Philippines, as well as on the African continent (Hoga, et al., 2001; Toro, Jato, & Baro, 1998b). For example, in a qualitative study in Nicaragua, Sternberg (2000) found that men's concept of machismo views women as sexual objects. They believe their sexuality is inborn and requires effort to control their craving for women and, therefore, view their sexuality through force and strength.

There are social pressures for men to conform to construction of hegemonic masculinity because if they do not conform, the consequences can be severe (Esplen, 2006). Hegemonic masculinity is a pattern of practice which allows men to dominate, oppress and subordinate women (Connell & Messerschmidt, 2005). Esplen (2006) argues that these prescribed traits, as well as the notion that men's sexual needs are uncontrollable or men should have multiple sexual partners, have serious consequences for both men and women, particularly in an era of prevalent HIV/AIDS infection. Clearly, understanding men and constructions of masculinities will assist in working towards gender equality (Bhasin, 2001), avenues for analysing and challenging dominant masculinities (Women's Commission for Refugee Women and Children, 2005) and, hopefully, better reproductive health outcomes for all.

2.6.2 Gender Inequality

Unequal power relations between men and women often limit women's control over sexual activity, reproductive decision making (Drennan, 1998) and their ability to protect themselves against unwanted pregnancy and STIs including HIV/AIDS (United Nations Population Fund, 2000). International agreements and plans of action call for gender equity and equality to be based on principles of human rights as a way of bringing about equality for women (The Manager's Electronic Resource Centre, 2001). Limited education, poverty, high maternal mortality, low life expectancy, constrained opportunity for economic participation outside the household, and early marriage and reproduction (World Bank, 1994) contribute to gender inequality in developing countries. For example, in some developing countries, some women are committed to marriage before they are born (Lauglo, 1999). The risk of school dropout in such countries increases with the number of siblings, with daughters being more likely than sons to stay home to help with household duties (Edouard & Bernstein, 2006). The World Bank (1995) further

points out cultural factors including early marriage, pregnancy and household responsibilities such as performing household tasks and childrearing activities as gender related issues that will prevent girls from remaining in school.

United Nations AIDS (2008) suggests that strategies that can reduce gender inequality and change harmful gender norms should be developed through dialogue between policy makers and the community, have multiple components, and include promoting universal education. Income-generating strategies may be used to empower women to be economically independent rather than depend on their husbands (United Nations AIDS, 2008).

2.6.3 Socio-cultural Factors in Pregnancy and Childbirth

According to United Nations Population Fund, (2001) socio-cultural factors related to pregnancy, childbirth and postnatal care have not been studied widely. They argue that, if these factors were studied, they would play an important role in determining maternal and neonatal outcomes. Nafis Sadik in her address to the Frank A. Calderone lectureship (2001) stated “the frustration is that the area of maternal mortality is a subject about which we know so much in the clinical sense but so little in the social and cultural sense.” She advocates for an understanding of the social and cultural environment if women’s lives are to be saved. This view suggests that, thus far, there is little exploration of social and cultural issues related to childbirth and postnatal care as important elements in reducing maternal deaths. Dungeon and Inhorn (2004) support the need to understand a range of meanings of reproductive behaviour and beliefs within particular social and cultural settings (see also Greene, 2006). As Paulson & Bailey (2002) point out, problems and rights related to reproductive health are formed or constructed at the family, social, cultural, economic and political levels and that is where the focus of interventions should be directed.

In many African countries, sex and reproductive health issues cannot be discussed; they are a taboo (Drennan, 1998). In fact, for women to have too much knowledge about sex is perceived as a sign of immorality. For example, married women who may request safer sex are seen as being unfaithful to their husbands (S. Kim, 2006) and therefore condoms are associated with unfaithfulness. Evidence further suggests that in some communities, particularly in Africa, women are not

permitted to leave home to obtain care unless accompanied by a male family member to the hospital (Greene, 2000), even in emergencies where their spouses may not be available (Orji et al., 2007). In addition, other factors such as religion, local beliefs and other community norms determine individual childbearing and sexual and reproductive behaviour (Oladeji, 2008). These findings clearly indicate the need to study the social and cultural factors in reproductive health including pregnancy, childbirth and postnatal care so that measures, policies and strategies can be developed which are culturally and community sensitive.

2.6.4 Gender Roles and Norms

Gender roles are socially constructed by society and are based on learned behaviours and conditioning (Ministry of Gender and Community Services, 2002). Gender norms refer to societal expectations for males and females and reflect the value that is placed on males vis-a-vis females (Murphy, 2003). Key to both definitions are learning and societal expectations which are acquired through socialisation (Gecas, 2001). According to Gecas (2001), socialisation is a result of social influence which a person acquires through the culture or subculture of his/her group. As individuals acquire these cultural elements, the individual's self and personality are shaped (Gecas, 2001).

The shaping of personality is through "modeling," "reinforcement," "role playing," "social comparison," "direct instruction" and "reflective appraisals" (Gecas, 2001, p. 14527), which takes place within specific contexts of interaction such as family, peers, workplace, day care, the school and even churches (Gecas, 2001). Evidence suggests that the most important context of socialisation is the family, with parents as the most effective agents for socialisation (Gecas, 2001). Within the family, gender roles take on meaning as men and women interaction in relation to one another. They prescribe the division of labour and responsibilities between men and women and assign different rights to them (Murphy, 2003). Further, in a stable marriage or relationship, it is a man's right to decide when the woman should have children (Sternberg, 2007). In Asia, it is claimed that gender roles do shape adolescents' lives and undermine their ability to make informed choices related to sexual and reproductive health. A case in point is where parents prevent sexual activities among adolescent girls but allow sexual encounters among boys (United Nations Economic and Social Council, 2002).

Gender roles discourage couples from discussing sexual and reproductive health matters that encourage risky behaviours and lead to poor reproductive health among men and women (Drennan, 1998). Strong male dominance, particularly in developing countries, contributes to women having little control of their lives and decision making in how many children they wish to have, when they have sex, and whom to marry. From a public health point of view, it is these gender-related inequalities that contribute to reproductive health problems including deaths related to pregnancy and childbirth (Murphy, 2003). Therefore, an understanding of gender related issues between men and women in Malawi will offer ways of developing gender-sensitive sexual and reproductive health programmes.

2.6.5 Women's Empowerment and Autonomy

Women own one percent of the world's property and receive less than 10 percent of its income despite performing nearly two thirds of its working hours (Lupton, et al., 1992). These statistics reflect many societies' patriarchal assumptions (Lupton, et al., 1992). The 1979 UN Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) adopted by the General Assembly (United Nations Economic and Social Council, 2000) and the Fourth World Conference on Women in Beijing held in 1995 acknowledged an agenda for women's empowerment based on the principle of shared responsibility between women and men at home, in the workplace, and in the wider national and international community (Bahai International Community, 1996). The ICPD espoused the view that the empowerment and autonomy of women and the improvement of their political, social and economic, health status are essential for achieving sustainable development.

Empowerment has multiple meanings and interpretations and is more dynamic and comprehensive than the relatively static concepts of "status of women" and "female autonomy" (Dixon-Mueller, 1998). Empowerment is both a group and an individual attribute, both a process (that of gaining power) and a condition (that of being empowered (ibid). Pollack (2000) argues that empowerment refers to a desired outcome or product of social service intervention. Malhotra et al. (2002) take this position further by pointing out that empowerment is used to represent a wide range of concepts and to describe a proliferation of outcomes, including fertility and birth rate decline, access to safe abortions, reduced maternal mortality, reduced incidences and prevalence of infections, migration and individual behaviour. They also contend

that empowerment has been used more often to advocate for certain types of policies and intervention strategies rather than to analyse them.

The issue of empowerment as a “process” has been widely cited in the literature. On the one hand, it has been conceived as a process that people undergo which eventually leads to changes. On the other, it has been defined as a process to change the distribution of power both in interpersonal relations and institutionally throughout society (Lazo, 1993; Maholtra, et al., 2002; Stromquist, 1993). According to Lazo (1993), the process of empowerment has three dimensions. First, it refers to an individual’s potential to acquire power upon (in this case) her own initiative, what Maholtra et al. (2002) call “agency,” or another party empowering her. Second, it is a process of enabling the woman to gain insight and awareness of what is undesirable and unfavourable about her current situation, again what Maholtra et al. (2002) call an “enabling factor” to foster an empowerment process. Third, it is a process for women to generate choices and the outcomes arising from those choices (Maholtra, et al., 2002).

There is consensus that empowerment is based on cognitive, psychological, political, and economic components (Stromquist, 1993). The literature points to interpersonal relations as possible sites of empowerment, which can change over time. It is exercised both by an individual and a group and it suggests that gender relations are, at their core, relations of power (Mason & Smith, 2001). Extending this understanding of empowerment and applying it to women’s reproductive health before, during, and after childbirth means that it will take information and action on the part of women and men to facilitate change that leads to improved reproductive health outcomes for women, men, and their children.

Some researchers link empowerment and autonomy, with the terms being used interchangeably. For example, one study of female autonomy in India notes that autonomy represents the capacity to manipulate one’s personal environment (Mullany, et al., 2006). Autonomy between sexes implies equal decision-making ability with regard to personal affairs and opportunity to make choices that affect women’s life and environment (Mullany, et al., 2006). It has been argued that autonomy specifically implies “freedom” (Dixon-Mueller, 1998; Mason & Smith, 2001), including the ability to leave the house without asking anyone’s permission, the ability to make decisions regarding contraceptive use, freedom from domestic

abuse, and freedom of movement (Lazo, 1993). Autonomy is an anti-hierarchical concept which stimulates critical and creative thinking and action (Stromquist, 1993).

Researchers have further argued that the degree of personal autonomy that a woman can hope to develop depends on the potential autonomy of her social group and of women in general in the society (The Millennium Development Goals, 2005). This means that the autonomy of a social group does not depend exclusively on the personal desires of its members in order for individuals to know what they want in life and how to achieve it, to feel entitled to say no and to affect changes in their environment with a view to fulfilling their aims. They must possess a type of subjectivity that cannot be constructed on the basis of their individual human soul and mind alone (The Millennium Development Goals, 2005).

Several pieces of evidence suggest that women's autonomy and empowerment is associated with, or may have some effect on, lower fertility, reproductive preferences and greater use and adoption of contraceptives (Allendorf, 2006; Dixon-Mueller, 1998; Sandberg, 2006), decreased infant and child mortality and better maternal and child health (Allendorf, 2006). Since empowerment is a process of acquiring, providing, and bestowing resources, it does not just mean "bringing children to immunisation clinics," or attending a health education lecture or participating in micro credit groups, it is about a transformation of power relations between individuals (Ahmad, 1997). According to Program of Action of the United Nations Population Fund (United Nations Population Fund, 1994), education is one of the most important means of empowering women with the necessary knowledge, skills and self confidence necessary to participate fully in the development process and is a key social determinant of health.

Similarly, the Millennium Development Goals have identified that realising gender equality and women's empowerment help to combat poverty, hunger and disease, stimulate sustainable development and foster better reproductive health outcomes. For example, a Nepalese study found that "conjugal rights were extremely unequal and husbands' domination was felt everywhere" (Chapagain, 2006, p. 171). In this study Chapagain (2006) argued that power relations between wives and husbands were determined by factors such as age, education, and income/wealth, position in the family, societal knowledge and exposure to information. That study

found that the right to decide when to enter into marriage, sexual decisions, the timing and the number of children to have, and the right to choose contraceptive methods were controlled by the husband.

2.6.6 *Reproductive Health Rights*

The 1994 International Conference on Population and Development (ICPD) held in Cairo highlighted in the Plan of Action (POA) improvement of sexual and reproductive health as a human rights issue. These rights were internationally recognised and contained fundamental human rights which were also affirmed at the Beijing Conference and various other international and regional conferences (United Nations Population Fund, 2001). They place special importance on the “right to the highest attainable standard of sexual and reproductive health” (Bueno de Mesquita & Hunt, 2006). According to the ICPD’s Plan of Action 1994, reproductive rights:

Embrace certain human rights documents and other consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes their right to make decisions free of discrimination, coercion and violence as expressed in human rights documents (Paragraph 7.3).

According to Glasier et al. (2006), these rights include the advancement of gender equality and equity, the empowerment of women and elimination of all kinds of violence against women, and ensuring women’s fertility control as a basis of population and development related programmes. These rights are not only for women, but men as well. The United Nations Population Fund (2001) advocates for rights for men and women for their overall health throughout their life cycles. They should both be included in making decisions about how many children a couple needs to have, when to have them, and have access to information which should help them make informed decisions. Reproductive rights for men and women mean they should be informed and have access to safe, affordable and acceptable family planning methods of their choice (Bueno de Mesquita & Hunt, 2006).

Reproductive health rights are at the intersections of gender, culture, economy, and reproduction. Meeting these rights in most developing countries is challenging because of social, economic and political barriers to the attainment of good health for girls and women (Thompson, 1999). These factors include women’s

low status in society which places them in subordinate position (Kasanda, 2005). Particular cultural beliefs and practices are also barriers to the provision of sexual and reproductive services (Bueno de Mesquita & Hunt, 2006) including opposition to the exposure to new ideas and information (Thompson, 1999). The inability for women to access emergency obstetric care when they need the services, the non-availability of skilled attendants during childbirth, lack of access to education which results in illiteracy and poverty, particularly among the rural women (Kasanda, 2005), the inability of women to take control of their reproduction, and a country's lack of political commitment are some challenges that need to be overcome (Bueno de Mesquita & Hunt, 2006) if reproductive rights are to be realised.

Internationally, commitment to sexual and reproductive health has dwindled in recent years; some have argued that the ideas promoted in Cairo were idealistic because of the emphasis on issues of empowerment and human rights rather than provision of services (Glasier et al., 2006). In addition, in the face of health sector reform, others believe that decisions to use scarce resources are based on the burden of death and disability attributable to a particular disorder on the basis of measures such as "disability adjusted life years" (DALYs) (Glasier, et al., 2006). Disability adjusted life years (DALY) is a standard indicator of disease burden designed to quantify the burden of disease by taking into account mortality and morbidity (Vlassoff, Singh, Darroch, Carbone, & Bernestein, 2004). What is perhaps of greater concern is that the debates for sexual and reproductive health continue while women die from pregnancy related causes which can be avoided. What is important is that states provide services that would reduce maternal mortality and realise that no one "magic bullet" will achieve sexual and reproductive health for all, but what is required are multifaceted interventions which are tailored to local needs (Fathalla, Sinding, Rosenfield, & Fathalla, 2006). Interventions should include appropriate services for women related to pregnancy, childbirth and postnatal care, access to family planning, emergency obstetric care and information (Bueno de Mesquita & Hunt, 2006).

2.7 Chapter Summary

This chapter explained the need to involve men in reproductive health during pregnancy, childbirth and postnatal care. Contributive aspects of recent international

health programmes and services that involve men including those focused on family planning, gender equality, women's empowerment, gender based violence prevention and prevention of HIV/AIDs/STDs have been discussed. Additionally, the need to incorporate social and cultural factors in male involvement programmes has been identified as critical for successful outcomes. These services have shown that for better reproductive health outcomes to be achieved, men's support is essential because men hold the power to influence societal thinking and decision-making. The next chapter of this thesis discusses the methodology for the present study.

CHAPTER THREE: METHODOLOGY

3. INTRODUCTION

Social constructionism, which underpins this research, requires that processes by which people come to describe, explain and account for the world they live in be analysed and explained in detail (Gergen & Gergen, 2003). People develop subjective meanings of their experiences that are directed towards certain thoughts or actions (ibid). Thus, social constructionism focuses on the generation of meaning and its transmission (Crotty, 1998). These meanings are diverse and multiple, leading the researcher to look for the complexity of views rather than narrow the meanings into a few categories and concepts (Gergen & Gergen, 2003). In addition, knowledge and meanings are historically and culturally constructed as people engage with the world they are interpreting. Meanings are not just stamped on individuals but are produced through interaction with others. Human beings construct knowledge; they create abstract ideas and models to make sense of experiences (Schwandt, 2007). As new experiences emerge, individuals are able to test and modify these constructions (ibid). In Malawi, cultural practices and beliefs have been constructed and upheld over a long period of time. Beliefs have been passed on from one generation to another. These beliefs influence people's behaviour and their interactions with one another. Therefore, if we are to understand the beliefs that people hold, what they mean to society, and how they influence behaviour, social constructionism is an especially useful framework.

From a social constructionist perspective, particular attention is paid to the ways knowledge is historically situated and embedded in cultural values and practices (Crotty, 1998). It tends to explain past and present knowledge with emphasis placed on the languages that support, maintain and determine what is known within cultural boundaries (Gergen & Gergen, 2003). With a social constructionist framework, researchers rely as much as possible on the participants' views of the phenomena under study (Gergen & Gergen, 2003). It was for this reason that in-depth interviews and focus group discussions with men and women were conducted.

Social constructionism focuses on constructed reality and according to Fuller & Loogma (2008), it is part of a wider theoretical framework of symbolic interactionism. The reality (ontology) that is constructed in people's minds is actively created by relationships and interactions. Blaikie (2007) contends that whatever is regarded as "real" is only as such because we think it is real. Epistemology entails how we know what we know (Crotty, 1998, p. 8). These interpretations, of what people know and how they come to know what they know, occur against a backdrop of shared understandings, practices and language emanating from historical and cultural factors (Fuller & Loogma, 2008; Schwandt, 1996). In this study, in-depth and focus group interviews provided the opportunity to engage with the community about gender norms and roles that impact the role(s) that men and women fill in reproductive health.

Drawing on a social constructionist framework, symbolic interactionism helps situate constructed knowledge about women and reproductive health at the micro level where gendered interaction takes place between men and women. Symbolic interactionism suggests that men and women's interactions are based on their gendered beliefs about each other (Snow, 2001). These gendered beliefs are learned through gender socialisation (social interaction, which is most salient in the family) and modified based on men and women's individual interpretations (Snow, 2001) of gender norms. Interactionists therefore, are concerned with the processes by which definitions of situations and self are constructed (Haralambos & Holbon, 1995) and examine how people make sense of their experiences through a common set of symbols (Liamputtong & Ezzy, 2005). Identifying men and women's perceptions of male involvement during pregnancy, childbirth and the postnatal period, which are shaped through gender interaction and shared cultural meanings about men's role in women's reproductive health, can shed light on key aspects of services to be organised and policies to be implemented (Patton, 1990).

3.1 Research Design

A qualitative design utilising both in-depth interview and focus group discussions were used for this research. A key strength of qualitative research design is the ability to gain rich, detailed knowledge about a subject when little is known about it. As this research was exploratory in nature, this design was considered

especially appropriate as the “fundamental purpose in qualitative research is to understand an event, process or situation in greater depth” (Marshall & Rossman, 1995).

There were specific restrictions of the present study that also impacted the decision to utilize a qualitative research design. The unique challenges of conducting research in rural and remote areas where people do not have regular access to telecommunications or electricity, the costs and time constraints associated with travel overseas to collect data, and the challenge of coordinating research funds and protocol across multiple institutions (such as Edith Cowan University, the government of Malawi, the Ministry of Health, and the Australian government’s Department of Immigration and Citizenship) made collecting data using other techniques quite impractical. A weakness of a qualitative research design is the inability to make generalizations from the research sample to the population of interest. To overcome this limitation, several regions of Malawi comprised of diverse groups (in terms of languages, religion and other cultural practices) were chosen to represent as much variability as possible in the population of interest. As a registered nurse, midwife, mother, wife, citizen of Malawi and principal researcher of this study, I was in a good position to identify these diverse research sites. The sampling strategy for this thesis is discussed later in this chapter.

Data came from eight focus group discussions with 93 men and women who are citizens of Malawi. In addition, data were collected from 28 Traditional Chiefs, Traditional Birth Attendants, health professionals, and representatives of civil society using in-depth interviews. Thus, a total of 121 individuals were interviewed for this study. Data were collected from February to July 2008. Participants were purposefully drawn from four rural districts (Dowa, Mzimba, Mangochi and Nsanje) and two urban districts (Blantyre and Lilongwe) based on variability in the tribal and religious groups residing in each district (see chapter one). Mzimba and Nsanje are both rigidly patrilineal and residents speak different dialects, while Dowa and Mangochi districts are matrilineal (see chapter one for details). Collecting data from these diverse groups helped to capture variability and complexity in multiple viewpoints and experiences.

Topics that are related to sexuality and reproductive health are taboo in some of the districts of Malawi where this research is based. As a result, it was important

to interview men and women in separate groups due to the sensitive nature of this research. Women were interviewed separately from men because, in my past research experience, women will not contribute much to discussions about reproductive health when men are present. Oftentimes, women may fail to respond to interview questions because culturally this is how women have been socialized to behave in the presence of men. Furthermore, because men are culturally seen as superior to women, it may be assumed that they know more about reproductive health issues than women. As one writer reported, even if men do not know about reproductive health issues, they may not wish to show their lack of knowledge in the presence of their partners (Ringheim, 2002). In addition, women depend on their husbands for most decision making about reproductive health issues (Bloom, et al., 2000), so it is not likely that women's responses will be independent of men's if they are interviewed at the same time. Finally, women and men needed to be interviewed because little is known about Malawian views about men getting involved in reproductive health issues particularly pregnancy, childbirth and the postnatal period. A list of specific interview questions asked of male and female participants can be found in Appendix A through C.

Interview and focus group discussions started with open-ended conversations to create a free atmosphere to collect rich, descriptive and detailed data. Due to the complexity of engaging with multiple groups of participants who came from different cultural backgrounds, speak different languages, etc. considerable preparation was necessary for data collection, transcription, and analysis. Below, I outline the specific procedures used to gain access to participants and select and train the research team who assisted with data collection and transcription.

3.2 Preparation for Research

Marshall and Rossman (1995) provide a useful description of negotiating access to the site through formal or informal gate keepers. Lincoln and Guba (1985) suggest devoting some attention in how the research team will be composed, how training of the research team will be conducted and how data will be collected. These aspects of research preparation for this thesis are discussed below.

3.3 Gaining Access to the Field

Gaining access to the site through gatekeepers was an important step in this study. Letters to important “gate keepers” (Marshall & Rossman, 1995, p. 69) in the districts were sent as a way of introducing the research topic, its purpose, and the research team. Gate keepers included the Women’s Lobby, Civil Liberties, Human Rights Resource Centre and Society for Advancement of Women, the central hospitals, the Ministry of Health and the Colleges, and then the District Administrators and District Health Officers in the four districts of Dowa, Mzimba, Mangochi and Nsanje. In central hospitals, several individuals were contacted such as the Director of the Hospital, the Chief Nursing Officer and the matron-in-charge of the unit or department that the interview was to be conducted. In the civil society organisations and the central hospitals, the primary researcher contacted the senior management and secured the approval for the interviews to take place. It was necessary to make these contacts in order to gain cooperation and trust from the District Administration and other organisations that were involved

3.4 Recruitment of the Research Team

To select the team of people who would assist with data collection, I chose individuals based on their previous research experience, their availability during the entire period of the research, and their ability to speak one of the languages in the selected sites. Patton (1990) confirms that one cannot understand another culture without understanding the language of the people in that culture. Furthermore, different cultures have special words to tell others what is important about culture and what kind of words they use to communicate with each other. It was therefore necessary to identify individuals to assist with interviewing who would converse with the participants in their first or native languages. Just as medical personnel have their own language with which they communicate to each other about the patient illness, so do the people of different cultures (Patton, 1990). One major task of the research team was to translate the interview guides into the local languages: Tumbuka, Chichewa, Sena and Yao.

Four people were identified to assist with interviews and translations. The team represented multiple disciplines, two teachers and two nurse/midwives were recruited. Although the teachers were not trained in health related issues, their

participation in the research was helpful in providing different lenses with which to view reproductive health issues. Additionally, their participation helped to minimise bias by recording participants' views without altering or editing them. The initial plan was to use a pool of enumerators from the Centre for Social Research (CSR) in Zomba or to use nursing students from College of Nursing. This was not possible for several reasons. Firstly, response from CSR was delayed and threatened the time line of the research. Secondly, transporting the research team from CSR to the central place where training was conducted would have been costly. Lilongwe district was deemed centrally located among the four rural districts for the research. This would have meant providing transport, accommodation and their upkeep, which would have been beyond the resources available for this research. Additionally, for the nursing students, the research timing would not fit in with their College's schedule. The initial plan also included site visits before collecting data but this turned out to be practically impossible due to cost implications and availability of the research team members.

For the above mentioned reasons, refinements had to be made for the plan to fit with the resources available and the schedules of activities for the research team. Marshall and Rossman (1995) provide good advice on these challenges. They suggest that researchers consider time, personnel and financial support for the research to be completed successfully, but also allocating a month or one day per week for the research task. Once the research team was formed, translation of the interview guide was organized.

3.5 Translation of the Interview Guide

Patton (1990, p. 283) defines an interview guide as "a list of questions or issues that are to be explored in the course of an interview." The guide's purpose is to ensure that information is obtained from a number of people in a systematic way (Patton, 1990). Two interview guides were translated; one for in-depth interviews which had three questions and the other for focus group discussion which had seven questions. The interview guides provided the research team members with the areas of interest to be explored during the interviews.

The interview guides were translated from English into three local languages by the research team: Sena, Tumbuka and Chichewa. Translation of the interview

guides into Yao (another local language in one of the research sites) did not take place following direct advice from the district management team that participants who spoke Yao also understand and communicate in Chichewa. The interview guides were translated sentence by sentence. Each translated sentence was then read aloud to another member of the research team to evaluate soundness and clarity, especially to identify if it was easily understood and whether it had the intended meaning or not. This approach was necessary because of the many meanings one Chichewa word has depending on the tone and context within which the word is used (see Patton 1990 for a discussion of how the same words can have different meanings in different cultures).

When translation of the interview guides was completed, training of the research team and pre-testing of the interview guides was undertaken. As Patton (1990) suggests, using an interpreter for conducting interviews is a very daunting task that requires translators or transcribers be adequately trained. This helps to ensure that questions are asked in the way that the researcher wants them to be asked. Additionally, it helps to ensure that during or after the interviews answers to the questions are translated by the research team systematically, without individual researchers summarizing them or editing participants' responses. According to Patton (1990), training translators or transcribers helps to prevent contamination of the participants' responses. In this study, interviews were conducted in the communities' languages. Even though members of the research team were recruited based on their ability to speak one of the languages of the interview site, training was important for consistency in the way they needed to conduct themselves during the interviews.

3.6 Training of the Research Team

Training for field work enhances the researcher's ability to collect accurate and comprehensive information. Training in field methods is very important but also requires individuals with well developed interpersonal skills and the ability to instill trust and good observation skills (M. Silverman, Ricci, & Gunter, 1990). Lettenmair et al., (1994) support this view and summarise three elements required for researchers to be effective: personality, education, and training. They further assert

that training is necessary in interpersonal skills even for the most talented individuals.

All four members of the research team were trained in interpersonal skills. Particular topics covered were: establishing rapport, group dynamics, the use of audio recorders and their role in moderating focus group discussions and the in-depth interviews. The training was held for two days. The first day was used to discuss the in-depth interview guide and logistics during the field trip. The second day was used to discuss the focus group discussion and role play in preparation for the pre-testing exercise. The issues stressed during the role play were: ensuring two way communication, eye contact and not to use mixed languages (English and the local language), not to interrupt before the participant finished his/her sentence, and at the end of the interview to give the participants opportunities to ask questions or make comments about the interview. Experience has shown that participants sometimes open up and add new information to the interview questions or even add some information which they did not remember during the interview this experience is also acknowledged by (Lincoln & Guba, 1985). Follow up or probing questions and treating each participant's views as important during the discussion were issues also covered during the training of the research team. It was pointed out that it was not important for the interviewers to reach a consensus among participants in focus groups, but to allow for diversity of opinion and use probes to obtain a detailed account of an issue or experience (Patton, 1990).

Following the training, the research team "pilot tested" (Creswell, 1998) the interview guides to women at the Antenatal Clinic of Bwaila Hospital in Lilongwe district of Malawi. The site was chosen because it was easily accessible to the research team and it was situated close to where the training was being conducted. Ten women between 20-45 years were interviewed as well as one nurse/midwife from the Antenatal Clinic (ANC). These women had either come to the clinic for antenatal care, family planning or Mother to Child Transmission of HIV (PMTCT). The results of the pre-testing exercise suggested that a question on advantages and disadvantages to male involvement be included immediately after the definition of male involvement on the interview guide. After pre-testing was complete, transcribers were paired up so that one of the transcribers conducted interviews while

the other took notes. Later, transcribers switched roles to ensure they could perform each task accurately and effectively.

3.7 Planning the Logistics

Logistics needed to be considered for the research project as a whole (Lincoln & Guba, 1985) such as finances for data collection, travel and maintenance costs, personnel to conduct the interviews, and time for data collection and transcription of tapes. The timing of data collection was also important. November to May is a very busy period in Malawi. It is the farming season, therefore, special consideration of the timing of interviews was necessary to avoid periods in which the participants would be busy with field work. Consideration was also made to accommodate the funding period of the project, which was from January to July of the same year and the schedule of the transcribers because they all had full time jobs.

3.8 Researchers as Human Instrument

In qualitative research a human (the researcher) acts as an instrument for collecting data and is fundamentally a part of the lives of the participants that are interviewed (Lincoln & Guba, 1985). In this study, the research team's encounters with participants during in-depth interviews and focus group discussions allowed the interviewers and research team to enter into the participants' lives as they narrated their experiences and meanings of male involvement during pregnancy, childbirth and the postnatal period. What makes the collected data legitimate, according to Lincoln and Guba (1985, p. 193), is the fact that humans as an instrument have "privileged access" with "sufficient intensity." This means that humans as an instrument engage with the participants in their own setting in order for the participants to express their views. Some of the characteristics identified by Lincoln and Guba (1985, p. 193) that qualify humans as an instrument are:

1. Being responsive so that the researcher can sense and respond to all individual and environmental signals that may exist;
2. The opportunity to clarify and summarise data immediately at the site and;
3. The ability to process data as they come available and are able to generate hypothesis on the spot.

In this study, the research team was the primary gathering instrument, interacting with participants in their natural setting (Lincoln & Guba, 1985). The research team was in contact with participants for four to seven days in each site in order to understand the realities and experiences of the participants' lives. The research team entered into the lives of the participants, as they constructed their meanings and realities of men becoming involved in pregnancy, childbirth and the postnatal period.

3.9 Purposive Sampling

"All sampling is done with some purpose in mind" (Lincoln & Guba, 1985, p. 199). Therefore, researchers choose their participants based on what they can draw from them (Huberman & Miles, 1994) and the features that are of interest to the researcher (D. Silverman, 2001). Silverman (2001) makes an observation that this does not warrant that any case be chosen but, it should be done within the boundaries that the researcher defines, and within the time available to conduct the research (Huberman & Miles, 1994).

There are several strategies advocated by (Patton, 1990) for purposefully selecting information-rich cases, such as intensity sampling, maximum variation sampling and extreme or deviant case sampling. Maximum sampling was suited for the purposes of this study. It involved selecting individuals from a wide range of roles and positions within civil society and the health care system of Malawi. This sampling technique was chosen to represent the variability of the true population of Malawi because random sampling was not possible and the sample for this study was relatively small due to its qualitative design.

The study population for this research was women and men age 20-87 years and living in Malawi in 2008. The sample consisted of 93 men and women (45 men and 48 women) from rural areas who participated in focus group discussion. Additionally, 28 (11 men and 17 women) people from urban areas participated in in-depth interviews, each of whom had knowledge and expertise in women's reproductive health, including: four Traditional Leaders, four Traditional Birth Attendants (TBA), four civil society members, ten health workers working in the maternity unit of district and central hospitals, four lecturers at College of Medicine and College of Nursing (two from each institution) and also those at policy level

working for the Ministry of Health (two). Given the diversity of roles that each of these groups of participants fills with regard to women's reproductive health, these participants were purposively selected to provide very rich, culturally specific information about pregnancy, childbirth and the postnatal period from several different perspectives.

3.10 Study Participants

A discussion of each group of study participants is provided below.

3.10.1 In-depth Interview Participants

3.10.1.1 Traditional Chiefs

Four Traditional Chiefs, who are very influential, respected and custodians of traditions and norms, practices and values were interviewed. The Traditional Authorities (commonly known as Chiefs) obtain chieftainship through their family clan. Chiefs participating in this research were men between 32 to 80 years of age. Most had no formal schooling or elementary schooling; the remaining had secondary schooling.

Chiefs play a pivotal role in the community as it is their action or inaction that determines the outcome of desired behaviours of the community (Ministry of Health, 2002). They command a great deal of respect from the people they serve. The Chiefs are responsible for dealing with cases of land, family disputes, and unruly behaviours such as thefts and issues related to witchcraft. In addition, they are responsible for development in their own areas in consultation with their group village headmen (see chapter one for details). As a result, Chiefs have considerable power to reinforce cultural beliefs and affect the behaviour of men and women in their villages. Each Traditional Authority was interviewed in his own home. In three of the four districts, Dowa, Mangochi and Nsanje, Chiefs preferred to be interviewed alone. In one district, Mzimba, the Chief's wife was present and he gave no indication (verbal or through his body language) that he was perturbed by his wife's presence.

3.10.1.2 The Traditional Birth Attendant (TBA)

Traditional Birth Attendants are usually older, illiterate women who have acquired skills through delivering their own babies and by working with other TBAs

(United Nations Population Fund, 1997). They conduct antenatal clinics, deliveries and refer mothers to the hospital for child immunisation and family planning services. TBAs perform cultural rituals such as traditional medicine to hasten labour (United Nations Population Fund, 1997). In recent years, due to global debate about their effectiveness in reducing maternal and neonatal mortality, TBAs roles have been refocused in some countries to include providing emotional support during labour and childbirth, identifying pregnant women in the community who might need maternity services, and acting as community educators to lend support for accurate maternal and neonatal health messages (Johns Hopkins Program for International Education in Gynaecology and Obstetrics, 2004).

In some cases, TBAs have wider clientele and conduct more deliveries than some health centres. Like Chiefs, they are well respected and are very influential in the community (Ministry of Health, 2002). While the role of the TBAs has been contested in recent years, critical human resource shortages in Malawi and other low-income countries make contact with professional personnel rare; therefore, adequate care is only available through TBAs or other non-professional health personnel (Oparkhurst & Rahman, 2007). In addition, access to health facilities is limited and most of the population relies on TBAs to meet their health care needs.

Four TBAs (one in each rural district), aged between 43 to 65 years old and married, were interviewed in their own homes, except one who was interviewed at a health post. This particular TBA received conflicting information about where the interview was to take place. One message sent to her was that the interview would take place at her home, while another stated that the interview would be conducted at the health post. She therefore decided to go to the health post for the interview. In another incident, one of the TBAs was visited twice following the transcription of her interview because some of her responses were not clear.

3.10.1.3 Civil Society Groups

Four representatives from civil society between 47 to 57 years of age, two married and the other two widowed, were interviewed from the following organisations: the Malawi Human Rights Resource Centre (MHRRC), Women's Lobby, Civil Liberties (CILIC) and Society for Advancement of Women (SAW). All of these participants had attended secondary education. These participants represent the voices of underprivileged women via their respective non-profit organisations.

They provide education and support to the community and are in an ideal position to deal more openly with issues that are sensitive and not easily discussed within the public sector (Ministry of Gender, 2000). For example, SAW generally provides psychological support to victims of domestic violence through counseling to both victims and perpetrators. They also provide dispute resolution by mediating between the concerned parties. They may refer the cases to the courts if not resolved, and also refer clients to service providers including the police, hospitals and faith communities. In contrast, Civil Liberties are concerned with civic education of good governance, human rights, gender equity and equality and HIV. This organization also provides legal aid services on human rights issues and lobbies and advocates on governance, human rights and HIV. Women's Lobby organization lobbies for increased number of women in parliament and local government. These civil society groups are influential in implementing health policy in Malawi.

3.10.1.4 Health Workers

Health workers, according to WHO's definition, are people who protect and improve health of their communities (World Health Organisation, 2006). Although the term health care is widely used to include even unpaid workers, health workers discussed in this research are paid workers, specifically, nurses, midwives and doctors. Four nurse/midwives working in the hospitals were interviewed in each of the four districts. One nurse was single, the remainders were married, and all nurses were between 29 to 59 years old. It was important to interview this group because they conduct antenatal care services and deliver women in the labour ward; therefore they have direct interaction with and an understanding of women and their experiences from a medical standpoint. Their views may help direct future policy related to male involvement during the antenatal care period, in the labour and postnatal wards.

Five nurse/midwives were interviewed (two from the training institutions and three from the central hospitals or major referral hospitals). Four of these nurses were married and one was a widow. Their age ranged between 38 to 56 years. They provide care to a wider population, not just the population around or within the district where these hospitals are located. In addition, they train other nurse/midwives to provide care. These health care workers are in an ideal position to identify the

gaps in the training curricula and be able to adjust to new concepts and procedures when caring for patients and teaching other nurses and midwives.

Initially, five obstetricians and gynaecologists were supposed to be interviewed. However only four were interviewed, all were men; (two from the College of Medicine and two from major referral hospitals). All of these doctors were married and aged between 41 to 55 years. A fifth obstetrician and gynaecologist refused to be interviewed. Instead, one of the Chief Clinical Officers, married, working in maternity was assigned by the hospital management to be interviewed. As with the nurse/midwives, the doctors in the hospitals are providers of care to pregnant women from antenatal period until delivery. Their views on the involvement of men during pregnancy, childbirth and the postnatal period are very important for policy change and implementation. Doctors in the training institutions prepare the health workforce to provide care. This preparation includes the construction and dissemination of new knowledge, health needs and emerging health demands in the health system (World Health Organisation, 2006).

Two officials from the Ministry of Health headquarters in Malawi (the Director of Reproductive Health and the Safe Motherhood Programme Officer) were also interviewed. These officers are responsible for policy, guidelines and the formulation of standards. In addition, they provide guidance in developing sectoral programmes and work plans in line with approved health policies to government hospitals and other stakeholders in reproductive health. They also facilitate implementation of the Reproductive Health Programme in Malawi. Therefore their contribution to this research was very valuable.

3.10.2 Focus Group Participants

Two focus groups were conducted in each rural district making a total of eight discussions. Participants were recruited through the District Health Offices which were provided with guidelines for selecting the participants. Forty-eight women aged between 20-80 years, and 45 men between 20-87 years of age, were interviewed. In general, focus group participants had received very little or no formal education and worked as subsistence farmers (in the districts of Dowa, Mzimba, Nsanje, and Mangochi). A total of eleven women had never been to school. Three women reached up to secondary school level, while the rest (34) attended up to

primary school level. Among the men, three had not attended school; fifteen had reached up to secondary school level and the rest (27) reached up to primary school level. These gender differences in education follow what has been reported in the literature that women are at a disadvantage compared to men in access to education (World Bank, 1994).

The interview guidelines provided to the District Health Offices required that participants had the ability to provide information about the research topic, that they were willing to participate in the research, that they were 20 years of age and over at the time of the interview, and that the community chosen for the interview was within reasonable distance of the hospital. However, the latter criterion was difficult to achieve particularly in three districts where participants were identified over 100 km from the district hospital. This meant additional cost for transport to travel to the interview scene. The research team decided to go along with the district decision to interview people over 100 km, but the team did reduce the length of time interviewing to defray transport expenses.

Several important aspects of the research sites needed to be considered. First, the communities involved had already been informed of the interviews and it would not have been appropriate to disappoint them by cancelling or rescheduling interviews as many of them had to walk to the interview sites. Secondly, sending information to rural areas is difficult. The privileges that western countries have, with telephones and internet services, are not available in these remote areas. Although some people in the rural areas may have mobile phones, the network may not be available. It may mean alerting an individual to be at a certain place at a certain time to give them information, which is practically impossible. The primary mode of communication is through the radio or organised meetings in the village where information is shared. Alternatively, a messenger can be sent to different places by bicycle to give information to the villagers.

Focus group discussions were chosen as the method to collect data from men and women in rural areas because such discussions may lead to conversations with greater depth and breadth than would normally occur on an individual interview basis (Halcomb, Gholizadeh, DiGiacomb, Phillip, & Davidson, 2007). At the same time, in some districts of Malawi discussions of reproductive health issues are taboo and rarely discussed, especially outside of the home. For example, women and men

in Dowa were more conservative in their discussions of reproductive health compared with their counterparts in Mangochi, Mzimba and Nsanje. Although the privacy of some focus group participants meant less lively discussions in some instances, focus group discussions generated more data and data with greater detail than the in-depth interviews with individuals. It was through focus group that men and women from conservative and rural areas could voice their views about male involvement during pregnancy, childbirth and the postnatal period.

3.11 Data Collection Methods

3.11.1 In-depth Interview

Talking to a person for an hour or more is rewarding because it provides opportunity to understand and appreciate the person's life (Liamputtong & Ezzy, 2005). When individuals speak, it is their voices, expressing their points of views and feelings that is important (McBride & Schostak, 1994). In-depth interviews aim to explore the complex nature of meanings and interpretations that cannot be investigated using structured interviews (Liamputtong & Ezzy, 2005). In-depth interviews can take a myriad of forms they can be focused interviews, unstructured interviews, and non-directive, open-ended, active or semi-structured interviews (Fontana & Fray, 2008). This research entails in-depth interviews based on semi-structured questions that allow room for participants to elaborate on their responses through interviewers' probing. This approach of interviewing allows the interviewer to follow up with issues raised by the participant including those issues that may not be anticipated by the interviewer (Burman, 1994).

As previously mentioned, in-depth interviews were used to collect data from key informants including the Traditional Authority (TA), civil society groups, health workers from hospitals and colleges, and Traditional Birth Attendants (TBA). A four question English interview guide was used to collect data from all the health professionals and the civil society groups. For all but one Traditional Authority who chose to be interviewed in English and for all Traditional Birth Attendants, the interview guides were in participants' native languages of Chichewa, Tumbuka and Sena.

Each interview took between 15 to 60 minutes, which reflects considerable variability in the knowledge and interpretations of participants about the subject of

men's involvement in reproductive health. Some participants simply had much more information to share, while others struggled to respond to the questions on pregnancy, childbirth and the postnatal period. In order to elicit information from the participants, several strategies were used as recommended by Liamputtong and Ezzy (2005). These strategies included wording and rewording the questions as understandings emerged during the interviews. Probing based on participants' responses to the questions and follow ups increased the richness of the data.

In one particularly long interview, the interviewee continually checked his computer throughout discussions. In this circumstance, the primary researcher was patient and asked if it was alright to continue with the interview or make another appointment. The interviewee preferred to continue with the interview rather than reschedule. In another development, one interviewee did not consent to the use of audio recording equipment and his views were respected. Taking notes for this interview was a challenge because it was not easy to keep up the pace with the interviewees responses. As Patton (1990) points out, it is difficult to write down every word as the interviewee is talking and be able to respond in good time to needs and cues. However, immediately after the interview, notes were checked and where there were gaps in the responses, the researcher contacted the interviewee for clarification.

3.11.2 Focus Group Discussions

A number of authors have defined focus group differently. Kitzinger (1995) and Patton (1990) define focus groups as a form of group interview that generates data through the interactions with the participants. Liamputtong and Ezzy (2005) argue that a focus group is not a group interview but a discussion of a focused issue of concern. However, all agree this is an appropriate method to collect and examine data about sensitive issues of culture and sexuality. The nature of this study necessitated that focus groups be used to explore people's perceptions, interpretations, beliefs and attitudes on male involvement during pregnancy, childbirth and the postnatal period in different districts. The reason for choosing focus group discussion was based on the premise that the group interaction will assist people to explore and clarify participants point of view from people with similar social and cultural backgrounds but also from people who may have similar experiences (Minichiello, Aroni, Timewell, & Alexander, 2004). The advantages of

using this method were that more people were reached and able to provide detailed data about their thoughts, feelings, and interpretations of male involvement (Kitzinger, 1995). Focus group discussions further gave voices to rural communities who otherwise would not have had the opportunity to verbalise their experiences and ideas about male involvement (Kitzinger, 1995).

With every advantage there are also disadvantages. Liamputtong and Ezzy (2005) point out those focus group discussions may not explore the complex beliefs and practices of an individual person as with in-depth interviews. However, the experience during the research was that focus groups produced more rich data than the in-depth interviews. The interaction provided insight into the cultural factors and beliefs to male involvement. Focus groups discussed in greater detail issues concerning cultural and institutional barriers to male involvement, reproductive health problems, information and support that women need during pregnancy, childbirth and postnatal care.

In this study, focus groups were organized into groups of twelve participants. This size was considered ideal due to the possibilities that participants may not show up for focus group discussions because of funerals and village events. In such cases, if people did not turn up, the size of the groups would still be adequate to conduct the interviews. Liamputtong and Ezzy (2005) argue that if the numbers are less than six and the participants' contributions are low, it may be difficult to generate interest and maintain the discussion, making it easy for a few individuals to dominate the discussion. As it turned out, the groups' numbers varied from ten to thirteen and very rich data were collected about the phenomena under study. The environment and the seating arrangement (circular so that no one felt superior to the other) made it possible for participants to discuss freely and share their views and feelings about male involvement during pregnancy, childbirth and the postnatal period.

The focus group discussions were conducted in a native language and the moderator's role was to stimulate discussions and keep things focused on the topic (Liamputtong & Ezzy, 2005). Focus groups were conducted in the same village where the participants were drawn from but at a neutral location within the villages. For example, one discussion was conducted in a church, one at a health centre and the other at the Agricultural Training Centre. The sites were chosen by the district hospital team so that the research team could conduct the discussions in locations

that were reasonably quiet and free from distractions (Creswell, 2007). However, the interview conducted at a health centre was conducted in the office of the officer-in-charge. This caused concern that the interviews would disrupt the health centre's activities and it may also have made participants uneasy. Disruptions like these added to the length of time taken to conduct the focus group discussions.

Before each focus group discussion commenced, introductions were made between the research team and participants. Thereafter, the facilitator of the focus groups explained the purpose for the research and how long the session was expected to last. Information sheets explaining the research, participants' rights, and contact persons (should the participants require further information or have concerns with the ethics of the research) were read aloud and distributed. It was necessary to read the information sheets aloud because some participants were illiterate. Participants were asked to sign a consent form. For those participants that were not able to sign the consent form, a rubber stamp was given to them for their thumb print.

3.12 Culture Sensitivities

It was important that interviewers pay special attention to the language used for issues related to sex, childbirth or reproductive health. During the interviews, sensitive questions like culture and childbirth were not responded to directly. For instance, when participants were asked about barriers to male involvement, a common response was "we should not do those things." What this means is that men and women should abstain from sexual intercourse when the baby is born. Mentioning sexual intercourse is considered taboo and participants found it difficult to discuss some of the words associated with male and female anatomy. When the subject was brought up, participants directed their gaze away from other participants and interviewers, or avoided the question by responding to something off the topic. This was evident in all the four districts particularly during the early stages of the discussions among older men and women.

In instances where older participants were hesitant to talk about sex related issues, younger participants would jump in and explain what the other person was trying to say. The interviewers were therefore very sensitive to the way questions were framed. Using translators/transcribers was extremely helpful because they used words that were culturally acceptable in certain circumstances. Kitzinger (1995)

attests that interviewers need to be keenly aware of different forms of communication that people use in discussing sensitive topics like sexual and cultural issues. As the interviews progressed, participants gained confidence in the interviewers, and opened up and shared their thoughts, meaning and experiences. For instance, during the initial stages of an interview, one participant expressed her concern that discussing issues related to men being present during childbirth was “difficult,” but as the interview progressed, she opened up and expressed that “men should be present during childbirth [because they will know] that we suffer during childbirth.” As Patton (1990) points out, being sensitive and respecting other people’s values and norms builds trust on the part of the participants, allowing them to open up and share their knowledge and experiences.

3.13 After the Interviews

After the interviews, participants were given opportunities to ask questions related to the topic of study and make any last minute contributions or comments. These last minute comments provided additional responses to some of the questions already asked, contributed new information to the research questions and deepened the richness of responses. Some participants took the opportunity at the end of discussions to ask questions related to hospital management. For hospital related questions, the interviewers referred participants to the hospital personnel who accompanied the team to research sites. Thereafter, the interviewers thanked participants for their participation in the study. Before leaving each district, the interviewers also provided feedback to the District Health Officers about how the interviews progressed, and thanked the officers for allowing the research team to conduct interviews in their district. The research team met after each interview to discuss how the interviews of the day progressed and what, if anything, needed to be done to improve the next interviews.

3.14 Audio Recording

Using audio recorders during interviews has many advantages. Audio recorders provide data which is complete, so the researcher has the opportunity to review the tape as often as is required in order to have a full understanding of the data (Lincoln & Guba, 1985). Audio recording also allows the interviewer to maintain eye contact with the interviewees so that it is possible to take notes about

the context of the interviews, characteristics of participants, etc. (Liamputtong & Ezzy, 2005).

Audio recorders were used for both in-depth and focus group discussions in order to increase the accuracy of the data collected. Two recording devices were used, a tape recorder and a Dictaphone, in the event that one piece of equipment failed to function. During the first focus group discussion, the audio recorders were positioned at the centre of the circle and participants were asked to project their voices when talking. Each participant was given a number which would identify him/her during the transcription. After the interview, transcribing the tapes proved to be very difficult because some of the participants spoke very softly and quietly and were difficult to comprehend, a problem experienced by Liamputtong and Ezzy (2005). Even though it took a long time to transcribe this recording, it was possible to fill in the gaps by using both devices. The Dictaphone proved to be more powerful than the tape recorder for this purpose.

The experience of the first interview with the tape recorders made the research team change the strategy of recording. During the subsequent interviews, one member of the research team was assigned to move around with the devices to record each participant who wanted to contribute. As a result, recordings were more audible and provided a detailed and accurate account of all verbal communication. The other member of the research team was assigned to take notes during the interview by locating important words or quotes and noting non-verbal cues. A tape was used for each interview and labelled thereafter to prevent the recording over a previous interview (Liamputtong & Ezzy, 2005).

3.15 Transcribing Interviews

Transcribing interviews means representing the recorded interviews on paper in a form of a text (Huberman & Miles, 2002). Strauss and Corbin (1990) suggest transcribing only as much as needed. On the other hand, Patton (1990) prefers to obtain full transcription of the interviews because the raw data of interviews are quotations. Various types of transcription are available (Kowal & O'Connell, 2004). For the purposes of this research, standard orthography and eye dialect were used. Standard orthography is based on written language norms which make transcription easy, but it fails to distinguish the language that is spoken, for example omission of

sounds. Eye dialect departs from standard orthography and uses colloquial language in terms of sounds such as laughter.

The research team transcribed all the tapes verbatim to ensure that meanings and experiences were captured in the participants' own words as faithfully as possible. After each interview was transcribed, the research team members cross-checked each transcript to ensure reliability by listening to the tape again. In one case, transcripts from one district required re-transcribing by the principal researcher due to a transcriber's error.

There were several advantages to having the research team transcribe the tapes from interviews. Transcribing the tapes helped us to know the data very well and appreciate the participants' views, attitudes and experiences about the topic of the study. It also helped the primary researcher to identify the values, beliefs and understandings of each person interviewed (McBride & Schostak, 1994). Furthermore, it helped the principal researcher to identify common words which frequently recurred throughout the transcriptions and to note quotes that were very important to the study questions. In addition, it allowed for the identification of key themes that were emerging (McBride & Schostak, 1994) in the data as it was collected. Transcription provided insights to uncover gaps regarding how questions should be asked in the future, worded, and what other questions needed to be asked as follow up (Liamputtong & Ezzy, 2005).

Because interviews were conducted in several languages, the process of transcription involved first transcribing the interview in the language that the interview was conducted. The interview was then translated into another native language which is nationally spoken to ensure the interviewee's and participants perspectives were not lost. Finally, the transcripts were translated into English. During transcription, there were local words that proved to be difficult to translate in English as (Patton, 1990) also observed. In such cases, the words were quoted in the local language and transcribers offered explanations for the words or ideas illuminating from them.

Each transcript had the following information: participant's name, date, time and place of the interview, length of the interview and background information. After transcription was complete, two copies were made of each. One copy was kept

securely in a safe together with all the tapes, while the other copy was used for analysis as recommended by Patton (1990), and then the transcripts were imported into NVivo 8 to facilitate analysis.

3.16 Data Analysis

Qualitative data analysis, as Huberman and Miles (2002) point out, is about detecting and defining the tasks, categorising, theorising, explaining and exploring the data. It is a process which brings order, structure and meaning to the data (Marshall & Rossman, 1995). The procedures used to analyse the data for this thesis are explained below.

3.16.1 Thematic Analysis

Thematic analysis is the process of identifying, coding and categorising primary patterns of data. This means analysing the content of the interview or observations (Patton, 1990, p. 381). It involves inductive identification of the codes from the data, and examining the codes for meaning (Minichiello, et al., 2004). In addition, the interviewer looks for themes expressed in the transcripts. The steps used for analysis of the data were: immersion of data or familiarisation (Huberman & Miles, 2002), coding, creating categories and the identification of themes.

3.16.2 Immersion of Data

The primary researcher immersed herself in the data by reading and re-reading the data and highlighting key words to gain an overview or general picture of the data. This process began as the data were being transcribed. After transcribing, the primary researcher read through all the transcripts and field notes to get a sense of the main data issues (Gibbs et al., 2007; Huberman & Miles, 2002). Immersion in the data led the researcher to create a list of key ideas for analysis (Pope, Ziebland, & Mays, 2000).

3.16.3 Coding

The next stage was to create clusters identified as concepts to form categories and their sub-categories. The data were reorganized according to conceptual themes. The concepts were coded to each “node” according to their meanings and content in NVivo 8. Nodes consist of thematic categories (parent nodes) and their sub-categories (child nodes) organised in a hierarchical order moving from general

categories to specific categories of data. Similar themes and ideas were put together. This process involved sifting and sorting concepts according to key issues (Huberman & Miles, 2002). By continuously looking for similarities and differences among categories and refining the data to ensure homogeneity within categories and heterogeneity between the categories, a reduced data set for both focus group discussion and in-depth interviews was achieved from 509 to 200 key concepts.

Table 2: Sample of Coded Data

Parent Nodes	Child nodes
Understanding of Reproductive Health	<ul style="list-style-type: none"> • Promiscuity
	<ul style="list-style-type: none"> • Maternal death
	<ul style="list-style-type: none"> • Neonatal death
	<ul style="list-style-type: none"> • Loose blood after delivery
	<ul style="list-style-type: none"> • Swelling of legs

Table 2 illustrates what men and women defined as reproductive health during the interview.

3.16.4 Cases and Attributes

Upon completion of data coding, the primary researcher created cases for each participant interviewed. Each participant's attributes including age, gender, education, language and district were identified to be important elements for analysis and these data were attached to each case. Attributes assisted the researcher in answering research questions related to participant's thoughts about male involvement during pregnancy, childbirth and postnatal care as they varied by districts, age-group, education level, and gender.

3.16.5 Development of Themes

Data sets for both focus groups and in-depth interviews were merged so that all data could be coded for major themes related to male involvement in reproductive health. The merging of categories that were identical continued until no new

information was obtained to provide further insights into the sub categories (Creswell, 1998). Though Creswell (1998) recommends reducing the number of codes to five or six categories that become themes in the study, this research reduced the categories from eleven to eight:

1. Main reproductive health issues;
2. Cultural and religious beliefs;
3. Barriers and cultural beliefs to childbirth;
4. Knowledge and understanding of reproductive health;
5. Thoughts about men being involved;
6. Support services women need;
7. The community needs information;
8. Effects of male involvement in reproductive health.

From these categories the following themes were derived:

1. Gender similarities in male involvement
2. Gender differences in male involvement
3. Barriers to male involvement
4. Overcoming barriers and motivational factors to male involvement
5. Information and support needs for pregnant women.

These five analytic themes of the data are discussed in chapters four through eight.

3.16.6 Data Queries

After creating nodes, cases, attributes and coding all of the data, it was necessary for the researcher to interrogate the data to find patterns, specific words and frequently used metaphors and phrases to answer the research questions. Queries were run via the NVivo 8 computer programme on issues such as the knowledge and understanding of male involvement, benefits of male involvement, health beliefs, barriers to pregnancy, childbirth and the postnatal period, community sensitisation and what men and women think about men getting involved during pregnancy childbirth and the postnatal period.

3.16.7 Rigour Procedures

Rigorous methodological procedures are essential if the research is to be accepted as reliable and useful by other researchers. Available literature indicates that the quality of qualitative research cannot be determined by following prescribed formulas (Seale & Silverman, 1997). Others have argued that qualitative research cannot be reproduced or replicated by different researchers and that therefore it lacks generalisability (Mays & Pope, 1995). Others contend that quality of qualitative research “lies in the power of its language to display the picture of the world in which we discover something about ourselves and our common humanity” (Seale & Silverman, 1997, p. 380).

The debates have lead to some qualitative researchers adopting new criteria for determining reliability and validity to ensure rigor in qualitative inquiry (Lincoln & Guba, 1985). Guba (1990) translated internal validity to credibility, and external validity to transferability, reliability, dependability, confirmability and authenticity criteria as one way of ensuring rigor, particularly in constructivist assumptions (Morse, Barrett, Mayan, Olson, & Spiers, 2002). For this research, rigour was achieved systemically using in-depth and focus group interviews to collect “authentic” understanding of people’s views (Seale & Silverman, 1997) in their own environments by using interview guides. Interview guides ensured that interviewers asked questions that allowed them to follow up issues raised by participants that were of interest to interviewers. The main questions were asked in the same way during interviews and focus groups. This increased the likelihood that participants understood the same questions in the same manner and that if asked these interview questions again, their responses may be similar or the same.

3.17 Chapter Summary

This chapter has presented the methodology and methods for data collection for this research study. A social constructionist framework and symbolic interactionist perspective have been used to make sense of the meanings that people have about their world view and how they interpret these meanings. Focus group discussions and in-depth interviews are the methods of choice to capture people’s views about male involvement in childbirth, delivery, and postnatal care.

Focus groups discussions were conducted with men and women of reproductive age group and beyond in four rural districts. Additionally, in-depth interviews were held with Traditional Leaders, health workers and civil society groups. Preparation for research included getting resources to conduct the research, training the transcribers and scheduling field work. Access to the field to collect data required permission from different gatekeepers by writing to them or by contact through telephone so that data collection could commence. Raw data were then transcribed verbatim, coded and analysed using thematic analysis. The results of this research are presented in the next five chapters.

CHAPTER FOUR: RESEARCH FINDINGS

GENDER SIMILARITIES IN WOMEN’S and MEN’S PERSPECTIVES OF MALE INVOLVEMENT

4. INTRODUCTION

This chapter presents women and men’s understandings of male involvement in reproductive health during pregnancy, childbirth and the postnatal period. In particular, I discuss gender similarities (or agreement) between men and women in their perceptions of the roles that men should fill (or not fill) during their partner’s pregnancy, childbirth, and the postnatal period. Both men and women were asked to describe what reproductive health means to them, what male involvement means, and then to discuss their attitudes about male involvement during pregnancy, childbirth and the postnatal period.

4.1 Background of Female Participants

Data came from a total of 65 women who were of childbearing age (20-49 years) and older (50 to 80). Forty-eight women were from rural areas (Dowa, Mzimba, Mangochi, and Nsanje) and participated in focus group discussions. The remaining women were from urban districts in Malawi (Lilongwe and Blantyre) and were interviewed face to face. Participants from urban districts had experience working in reproductive health or assisting women with childbirth and included four Traditional Birth Attendants (these four TBAs were from Dowa, Mzimba, Mangochi and Nsanje), four members of civil society groups focused on gender issues, and nine health workers. Out of these nine health workers, two were nursing/midwifery lecturers, three nurse/midwives from central hospitals, and four were nurse/midwives from the four district hospitals. The table below presents a summary of demographic indicators of the women interviewed expressed in percentages. The demographic backgrounds of women are diversely represented, although the majority of women (most especially from rural areas) have little to no formal education and nearly all women are married.

Table 3: Demographic Characteristics of Women Interviewed

Age	Number of Participants	Percent
20-29	12	18.5
30-39	11	16.9
40-49	10	15.3
50-59	17	26.1
60-69	8	12.3
70-79	6	9.3
80-89	1	1.6
Educational status		
No Education	11	16.9
Primary	39	60.0
Secondary	15	23.1
Tertiary	0	0
Marital status		
Married	51	78.5
Divorced	1	1.5
Widow	12	18.5
Single	1	1.5
Districts		
Blantyre	4	6.1
Dowa	12	18.5
Lilongwe	4	6.1
Mangochi	14	21.5
Mzimba	16	24.7
Nsanje	15	23.1
Total	N=65	100%

4.2 Background of Male Participants

Fifty six men between the ages of 20 to 87 years were also interviewed. Forty five of these men lived in rural areas and were interviewed in focus group discussions. Eleven men from urban areas participated in in-depth interviews. These eleven men comprised doctors/lecturers, Traditional Leaders and government officials. Men working in these roles were interviewed for specific reasons. It was important to capture the views of the Traditional Leaders as these are people of influence in their villages. The doctors, on the other hand, are responsible for delivering and managing pregnant women. Pregnant women need to receive appropriate and timely care and this may happen if practitioners are well educated in obstetric and midwifery skills (Sherratt, 1999). The lecturers impart knowledge and prepare practitioners like doctors with skills that will help to reduce maternal morbidity and deaths. Their training, teaching, and administration of reproductive health shape future services provided to women in Malawi. The government officials are responsible for policy formulation and provide guidance for reproductive health services in Malawi. It was important to get their views with regard to male involvement during pregnancy, childbirth and the postnatal period.

The table below presents demographic information about the male participants in this study. Compared with female participants, men were more likely to have a higher level of education (beyond secondary school) and less likely to be widowed or divorced.

Table 4: Demographic Characteristics of Men

Age	Number of Participants	Percent
20-29	14	25.0
30-39	12	21.4
40-49	12	21.4
50-59	5	8.9
60-69	8	14.3
70-79	3	5.4
80-89	2	3.6
Educational status		
No Education	4	7.1
Primary	27	48.3
Secondary	19	33.9
Tertiary	6	10.7
Marital status		
Married	53	94.6
Divorced	0	0
Widow	0	0
Single	3	5.4
Districts		
Blantyre	3	5.4
Dowa	11	19.6
Lilongwe	3	5.3
Mangochi	14	25.0
Mzimba	12	21.4
Nsanje	13	23.3
Total	N=56	100%

In this study, women's and men's accounts are presented as they were spoken during interviews, in order to stay as close to the data as possible. In places where a

participant discussed things that were not directly related to the discussion or interview questions, this was omitted and is indicated by an ellipsis (...). In other places, words have been added to better explain what the participant was referring to and this is indicated by brackets [].

4.3 Research Context

There were some important differences in how participants reacted during focus group discussions in each of the four rural districts. Before discussing participants' responses to interview questions, I explain differences in participants' reactions and provide potential explanations for these differences.

4.3.1 Dowa District

Women in Dowa district were very conservative in discussing cultural and sexual issues surrounding reproductive health. Some women initially suggested that these issues should not be discussed; however, as interviews progressed, women opened up slightly. This was in sharp contrast with men. Men were relatively forthcoming about sharing their experiences and cultural beliefs with the research team. Women's hesitancy to discuss reproductive health did not come as a surprise as issues related to sex and culture is considered taboo. Recall that Dowa is considered a politically conservative district compared to the other districts in this study. This reluctance to be forthcoming about their experiences and cultural beliefs about male involvement may be related to the composition of the focus groups, which were sex segregated. As Walston (2005) notes, opposition to male involvement often comes from women themselves. The implication of women being interviewed in a group of all women is that some of the more conservative women were inhibited in their discussions during the focus group. Despite this and considering the cultural context of the research sites, women were more likely to participate in focus groups with other women, and the data richer, than in focus groups comprised of men and women.

One woman in Dowa indicated that the hospital usually tells women what to do and was concerned when the research team did not do the same during her focus group discussion. Based on her experiences at the hospital, she held the expectation that the research team would provide answers to interview questions for participants.

“It’s because...we were taught that after six weeks when a woman has delivered, we should tell her that she should be going to the hospital to start family planning injection, that is what we tell them, it’s because we did not learn this.” A 62 year old woman, Dowa

This woman was emphatic that the research team teaches her how to respond to the interview questions despite the researcher informing her that it was not my role to tell her what to say. *“Yes, I told you that you should teach me because I am gasping for air (ndikubanika),”* a 62 year old woman from Dowa proclaimed.

Participants in Dowa gave the research team the sense that in the past, they had experienced interactions with health workers as orders, rather than opportunities to gain knowledge to make informed choices. In situations where women expressed concern about answering questions, the research team reiterated that the purpose of the study was to hear participants’ thoughts and document their viewpoints. This helped participants understand the need to be honest and open during interviews, rather than provide information that they thought the hospital wanted them to, or what they anticipated that the research team wanted to hear. In the focus groups in the other three districts, Mzimba, Mangochi and Nsanje, men and women were less restrained in their discussions of sensitive issues related to women’s reproductive health.

4.3.2 Mzimba District

Initially, the Mzimba women were not entirely at ease to discuss cultural issues related to reproductive health. As the focus groups gathered momentum and a few women participated in discussions, more participants opened up and informed the researcher about their cultural beliefs relating to pregnancy, childbirth and the postnatal period. Similarly, men found it difficult to talk about cultural factors related to reproductive health, but were able to freely discuss other questions related to pregnancy, childbirth and the postnatal period. I explore the sensitive nature of participants’ discussions of cultural aspects of reproductive health further in chapter six.

4.3.3 Mangochi District

Like in Mzimba, Mangochi women were initially shy to discussing sensitive issues related to reproductive health. During interviews in this district, participants looked to the older women to start the discussion and then others joined in and

contributed. The younger women may have been afraid to respond initially for fear of saying something that the elders may not have wanted revealed and this would have caused problems for them. The men, on the other hand, stated outright that men's presence during childbirth is obscene and disrespectful to women. In this district, young and old men had heated debate about men's presence during childbirth (I discuss this later in this chapter).

4.3.4 Nsanje District

Nsanje women were perhaps the most open to discussing sensitive issues of reproductive health, and provided more information than was asked. The young and the old shared their views with regard to male involvement during pregnancy, childbirth and the postnatal period. A possible reason for their openness could be that they have been interviewed before by other researchers. Some women in Nsanje had previously participated in a radio programme about women's issues and this may have given them the confidence to talk freely when interviewed for this study. Secondly, it could be that they wanted a forum to vent their frustrations with regard to the violence and cruelty they were experiencing. Women interviewed in this district indicated there was a prevalence of domestic violence experienced by some participants. It may also be due to the fact that they were well informed by the District Health Officer, the District Commissioner and the Traditional Authority of that area about this research and may well have been told that this would be an opportunity for the villagers' voices to be heard. Similarly, men in this district were generally open in their discussions, but a bit guarded when discussing cultural beliefs about male involvement.

Next, the results of focus group discussions and in-depth interviews with the women and men in this study are presented. There were similarities in men and women's views about male involvement in reproductive health and these similarities are discussed as five main themes derived from the data. These themes concern the type of work men and women should do when women are pregnant, that reproductive health should involve family planning, men's roles in pregnancy, childbirth and the postnatal period, the benefits of male involvement, and the ways in which men should take care of the mother and baby in the postnatal period. Given the complexity of the languages and meanings expressed by participants in this study, it is important to note that participants rarely discussed these issues in a linear

manner. Although some of the discussions presented in this chapter may seem repetitive, the complexity and connectedness of these themes about male involvement in reproductive health must not be viewed as mutually exclusive concepts. These themes are discussed in detail below.

4.4 Work for Women and Men

Participants explained that women and men in Malawi perform different kinds of work. Work for women involves daily, routine, physically difficult household labour. This includes farming, cooking, sweeping, fetching water, collecting firewood, and pounding maize, while simultaneously caring for their children. Work for urban men may entail employment in the paid labour market, if available, or for rural men who are subsistent farmers, piece or casual work. These gender roles, Woody & Eagly (2002) argue, emerge from productive work of the sexes and distinguish stereotypic features of men and women required to carry out sex-typical tasks. Women occupy roles such as cooking and providing emotional support while men perform economic provider roles such as resource acquisition to support the family (Wood & Eagly, 2002). The roles that men and women fill in families, as mothers and fathers, are organised and maintained by cultural constructions of gender.

Participants explained that the work that women carry out when they are pregnant does not differ to the workload that they carry out when they are not pregnant. But, the work women do is physically taxing and therefore can have significant consequences on their health while they are pregnant. Work affects the condition of women's bodies, their energy levels, their ability for the bodies to provide nutrients to the unborn child, etc. Yet, in Malawi there are social expectations from peers, in-laws and their husbands that they remain strong, and that pregnancy does not make them "lazy." For a woman to continue working while she is pregnant, despite possibly affecting her health and her baby's health, gives her pride that she can work throughout her pregnancy (Huque, Leppard, Mavalankar, Akhter, & Chowdhury, 1999). Furthermore, such behaviour fits with socially constructed definitions of what it means to be a good wife (Do Thi Ngoc Nga & Morrow, 1999). This 20 year old woman from Mangochi explained what hospitals advise women to do:

“When the woman is expectant as they tell us at the hospital, she is supposed to do different types of work. But you should not overdo them, so that the thing [baby] inside you should be relaxed. And if a person is lazy, the baby also becomes lazy. [If you are] active, then the baby will be strong.”

Such statements reflect strong cultural beliefs that connect the behaviour of the mother during pregnancy to the health of the baby. Some men also explained why they should not expect their wives to do heavy work. They observed that when women are pregnant, consideration should be made on how much work they can do. Pregnant women should be given light work.

“When your wife is expectant, you should not allow her to work hard. No, she should be doing light work because some of us have this behaviour where you want [her to work] ... as if she were not expectant. You want her to be doing the same kind of work that she was doing before she got pregnant. When you are going to the garden, you say, „you are slow,” because as a husband you don’t know that she has a lot of problems thinking of her pregnancy. So you should be considerate to allow her to carry out light work.” an 80 year old man, Nsanje

Men equated the idea of women doing light chores as a form of exercise. Exercise during pregnancy is important because it helps with digestion, lowers stress, and it gives energy. Therefore, in some respects, men thought that women may benefit from doing light household chores because it would help them to stay active. One participant explained the importance of a woman exercising during pregnancy so that the baby grows strong:

“Another point [about] reproductive health, when a woman is pregnant, she should not just sit but walk around so that her body should not just sit and not relaxed, no! But she should be doing small chores and she should also be doing some exercises.” a 50 year old man, Nsanje

Participants’ general attitudes about work were that women do nearly all of the household chores, but those pregnant women should be exempted from some of the more difficult household chores for a short period of time. This begs the question: why are men failing to participate in the household labour, especially while their wives are pregnant? Research conducted in Zambia suggests that men do not get involved in household chores for fear of being ridiculed by their male relatives (Blanc, 2001). Men’s lack of involvement with household work has a significant impact on women’s overall well being. Another study conducted in Nepal by Mullany (2005), found that societal expectations play a role in discouraging

husbands to get involved in pregnancy. For those men that did participate in household labour, they were labelled as “hen pecked.” Similar name calling was evident in the present study. When a man is seen helping his wife with household chores, he is called a “sissy,” he is said to be “under petticoat government,” or “under his wife’s armpit.” Above all he is thought to have been given “juju” by his wife. (Juju is a love concoction which is given to husbands to prevent them from having affairs with other women.)

4.4.1 Men Should Help with Household Chores

A majority of male and female focus group participants agreed that men should help with some of the daily, routine household chores such as those mentioned earlier in this chapter. Both men and women acknowledged that pregnant women or new mothers should not perform physically demanding jobs such as farming, chopping firewood, fetching water, making maize meal, and being responsible for all of the child care. Men and women felt that these are activities that men should be involved in so that pregnant women have time to rest.

One participant pointed out that when women are pregnant, some do not have “energy” to carry out household chores.

“It is true when we women are pregnant, some do not have the energy to work. Some men who feel sorry do work to help the women...cooking nsima and giving it to her, boiling water and giving it to her...[the husband may] see...that my wife here, is not well. No, she has no energy to work.” An 80 year old woman, Mangochi

Another woman explained that women would like their husbands to be involved in household chores and identified some benefits to mother and baby of men’s involvement with household chores. She also suggested that women have clear expectations about male involvement and understand how male involvement can benefit their own health and the health of their unborn babies.

“We are just requesting that when a woman is pregnant, the man should see to it that the woman is pregnant. He should hold the house with love knowing that his wife is pregnant because one person has two lives. So she is tired, they have to help her with household chores so that the woman can find time to rest. And the man must not be running away often, no. If she is alone she may have worries. He should be close, loving her so that whatever the woman needs he should provide. The baby born will be intelligent, well behaved if the woman and the man cooperate.” A 58 year old woman, Nsanje

The participant's reference to "one person having two lives" is a concept that Draper (2003, p. 751) used to indicate that "during pregnancy, the woman experiences her body while experiencing another body which is not her own." The participant quoted above considered carrying her baby in her abdomen as work in itself, requiring her husband to help her with other work such as the household chores and provide her with emotional support during her pregnancy so that she can "have time to rest."

Some participants believed that the responsibility to get involved should be upon the men themselves. If helpers or relatives are around, they should not be expected to be responsible for all the household chores. They can help, but the majority of responsibility lies with the man. For example, a 70 year old male participant from Mangochi stated:

"No, for me to get involved with the woman giving birth, the responsibility should be with me, surely in the house. Because even if you have your relatives, whether it is your sisters that you have, it does not mean that they should be helping daily at your house, no! But the responsibility is yours to help her with all the household chores, water, chopping firewood."

The reality is that when a woman is pregnant or has delivered, a man may invite his mother-in-law or sister-in-law to come and assist with house work because it is a taboo for men to be seen cooking, sweeping or washing. However, there have been situations where men have been seen going to the well to draw water for the family, or even going to the hospital with a sick child. When this happens, it is assumed that there are no other relatives to come and assist. Sometimes the attitudes of health workers may discourage the man from going to the hospital with a sick child. In this case, some sympathisers may come to assist the man, usually neighbours, and if the man has gone to the clinic with the sick child, his child is given faster treatment so that he is able to return to his family as quickly as possible. In other words, people ask why this man is doing all the things that otherwise should be done by his wife.

A few participants indicated that it is important that men help to care for the baby and not leave the responsibility to women alone. The quote below indicates that men should help with carrying the baby so that the women have time to do other household chores.

“When a woman has delivered and has a baby, when she has been discharged after delivery you can help her carry the baby while she does other household chores. If not, then you can help her with household chores while she is breastfeeding the baby.” A 35 year old man, Mangochi

Men also mentioned that they needed to help out with caring for older children, mainly toddlers, while women are at the hospital. Female participants explained that while they are in hospital, they are comforted by the fact that their partners are looking after the children and are not overburdening their neighbours or relatives with their children.

4.5 FAMILY PLANNING

Another common theme among women and men about reproductive health was about family planning. Recall from chapter two that family planning is another component of reproductive health. Family planning may mean planning the number of children a couple would like to have, spacing of children in one’s family and selecting the means by which this objective is achieved (L. W. Green & Ottoson, 1994). This objective may be achieved by use of contraceptives. In this study, men and women felt that practicing family planning was important so that women should not deliver frequently and that women should give birth to a limited number of children, ranging from one to three. Even though family planning programmes have existed for the last decade in Malawi, there are still a small proportion of older women who think that limiting the number of children to two or three is not acceptable and that the current “generation has a problem,” a 58 year old woman, Nsanje. These attitudes may influence women not to seek family planning methods for fear of being ridiculed or rejected in society. As one author reports, a community’s influence can affect couples’ attitudes towards family planning by suppressing couples’ desires to have small families (Oladeji, 2008). One participant suggested that some women living in extreme poverty go to hospital for caesarean section because they want to limit the number of children they have.

“If a person is pregnant we suffer a lot [with] no nappies, clothes, nothing. You actually tear one of your old cloth and dress the baby...This is why these days, as... [Participant’s name omitted] has explained that in the past they were bearing 12 children without problems. But for our generation most of us rush for the knife [caesarean section]. Some when they have two children, they stop and go for family planning. Just two children, sure should you really go for family planning? One child you should go for family planning? Can we

really say things are ok? [Group responds collectively with, „na’] It means this generation things are very difficult.” A 58 year old woman, Nsanje

The woman’s connection of caesarean section to family planning is interesting. In Malawi, it is common practice that if a woman has a caesarean section for her first pregnancy, during the second pregnancy she is given a trial of labour. If she hasn’t progressed to a certain point (for example, if she is not dilated or contractions are not frequent enough), then she will have another caesarean section. Any future pregnancies will depend on her healing from the previous caesarean sections. Therefore, midwives may advise women who have had multiple caesarean sections against having future pregnancies. Furthermore, participants suggested that when women are in labour, if they do not want to deliver vaginally, they request to be delivered by caesarean section so that they are not able to bear future children. Rather than women intentionally seeking out contraception to prevent having children in the future, they may request caesarean section as a way of limiting the possibility, thereby not having to make a conscious decision about how many children they would like to have. The decision is made for them, so to speak, and they may avoid the judgments of others.

Similarly, men acknowledged the importance of women planning for their families and spacing pregnancies so that women are healthy and able to take care of their families. Some men felt that limiting the number of children was important for the health of mother and baby. Men suggested that limiting the number of children through use of contraceptives prevented women from getting pregnant frequently. Male participants also observed that limiting the number of children helps parents to better support their families by providing their children with education and clothing, and by promoting their children’s general wellbeing.

“I see that reproductive health related to childbirth is to be aware between the man and the woman of what is happening in their family. When I say this, I mean to have children by choice, to space children with the methods that are available these days. To know that our children whether we have three for instance that is good health. Because you don’t have the desire for too many things but just to take care of your family well. You can know that children are doing pretty well.” A 25 year old man, Mangochi

Other male participants expressed the importance of making decisions with their partner about the number of children to have in the family. This suggests that men are aware that one path of empowerment for women is for them to make

decisions about how often they would like to become pregnant with the support of their partners, rather than men simply making decisions for women. Others mentioned the age at which women should start having children. A 34 year old man from Nsanje suggested “18 years for women and 21 for men,” and that women should stop having children at “35 years [but] for men as long as it takes them.”

Participants cited several benefits for limiting the number of children that women bear. Men said that if women do not give birth frequently, their bodies are healthier and less likely to be malnourished, and this helps to prevent illness and disability as blood is restored in the body. Spacing gives time for couples to work together, like helping each other with household chores, thereby strengthening couples relationship so they can get involved in government development work like building schools.

“This reproductive health, I see that there is better life in the family when you space children. Also, development in the home takes place. You don’t have problems very often. People don’t get sick very often. Blood is restored and development goes on very well in the home.” A 42 year old man, Mzimba

Sentiments in the quote above are similar to findings of a study conducted in Jordan by Piotrow and Rimon (1996). In that study, participants felt that a lack of economic resources puts pressure on the family to provide food and shelter for the family, leading them to support having small families (Piotrow & Rimon, 1996).

For some women they felt that they should space the number of births between two to three years so that that they get adequate “rest before getting pregnant again” and so the body is “nourished and healthy,” a 32 year old woman from Mzimba.

Women were aware of the importance of spacing in between pregnancy to regain their strength from the effects of pregnancy and labour before getting pregnant again. Long birth intervals contribute to the survival of both the mother and the baby while short birth intervals have been shown to decrease the chances of survival for the infant and the mother (Edouard & Bernstein, 2006). Evidence suggests that birth intervals of 9 to 14 months are associated with greater risks of maternal death (150%), third trimester bleeding (70%), premature rupture of membranes (70%) and anaemia (30%). These figures confirm the importance of spacing the birth between pregnancies (Edouard & Bernstein, 2006).

4.6 Men's Roles in Pregnancy, Childbirth and the Postnatal Period

Both men and women observed that men can fill a number of roles during pregnancy, childbirth, and the postnatal period. These roles are based on men as economic providers in the home by giving pregnant women basic necessities such as nutritious food for a healthy pregnancy, escorting women to antenatal clinic visits before childbirth and to hospital for delivery, and being present in the labour ward when the baby is born. I discuss each of these roles below.

4.6.1 Providing Nutritious Food during Pregnancy

Nutrition is a key aspect of reproductive health for pregnant women. Most women in this study were aware that good nutrition is important during pregnancy that a good diet is the main source of nutrients for their babies, and that foetal growth depends on a well nourished mother. One participant explained nutritious food as:

"...Maize meal porridge in the morning, if there is ground nuts, pound it and add the groundnut flour in the porridge and the woman eats. Also she should be eating eggs, vegetables, but also if she does not look healthy she can be buying sobo [a type of soft drink]. Maybe if there is milk she should drink tea with milk, it means and like that she will look healthy, yes." A 24 year old woman Mangochi

For some women, it was not enough just to eat mixed foods, but also to consume food from each of the six food groups and exercise so that their bodies were strong and healthy.

"For a woman who is expectant to be healthy, she needs to be doing some of the things that other women do like physio, running, or playing netball that she builds her body. But also she should eat mixed foods like six food groups so that she is healthy and she should not worry." A 46 year old woman, Nsanje

The six food groups that pregnant women should consume as taught at the antenatal clinic are: carbohydrates, beans, vegetables, fruits, meat, and oil. During the interviews, it was evident that some women repeated what they learned at the antenatal clinic without really understanding the nutrient values of the food they actually consume. For example, some women interpreted eating "mixed foods" as eating different types of fruits.

Others may eat food rich in carbohydrates or proteins only. What may be helpful for pregnant women is to provide information that is tailored to controlling

iron deficiency, anaemia and malnutrition to ensure healthy foetal growth (Nanda, Switlick, & Lule, 2005). As studies have shown, inadequate dietary intake is related directly or indirectly to most maternal deaths along with stunted growth. Additionally, women who are undernourished are vulnerable to infections (Do Thi Ngoc Nga & Morrow, 1999). This means that nutritious food is good for foetal growth and for the mother's nourishment.

According to men, nutritious food is important for reproductive health. They also suggested that women should eat different types of food with mixed nutritional values. Mixed foods for men meant that the women should not eat the same food every day. For example, "a woman may eat „nsima“ with fish, eggs or meat with vegetables today [and] then the following day have nsima with vegetables, „bonongwe“ and „therere“ [okra] with soft drinks," a 26 year old man from Mangochi. While the reference to soft drinks is particularly alarming from a public health perspective and indeed this may be an issue which needs addressing, the important point to note here is that men recognised the value of a varied (nutritional) diet. Other participants said that men should consult with women about the types of food they would like to eat during pregnancy.

"For the woman who is expectant to be healthy, she should tell you what she wants in relation to food or even clothes. If you just buy the food she may not even like that food. She will not be happy to eat it. But you should ask her „what kind of food do you want me to buy you?" You will buy her [what she requests] so that her heart is happy but also...the baby she is expecting should be healthy." A 35 year old man, Mangochi

As economic providers in the home, men are aware of what pregnant women should eat in order to be healthy. However, being knowledgeable of what food pregnant women should eat does not mean that men will actually provide them with the type of food that women want or need. The men may not be able to provide certain food due to lack of financial resources. For example, most of the food mentioned, meat, fish, and in some cases vegetables have to be bought from the market. For men that are not working, it may not be easy for them to acquire the food that women want. Generally, good incomes are associated with good food because families are able to buy more food (Toroitich-Ruto, 1999).

Vegetables, pumpkin leaves, okra, and others are often grown in most of the households, and vegetables like "bonongwe" which are wild plants grow in

abundance during the rainy season. These vegetables are rich in iron, which is necessary for pregnant women. Proteins that are grown, such as legumes, were not foods frequently mentioned during the interviews with men or women. This may be because these are seen as low class commodities and yet these are foods that are grown and have high content of protein. Eating meat protein is interpreted as eating well. This may be the reason why meat and fish products are preferred. However, the consumption of these products is very low and this results in long term dietary problems (Banda, 2004) caused by inadequate intake of dietary nutrients and frequent infections. What men need to be aware of is that women's poor nutrition contributes to low birth weight in babies each year (Nanda, et al., 2005) and what matters in nutrition is what pregnant women eat and not how much they eat.

4.6.2 Escorting Women to the Antenatal Clinic and Delivery

Male and female participants thought that another important role for men to get involved in is accompanying women to the hospital either for antenatal care or to deliver. For those women that talked about men accompanying women to the antenatal clinic, they suggested that the husband or partner should participate by observing what is done to the woman, asking questions, and listening to health education talks. The results are similar to what Carter (2002) found in her study of male involvement in Guatemala. In that study, participants suggested that accompanying women meant not just travelling with them to the antenatal clinic but also asking the providers questions about the pregnancy. Women suggested that men's presence at antenatal visits would help them to understand the importance of nutrition during pregnancy and why women need to rest, perhaps leading men to take over household responsibilities. Men may also reinforce what they have learnt from the hospital, for example if their partner forgets to take drugs given at the hospital. Men's presence at the clinic would make them understand what women go through, as this 38 year old woman from Mzuzu suggested.

"I can say reproductive health issues like...let's say in antenatal, what is pregnancy and how does the woman feel during pregnancy. And what are the complications or maybe the experiences of the woman during, including may be sexual activity. What are the effects on the reproductive organs or maybe psychological impact of it? These are some of the issues I think the man should understand."

The results show that many women want men to be involved during antenatal visits. Women believed that if men were involved then they would understand what is needed during pregnancy, but also the pain that women go through during childbirth. Women hope that men's involvement will lead to their decreased expectations of having more children. These results are parallel to those of Carter (2002) who found that Guatemalan women wanted men to get involved during childbirth so that men witness women's suffering and appreciate the need for women to use family planning methods. Similar study results in Kenya showed that women wanted men to accompany them to family planning services and antenatal clinic, however women were apprehensive of men being involved in the labour and delivery ward (Muia, Olenja, Kimani, & Leonard, 2000). Women felt that the labour ward was their territory.

Male participants in the present study also felt that accompanying pregnant women to the antenatal clinic or hospital was their role. Many men felt that men should be involved in this process. Distance is the predictor for their escorting women to the hospital. If the hospital is considered "near" the village (5-10 kilometres from village to hospital is often considered a reasonable walking distance for rural people), men felt there was no need to accompany women to the antenatal clinic.

"Reproductive health requires that men should take part... when she is due to go to the antenatal clinic [and] her home is very far for her to walk to the clinic, it is very difficult and tiring. So it is necessary for the man to try his level best to accompany her to the hospital when necessary. In addition in case the man has what? [If he] has forgotten, she should remind him. At the hospital, they sometimes give drugs to take at home, sometimes it's possible to forget. The man should get involved by reminding her to take the drugs. Ask her if she has taken the drugs." A 24 year old man, Mangochi

Other men said that women should be accompanied to the clinic because this is where information about pregnancy is given. Information may include dates of the next visit, the progress of the women's pregnancy, and information about drugs to take home. This information may help men prepare for the pregnancy as one participant explained:

"[Antenatal clinic] is where she [a pregnant woman] is given advice ...dates to visit ... the progress of her pregnancy. These things will...help you as a man to prepare well. If she is told that „we think there are problems, things are not

ok, "[then] you can help your wife. You should also be there listening to this as a husband ... in that way you will be promoting good health of the expectant woman." A 50 year old man, Nsanje

4.7 Men Should be Present in the Labour Ward

Male and female participants referred to hospital policies as "law." The current hospital policies in Malawi restrict men from going beyond certain areas of the maternity ward. They do not allow or promote men's presence during childbirth, nor do they foster a conducive environment to male involvement. Sign posts are clearly written and hung near places that men are ordered not to go beyond. This restriction is one of the barriers that are further discussed in chapter six of this thesis.

When men and women were asked about their thoughts and attitudes towards men's involvement during childbirth, many participants favoured men's presence during childbirth. Those in favour of men's presence during childbirth included some health workers, civil society representatives, some Traditional Birth Attendants and several men and women from rural areas.

Women emphasised that there should be a law (policy) to allow men to enter the labour ward so that they can be physically present when women give birth. Other women, particularly health workers, explained that men's presence in the labour ward could help men to have empathy for the pain that labouring women endure. This focus group participant explained:

"If there was a law maybe that law would have been put in place that when a woman is going to the hospital, to the labour ward, the man also should enter the labour ward so that they see how the woman suffers." A 56 year old woman, Nsanje

Responses among men that were in favour of men's presence during childbirth were fairly uniform. For some young men, being present in labour ward was conditional on being told by health workers that they should be present during childbirth. They suggested during interviews that because they had not been specifically told to be present during childbirth, they did not enter the labour ward. This suggests that the policies and regulations of the clinic, hospital and health workers are quite influential on men's attitudes about being present during childbirth. One young man stated:

“If we are told that when she is in labour it is important for us to go and observe the delivery, on that one for me, I will be very happy because I will be able to learn the job so that if my wife is at home and would like to deliver, I would not have problems, no, because I would have... known the job.” A 26 year old man, Mangochi

This man expressed willingness to learn about pregnancy, childbirth and what roles he may play during childbirth. But some male participants did not agree with his sentiments. One man explained:

“We are tied because we fear the law because we don’t have the law that says we should be going to the labour ward.” A 42 year old man, Mzimba

Although hospital strategies to invite men to the clinic may work for some, others indicated that they may still feel shy because the clinics are filled with women. Thus, the gender composition of the hospital (its staff and patients) may make men feel uncomfortable about being present during childbirth.

4.8 Benefits of Male Involvement during Childbirth

Men and women in favour of men’s presence during childbirth felt that there were many benefits. The benefit of men being present in the labour ward would make men see the gift of the “job” that they perform (the job refers to the act of sex that led to women becoming pregnant). Also, they would be able to see the pain that women go through and provide them with emotional and physical support during labour and childbirth. In addition, after the baby is born, the mother, father and the baby benefit from the psychological bonding experience. The bonding experience allows the father to be closely attached to the mother and baby. A final benefit identified by participants was that maternal deaths may be reduced. These benefits are discussed in detail below.

Many participants said that women would benefit for men to be present during childbirth because they will see the pain that women go through. As a result, health workers and civil society members explained, men may desire to wait longer before getting their wives pregnant again. For example, the quote below from a civil society representative illustrates this point.

“Actually that process [men being present during childbirth]...brings men closer. They understand the pain that the woman goes through. And there are some men that because they have seen what the woman goes through, they will even sit down with the wife and say, „Do you want to have another child?

Maybe we should rest for a while," because he has seen the groaning that happened during the childbirth...[I] am saying that most men become sensible after childbirth." A 57 year old woman, Lilongwe

Another woman echoed these sentiments and stated that "men will see during that time [labour] that this job is very heavy," a 45 year woman, Dowa. "Job is very heavy" refers to the labouring process.

4.8.1 Psychological Bond and Support

Participants also associated male involvement in the labour ward with providing comfort and support to the labouring woman. They felt that these actions may promote the bonding experience between men and their wives and babies. The available literature indicates that bonding is made up of four elements: attachment, commitment, involvement and belief which promotes closely and emotional ties (Cusson, 2001). In this study, this has to do with having stronger bonds with the labouring partner, caring about how she feels and making her situation accepted rather than being criticized. Men's involvement during childbirth is associated with family togetherness and has shown to strengthen the father-infant relationship (Early, 2001), and the couple's relationship (Nejad-Modarres, 2005). In sum, there are many benefits to the labouring women if they are supported by a non-health worker (Simkin & Bolding, 2004). Participants in this study described psychological bonding and support as reassuring to the woman during childbirth.

"Men would not want to have many babies because they will experience together with the woman the difficulties that she undergoes during pregnancy. He will also develop love for the child because he knows where the child is coming from. Normally men have been understood to say this child belongs to you [meaning the woman], the mother, because he did not take part in the delivery. But once he takes part in the delivery, he will have that intimacy towards the baby and he will love that child." A 52 year old woman, Blantyre

Psychological support may be offered even when women have gone for caesarean section. This may lessen anxieties and fears about the operation when women have someone they trust, like their husbands, by their side.

"The benefit of their involvement is that...when you have somebody whom you trust who is on your side all the time... reassuring you when the operation is going on or when the childbirth is going on there is more cooperation from the woman. But (...) when she is on her own, most of the time cooperation is very difficult (...) to get. Actually if it was two people encouraging one another to be in childbirth...it gives her...a better site." A 41 year old man, Blantyre

Other participants spoke about bonding between the husband and the baby that is to be born. They believed there will be special attachment to each other in the family because of what the family has experienced in the labour ward. As this health worker stated:

“Certainly as far as male involvement is concerned regarding delivery or childbirth, we have the concept that the child is really the product of both the man and the woman. And as in as much as possible, it’s the ideal thing...that the man as the father of this child must be involved throughout the life of this child. So that means during pregnancy, during, delivery and obviously what happens in bringing the child which I think most men usually get involved in. So it is trying to emphasise on this delivery that a man must be part and parcel of the process that this woman undergoes. So I think the advantage to men is that it will psychologically also help them to bond a lot more closely with their wife and also with their child.” A 45 year old man, Blantyre

Women go through a lot of pain and suffering for the baby to be born. Many women fear the pain associated with it and fear they will be unable to bear it (Campero et al., 1998), but after the baby is born it is a joyous moment that eases the tension and anxiety. For a man to be present in the labour ward, it can make a difference to the woman, because it is someone whom the woman knows best and who can support her efforts. This is the time that the woman needs love, encouragement and support from her family members.

Participants further explained that the presence of the husband is likely to contribute “to a good labour outcome.” It may result in better “preparedness for childbirth,” a 37 year old woman, Lilongwe. For example, the husband can be assigned certain roles such as rubbing his partner’s back when the contractions start, and this may quicken the labour because the woman can feel loved, perhaps less worried or afraid, and this might promote muscle relaxation. One health worker acknowledged the importance of husbands’ psychological support during labour and delivery.

“During childbirth...the advantages...are...the psychological part...when the woman...has the husband there, she will be relaxed psychologically. When somebody is tensed even the contractions are not effective. She is likely to have prolonged labour, but when she has [her] companion in the labour [he] also can assist. Also, maybe the husband can assist with the backrubs if possible.” a 37 year old woman, Lilongwe

Available literature corroborates the above sentiments. The presence of the husband has shown to decrease the intensity and prevalence rate of reactions to stimuli for the mother (Nejad-Modarres, 2005). One author attests that anxiety during labour results in the endogenous release of catecholamine, which reduces contractions and decreases blood flow to the placenta. This chain of events may cause prolonged labour and foetal distress (Rosen, 2004). This may have severe health consequences. For example, prolonged labour may result in obstetric fistula and foetal distress may result in stillbirth or perinatal death.

In addition, a meta-analysis of trials revealed that women who receive continuous labour support are less likely to require analgesia or anaesthesia and instrumental delivery (Simkin & Bolding, 2004) and have increased breastfeeding (Pascali-Bonaro & Kroeger, 2004). Continuous support (Simkin & Bolding, 2004) means continuous presence of a partner or companion throughout labour and delivery, emotional support, physiological comforting, information and guidance for the woman and her partner. Many participants felt that husbands can provide this kind of support.

4.8.2 *Emotional and Physical Support*

Another important benefit for men's involvement during childbirth, according to participants, was the emotional and physical support provided to women during childbirth. Research suggests that continuous presence of a companion, partner or husband during labour and childbirth encouragement, praise, reassurance and physical support such as providing fluids to the labouring woman, reduce the need for analgesia, forceps/vacuum or caesarean section (Rosen, 2004). Additionally, guidance, unconditional acceptance of the woman's coping style during labour, and use of self-comforting techniques to reduce women's use of pharmacological methods to relieve pain and enhance labour progress (Simkin & Bolding, 2004). This kind of care increases women's ability to endure labour pains (Simkin & Bolding, 2004), lower rates of postpartum depression and the negative perceptions of birthing experience (Rosen, 2004). Emotional support brings a sense of comfort and makes a person feel admired, respected, loved and that people are willing to take care of her and make her feel secure during labour (Campero, et al., 1998). While most of this literature has focused on doulas and other female companions for women's support, an observation has been made that companionship can also include other family

members such as a woman's partner (Campero, et al., 1998). The few studies focusing on men's roles as labour assistants have had similar results (for example, see Nejad, 2005; Early, 2001). The results of these studies provide compelling evidence for men to provide emotional and physical support to their partners during childbirth. For some participants, men's presence during labour and delivery was enough source of emotional support for the mother.

"I feel if he participates in the labour ward there is not much he can do. He can just sit there with the woman and give emotional or psychological support and the woman also feels she is loved by the man and is also responsible for whatever she is undergoing" A 52 year old woman, Blantyre

Some health workers indicated that in one particular hospital in a district included in this study, some health workers had experienced the benefits of allowing men to be present during childbirth. Such experiences may strengthen the cause to have men present during childbirth. Lessons may be learned from the experience at this hospital and build on the interventions for male involvement in other hospitals in Malawi. For example, one male health worker stated:

"Most of them [men] are there rubbing the back, encouraging, giving fluids. And actually the doctors are there on and off. But this is the person who is constantly with the patient...and actually that has also helped us with family planning." A 41 year old man, Blantyre

According to one particular health worker, female companionship for labouring women has been piloted at Queen Elizabeth II Hospital in Blantyre. The health worker commented on the benefits of having a companion to facilitate pelvic examinations on adolescent girls during labour of their first pregnancies. By providing emotional support to the young girls while they are in labour, companions may assist doctors in evaluating a woman's ability to successfully have a vaginal delivery.

"One particular group of labouring women have been the adolescents in their first pregnancy. Labour can be quite overwhelming and therefore the companion has been a source of information as to desperation of this adolescent labouring woman. In a typical example, [an] adolescent mother...she doesn't want to be examined. We have found such cases before and we have hit a blank wall. Now with the companion there, we...certainly have orders. With them [the companion, we have] managed to make the woman understand the need, and therefore we've been able to accomplish an

appropriate vagina examination in certain situations.” A 45 year old man, Blantyre

Other participants stated that companionship is important in the labour ward because they are able to communicate with other members of the family anxiously waiting outside to hear the outcome of their labouring relatives. When a woman is in labour, a number of relatives accompany the woman to the hospital. These may include the husband, sister of the labouring woman and her mother. These people wait patiently outside the hospital waiting for the pregnancy outcome of their relative.

“We are usually not very good at communicating with the relations of this woman outside the labour ward. So the companion, when you adequately inform them, has been a very good source to communicating with relatives of this labouring woman outside the labour ward. Yeah, so these are some of the advantages we have seen so far.” A 45 year old man, Blantyre

In unfortunate circumstance where a woman’s baby dies during labour, the husband’s relatives are often quick to blame the woman for not doing enough during childbirth. The relatives may not understand that sometimes labour takes a long time due to several factors, such as stress, fear of being in a new environment and the fear of being alone with strangers, unfamiliar staff and the many procedures in the hospitals (Pascali-Bonaro & Kroeger, 2004). It may also be due to biological problems of the cervix or problems with the baby. If a husband is present during labour and delivery, he may be in a better position to communicate whatever transpired during delivery to relatives, thereby alleviating some of the stress and blame placed on his partner.

“I think during childbirth, it’s mainly the encouragement that a woman needs and maybe psychological care and pain relief which the husband can participate in. Actually, if he is there and something goes wrong he will be able to understand because if a woman comes out with a still birth or neonatal death. People think it’s the woman who did something wrong, but if the husband is there maybe he would be able to...see and appreciate what the problem was. And when the health providers are explaining they will be able to understand.” A 44 year old woman, Blantyre

Other participants suggested that the man’s presence would give the woman trust that she has somebody she knows with her and the man would give her the care that midwives may not be able to give due to critical shortages. Because of this shortage, midwives do not have time to take care of individual patients. Similar

findings were found in a study by Draper (1997) who found that partners need to be present during childbirth due to the lack of time that nurses and midwives have to help patients. A man's presence during childbirth may also give him the impetus to get involved in care of the baby at home, carrying on the care giving role he commenced during labour.

"Other advantages would be the company that his presence would provide to the woman. This is something that midwives are not able to do, not by design but there are not just enough midwives to be with every woman during the labour period ... the woman is fearful of what is happening to her and a lot of that is really taken care of by just somebody being there. If the man was there she knows very well someone she trusts that would reduce pain and control the labour process as it were." A 57 year old woman, Lilongwe

One participant said it is a privilege to be with the wife during childbirth. To welcome the newborn baby, it is a moment of joy and makes the man respect his partner because of what he has witnessed. Testimonies like the one provided below may also be used as an informational tool to help men appreciate the benefits of their involvement.

"I myself was definitely there when my child was born and it was a privilege. It was great, it was wonderful and of course it increases respect for your partner if you see what she is going through and you cannot just say she just gave birth, no! You have seen that its nothing called labour and of course to assist to welcome your child yourself which is also nice and to care for your partner afterwards because... she definitely needs support, emotional but also physical support. Again that shows her and then also take care, I think, in looking after the baby." A 55 year old man, Lilongwe

These benefits may form a strong foundation for building interventions to promote male involvement during pregnancy, childbirth and the postnatal period in Malawi.

4.8.3 Reduction of Maternal Deaths

Male and female participants emphasised that a significant benefit of male involvement during childbirth was that men, as decision makers in the home, can encourage women to seek care in a timely manner and thereby reduce maternal mortality. Participants suggested that men may contribute to the reduction of maternal mortality by ensuring that delays in taking the woman to the hospital are minimised and by recognizing the danger signs during pregnancy and labour and act promptly. As this 57 year old woman from Lilongwe stated:

“There are more advantages than disadvantages... getting men involved it will reduce a lot of maternal deaths. The man will be aware of the situation that the woman is living with while she is pregnant. And it will be easier for the man to encourage the woman to take her to hospital. And then she doesn’t have to struggle to go to hospital alone where it is a long distance.

As the above response indicates, men can be involved in particular ways that help lower women’s risks of complications during pregnancy and childbirth. Men can be physically supportive by ensuring that transportation is arranged for their partners to get to the hospital. They can provide financial resources so women have what they need during pregnancy. And they can help their partners to rest after childbirth. These role expectations are in line with dominant constructions of masculinity (see chapter two) that promote men as the economic provider in the family and also signify all the things that a man is expected to do.

For men to take part in the reduction of maternal mortality would require that they know of possible complications and risk factors that cause deaths during pregnancy, childbirth and the postnatal period. A growing body of literature indicates that men, relatives and other members of the community do not recognise danger signs in pregnancy, childbirth and the postnatal period and this has contributed to women dying unnecessarily in developing countries (Gay, Hardee, Judice, Agarwal, Fleming, & Hairston, 2003). Giving information to men and other community members to recognise pregnancy and post delivery complications can make a difference in the lives of the baby and the mother.

4.9 Taking Care of Mother and Baby after Birth

A final theme expressed by participants was men’s role in taking care of the mother and baby. Both women and men emphasised the importance of taking care of the mother and baby during pregnancy and especially during the postnatal period. First, a note on language, when participants talked of male involvement in taking care of the baby, they often described the “thing.” For most rural women, when they are pregnant, they talk of the “thing” in the womb. This is because they do not know yet whether they will successfully deliver a baby or not. They start talking about the baby as “a baby” when it is born, once they have seen with their own eyes that it is breathing, crying, and that it looks like a human being. Furthermore, participants explained that women in rural areas do not attend antenatal clinic until their pregnancy is past six months gestation or more.

This situation has also been observed in Nigeria where women start attending antenatal clinic late in the pregnancy (Nwokocha, 2006). The reasons are similar to the belief of the “thing.” Some women want to wait until they are sure that they are pregnant and that there are movements in the womb. For those that may go early to the antenatal clinic, early in this case may be three to four months of gestation, they often do so only if they feel unwell.

Women defined an important aspect of reproductive health as “taking care of the thing.” This phrase has different meanings; therefore, it is important to consider the context in which it is used. Taking care of the thing may mean buying clothes, supplies and food for the baby. But it may also mean that the husband should not have sex or extra marital affairs while his partner is pregnant or after she has delivered. It is believed that if he does, the delivery may be difficult. Alternatively, if a woman has had sex with her partner after delivery, it is believed that the baby may die of chest pains. As this 58 year old woman from Nsanje stated:

“Reproductive health when you are pregnant, the thing that is inside if you take care of it very well, it comes out well if you have prepared for it. But if you do things that are not acceptable that thing is delivered not in a good way.”

These cultural beliefs play a dominant role in dictating the appropriate behaviours of men and women after babies are born. I discuss this in detail later (see chapter six).

In addition to identifying involvement by caring for the baby, men also spoke of satisfying the woman sexually so that the marriage continues. Several men recognised the need to give women time to recuperate for at least six weeks after delivery, so that women are fully recovered from labour. This is what is referred to as “the man finding or holding his heart.” Finding or holding his heart means that the man should be patient with the wife after delivery and suppress his sexual desires. Men may demand to have sex with women, but if they are not ready for it, men should be understanding and not force women to have sex. However, this may not always occur because in Malawi there are strict cultural beliefs that women are not supposed to deny their husband the right to have sex because of the notion that men own women (The Johns Hopkins School of Public Health, 1999), particularly in a patriarchal society.

“I believe that...the man wants to have sex with his wife so that the marriage continues. What can make the wife miserable means the husband should find his heart [aupeze mtima]? When we reach that stage then we know that the man has been careful. The woman should be caring for her baby happily and with no disappointments. Because what some people do is, the woman has just come back from the hospital maybe she has been home for only two weeks, and then he starts touching her. So how do we take care of the baby? So for this, it is very important for the man to get involved in caring for the baby, also caring for the woman.” A 49 year old man, Mangochi

Other ways of caring for the mother include providing food so that the woman has enough breast milk. The majority of women in Malawi breastfeed their babies for two or more years. Part of the reason may be that breastfeeding is convenient and very nutritious for the baby’s growth and development. The Ministry of Health promotes exclusive breastfeeding for the first six months of life and suggests women continue with complementary feeds for two years and beyond (Banda, 2004).

4.9.1 Transport Women Home from the Hospital

Participants felt that men can be involved in taking care of women after childbirth by transporting women and their new babies“home from the hospital when they are discharged. One man explained:

“After discharge, to take her home, some do come from very far away. You need to consider how the woman will travel after giving birth. The woman who has just delivered or she has stayed two days after delivery, transporting her is difficult for her to walk a long distance. You can organize some mode of transport like if there is a bicycle nearby.” A 30 year old man, Mangochi

In rural areas, transport is a problem. Transport that is available includes bicycle, oxcart and private vehicles that may be licensed by the government. Oftentimes these vehicles may be illegal, or sometimes not road worthy (known as matola), but because people have no other alternative, they often rely on unsafe transportation. If in those areas, there are no private vehicles for matola or authorised vehicles, a couple may hire a bicycle or an ox cart for the mother and baby to be transported home from the hospital. Transporting the mother and baby on the bicycle may not be comfortable as the mother is made to sit on the carrier with the baby. However, preference is usually to travel by car. The reality is that many people walk because of the cost involved (Richard, Witter, & De Brouwere, 2008) and the non-availability of regular transport, especially in the remotest areas. Men can play a key

role in helping women after childbirth by ensuring they have easy and safe transportation to return home.

4.10 Chapter Summary

This chapter presented gender similarities among women and men on their perceptions and thoughts about male involvement during pregnancy, childbirth and the postnatal period. The results of this chapter focused on five themes about male involvement: work for women and men, family planning, men's roles in pregnancy, childbirth and the postnatal period, benefits of male involvement, and ways men can take care of the mother and baby after childbirth. The voices of women and men indicate that although pregnancy, childbirth, and postnatal care are culturally seen as women's business (and women's business only) they acknowledged that men should be involved in many aspects of reproductive health issues. This is especially the case during pregnancy, for antenatal visits, childbirth and in the postpartum period. The type of involvement most emphasized was for men to be good providers in an economic sense, a role in line with dominant constructions of masculinity in Malawi.

Women and men have been taught to believe and think that reproductive health is a woman's issue. How do we change this practice so that reproductive health is inclusive of men? Concerns and fears may arise if men get involved. A primary concern of women is that most men do not assist women with household chores when they are pregnant and women are overworked, which men acknowledge and see the need to support and assist women with household chores. In this regard, women and men believe that men's involvement would be beneficial to the family. The next chapter presents gender differences in men's and women's views and attitudes about getting involved during pregnancy, childbirth and the postnatal period.

CHAPTER FIVE: GENDER DIFFERENCES

MEN’S and WOMEN’S PERSPECTIVES OF MALE INVOLVEMENT

5. INTRODUCTION

This chapter presents gender differences (or disagreements) in women’s and men’s perspectives of male involvement in pregnancy, childbirth and the postnatal period. I discuss key themes in which men and women differed in their views. I also identify themes about male involvement that only men or only women discussed during focus groups and in-depth interviews. These themes include: 1) avoiding violence which may have health consequences for the baby and mother; 2) ways male involvement is related to love in the family; 3) the main reproductive health problems that women face; 4) safe motherhood as a way to overcome maternal and perinatal deaths; 5) reasons for opposition to male involvement during childbirth; and 6) disadvantages of male involvement in pregnancy, childbirth and the postnatal period. For a review of demographic information about participants in this study, see chapter four. Each of these themes is discussed in detail below.

5.1 Avoiding Violence against Women

Recall from chapter two that violence is one of the components of reproductive health that predisposes a woman to many sexual and reproductive health problems such as unwanted pregnancies, sexual and physical abuse.

In this study, men and women discussed violence against pregnant women as problematic, yet they differed in their definitions of what constitutes violence. Men from rural areas defined reproductive health as men avoiding violence against women to protect two lives, that of the woman and the baby, and to avoid the baby’s miscarriage. They gave clear indication that they understand the consequences of abuse against pregnant women and that this is an important reproductive health concern. Participants explained that some men have tempers (called a “high heart”) and are violent against their pregnant wives. Some men are short tempered and rather than responding to pressures by listening, they physically abuse their wives. Pressures may come from fear that they will not be able to provide economically for

women during pregnancy. Men often expressed anger at women demanding help or resources for the family. When this happens, it leads to “judo.” In this case, “judo” means beating.

“The man is not supposed to be cruel to his wife because when the woman is expectant, some become easily irritated [with high hearts]. So when she starts to talk about something then [her husband may] judo at the same time.” That may cause the woman to miscarry.” A 20 year old man, Mangochi

While men understood why they should not be violent or cruel to pregnant women (because it can lead to harm to their unborn babies), several women expressed great concern about men not participating in any household work and expecting pregnant women to perform most of the routine household chores. Recall from chapter four that men and women agreed that men should contribute to some household chores while women are pregnant. At the same time, participants suggested that men and women do not agree about what types of household chores men should help with. Female participants suggested that men may hold unreasonable role expectations arising out of lack of knowledge on the part of men that women need to rest during pregnancy. Participants explained that men expect their pregnant wives to continue doing the household chores, and ridicule women when they do not maintain the household, because traditional norms dictate that pregnant women should continue to work hard in order for smooth delivery to take place. However, men may not be aware that a lack of rest has negative health consequences (Do Thi Ngoc Nga & Morrow, 1999) for both the babies and the women. Women feel that this kind of attitudes amounts to cruelty or violence to the pregnant woman. These concerns are echoed by a 58 year old woman from Nsanje:

“If you are pregnant...there are certain men, they know that the woman is pregnant, and when she is pregnant she needs to perform some reasonable chores. So you find the man telling you to go to the garden, when you go to the garden, when knocking off, he says you should go to fetch water. When you come from there all the household chores are heaped for you. You have no space. Sometimes when you say [I] am tired, this is my last month [of pregnancy], you hear, „Let’s go to the garden. What are you going to eat (unadyanji) if you sit here? Are you going to eat your pregnancy?””

These kinds of sentiments may illustrate some of the abuse that women endure from their partners during pregnancy. Abuse includes psychological torture, verbal abuse, and deprivation of freedom to rest. In addition, it is evident from this

discussion that women do not challenge, let alone discuss with their husbands, what they think and feel even if they are tired. Women may not inform their husbands about their feelings because they may be afraid of being beaten. As a 58 year old rural woman explained, “Women here at home in Nsanje, we fear our men very much so we just accept anything.” These situations make women feel powerless and inferior to the men. Thus it appears women’s rights are not respected by their partners or the partners may not be aware that women have rights to be supported by their partners with household chores. Women felt that the lack of household support in the home showed cruelty on the part of men. Women believed that this cruelty can cause the baby to go to the nursery (a ward where premature babies are nursed) and that it may suffer mental retardation. The belief that strenuous work may harm women’s unborn children may have legitimacy as strenuous work may cause premature labour and result in the baby being admitted to the nursery.

“The men continue to be cruel with a pregnant woman. She does not rest. From the garden she is busy so the woman does not feel good. If cruelty/violence is continuing like this the baby who is to be born inside the abdomen can it be good? Is the baby not going to be an imbecile? This baby is going to be a „abgabe,” it may even go to the nursery so this cruelty/violence exists here and it is common. If it is possible to assist us on this cruelty/violence, it will be very good.” A 59 year old woman, Nsanje

Although men’s lack of participation with household labour does not cause abnormalities in babies, an abundance of research suggests that domestic conflict and violence causes risks to the unborn baby and premature labour (Koenig, Whitaker, Royce, & Wilson, 2006; United Nations Population Fund, 2005). In addition, domestic conflict may arise when pregnant women perform the majority, or in many cases all, of the household chores with little support from their partners.

Some rural men in focus group discussions observed that if there is no love in the home, then wife beating will be prevalent. Recall that female participants discussed the role of love in their definitions of male involvement. Women spoke of love in emotional terms. In contrast, male participants discussed the role of love in their definitions of reproductive health and spoke of love in physical terms, such as doing things for and providing women with all that they might need during pregnancy.

*“What is important on issues that we are discussing here when the woman is expectant is love. If there is love, all those things that we have discussed here will be done. But if there is no love with your wife, all what we are discussing here, will just be a talk, nothing will be done. Because what is important to say the truth is to feed and clothe her. That is what is required for the expectant woman.”*87 year old man, Mangochi

Men also spoke of love as entailing sexual intercourse. When men spoke of no love in the home, this may be due to cultural restrictions placed on men and women about when they can resume sexual intercourse after the birth of their baby (see chapter six). For example, a 49 year old man from Mangochi suggested “that marriage without sex does not exist.”

Comparing data from focus group discussions with in-depth interviews, it appears that wife beating is more prevalent in rural areas. Why is this case? One possible explanation for why men beat their wives is that some men may not feel capable of meeting the needs of their wives during pregnancy and may fear being seen by their wives or others as failing to support their families (economic insecurity). Most men may want to be associated with success rather than failure. Most rural men are subsistence farmers and income may be seasonal at times. As a result, income is dependent upon the produce from the gardens. If rainfall is erratic it means the family may not have enough food, and therefore no food reserves for the market. These sorts of financial pressures are acknowledged in the literature as contributing to violence. Violence is associated with socio-economic and behaviour factors such as unemployment, low income (Esplen, 2006) and alcohol use (Conner, 2001).

5.2 Compatibility of Blood

“Your blood is compatible” is a theme discussed exclusively by women to define reproductive health. Women used it in reference to a woman’s blood being compatible with her husband’s blood (what may be described as chemistry between a man and a woman). It is believed that compatibility is shown by women getting pregnant quickly, for example within one to two months after a couple is married. If several months pass without the wife getting pregnant, it is cause for concern as it is assumed that the wife or the husband has a problem. Most often, the wife may be questioned. When blood is not compatible, it is believed that it may be due to her blood rejecting her partner’s because there isn’t a match with each other. This notion

of blood compatibility is interesting, as it seems to draw from ideas used in public health regarding blood compatibility between donors and recipients. In public health, compatibility of blood usually relates to blood groups of donors who are tested to match their blood to a recipient. This recipient may be male or female, young or old and may require blood due to accidents or diseases. If a blood group donor does not match the recipient, they are said to be incompatible. It appears there are similarities in the thinking behind cultural ways of interpreting compatibility (as women in the present study did) and the manner in which blood compatibility is defined in public health. One female participant stated that:

“Compatibility of blood, there is good flow of blood because if the blood is not compatible they say the blood is not compatible. But if the blood is compatible some people easily get pregnant in the house because the blood is flowing very well.” A 70 year old rural woman, Mangochi

Even though compatibility may not have a real public health basis, culturally it may need to be addressed to deal with misconceptions attached to issues related to fertility and miscarriages of pregnancy. For example if a woman may not conceive or continuously miscarry her pregnancy, it may be presumed that it is because man and wife are incompatible. The family may need to be informed about the causes of miscarriages and infertility.

5.3 Love the Family

Both male and female participants spoke of male involvement entailing love in the family, but they defined the ways in which men may demonstrate love in very different ways. Most women defined male involvement in emotional terms, as the need to love the family. This love should include helping the woman with household chores, providing her with whatever she needs, and ensuring that the husband is available for her so that she is not worried. According to women, if men provide them with what they need during pregnancy, they believe that the baby will be born intelligent and it will be well behaved. Women expressed their disappointment when husbands don’t show love for their pregnant wives. It may not be all men that do not show love to women when they are pregnant. Some men do love their partners and do support them during pregnancy.

“The woman faces a lot of problems, going to collect firewood, goes to sell the firewood to get some money to do what, to buy what she wants. But if these

men were changed and had love because for all this to happen it is love. But love in the home is very minimal when the woman is pregnant.” A 58 year old woman, Nsanje

The love for the family also meant that the husband should be interested when the wife is “sick.” “Sickness” is a term sometimes used to denote a pregnant woman, “ndi wodwala” or “wapakati” (middle) in participants’ native languages. People may say a pregnant woman is sick because of problems that are associated with pregnancy, for example vomiting, heartburn, swelling of feet or face, and anaemia among others.

Women also wanted husbands to be sensitive to their needs, to provide emotional support by giving affection, love and understanding and enjoy companionship. Older yet still informative research by Otto (1962) suggests that in terms of men and women’s perceptions of power structures, women are more sensitive to the needs of their husbands than husbands are to the needs of their wives. Women want men to love them and be considerate, particularly when they are pregnant. When husbands do not communicate, do not show interest in their partner, or are not involved in household chores just as these women have expressed, then these are the major reasons for women to assume that their partners do not care or love them.

Men also suggested that men can be involved in pregnancy, childbirth, and postnatal care by conveying love for the family. Men’s demonstration of love may include bonding with the baby and supporting their wives in different ways – emotionally, psychologically, and physically. This may be done by welcoming their wives from the hospital, staying nearby while they are in hospital, and telling women how happy they are to see them when women return home with the baby. In this study, men and women had different interpretations of ways in which men can show love for the family. It appears women want more affection, conversation and family commitment while men would like to show their love by providing support to the women. For example this man indicated how men can show love to their wives.

“There is nothing that can supersede [chingapose] entertainment. Wherever the woman is, whether she is in postnatal care or not, once she sees you, she just knows that my friend who entertains me has come. So what we can get involved in as men when ... she comes back home with the baby, is that everything at home requires you to get in where she is nursing, because you are not a visitor. Tell her that..., this is what I was waiting for. You should

expect that everything will [be] alright. "These are the words that you should be telling her, because she is the one person you love, the one you are free to tell all what you have in your heart. So the man is supposed to thank her." A 49 year old man, Mangochi

"Entertainment" in the above quote is a way of indicating how close the husband is with his wife. The husband may entertain his wife by fulfilling her sexual desires and saying words of love.

Another way of showing love to the family is for men to "take care of themselves" meaning that they should remain faithful and not go out with other women. For other men, showing love involved a more hands on approach in which men are involved in taking care of children that are at home when women have gone to the hospital to deliver. It also means overseeing the welfare of the family in the home by ensuring that family members have everything that they need.

"It is true that...a woman has delivered, you need to get involved, dedicated and with love because all the things at the house you are the one to oversee. There are children that you started bearing before the new one. You should give them a bath because they are very small. The reason is the woman has now a small baby so... you should try to look after the children and their mother." A 62 year old man, Mangochi

Although some men felt that participating in some household chores and childcare of older children were ways men could be involved, strict gender roles remained about what tasks men should or should not do. For example, one task men refused to do was to wash children's diapers/nappies because "nappies are supposed to be washed by the woman but not a man, no," a 38 year old man, Mzimba. This participant explained that he was only willing to hold his baby while his wife washed the nappies. Examples such as these suggest that beyond individuals' perceptions and attitudes about male involvement, shared cultural beliefs play an important role in dictating the "appropriate" roles that *men as fathers in relation to women as mothers* may fill in pregnancy, childbirth, and the postnatal period.

5.4 Reproductive Health Problems

Men and women defined women's reproductive health issues differently. Women identified reproductive health issues as teenage pregnancy, promiscuity, bleeding during and after delivery, and malpositioning of the baby in utero. In contrast, men saw childbirth/delivery, perinatal and maternal deaths as important

reproductive health issues. Men also explained the role of safe motherhood activities in keeping women healthy.

Understanding differences in women and men's perceptions of reproductive health problems is important because it helps to identify areas where people are misinformed, or lacking in knowledge about reproductive health. Additionally, understanding issues that women vs. men consider to be important can help establish ways of promoting social change in health behaviours, especially among couples, and changes to foster male involvement. The reproductive health problems discussed by participants are presented in detail below.

5.5 Women's Views of Reproductive Health Issues

5.5.1 Teenage Pregnancy

One of the reproductive health problems that rural women mentioned was teenage pregnancy and this was not discussed by men. Early teenage pregnancies contribute to high maternal deaths among girls between 15 to 19 years of age. Early teenage pregnancy is estimated to be about 70,000 per year internationally (United Nations, 2009). Part of the reason for such high rates is that some girls marry at a very young age and get pregnant early which may result in complications or deaths (United Nations, 2009). Another contributing factor to deaths are the unintended pregnancies which result in illegal, unsafe abortions (Glasier, et al., 2006) particularly in countries like Malawi where abortion is illegal. In Malawi for example 30 percent of maternal death are due to abortion (Ministry of Health, 2005b). Conversely, fear, shame and lack of resources inhibit adolescents from seeking safe abortion services (United Nations Economic and Social Council, 2002). When abortion has taken place, girls often bleed to death and when they are taken to the hospital, they may not reveal to the doctors that they have had an abortion.

Sometimes adolescent girls are encouraged to engage in prostitution by their parents for economic gains. During interviews two women shared their concerns on the consequences of these practices:

"The other thing is, we women in our houses, we give our children to boys. When we go to bed that's when our children are going out at night. They go out and come back at 12 midnight. When they come we go to open the door for them and ask them to come in. When the child comes in, she takes the money that she has been given by her boyfriend and gives it to the mother and the

mother ties the money on her cloth, "you should not tell your father." We are the ones giving away our children in a disgraceful way because we don't follow the child. We are letting them do prostitution because of us parents. Some of us parents don't find out how our children are behaving." A 76 year old lady, Nsanje

"You see these days many children are getting pregnant without a man. When they see that there is a problem, they get medicine and drink, when they go to the hospital, they don't explain; many are losing their lives. Now, this kind of thinking should...If the man who wanted you refuses [to marry you], just stay at your father's place and work. God will provide until you deliver your baby. Once you have delivered, you should use contraceptives and then get properly married. Most [girls] are facing these problems, and marriages don't last. As for these days, they stop quickly to have children. She will leave 2 or 3 children and then close the womb. The wife goes to other men and the husband goes to other women and when they meet, in the house, they just sleep like a dove ... Today's children are not intelligent. They don't think even bearing a child, and it is not with one man but several of them." A 73 year old lady, Nsanje

The above quotes reflect how the socio-economic and cultural environment motivates adolescents to engage in sexual practices at an early age leading to unwanted pregnancies. According to United Nations Economic and Social Council, (2002) poverty in families results in adolescents being sent for prostitution by their parents. In some cases marriages are arranged between older men and adolescent girls, often against their will. As a result, these adolescents may have problems communicating, making decisions about reproductive health issues, and this put these adolescents at greater health risks (ibid). Many adolescent girls may resort to clandestine abortions which has severe health consequences such as infection, severe bleeding and deaths (United Nations Economic and Social Council, 2002). Furthermore, parents who encourage their children to engage in prostitution may not value education for their children. Parents may not discuss issues of sexuality with their children (Rani, Figueroa, & Ainsle, 2003). Such parents need information about the consequences of prostitution and early marriages to help them identify alternative methods of generating income for their families.

5.5.2 Promiscuity

Related to teen pregnancy was men's promiscuity, which puts the lives of adolescents at risk. Most women mentioned promiscuity by men as one of the primary reproductive health problems. However, none of the participants mentioned the dangers of promiscuity, nor did they indicate an awareness of how promiscuity

may lead to women acquiring HIV and other sexually transmitted infections (STIs) and how the infections can be prevented. For them, promiscuity results in marasmic looking baby. In public health, marasmus refers to a condition arising from malnutrition. Participants viewed marasmus as a condition arising from men's unfaithfulness to their wives. In addition, due to culturally prescribed long periods of abstinence after childbirth (see chapter 6 for an in-depth discussion of abstinence as a cultural barrier to male involvement), women don't trust their husbands to be faithful in their relationships.

"The baby becomes so thin. The legs are so small "tomzwoleke" because of the father who is not steady, just going about with other women. So the elders advise you that when the wife is pregnant, you should not go out with other women and have sex with them no. You should do what? Wait for the woman. But the men do not listen. So I don't know what we can do there!" A 58 year old lady, Nsanje

"Yes, they [men] were just going out womanizing knowing that the wife is "bzyade." [The husband asks] ,Should I wait for her?" Provided she has delivered. As for me [the man, he thinks] ,this [the woman's body] is my body." He goes to drink his beer and when he comes back, ,my wife is indeed bzyade, liar." A 73 year old lady, Nsanje

Promiscuous men's behaviour makes it unlikely that they will be involved in assisting women during childbirth or in the postnatal period. In the first instance, men are not available to be involved because they are engaged in relationships with other women. Secondly, women may not want them to be involved because of their promiscuous behaviour. Such situations represent a challenge that must be dealt with in socially and culturally sensitive ways.

Women in this study did not perceive real risks to their reproductive health such as HIV/AIDS and STIs, abortions, puerperal sepsis, sexual violence and exploitation, infertility, cervical cancers, pregnancy at an early age, multiple pregnancies and those at short intervals. This suggests that women can be empowered through knowledge. Empowerment can occur when women are knowledgeable about their bodies and what behaviours put their health at risk. Once this occurs, women may be in a better position to discuss sexual and reproductive health issues with their partners and get them involved in preventing some of these problems.

5.5.3 Lack of Blood during Pregnancy and Blood loss during Childbirth

Blood loss during and immediately after childbirth is one of the major causes of maternal deaths. Twenty five percent of women die due to severe bleeding and severe blood loss results in anaemia (AbouZahr, 2003). Women in this study identified blood loss as one of the reproductive health issue that jeopardise their health before, during and after delivery. Anaemia in pregnancy results in low birth weight and is an indirect cause of maternal mortality (Nanda, et al., 2005). The effects of anemia may be compounded with women's blood loss during childbirth and after. (AbouZahr, 2003). Preventive measures in the use of iron and folate supplementation during antenatal period have shown to reduce the prevalence of anaemia (Nanda, et al., 2005). It is important that men are aware of problems like these, and information be given to them about what action they need to take if a woman starts to bleed. Women in this study recognised that if anaemia is not treated, death may result. As one participant acknowledged:

"It can be possible that the time a woman is giving birth, there is heavy loss that fails even giving injection it does not work. So if you have travelled with the misfortune, it is possible for the woman to die." A 22 year old woman, Mangochi

5.5.4 Malposition of the Baby

Another point made by female participants with regard to reproductive health problems relates to the position of the baby in utero. Babies may present in different positions before birth, for example, in transverse lie (dziwi), oblique, breech (fulato) or face positions. I previously discussed in chapter four that participants identified that men can play a critical role in getting women to antenatal clinic for visits throughout their pregnancy, so that babies' growth, development, and the position of the baby can be assessed in each trimester. Having knowledge about these aspects of their pregnancies can help women be prepared for assisted deliveries or lifesaving interventions, such as caesarean section. Given that some participants believed caesarean section was a result of women being lazy, and they did not consider caesarean section a necessary lifesaving intervention, men can influence these women to change their perceptions of necessary interventions and increase the likelihood of safe deliveries. One woman explained the possible benefits of medical interventions.

“The problems that childbearing women face, some of us are found that the baby has not lied properly. It has lied across in the womb, so they tell us that your baby has not lied properly, so you should go and give birth at Mangochi District Hospital. So when we deliver in Mangochi, we are seen by doctors. Sometimes we go to theatre [surgical room] and deliver without problems, yes.” A 20 year old woman, Mangochi

The position of the baby can make delivery difficult for women. Difficult deliveries happen even at hospitals, but the difference is that the hospitals may have timely treatment in cases of emergencies whenever possible. That is, not all health facilities can provide timely treatment due to lack of equipment, drugs and shortage of personnel. In western countries, for example Sweden, a midwife is available to help with the delivery in the home (Sjoblom, Nordstrom, & Edberg, 2006). Conversely, the same opportunities are not available in Malawi due to critical human resource shortage. Women may deliver with the help of a Traditional Birth Attendant or a relative (Lule et al., 2005). The major causes of difficult deliveries presented in the literature include disproportion between the fetus’s head and the mother’s pelvis (cephalo pelvic disproportion), which may have multiple effects such as prolonged, obstructed labour which may result in long term consequences like vesicle vagina fistula (Bangster, Gumodoka, & Berege, 1999). It may also be due to malpresentations such as “dziwi” (transverse lie) as men and women attested in this study. The results of malpresentations may be brain damage to the baby, asphyxia, and the baby may die before it is born or soon after birth.

Women with obstetric complications such as transverse lie, oblique presentations, eclampsia, and obstructed labour or previous caesarean section are referred to a hospital where emergency services are available. But, unfortunately, most rural health centres in Malawi do not provide Basic Emergency Obstetric Care (BEOC) which is one of the life saving interventions for women with pregnancy complications. Basic Emergency Obstetric Care facilities are supposed to perform the administration of parenteral antibiotics, parenteral oxytocins drugs and parenteral anticonvulsant drugs. In addition, procedures such as manual removal of placenta, removal of retained products and assisted deliveries are supposed to be performed (Wardlaw & Maine, 1999). Complications are referred to a district hospital which may not be within easy reach of the labouring or a bleeding woman. This presents another way that men’s involvement is critical to good outcomes for labouring women and their babies. Men’s awareness of women’s complications during

pregnancy and men's assistance in getting women to hospital at critical times can prevent maternal and foetal deaths. Additionally, unless essential obstetric care services are provided at the point of contact for the pregnant women, risk of dying from complications of pregnancy remain a threat (Maine, 1999).

5.6 Men's Views of Reproductive Health Problems

5.6.1 Deliver without Problems

Men defined reproductive health as women delivering their babies in a safe way, either at a hospital or with a Traditional Birth Attendant (TBA), to limit the chance of complications, maternal or perinatal deaths. While men acknowledged that women need a safe place and trained assistants during labour, they did not specifically discuss their role in escorting women to hospital as female participants discussed in their interviews. Additionally, there was some disagreement among men on where it is safest for women to deliver. Most male participants suggested that, in general, having trained assistants to help women deliver can result in good pregnancy outcomes. As one participant explained:

“Reproductive health is when a woman during childbirth should have enough materials. She should not deliver at home. What do I mean when I say she should not deliver at home and who helps her deliver? The woman delays going to the hospital. She thinks that parents will deliver her, but it is not like that. It is better for the woman to go to the TBAs or to the hospital where she will meet other people.” A 23 year old man, Dowa

One point of contention among male participants was whether it is better for women's health to deliver at the hospital or with a TBA. Many men agreed and recognized that delivery at home with one's parents is the most risky and may lead to complications. Even though hospitals in Malawi have inadequate health workers, lack equipment and supplies, and the quality of care may be poor, the majority of male participants felt that women should deliver at the hospitals for better pregnancy outcomes.

“The important information is that the woman should deliver her baby in the hospital. At the hospital is where you can get help because there are some women in the village who rush to Traditional Healers where there is little help.” A 38 year old man, Mzimba

Men's awareness of the importance of trained assistance during childbirth is encouraging. Available evidence indicates that a skilled attendant during births plays a major role in reducing maternal and neonatal deaths because they are able to recognise, manage and refer complications in a woman and her newborn baby in a timely manner to avoid death and disability (World Health Organisation, 2005). Beyond a hospital birth, men also observed the need for women to deliver with a TBA instead of delivering at home with their parents.

Traditional Birth Attendants are contested terrain; available literature has expressed doubt on how effective the TBAs are in reducing maternal mortality. For example in Malawi, it is claimed that TBAs are a source of maternal and infant mortality and therefore should be banned (Nyasa Times, 2009), while other commentators argue that using maternal mortality as an indicator for measuring TBAs success (Kruske & Barclay, 2004) is problematic. The claim in Malawi may be due to Traditional Birth Attendants not referring pregnant women with complications to the hospital. The UNFPA/WHO joint statement argues for TBAs only as an interim measure until all women and children have access to acceptable professional and modern health services (Kruske & Barclay, 2004).

Whatever decisions are taken at a local level, the important thing to remember is that TBAs will exist regardless of whether they are formally recognised as being important in assisting women or not. Traditional Birth Attendants will remain an important option for labouring women in rural areas as long as staff attitudes in hospitals remain aloof, and there is a health care staff shortage. Shortages are a reality in Malawi. In some cases, health facilities are manned by a maid or orderlies. A safe motherhood study reported by Matinga (2000) in Chikwawa, Mangochi and Thyolo districts in Malawi found that accessibility is a barrier to women during pregnancy due to muddy, sometimes bumpy roads and the distance covered to reach the hospital. These are important factors that impact where the community goes for services. Therefore, banning TBAs may not solve the problem. The decision to ban Traditional Birth Attendants should be made in light of the country's needs, resources and the available policies (Nanda, et al., 2005).

The Traditional Birth Attendant can be given other roles such as providing birth preparedness, social support to women during childbirth, and community based activities as deemed necessary. Traditional Birth Attendants may serve women in

much the same way that doulas assist women in western countries. The way forward would be to revitalise health systems and ensure that staff are available and can work at anytime in the most remote areas where services are needed most, with receptive attitudes. In addition, health facilities should be well equipped with drugs and supplies, equipment, a good referral system, and transport and communication (Nanda, et al., 2005). Not only will women feel comfortable to deliver at the hospital, but TBAs may phase out without having to be banned because users can be satisfied with available health services.

5.6.2 Men to get involved in Safe Motherhood Activities

Recall from chapter two that safe motherhood was discussed as an important component in reproductive health in order to achieve the Fifth Millennium Goal which relates to improving maternal health. In order to improve maternal conditions, interventions need to address issues that contribute to maternal and neonatal mortality and morbidity and those other conditions already mentioned in chapter four, five and six, such as nutrition of women, society norms, and violence against women. Next, I give a brief background of the safe motherhood initiative.

Safe motherhood is an initiative that was launched in Nairobi in 1987 at an international consultation of United Nation agencies, governments, donors and non-governmental organizations (NGOs). The initiative was established because of the high levels of maternal mortality and morbidity in developing nations. The prime concern was to prevent deaths through effective evidence –based policies and programmes (Berer & Ravindran, 1999). Following the launch, most governments, including Malawi, made commitments to reducing maternal mortality. Maternal mortality is a public health as well as a social justice issue, it is therefore important to ensure that pregnant women do not die unnecessarily by raising awareness in the community to take action to prevent these deaths (ibid).

In this study, some men were aware of the need for pregnant women to receive antenatal care and that such care could prevent pregnant women from dying. Men defined male involvement to include safe motherhood. The quote below indicates that men hold respect for women because of their abilities to reproduce and that this capacity deserves protection and care.

“Because for a country to be what it is called, it’s because of women who give birth even to Chiefs or any other person is born from a woman. So if men cannot be involved in safe motherhood it means the country is destroyed. That’s why Chiefs or men should get involved by encouraging women to do better.” A 44 year old man, Mangochi

Men felt that they should encourage women to go to the hospital when they realise that a “woman has missed her period” and when the “woman thinks she is pregnant” rather than wait “until six to seven months” of gestation and then “rush to the hospital for antenatal care,” a 42 year old man Mzimba. Men indicated that they could participate in this role, encouraging women to receive care to ensure women’s safety and the health of their unborn babies.

5.6.3 Perinatal Deaths

According to the men, one of the most pressing reproductive health issues is the death of the baby in pregnancy, during delivery, or immediately following birth. Perinatal deaths are those deaths that occur from 28 weeks of gestation to the first week of baby’s life. Still births are those babies that die in pregnancy or during delivery (Graham et al., n.d.). These deaths are directly linked with complications experienced by the mothers (Graham, et al., n.d.). Some men stated that a woman will deliver a dead baby if she does not go to the health clinic.

Death to newborns is likely to occur in situations of undernourishment of the baby when a woman is not cared for, for example if she is not provided with appropriate food during pregnancy. One participant commented on the health of a baby being connected to the health of its mother:

“If in the first instance when the woman was ‘sick’ [pregnant and] not well cared for, the problems that she faces are that the baby is born undernourished and it does not live a healthy life. It goes to nutrition clinic. In addition, for the woman if the man does not give her enough support, she does not provide enough milk to the baby. The baby is sick most of the time such that it is difficult to know whether the baby will be alive or not.” A 24 year old man, Mangochi

Men’s awareness of the connections between the health of women and their babies suggests potential areas of their involvement from the early stages of a woman’s pregnancy, during childbirth, and following the birth of the baby.

5.6.4 Maternal Deaths

Male participants discussed a number of factors related to reproductive health that contribute to maternal deaths. These include distance, lack of transport, equipment, drugs and shortage of personnel. They also explained that women die during childbirth, in many cases due to blood loss. Conversely, men did not relate blood loss to be a compounding factor for anaemia as some women discussed, nor did they consider high blood pressure during pregnancy as one of the causes of deaths in pregnant women. Some husbands considered it their responsibility to encourage their wives to go and wait at the hospital because staying at home meant women delivering without assistance and losing blood.

“I have been told to go and wait at the hospital [by midwife]. The fear is, if she stays at home, it is possible that during childbirth she may lose a lot of blood...but if she were to deliver at the hospital she would have been assisted. From the village, to take her to the hospital, like this one [pointing to the health centre of the area] they cannot give blood. So you hear them say you need to go to Mangochi. On the way, the woman dies.” A 35 year old man, Mangochi

Others observed that giving birth frequently leads to the loss of blood because the tonicity of the uterus wears off making women vulnerable to postpartum haemorrhage, which is one of the causes of maternal deaths.

Male participants were keenly aware of the risks associated with delivery. The lack of emergency obstetric care (EOC) services such as blood banks and the significant distances that women must be transported in emergency situations to get to hospitals suggests that men can play a key role in preventing maternal deaths from blood loss. Men may also encourage women to seek care in a timely manner and ensuring that delays in taking the woman to the hospital are minimized. Furthermore, by recognising the danger signs during pregnancy labour and after delivery and acting promptly, maternal deaths may be averted. They can do this by being trained in how to prevent blood loss after delivery and by getting women medical help as soon as possible.

Thus far, I have presented gender differences in women’s and men’s perceptions of reproductive health issues as they relate to male involvement. The next section presents women and men’s views of men participating in labour and childbirth.

5.7 Opposition to male involvement during childbirth

In chapter four, I explained benefits to male involvement as identified by male and female participants. In contrast to those who broadly supported male involvement throughout pregnancy, childbirth, and the postnatal period, a good majority of participants expressed deep opposition to one specific aspect of male involvement, men being present during childbirth. In the next section, I explain reasons for this opposition and discuss participants' views on the disadvantages of male involvement.

5.8 Opposition to Men's Presence during Childbirth

Childbirth represents the period where women are perhaps the most vulnerable, physically, psychologically, and emotionally. Out of forty eight rural women interviewed, only seven wanted their husbands to be present during childbirth, while the rest had reservations about husbands witnessing childbirth, even though some women seemed to be of open mind about men being involved during childbirth. For rural women who were against their husband's presence in the labour ward, some reacted to interview questions by facing away from the interviewers or avoiding answering the question completely. Many participants expressed concern that childbirth is a woman's issue and felt that if men witnessed childbirth, marriages will end or men will be bachelors because they will have seen or heard unpleasant things during childbirth.

5.8.1 Marriage will End

Women in the focus group discussions feared that if men witnessed childbirth, their marriages would end. They reasoned that when the "face" (birth canal) opens widely and the baby is being delivered, men will be put off to such an extent that "they will not want to enter there again," a 67 year old woman from Nsanje explained. By this she meant that men will not want to have sex with their partners again.

Some rural women expressed how pervasive men's lack of involvement is and how it is embedded within their culture.

"No, for us Chewas in relation to culture, we don't have such kind of a culture. This is why I said I have failed. Before labour starts, the man even at my place, the man just leaves his wife [at a health facility] that is all and he goes back

[home]. The reason is for the baby to be born that is all, but for them [men] entering the labour ward, it has never happened.” A 62 year old woman, Dowa

Participants in Mangochi explained that at one of the health facilities, a safe motherhood project in the district, tried to encourage men to accompany women to the hospital and witness childbirth. This was a strategy used to “punish” men who did not allow their wives to use contraceptives and to promote family planning. Some of these women were told to stop bearing children due to medical reasons, but their husbands still wanted them to bear children. This deception on the part of health workers is not a strategy likely to be successful in encouraging men’s involvement in pregnancy, childbirth, and the postnatal period or promoting family planning. Rather, it may create feelings of mistrust among couples, further alienating men from participating in childbirth, and doing little to empower women in making decisions about their own reproductive health.

This scenario is similar to what Ringheim (2002) found in a study about women in India. In this report, women informed health service providers that they were powerless to inform their husbands about health related changes suggested by the service providers in order to protect the women’s health (Ringheim, 2002). This is another illustration of gender inequality expressed through gender roles that dictate that women may not make decisions about their own health without their husbands. Male involvement should not be seen as a punishment for men, but rather as a way to bring couples together to support and communicate with each other in order to promote health behaviours. Promoting health behaviours requires that men are knowledgeable and given skills about how they can promote the health of pregnant women (Nanda, et al., 2005). This rural woman explained:

“When a person goes to the labour ward, there was a rule that everyone should be going there with her husband because men were refusing family planning. So when a woman is giving birth, you should be where? You should be there so that you should see how the woman suffers. So in those days it happened, the man entered [labour ward] but he was frightened with what was happening there, until the marriage what? It was finished, so this tradition was ended.” A 28 year old woman, Mangochi

In another interesting situation, a debate between two groups of rural men centred on the appropriateness of men being present during delivery. Older men said that it was disrespectful, embarrassing and obscene to witness childbirth, and that it was a responsibility solely for the doctors to be with the labouring women in the

labour ward. In contrast, most (but not all) of the young men were in support of men getting involved during pregnancy, childbirth and the postnatal period.

For example, older men that were against getting involved during labour had this to say:

“As for me, that wouldn't be humane. No, going to observe a delivery when the woman is giving birth! No. For me it's just to hear because this is where we were made different between a man and a woman. What is needed from there is for me to wait. I should be outside. I should just hear from the Traditional Birth Attendant or the midwife in the labour ward that the woman is having problems. So we are increasing the way for the baby or she has a baby born without problems, much on that score my heart will be at rest.” A 62 year old man, Mangochi

A young man responded:

“As for me, it may not be something intelligent to do that. An expectant woman is going to give birth at the hospital, then you should be sitting there observing. I understand that a lot of things happen. Some, I am told cry during childbirth. Some have their legs facing upwards, difficult things. If I do that [fail to sit and observe] it means on the part of being humane, I have lost it.” A 34 year old man, Mangochi

Women's vulnerability during childbirth is a primary reason why some men felt it would be inappropriate and disrespectful to be present in the labour ward. Emotionally, women often cry or get angry, and physically they are vulnerable. They are in a supine position and are naked making men even more embarrassed to be present.

“Yes, on the part that a baby is coming out and she should be crying and I should be seeing the way she is crying, and her nakedness [psyata] it's no good, no!” A 34 year old man, Mangochi

Another reason men thought they should be absent during childbirth relates to the other people who are present during delivery. Often when women are going to give birth they are accompanied by their mother, mother-in-law or sister. Thus, men argue that they cannot be in the delivery room when their sister or mother-in-law is in the room.

“As for me also, I don't think it is a good idea on my part yes because ... it is possible that you may have come with your sister in the ward or may be the woman has come with her sister. Yeah, that you see these things at home, so now with your in-laws you should be seeing these things at the hospital, you

are bound to be shy. Because when you are at home, you are just the two of you. If there is a visitor that you don't know, you become courageous to yes, observe, like that." A 30 year old man, Mangochi

Sexual issues are considered private. These are not things that men and women want others (especially close relatives) to imagine, particularly the actions that it takes for women to get pregnant. Furthermore, men don't want to get involved in childbirth because they may lack knowledge and training about labour. This is in line with the findings from the literature (see Ringheim, 2002; Shefner-Rogers & Sood, 2004). Many men subscribed to the notion that pregnancy is considered a woman's issue only for trained professionals. Men's reluctance to being present during childbirth stems from the belief that childbirth is women's business; this is how men have been socialised to think, act and accept as part of their masculine ideology (Esplen, 2006). Participants felt that assisting women to give birth is "the doctor's job," (a 49 year old man, Mangochi) because that is what they have been trained to do. One possible explanation for some participants' opposition to involvement during childbirth may be that they misunderstood male involvement to mean that men should conduct deliveries. For example, one man commented:

"The seminary of their training is where? So you are taking someone who doesn't know anything that come and stay here, is it not embarrassing?" A 49 year old man, Mangochi

Another reason for men's absence during labour relates to the cultural belief of becoming impotent by observing labour and delivery. Participants explained that if men were to observe childbirth, then they believe that their tail "would not rise for may be five months" [the penis would not erect] again and they would be impotent. There is fear that men will not be able to have sex again because they have seen something that is culturally considered obscene. The result will be that "men may abstain for a year and the woman may think that it is because her husband is seeing another woman," explained a 49 year old man, Mangochi. It is for this reason that men need to be educated about women's health care needs during pregnancy and childbirth (C. P. Green, et al., 1995).

"We are used to our behaviour, that men are not supposed to be there. That is [the] requirement, because if men are there they will see obscene things so that mentality is continuing up to now. They are afraid." A 38 year old man, Nsanje

Another reason that men identified as to why men are not involved during childbirth are that women themselves seem not to be very keen to have their husbands present during childbirth. Women become jittery to have men present in the labour ward. Similar results were found in Kenya where women did not want their partners to be present in labour ward or delivery room (Muia, et al., 2000). One participant explained the role of culture in influencing women to expect only women to assist with labour and delivery.

“But even today, expectant women when they are to deliver, when the husband is there, she becomes jittery. She is not relaxed. She is not herself. So when she is in the labour ward, a nurse helps and encourages her to be doing like this and that. Still she becomes jittery because our culture in the previous years, they used to deliver alone with women only. Yes, for her to deliver while her husband is present, it becomes a problem. She is not relaxed as the Chief has said.” A 50 year old man, Nsanje

Thus far, I have emphasised reasons why men did not want to be present during delivery. An understanding of these attitudes and beliefs can go a long way to promote positive change through appropriate interventions to address these attitudes (Efroymson, FitzGerald, & Jones, 2006). The next section presents the disadvantages of male involvement as identified by participants.

5.9 Disadvantages to Male Involvement

During interviews with civil society representatives, health workers and Traditional Leaders, they acknowledged that male involvement would benefit women (see chapter four). Participants also felt that male involvement would affect men negatively by leading them to blame themselves for making the woman pregnant, by getting emotionally involved, and that working men may not be in a position to get paternal leave for fear of losing finances to support their families. Each of these issues is discussed in detail.

5.9.1 Men feel Guilty

Men and women interviewed felt that if men were involved during pregnancy, childbirth and the postnatal period, men will feel guilty if they witness the agony the women go through during childbirth. Their reaction may be that of distancing and disengaging themselves (Chapman, 1991). They may think the pains

and moans experienced by women in labour would make them resent men. This man shared his views about disadvantages of male involvement.

“Are there any disadvantages for male involvement? I wonder we may consider the situation where the man is allowed to witness the actual delivery. After that he will fear childbirth. He may think that the woman is going through „hell“ because he made her pregnant. So he may fear or worse refuse to have any sexual intercourse with her after this, thinking that she may get pregnant again and go through the same process! This could be a disadvantage for the woman.” A 62 year old man, Lilongwe

Another participant stated that men may not want to have sex with women after witnessing childbirth because men cannot comprehend how the baby can come through the birth canal and expect that women will heal so that men can have sexual pleasure again. One health worker responded.

“There are some couples, of course, where it may be problematic for the husband to be there. And there are these rumours that some husbands are sexually put off afterwards because they have seen all this blood and all these things that they are not attracted to their wives anymore. I do not believe that it is a big problem but occasionally maybe that could be the case?” A 55 year old man, Lilongwe

In general, health workers, civil society groups, and Traditional Leaders were supportive of the idea that men could be involved during childbirth but acknowledged there may be a few men turned off by participating in childbirth.

5.9.2 Emotional Involvement of the Husband

Another disadvantage that men and women were concerned about was the emotional involvement of husbands during childbirth. Draper (1997) found that men’s presence may interfere with the labouring process, and further contends that if the couple’s relationship is not good, emotional and practical support may prove to be difficult for both the woman and the man. These sentiments were also echoed by this respondent, a 45 year old man from Blantyre.

“The disadvantage... there has been some research in the UK that I am aware of... in one study they said that hospital ... is better for women to be with somebody else because husbands tend to be so much emotionally involved that the delivery goes a bit more complicated, obviously sometimes it is better.”

Men’s actions are congruent with what is expected of them by society. They are supposed to protect the welfare of their families from danger and provide

resources for the family. If in the men's opinion, women are ill treated by health workers, they may react with aggression. They may voice their displeasure with the way health personnel are handling the situations of their partners, as this 45 year old man argued:

"Yes, there are disadvantages of involving men. There is no doubt that, in general, men are a lot more violent than women. And you will certainly experience episodes of either disharmony or even verbal or physical violence between men and health worker. This is something that I think we can expect. So in itself, it might be a disadvantage but my belief is that, that would be in great minority compared to the benefits of the whole process."

Asked why men may be violent, the respondent had this to say:

"I think probably for two reasons. The first reason is that they may misunderstand what health workers maybe doing and they may immediately interpret this as lack of care of their wife. And men tend to be protective. If it was something that was done to them directly, they ... may not react so bad, but when they see something is being done to their wife so that protective response may contribute to them being violent." A 45 year old man, Blantyre

Health workers may escalate the tension because they may resent the additional time involved in attending to two individuals (husband and wife), and having to explain how the pregnancy is progressing. The argument is that if men are involved during childbirth, it may be time consuming for health workers to counsel husband and wife for them to understand what is going on with the labouring woman. In addition, in the event that the husband faints, the health workers may have to deal with two patients creating more work for themselves than if they only had one patient:

"Time on the part of the health workers to counsel two people certainly, I think will take longer time in explaining issues about delivery ... So there will be greater time involved on the part of the health worker. That would be the disadvantage." A 45 year old man, Blantyre

Men explained that they may be overwhelmed by the amount of pain women go through and may not understand why women are behaving in the way they do during childbirth. Inevitably, they may find the women's action very intimidating and they may be tempted to discipline them. This may be because men may not have been prepared for what to expect during childbirth. Ironically, even to those men that may have gone through childbirth education, they may find labour pains very challenging and may feel helpless to assist the labouring woman. This is in line with

what Mardorossian (2003) experienced during her labour. She observed that the realities of labour were different from what was depicted in childbirth education because her husband who was present to coach her during labour found the situation very intimidating (Mardorossian, 2003).

5.9.3 Working Men

Another disadvantage of male involvement that was discussed was that because men are breadwinners and often provide money, food, clothing and shelter to their families (these gender roles are considered masculine), their involvement may mean sacrificing some household income. The Malawi government does not yet have a paternal policy to allow men to be with their wives during antenatal or childbirth. Men may have to take time off from their workdays. To take time off may mean sacrificing one's annual leave or opting for unpaid leave. Thus men may not accompany the women to the labour ward because of work.

"The disadvantages... are many since [some] men are working class. They have to fend for their families. So if they disrupt what have been their work to attend to these programmes, with the lady at the hospital and or health centre, that may create some conflicts unless policies are harmonized, sure. I have heard elsewhere they do provide fathers maternity leave." A 50 years old man, Mzimba

Another view was that men will waste time being involved during pregnancy, childbirth and postnatal care instead of working to support their families.

"Yeah, why should there be disadvantages? Now males will take responsibilities of making small families which are responsive enough. They can manage the families. The only disadvantage I could think of is that financially they will be wasting time to come to the clinic. They may find themselves starving again at home. That's the only disadvantage I can think about." A 52 year old man, Mzimba

Some men argued another disadvantage of accompanying women to the clinic is leaving their older children alone without any caretaker at home. These reasons are common when women have been advised by health workers to be admitted in hospitals for further management in cases of complications during pregnancy.

The comments of men and women in rural areas and health workers suggests there are few perceived disadvantages for men's involvement during pregnancy,

childbirth and the postnatal period. Most of the discussed disadvantages are rooted in beliefs that could be changed through adequate knowledge and information. Men and women indicated that men's involvement during pregnancy, childbirth and postnatal care depends on favourable policy. For working men, it may be difficult for them to ask their bosses for time off to go and support their wives even if for a brief period during labour and delivery. In the context of Malawi, where unemployment and poverty are high, bosses and supervisors are likely to question a man who would miss work to support his wife during childbirth. Furthermore, cultural expectations about men's roles might lead some men to be perceived as being controlled by their wives and called "sissies or bumphu."

5.9 Chapter Summary

Men's involvement in childbirth is a contentious issue. Views differed between men and women on their interpretation of reproductive health, some aspects of male involvement and the reasons why men should not be involved during childbirth. In this chapter, I explained why some participants felt that men should not be involved during childbirth. Men feared their manhood will be lost if they witness childbirth. In addition, witnessing women in pain and seeing discharges such as blood during childbirth may put them off. They also felt that it is not culturally acceptable. Women feared that men may not want to have sexual intercourse with them after witnessing childbirth and perceived this as a threat that their marriages will end. All of these factors need to be put into perspective and considered when making any policy change.

While acknowledging that culture is an issue, lack of knowledge of the benefits of men's presence during childbirth is also an issue. At the end of it all, men are responsible for making choices whether to be involved or not during childbirth. Even though some men and women expressed opposition to men being present during childbirth, information should be available for men to make informed decisions to be present or not.

Disadvantages of men's involvement were also discussed. Men indicated that their presence during childbirth may make them feel guilty seeing women in pain. Furthermore, health workers expressed concern that men might become emotional and interfere with labour. Another concern was about men sacrificing their income

for paternal leave. In the next chapter, the cultural barriers identified by participants that prevent male involvement in pregnancy, childbirth, and the postnatal period are discussed.

CHAPTER SIX:

BARRIERS TO MALE INVOLVEMENT

6. INTRODUCTION

This chapter focuses on structural barriers to male involvement during pregnancy, childbirth, and the postnatal period. Data came from focus group discussions and in-depth interviews with men and women from the rural districts of Dowa, Mzimba, Mangochi and Nsanje and two urban districts of Blantyre and Lilongwe and are based on the following question:

What do you consider if any, are barriers to men being involved in pregnancy, childbirth and postnatal care?

The main themes identified by participants include: cultural barriers, financial barriers, the infrastructure of healthcare facilities, and healthcare policy in Malawi. Each of these barriers is discussed in detail below.

6.1 Cultural Barriers to Male Involvement

Culture is defined as “that complex whole produced by people’s historical experience which includes knowledge belief, art morals, law and custom.” Culture also includes any other capabilities and habits acquired by man (or woman) as a member of society (Harouel, 2001, p. 3180). It consists of accepted and expected ideas attitudes, values and behaviours which are transmitted from generation to generation through learning (ibid). These cultural processes give the community a distinctive personality and these habits may influence positively or negatively the health of the community (L. W. Green & Ottoson, 1994). These processes are guided by gender in defining what it means to be a man or a woman, what roles men and women may fill, and how men and women interact with and relate to one another. It is therefore important to understand ways that culture may disempower women, or promote positive change, and to capitalise on them to encourage male involvement (Efroymson, et al., 2006). It is also important to recognize that while cultural expectations and norms limit women’s ability to make decisions about reproductive health issues, they may also limit men’s decision as well, even though men are in the

place of power. Cultural practices that give men power may also constrain men's behaviour in ways that prevents their involvement in reproductive health issues.

Results show that cultural barriers are a primary reason for men's lack of involvement in reproductive health issues in rural districts in Malawi. According to participants in this study, their village elders and parents play a key role in promoting and maintain specific cultural beliefs about men and women's behaviour with each other and their newborn babies following childbirth. Pregnancy entails strict observations of cultural practices by both the husband and wife, and sometimes the entire family. In Malawi, cultural practices such as abstinence and baby cleansing rituals and ceremonies are seen as a means for achieving a healthy family. Participants also discussed several ways in which gender segregation contributes to obstacles of male involvement. I explain how each of these cultural practices presents a barrier to male involvement below.

6.1.1 Abstinence

Abstinence is the period when couples are requested by the elders to abstain from having sexual intercourse until baby cleansing rituals and baby cleansing ceremonies have been performed. Participants identified abstaining from sex during and after pregnancy as a major factor in men's lack of involvement with care after delivery. It is believed that if a man sleeps with his wife after childbirth, the man will suffer from a disease called "phudzi" (hydrocele) and the baby may also become ill and perhaps die. In some respects, the cultural practice of abstinence is beneficial to women because it allows them to recover from the effects of childbirth, it prevents them from becoming pregnant soon after birth, and it helps to prevent the spread of sexually transmitted infections. But as one male participant suggested, abstinence may also have serious negative consequences as it may lead men to engage in extramarital affairs or polygamy.

"For men not to get involved...when the baby is born. Immediately the baby was born, they were saying you should stay [not have sex] for... six [months] while others it was seven months of waiting for the baby to grow. [Why] should [I] wait for all these months? I will just ignore her and go where? On the roadside. So the woman [from the roadside] wanting you maybe she was already admiring you. You will stay with her. But it means you are ignoring your wife. These beliefs are the ones that are barriers to men getting involved." A 35 year old man, Mangochi

Although the participant above indicated people in his village practice abstinence for six to seven months, another participant explained that in some cases men and women abstain from sexual intercourse for several years.

“Indeed in the previous years it was difficult when our wives have just delivered. Our parents were saying that you should not sleep with your wife until three years have elapsed.” A 42 year old man Mzimba

In Nsanje district, the responses were similar to those expressed in Mzimba. Mainly, men were made to wait for too long before they were allowed to sleep with their wives, and this affected their level of involvement after the baby was born and often led to extramarital affairs.

“Some men fail because there are too many cultural practices. In the past when you go in the house, when a woman is eight months pregnant, the man had to wait until the child born is six months old. So men could not manage all these months. They see it as a problem. So they could go and sleep with other women in the bush.” A 49 year old woman, Nsanje

In Mangochi, most families in rural areas follow the cultural teachings of their parents at the expense of their individual desires. If a couple is told by elders to abstain “until the chicken has hatched its eggs,” (a 62 year old man Mangochi) they succumb to the request.

The consensus among men and women in all three districts was that the period with which they abstain is too long. In the three districts of Mzimba, Mangochi and Nsanje, men begin abstinence when their wives are seven to nine months pregnant. In Nsanje and Mangochi, they continue to abstain until four to eight months after their wives have delivered. In Mzimba this period ranges from eight months to three years. Men said they abstain to ensure that their wives recover from the childbirth effects, but abstaining for more than two years is leading them to engage in risky behaviours and affecting their partner’s and children’s health.

For men to have multiple sexual partners during periods of abstinence presents a significant risk factor to their wives in a country where HIV prevalence is very high. Some participants suggested that these behaviours are phasing out; others contended that they continue to be practiced. Such beliefs and behaviours call for urgent attention to raise awareness to the community of the risks associated with

polygamy, and to increase knowledge about sexuality and other reproductive health issues.

6.1.2 Baby Cleansing

Almost two-thirds of men and women in focus groups referred to baby cleansing rituals as a major barrier to male involvement. Baby cleansing rituals occur after the first child is born and involve the elders giving instructions to men and women about how to behave with one another. This cultural practice is based on beliefs about ways that men and women can protect the health of their baby. These rituals provide guidelines as to when couples may resume having sex after delivery and a specified abstinence period discussed above, although how these rituals are practiced within each region may vary.

In Dowa, participants explained that couples wait for the baby's cord stump to fall off before resuming sex after delivery. After the cord is off, the elders inform the husband about this and it is at this stage that the husband is allowed to come in the postnatal room, usually referred to as "mchikuta," to hold his baby. Up until this point, he may have no contact with his baby. This act of the husband coming into the space where the wife is with the baby symbolizes that the "disease" (i.e. post delivery bleeding) that the woman had is over. The period to resume sex varies even within the same ethnic groups from four to eight months. In addition, there are a number of cultural practices that dictate to men what kind of contact they can have with their baby and when it is appropriate to do so. These rituals carry and communicate in symbolic form the values and norms of culture in four rural districts (Draper, 2003).

Similar results were found in Mzimba, as stated by this 53 year old man.

"When the baby is small, according to our Ngoni culture, we wait for the umbilical cord to fall off, so when it has fallen off, and the baby can be taken outside, that is when the man can now carry the baby and even hold it."

In addition to influencing when men may have contact with their babies, specific cultural beliefs and practices also influence women's behaviour. For example, once the baby's cord has fallen off, a woman can start cooking and resume adding salt to her food. Women stop putting salt in food during pregnancy because it is believed that if they put salt in the food and the family eats the food they have

prepared, they will “*jump*” the baby. The “jumped baby” may show visible veins on the face, faint, or fall ill, giving an indication that the baby has been carried or held by a person who had sexual intercourse. These beliefs play an important role in dictating what women can do and suggest that if women do not follow these culturally prescribed practices, there will be physical evidence (i.e., damage to the baby) of their deviant behaviour.

One participant went on to explain that after the cord has fallen off, “they [the mother and father] were calling elders to come and bath the baby with herbs known as likambako so that the baby can go with the woman anywhere” (a 32 year old woman, Mangochi). Without the baby being cleansed by elders, women’s mobility is restricted. It is believed that women cannot go out with the baby because it will risk the baby’s health. Once the baby has been bathed with herbs, it can be carried by family members who are “hot” (in this case, hot means sexually active). If a “hot” person carries the baby without it being bathed and protected, it is believed that the baby will be sick and will show signs of marasmus or have an elderly looking face with visible veins. These are predominant beliefs in Mzimba, Mangochi, and Nsanje.

After baby cleansing rituals are completed, a ceremony is performed to mark the end of the abstinence period between husband and wife. In one ceremony, the elders visit the house and assess the baby by carrying it to see whether it feels heavy or light. If, in their opinion, the baby feels light, it means the instructions were not followed and it is called “missing the baby” (kumphonya mwana). The hyena is then called in to correct the situation. A hyena is a metaphor for a man who is hired either by the elders or the parents of the couple to have sex with the wife to correct the situation. A hyena presents further risks to women’s health in an environment where HIV and other STIs are very high.

In another type of ceremony following baby cleansing rituals, a couple is required to engage in sexual intercourse with the baby placed in the middle of the mat. The husband will lie on one side and the wife on the other and then the couple can have sex. In a third version of a baby cleansing ceremony, a couple will light a fire in the bed room in preparation for sex. Then the couple will have sex. After they have finished the act, the husband kneels on one side of the fire and the wife will pass the baby over the fire to the husband.

Couples do not question why they must perform baby cleansing rituals or subsequent ceremonies in order to resume intercourse; rather they accept that their parents and elders of the village know best. This kind of social pressure to conform to what the elders want does not give the couple freedom to exercise their sexual right and freedom to choose when they can “accommodate” the baby. They are coerced into the traditions and they may not understand why they need to do them. One participant summarised such practices:

“This issue [baby cleansing] is valid because old cultural beliefs are just too many. How do we care for it? Isn’t it that when you are taking the baby so that she is in the village? There are others who take the baby and lay her in between the parents. They take it while having sexual intercourse and the baby is where? In the middle. Some do take the baby while having sexual intercourse. After they have finished, they take the baby and make it jump the fire.” An 87 year old man, Mangochi

Each of these cultural practices represents barriers which may result in men’s lack of involvement with their partners and newborn babies. Female participants were apprehensive about these cultural barriers imposed by their forefathers because “the children are just advised that when a woman is pregnant...you should not touch the baby, this is one of the cultural belief that is preventing men from getting involved,” (a 67 year old woman from Nsanje).

6.2 Gender Segregation

Societal expectations about the type of social interaction that men and women can have and gender roles within the household represent another barrier to men’s involvement in pregnancy, childbirth, and the postnatal period. Through socialization, the segregation of men and women from interaction with each other and in the household culminate over time, leading to men’s lack of involvement. One participant, a health worker, commented on gender segregation and its occurrence early among young boys and girls.

“Right from the beginning when boys and girls are growing up we tend to separate them. You find that many grow up not knowing how to cook because they are not allowed to enter the kitchen and these conceptions continue [into] obstetric care services and so on. For example, when a woman delivers there is separation with a spouse and therefore the husband is not directly involved.” A 64 year old man, Lilongwe

In general in Malawi, interaction among men and women is considered acceptable, but it is unacceptable for a woman to be present with a group of men, and for a man to be present with a group of women. If for some reason a woman is in the presence of a group of the opposite sex, she is seen as being promiscuous. Women receive considerable scrutiny and such behaviour is considered uncultured while men are not scrutinised because of the belief that it is their right to behave so (Oladeji & Adegoke, 2008). Traditionally, men and women are not supposed to be together in terms of physical presence or interaction if they are not married, and a girl cannot claim to have a boy as a friend. Relationships are not seen as plutonic, rather sexual in nature.

“Traditionally men meet to discuss issues related to men. Women do not join men’s groups. Likewise women meet as women to discuss issues of women; men do not join women’s groups. In addition, if you take young people, boys and girls are not initiated together. They don’t know what happens to initiation ceremony for girls or boys. Culturally this is how it has been.” A 62 year old man, Lilongwe

The socialisation process also contributes to men’s lack of participation in household chores. Men socialise with each other, separately from women. Men drink beer to socialise with their friends or to deal with problems related to lack of employment or financial problems. In some instances, beer drinking has been a source of violence in the home (Oladeji & Adegoke, 2008). Women who were interviewed explained that men go out to drink beer and eat very good meals like roasted meat which is called “kanyenya” while the family is left at home starving. For example, one woman expressed concern about men’s behaviour and stated:

“As he comes home he is drunk, has eaten roasted meat (kanyenya) at the bar. He deliberately comes [home] late so that when a woman shouts he should go away looking for other women. It is worse during hunger periods then they just go to their parents homes looking for food.” A 67 year old woman, Nsanje

Men’s behaviour of socialising while drinking beer is the cause of many problems in the home, especially wife beating. It is also a contributing factor for lack of involvement in pregnancy, childbirth, and the postnatal period.

Another aspect of gender segregation that relates to men’s lack of involvement concerns information. A consequence of boys and girls, men and women being socialised to fill different roles in a rigid division of labour is that they

receive different types of information. While women may be taught about aspects of reproduction, men lack this information. Most men in this study observed that information about reproduction is hidden from them. They are excluded from the process in many ways, particularly when their wives are in labour. One male participant explained:

“When a woman is giving birth, like in my village, they hide things from men, they don’t tell us quickly, no! They just come and collect your wife and maybe tell you to go away so that they do what they want to do until you hear about finished business, that she has a newborn baby. So as a man you cannot get involved in anything because they don’t inform you, no! These are women’s issues and men should not what, they should not know.” A 25 year old man, Mangochi

The little information men do receive comes from their parents and only concerns traditional medicine and traditional beliefs about illness.

“For the people to be taught to follow today’s health at the hospital, the information does not reach us. So people still have that old life that when things happen, then they go and touch the traditional medicine...so information is what seems to be the problem. People are not taught for them to be aware.” A 42 year old man Mzimba

According to participants, even if the man wants to support his partner, he will not show up and attend the birth because it is not culturally acceptable to do so. In matrilineal societies like Dowa and Mangochi, family members may serve as gatekeepers in making decisions on when the woman can be taken to the hospital. Such behaviours risk women dying during labour if gatekeepers cannot make prompt decisions to take women to the hospital. One participant succinctly described gender segregation as an obstacle to male involvement.

“An example would be in certain cultures, an uncle would be a gatekeeper...deciding whether the woman is taken to a hospital or not. So in those grouping within Malawi that insist on this, then I certainly think I will take that as an illustration of culture being a barrier to male involvement in reproductive health matters. When we look at childbirth at the moment...the setting that we have in Malawi where women deliver, are settings where culturally...they form a barrier in the sense that it’s not acceptable that where a group of women are gathered, that a man should show their face in such a place. Well, people would say that this man is uncultured if he finds himself among a group of women.” A 45 year old man, Blantyre

All these societal expectations shape the way men behave. From social constructionist perspectives, men think and act the way they do because of ideologies

of masculinity (Courtenay, 2000). Some men may assist their wives in private, but when they are in public they want to show that they fit with normative definitions of what it means to be a man. This 55 year old man from Lilongwe explained:

“I do believe this that in general masculinity is many times associated with strength with being hard, being strong, being aggressive not so much being loving and caring and tender and maybe soft. But I do also see many soft fathers towards their children and then it’s more like a public picture that you do not want to appear as being soft. But maybe when the door is closed you are cuddling your baby and you are happy with the baby, maybe you just have to learn to say it’s alright to cuddle your baby in public! There is nothing wrong with that!”

6.2.1 Lack of Respect

Participants explained that the cultural practices that segregate men and women from each other for most of their lives, while also relegating the household work to women lead some women to lack respect for their husbands. This is particularly the case for women who do not subscribe to dominant gender roles. Ironically, it is the cultural devaluation of women in relation to men that leads women to perform undervalued, unappreciated work and, in turn, lack respect for their partners. Thus, women’s reactions to their subordinate status, according to participants, were a major reason for men’s lack of involvement in pregnancy, childbirth, and the postnatal period.

One societal expectation for families in Malawi is that women respect men while men “are given free reign” (Oladeji & Adegoke, 2008, p. 58) because of their role as economical providers. Men are therefore considered superior to the women. A woman is not supposed to question her husband if she senses, for example, that he has had an affair (Oladeji & Adegoke, 2008). In fact questioning him may be interpreted as blaming him for having an affair. During marriage counseling, brides are told not to be jealous, not to question their husbands’ integrity, and not to walkout on their husbands. It is argued that women should persevere to make their families strong. In addition, women are instructed to serve their husbands’ social and sexual needs. Promotions of such messages contribute to systematically disadvantaging women by continuing to keep them in a subordinate position (Courtenay, 2000).

Participants provided examples of ways in which women may be seen as disrespectful for not following society expectations about their subordinate status. For example, women who do not provide food for their husbands do not welcome them home, or who tell their husbands that the pregnancy is not theirs are seen as disrespectful to their partners. Further, if the husband perceives his wife is being disobedient and disrespectful to him, he may react violently (Oladeji & Adegoke, 2008).

This lack of respect was reported by participants in all four districts. One possible explanation for this kind of behaviour may be that women feel neglected and unsupported during pregnancy. Women may feel that their husbands no longer love them, and they may be experiencing emotional, physiological and psychological pressures that pregnancy brings. If husbands do not understand what is going on in their wives' bodies, they are bound to misinterpret the situation as women being intentionally disrespectful. In addition, the pressures women face when they are expected to work in the farm and bear responsibility for the household labour put a tremendous strain on women. Women may not feel appreciated for their long hours of household work when their work goes unnoticed. As one participant explained, this burden is magnified when there are multiple children to care for.

“There are other families who when they have two children, they start quarrelling in the family. She says there is no child of yours here because the one who knows childbirth is the woman. So the next pregnancy that comes, you become powerless. If she is saying this without any remorse, that I don't have my children here, so why should I bother getting involved on this baby? So some men become weakened and they say the one who has born these children should what? Should help her.” A 25 year old man, Mangochi

Women's inability to communicate with their partners about the stress and burden associated with being pregnant and taking care of the household may escalate tensions between men and women thereby contributing to men's lack of involvement. However, it is the cultural expectation that women do most, if not all, of the work in service to their husbands that devalues women and contributes to these tensions in the first place.

Thus far, the cultural and societal beliefs and practices of men and women in rural areas of Malawi have been discussed as preventing men from being involved in pregnancy, childbirth, and the postnatal period. Beyond what happens within the

household between men and their partners, the infrastructure and policies of the health care system and its workers in Malawi also prevent male involvement. These factors are discussed below.

6.3 Attitude of Health Workers towards Men

In most government hospitals, maternal health services are free but one can choose to pay for the services in the same hospital but in a private ward, or one can receive care or deliver in a private hospital run by a private institution. The general belief is that where the services are free, quality of health care is low. Where clients pay for services, the quality is high. In most government hospitals quality of care is said to be low because the services are free and yet this is where the majority of people seek health care. Client-provider interaction is poor, examination and counseling is almost non-existent and in addition, drugs are in short supply. Oftentimes, clients and patients accept whatever care is given to them, and they have no voice to demand better services for themselves. This context of poor quality of care in hospitals impacts the working conditions of health workers.

Another important theme identified by participants as a barrier to male involvement was the attitude of health workers towards men. Most male participants noted that health workers are disrespectful to them and send husbands home before assessing the needs of women in labour. An assessment conducted by the Ministry of Health in 2005 found that factors contributing to health workers' negative attitudes towards men are lack of transportation and communication, lack of electricity, low salaries and heavy workloads (Ministry of Health, 2005b). These are realities on the ground; however the frustrations of health workers are often directed towards men with the effect of alienating men from assisting their wives with labour and delivery. This is what this 58 year old woman from Nsanje said:

"Sometimes, at the hospital when the woman goes into the labour ward, the doctor tells the man to go home. So when he goes out, he goes very far. If they were told to stay near or get them into their offices when the woman is in labour, it would have been nice. But they tell them to go home and then the woman has no what? [She has] no blood."

As the participant suggests, a consequence of men leaving the labour ward during childbirth is that in the event of complications, husbands are not present to provide their wives with for example, blood for transfusions, if they are needed.

Health workers and hospital servants (as they are called in Malawi) send patients away if they are found loitering near the labour ward. Additionally, guardians, regardless of whether they are male or female, are perceived as people who complicate things in the hospital and therefore health workers do not welcome their presence. Midwives or health workers may not be comfortable for guardians to be around labouring women because guardians may voice their objections about the care provided to their relative, friend or spouse. In some cases, guardians from the rural areas may not question the behaviours of health workers for fear that the patient may be ill-treated. One 55 year old health worker from Lilongwe spoke about the difficult working conditions in Malawi.

“We health workers are bad at it because we in Malawi are terribly understaffed. So generally speaking guardians and family of patients are very often perceived as people who complicate things but we should approach them as people who can help us. But they tend to be more critical because they see their beloved ones in pain and might be demanding, which on its own I think it’s a good thing. It’s not bad...do because we are overworked or understaffed...but I do believe that our attitude puts men off and also puts women off. But the women have no choice. They have to come. The man can choose not to come.”

Health workers further observed that midwives are not receptive to men who fail to bring new clothes for the baby or wife. During the antenatal period, pregnant women are advised to prepare for the baby by bringing clothes, basins to bath the baby, razor blades to cut the cord, and in this era of HIV their own draw sheets. Draw sheets are plastic sheets put underneath the woman to prevent her from soiling the bed sheets. In some cases, health workers and hospital servants take advantage of poverty stricken women that do not bring these things to the hospital and ask women to buy from them. Such events may discourage women from going to the hospital to deliver their babies.

It should further be noted that most of the health centres in the rural areas don’t have electricity. In these areas, “women are asked to bring paraffin” (a 59 year old woman, Nsanje) with them when they are in labour. They use paraffin lamps at night to conduct deliveries and this is a big challenge. Not only is the situation prone to fatal errors in the management of women, but also the midwives concerned may just want to deliver the women and go home because the environment is not conducive to working. As a result, quality of care may be compromised. Asking

patients to bring paraffin is a gross violation of the health workers jobs because paraffin is supplied by the district hospitals to health centres of their jurisdiction. The Ministry of Health may need to consider using other source of lighting such as solar electric solutions so that patients are not asked to bring paraffin to the hospital.

In this study, the majority of the female participants had concerns with the way health workers treat them as patients in the labour ward. Some women reported workers yelling, swearing, scolding, slapping or treating patients poorly. Similar results were also found in a study conducted by Matinga (1998). One man stated that health workers say bad words that discourage men to get involved such as “When you were getting pregnant was I there?” (A 46 year old man, Nsanje). (This statement from the health worker was poignant given that sex is a sensitive subject rarely spoken of in public.) These sentiments were expressed in all the four districts including the two urban districts.

“Sometimes when women go to the hospital to deliver, the nurses ill-treat us. They are violent, and it is a problem that we face!” A 20 year old woman, Mzimba

“I was pushed around, pricking so I thought that this was violence. Yes, I had a lot of luggage, so I wanted to leave some of it outside. But they did not speak to me well, it was violence.” A 20 year old woman, Mzimba

One man expressed his concern at such treatment from health workers.

“There are some, on the issue of good reception, there is no problem. But there are some who act as if they are being forced to work if they speak to you. The person [health worker] scolds you, „Go away. What do you want here?“and then they send us back. So as men, we easily get disappointed. So you just say, „I should not bother.“ You just keep those things in your heart, and then these things hurt us...because we don't know where to go. So these are some of the things that prevent us from getting involved.” A 29 year old man, Dowa

Some participants explained that health workers have associated them with witchcraft when they insisted on being near hospital premises. Associating men who want to be with their wives as practicing witchcraft is unprofessional on the part of health workers.

Nurse's attitudes towards patients and their partners is a barrier to women accessing services, and also for men getting involved during childbirth. Surprisingly, even the health workers interviewed acknowledged that health workers' attitudes prevent men from getting involved. Possible explanations for such kind of behaviour

may be attributed to lack of understanding of the importance of male involvement during childbirth. Critical shortages of personnel in some health centres, a lack of supervision, and the personality of individuals may also be factors. Health workers need to treat patients with respect and dignity regardless of their status even in hard times, such as when human resource shortages are being felt.

6.4 Infrastructure Barriers

Beyond the attitudes of health workers, participants also highlighted the lack of privacy at hospital, inaccessible hospitals, and shortage of personnel as infrastructure barriers to male involvement. More than half of the participants noted that the hospital environment at the maternal health services is not male friendly in a number of ways, which I explain below.

6.4.1 Lack of Privacy

Over half of those interviewed reported that there is no privacy in the labour ward. They argued that most of the labour wards are only separated by a screen and therefore not conducive for men to be present. They stated that if men were to be present, they would clearly see the other women admitted in the labour ward and hear them as they give birth. This is the case in non-paying wards as opposed to private or paying wards. Overcrowding was another barrier that was cited. In most of the public hospitals, there are too many patients because of free services that are provided and not enough space to accommodate all patients. Therefore, health workers felt that men may not be comfortable to accompany their partners in those crowded places:

“Here it’s the infrastructure. Men cannot be there. It’s like it’s overcrowded, so men...don’t feel comfortable to be among the women. So like in the labour ward, the way our labour ward is built, there is no privacy. It’s like...labour beds are demarcated by curtains so if a man has accompanied the woman in the labour ward to watch a delivery it will be easy for that man to be able to hear whatever is happening with another woman on the other side.” A 37 year old woman, Lilongwe

Other participants expressed concern for the way women may compare their circumstances, especially in cases where one has been accompanied by her husband and one has not. The women labouring alone may be psychologically affected by the presence of another woman’s husband. She may feel isolated and neglected by her

partner for his lack of involvement. She may fear the midwives may not be able to take care of her. Midwives may not be in a position to fully support the patient because they also may have other patients requiring their attention and therefore they may not be onsite every time the labouring woman needs them. Additionally, the way the labour ward is structured does not provide privacy. Beds are lined up next to one another and women are not given private rooms. As one participant explained:

“At the hospital men cannot be involved. In the labour there is a bed here, a bed here, and a bed here. All these women are giving birth, so if a man comes in, looking at them each one looking after his, can that be possible? If each woman had her own room, then men can come in. If they are there... lined up] on the beds, can a man come in?” A 58 year old lady, Nsanje

6.4.2 Non-accessibility to the Hospitals

Most participants explained that the hospitals were very far away and that such distances were a risk to women’s health.

“For our health, what we want is that the hospital should be near but not far away, no, because our life...depends on the hospital. Just imagine from Saiti Village to Tibutibu, the only hospital is Nankumba. So for us to walk with a person who may be pregnant, going to Nankumba, she may lose her life because of the distance to the hospital.” A 49 year old man, Mangochi

In some cases, labouring women have to travel 20 to 100 kilometres from their home to the hospital. In most rural areas, transport is unreliable and even if transport is available, it takes significant time to get to the hospital because of the terrain. Some roads are impassable during the rainy season. These problems have consequences for the pregnant woman who might bleed to death or deliver on the way to the hospital and sustain injuries.

“Women face a lot of problems. They face difficulties during childbirth. When you look at the hospital the way it is, Mzimba is very, very far. Sometimes transport is a problem. Women sometimes die because the hospital is very far in Mzimba.” A 29 year old man, Mzimba

The problem is further exacerbated by the lack of ambulances stationed at health centres. Most of the health centres depend on ambulances from the district hospital which may be over 100 km away, and the distance make it impossible to transport emergencies for better management at the referral centre leading to the deaths of patients. While ambulances are a challenge to transport emergencies, communication between the health centre and the referral unit pose significant

challenges because of the non-availability of telephones. But even if telephones or other communication devices are available, they may not be working.

“It is very true that the location of health facilities is another critical factor that has got to be looked into seriously. These days we are saying people demand facilities of their choice but then the government has its own ...criteria for allowing such things like infrastructure to be built. Geographically, yes, there are some places which are very, very bad. People have to climb several hills before they reach the facilities. They deter people they cannot go to such facilities.” A 50 year old man, Mzimba

Several studies have shown that distance to health centres, lack of transport, and lack of privacy are barriers to accessing health services and this appears to be the case in this study (Ministry of Health, 2005b). These sorts of obstacles in accessing health services decrease the likelihood that men will be involved with their partners labouring at hospital.

6.4.3 Shortage of Personnel

The shortage of personnel was mentioned by participants in Mzimba as a primary barrier to male involvement, but it was not mentioned in the other districts. This may be because the other districts did not recognise it as a problem or because the quality of care may be the same (i.e., poor) regardless of the number of health workers employed in the district. Mzimba participants stated that sometimes there is only one health worker to help in the maternity ward and sometimes she gets very busy, resulting in women delivering on their own and sometimes dying. One nurse might cover the outpatient, family planning clinic, immunisation and maternity ward. Sometimes there are many women in labour and all of them require care from one health worker simultaneously. These are some of the challenges that health workers in rural communities have to deal with. In these circumstances, if men are involved they may be in a position to report any developments to the midwife and help with tasks such as providing support to the labouring woman. As with any new intervention consideration needs to be made on how best the available staff might be utilised effectively, in order for male involvement services to be initiated. Other avenues might need to be explored, such as using some organisations to compliment public sectors to take the male involvement agenda forward.

What might explain these critical shortages of health workers in health facilities in Mzimba? Possible explanations are an abundance of recent resignations,

which accounted for 22 percent of the overall losses in 2004-2006, deaths which accounted for 45 percent in 2006, and about 5 percent attrition rates of high level professional staff leaving the health sector annually for jobs in other places (Ministry of Health, 2006). In addition, low salaries and poor staff morale contribute to these attrition rates (Ministry of Health, 2005b). These harsh realities of human resource shortages in the health sector are felt particularly in the remotest areas where most of the health facilities are manned by one health worker and sometimes an orderly or maid. This is where the services are needed most as 85 percent of the population resides in these areas. Therefore, care provided to the clients or patients may be sub-standard and far from being responsive to clients needs. Appropriate policies to address health worker coverage in rural areas (Lule, et al., 2005) may improve accessibility of women to maternal health care.

6.4.4 Hospital Policy

Recall that participants from rural areas suggested that the attitude of health workers presents an obstacle to male involvement. Building on this theme, participants also suggested that hospital policies are a barrier to male involvement because they are restrictive. Most participants felt that the policies regarding the design of the labour ward were discriminatory in nature as they only favour women. In some hospitals, sign posts say “no men allowed beyond this point,” (a 55 year old man, Lilongwe). Many participants saw this as a barrier because it suggests that hospitals perceive labour and delivery only as a woman’s issue. While participants did recognise the need to have security and protection for labouring women, they suggested that male family members do not represent any threat during delivery. This participant explained:

“In the past they did not allow us. They were saying, „men do not enter this place.” So as a man you were just waiting outside, waiting to know how things will be. If things go well there, the nurse would come out to tell us that, she has delivered...a baby. After preparing the baby, then they put it on the bed and then...you come and see the baby. Only then can you enter to see the baby. But to the labour ward, they did not allow us.” A 77 year old man, Nsanje

Most hospital policies require only one guardian per patient. Because the patient is in the labour ward, choices are given among the relatives to decide which guardian will be with the labouring woman. The guardians are not allowed inside the

labour ward unless the labouring woman is not co-operative; otherwise they wait outside the labour ward.

“Things are that only women are the ones that are found there. They [midwives] say a patient should only have one person. So we say [to the midwives], „do you want to stay with her yourself? Or maybe you should go in there?” So I wanted to ask, „how can we go in there us as men?”” A 65 year old man, Dowa

Relatives wait anxiously outside the labour ward to be informed about the outcome of childbirth. In situations where the outcome of childbirth is, for example, still birth or perinatal death, then health workers have difficulties informing the relatives. This may be because health workers fear being blamed for the death of the baby. Participants suggested that if men are present during childbirth, they will be able to witness the situation that led to the death of the baby and be able to explain to their relatives what happened.

Other participants, particularly health workers, argued that policy is not a barrier but the problem is at the implementation level. It could be that policy is misinterpreted at the implementation level or that health workers are themselves influenced by their own culture, especially gender roles, thereby affecting their decision to send men away from the labour ward.

“A[s] far as the policies are concerned, I do not think that [they] in themselves are barriers to male involvement. I think the lack of male involvement is something that happens at the level of implementation. So the unit that is offering the services themselves that's where I think the problem is. So that if we were to address at that level, I don't think there would be any policy that would be against male involvement.” A 45 year old man, Blantyre

It is evident that policies in the health facilities are not male friendly. Another factor is that policies may require explanation at the implementation level. Questions may arise as to what is contained in the policy, whether or not health workers are aware of these policies and what it means to the delivery of services. Speaking from my own experience as a health worker in Malawi, there have been times when documents have been sent to the hospitals but health workers have not read them. Health policies may not stipulate details of how each hospital should manage its own affairs but it is up to the hospital management to determine the needs of the patients or clients. It is necessary to ensure that health workers are knowledgeable about

policies, provide them with guidelines on male involvement and that mechanisms are put in place to monitor the implementation of such policies.

6.5 Financial Barriers

Financial barriers are another reason why men are not involved in reproductive health issues specifically during pregnancy, childbirth and the postnatal period. Even though maternity services in public hospitals are free, participants have to pay for transport to get to the hospital, the value of food at the hospital, baby and women's clothes, washing materials, and their length of stay in hospitals. All of these become a deterrent for poor families to seek care. In many cases, particularly in rural and urban slums, financial constraints in the family result in social tensions (Borghi, Storeng, & Filipi, 2008). Participants highlighted poverty, lack of jobs, and hospital demands as the primary financial barriers to male involvement. These are discussed in detail below.

6.5.1 Poverty

Participants cited poverty as a barrier. Most participants said that they don't have regular jobs but are subsistent farmers or small business vendors. Others depend on piece work, for example, if there are projects like road construction or school building. Some piece work is locally known as "ganyu." This piece work may be seasonal like farming, planting and harvesting season, but thereafter the men are jobless. Evidence suggests that reliance on subsistent farming or other casual jobs may prove difficult for families to access immediate cash in times of need (Borghi, et al., 2008). One concern which the participants expressed was that after work, they expect to be paid but sometimes their employers inform them that their payments won't be given until the end of the month.

"The barriers to us men, like myself [during], the time that we are preparing that my wife is going to deliver. During that time, I go to look for piece meal work, so I farm somewhere to earn money to buy things that are needed for the baby. Now the employers say you should wait until month end so I find myself having no money. That's what bothers me very much - having no money to take care of my family." A 42 year old man, Mzimba

Participants noted that if they are not working and have no money, they would not be able to buy the basic necessities for the pregnant woman "like soap, nappies, salt or even clothes for the baby" (a 38 year old woman Dowa). Poverty

contributes to mothers opting to deliver at home or with a Traditional Birth Attendant (Matinga, 1998), because it is expensive to go the hospital. Furthermore, some women may not be able to go to the hospital because they have worn out clothes and may not afford new ones. They are shy because they believe health workers may judge their appearance and not attend to them.

Men as providers of resources are expected to support their families, even though they may not have the means to do so. During season of drought, it is a challenge because it means they will not have food. The societal expectations of men cast them as breadwinners, yet only casual work may be available and they may be unable to find food for their families. For men who cannot provide food, rather than being involved with their families in other ways, they respond by being violent because they do not want to be seen as failures to supporting their families.

“Yes, the barrier to our involvement is mainly because of poverty, because sometimes it is during the drought season. You have no money and yet you are required to provide food to the expectant woman. She is sick so it will only be me troubled to assist to find food but the money then is not enough so that [is] what prevents us from getting involved.” A 32 year old man Mzimba

While some participants mentioned poverty as a barrier, others suggested that lack of finances cannot be a barrier because men know the end result of sexual intercourse is pregnancy and it takes nine months for the baby to be born, giving ample time to prepare for the baby’s coming. What participants advocated is that if a woman is pregnant, the husband should ensure that he prepares for the baby by putting nappies together, buying clothes for the baby and his wife before delivery, and planning for transport to take the wife to the hospital over time, throughout the course of the pregnancy. These are tenets of birth preparedness discussed in chapter four.

“Sometimes when the pregnancy comes, you have nothing until the woman delivers, but you still get prepared little by little that some of the things I must what? I must find them knowing that you are poor.” A 49 year old man, Mangochi

Even though poverty may be difficult to eliminate, families can engage in income generating activities or small businesses to earn income. It is important that men plan how they will support their partners during pregnancy, childbirth and the postnatal period.

6.5.2 *Utilisation of Finances*

Even though most men in the rural areas are subsistent farmers, some do have professional jobs like teaching, or working as veterinary or agricultural assistants, and therefore earn monthly salaries. Of concern in the interviews was how men with regular and adequate income use their salary funds. Having enough resources for some may not necessarily mean happiness but misery. More money may mean more women or girlfriends to provide for.

“Yes, it is true that the husband is failing to have money because of moving around in search of women. He does not take care of his family, no. So when he has money, he spends it outside the home during his walk about spree.” A 70 year old man, Nsanje

Other participants claimed that having lots of money drives men mad to the extent that they neglect their families in order to entertain their mistresses. Such kind of action may have negative effects on the family’s health because the man’s attention is divided between his family and the mistress, and therefore resources that would have supported the family with basic things like food may not be readily available.

“What happens in the house when a man has money for his family to be destroyed? His thoughts when he has the money... [are] what destroys him. He does not think about his wife or his family. He is thinking of other women outside because he has the money. The women too do come closer to him quickly because he has the money. They are waiting to eat what? To eat the riches! But inside the house support is not there.” A 62 year old woman, Mzimba

The above results are in line with the findings of a study in Ethiopia. In this study, women stated that when the man’s pocket is full, he brings a new wife and the man ignores his other wife (Berhane, Gossaye, Emmelin, & Hogberg, 2001). This is in sharp contrast with women’s priorities when they have money. Women use such resources to take care of their families (ibid). The availability of funds may bring joy or misery depending on how the finances are managed in the home. If men listen to health education talks at the antenatal clinic, they may be able to understand why women need to plan for the baby’s arrival and they might provide care for their partners during pregnancy.

6.6 Chapter Summary

This chapter has explained barriers that hinder men's involvement in pregnancy, childbirth and the postnatal period. I have highlighted cultural practices including abstinence periods, baby cleansing rituals, and baby cleansing ceremonies (that mark the end of abstinence) as significant factors contributing to men's lack of involvement after babies are born. Gender segregation operates to further separate men and women in their roles and interactions with each other, resulting in men having neither the knowledge nor desire to be involved. In terms of infrastructure, there are significant inadequacies in the resources and health services provided to public patients. These inadequacies are combined with ill tempered health workers who are stretched thin from a lack of hospital resources. Poverty is a final obstacle to men's involvement. When hospitals and health centres lack basic supplies and materials and there are expectations that patients bring items for their care, poverty means that it is easier for women to avoid long journeys to hospital and risk delivering at home without skilled attendants. This situation is exacerbated by hospital policy that does not allow men to be present with their wives or to be anywhere near the labour ward. These barriers are significant, but the situation is not insurmountable. In the next chapter, chapter seven, I present ways of facilitating male involvement as identified by male and female participants in this study.

CHAPTER SEVEN:

OVERCOMING BARRIERS AND MOTIVATIONAL FACTORS TO MALE INVOLVEMENT

7. INTRODUCTION

Several barriers to men's involvement in their partners' pregnancy, childbirth and postnatal care were presented in the preceding chapter. This chapter addresses overcoming those barriers by identifying participants' views about ways men can be involved. Responses came from both in-depth and focus group discussions based on the following interview questions:

- Can you describe ways that you think these barriers could potentially be overcome?
- What do you consider if any, are motivating factors to being involved in pregnancy, childbirth and postnatal care?

Ninety-three rural men and women between the ages of 20-87 responded to the question of how barriers could potentially be overcome. A second question regarding motivation factors was asked to both twenty-eight men and women in the in-depth interviews and the rural men and women in the focus group discussions. Participants suggested ways in which barriers could be overcome and these are displayed in figure 2. Note that figure two shows participants' views about the necessity of engaging multiple constituent groups at several levels. At the level of the individual, community leaders play a key role in the support and development of programmes aimed at increasing male involvement. As shown in the literature, the capacity to design and implement male involvement programme lie within the community (Mehta, et al., n.d.). Therefore, as a first step, engagement with and education of community leaders is important. Education may be disseminated via formal programmes aimed at improving reproductive health, or informally via primary socialising agents such as family and village leaders. Education should target youth early. At the structural level, policy change must come about through civil society education and community sensitisation. Each of these aspects was

identified by participants as being a necessary step in facilitating male involvement in maternal, sexual, and reproductive health.

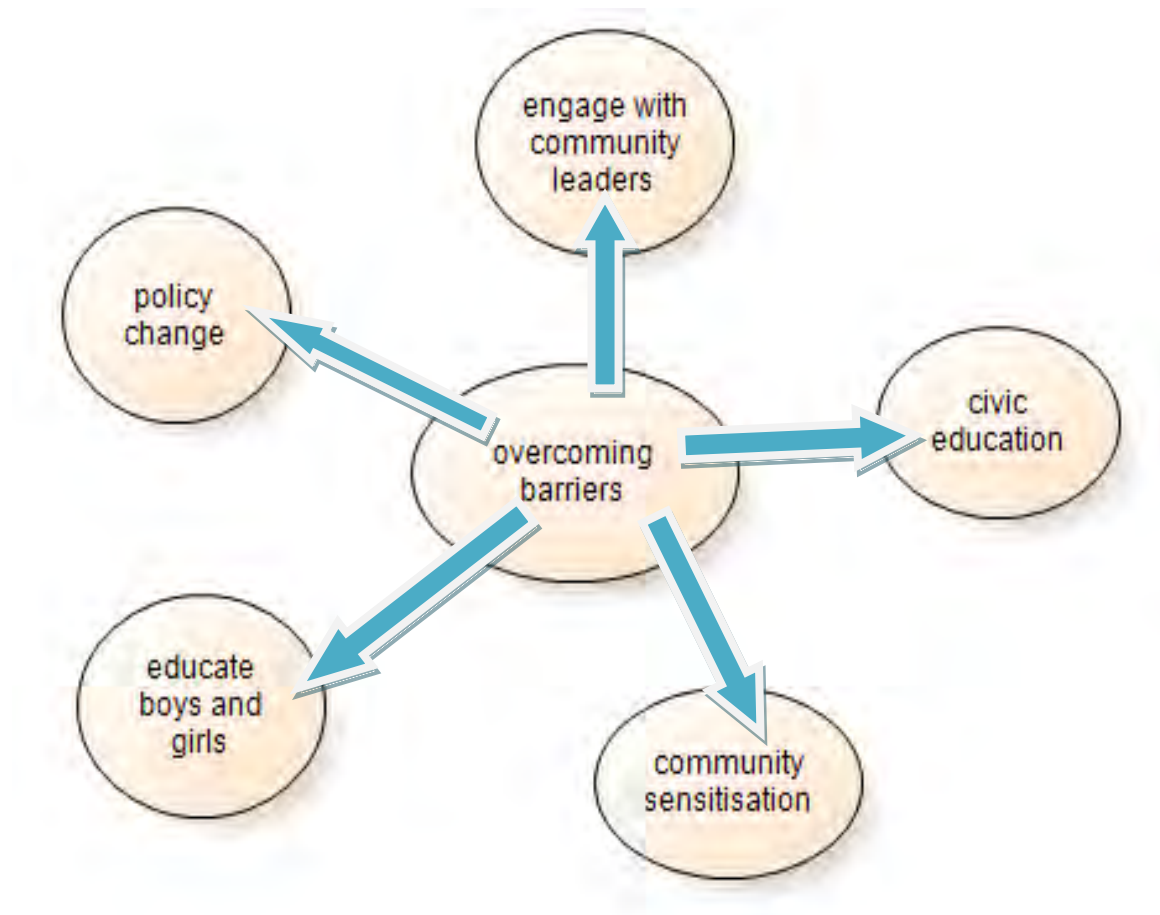


Figure 2: Overcoming Barriers

7.1 Engaging with Community Leaders

As a first step to overcoming barriers to male involvement in pregnancy, childbirth, and the postnatal period, participants suggested that reproductive health programme planners and developers engage with community leaders. Participants' definitions of community leaders included politicians, religious leaders, Traditional Leaders and gatekeepers such as grandparents and uncles. In this study, all participants agreed on the importance of engaging with community leaders to get men involved. They suggested that there "is need to engage with local leaders such

as Village Headmen.” The Village Headmen, for example, can disseminate information with the help of the health workers about male involvement. For programmes to be successful, programme developers and administrators must be cognizant of the power structures in the community. Initial contact should be made with the local leaders to brief them of the intended interventions and seek their views about how to move forward and plan delivery of interventions within communities. For example, one woman noted how information “can come through the chiefs” about male involvement then people will act from the chief’s advice “to take part [in community programs] by informing the communities the intentions and benefits of the programme” (a 62 year old woman from Dowa).

Participants also discussed engaging with community leaders by meeting with them and talk about male involvement and the role that men can fill using the community structures in their villages. The community needs to be provided with skills in order to affect change. The skills may centre around forming social groups to work specifically on promoting male involvement. From my experience working with communities in Malawi, if programmes are introduced without the support of the leaders, they are not successful. It is therefore important to ensure that community leaders understand the intentions and benefits of any new programme or intervention.

Some researchers have pointed out that community participation sometimes inadvertently exploits people to use them for the purposes of the project without taking into account the cultural context in which the project is implemented (L. W. Green & Ottoson, 1994). However, if consultations are made based on the community’s needs, and if this ensures that the community is part of the planning process throughout all the stages of the male involvement programme, most communities may feel empowered and take ownership of the programme (ibid).

Participants acknowledged that in addition to engaging community leaders, health workers should provide community leaders with more information about health problems prevalent in their districts, and explain the advantages of women delivering at the hospital as opposed to home delivery. One participant outlined a possible plan for a call to action, engaging many people in the community beginning with those who are most influential.

“We will start with the Chiefs, then the Chiefs will call their people or let’s say the Village Headmen or the group Village Headmen [village development committee chairpersons] making them aware that these people will come any day with this information and its sort of knocking to the community [letting them know ahead of time] because you cannot just go to the community without the elderly people knowing without bow[ing] and say we will be coming with information. Because maybe they will appreciate with the indicators which are there that Nsanje is high in a lot of indicators [such as] the infant mortality rate, maternal mortality rate, nutrition, diarrhoea cases.” A 59 year old woman, Nsanje

Another participant added to this by explaining how community members can participate in multiple aspects of setting up infrastructure to deliver interventions.

“As for the communities themselves...now they have decentralization programme that also has a health aspect of it through that programme at district level. The communities would be involved by being part and parcel of the planning, planning of programmes in the health sector that would be their involvement because then you have services that are tailor made to their needs. I think it is their involvement and planning, but even at implementation, for example if the issue of... community clinic then male involvement would be participating in mobilizing things like building materials, things like sand, things like bricks.” A 57 year old woman, Blantyre

Other participants stated that the community can be reached through existing structures used for development activities within their communities. Such organised structures include: The District Assembly, which is comprised of chiefs, members of parliament and five representatives of interest groups; the Area Development Committee made of Chiefs, Group Village Headmen, non-governmental organisations, two members of the Village Development Committee, and one representative woman; interest groups and political parties; an Area Executive Committee comprised of area extension workers; and a Village Development Committee consisting of representatives elected by their communities (The United Nations Capital Development Fund, 2001). These existing structures can be used to advance male involvement in pregnancy, childbirth and the postnatal period agenda, in addition to developing programmes through education. Next, I explain how participants” discussed the role of education in promoting male involvement.

7.2 Education

There was a consensus among the health workers, civil society groups and the Traditional Leaders interviewed that local leaders should be educated about male

involvement during childbirth and postnatal care, particularly with regard to statistics that measure the overall health of communities (as previously mentioned).

Participants also identified several groups who should specifically be targeted with education about male involvement in reproductive health. Of the utmost importance, youth and women were seen as benefiting from education.

Men and women of this study suggested that there is a strong need to educate youth to understand reproductive health issues and its consequences to their health and their families. Participants also suggested that education should also “include other decision makers” in the community who are very influential like “the grandparents (agogo), religious leaders and politicians,” a 62 year old man, Lilongwe. Education could be delivered in schools with content focusing on family life education and sexual and reproductive health issues including statistics on common reproductive health problems such as maternal and neonatal mortality, infant and under fives mortality and statistics of other common diseases. While participants did not suggest any particular media tools for raising awareness, posters, drama and music could provide the most ideal tool for rural communities given that most rural communities are illiterate. One participant called for education at all levels within communities:

“Educate young people, the whole society, [and] men, in charge of culture to understand these issues, including religious leaders, politicians and grandparents. All those are important including agogo [grandparents]. They all must understand this is not just a women’s affair. Public education is also important to explain [the] dangers of pregnancy and what dangers occur during pregnancy...” A 62 year old man, Lilongwe

Other participants suggested that the timing of delivery of information about male involvement is important. Given that many rural participants in this study had little to no formal education, information should be provided early. One man suggested “family lessons should be introduced in secondary schools” (a 41 year old man, Blantyre) if not introduced earlier; these lessons would buttress young people’s understanding of male involvement in reproductive health and prepare them for future roles. Similarly, another participant suggested “introducing family lessons in primary schools” (a 47 year old woman, Lilongwe). Although participants only discussed education in relation to schooling, consideration should also be made for out of school youths, engaging them in discussions related to sexuality, reproductive

health and fatherhood. Out of school youth may include those that have dropped out of school due to pregnancy, lack of interest pursuing education and those due to lack of resources to attend school. Such discussion should include aspects of mutually supportive male-female friendly relationships during pregnancy, childbirth and the postnatal period (Ntabona, 2002).

Other participants suggested specifically investing in and targeting girls' education as they will become mothers in the future. They noted that girls should be provided with an environment where decent education is available and where they can develop confidence and self-esteem. Self esteem is particularly important given that it enables girls to have self regard, respect, acceptance and self enhancement of who they want to be (Crocker, 2001). Self enhancement or self-actualisation is further acknowledged in the higher needs hierarchy of Maslow's needs, as such it may be that unless the lower needs are met for example good health and education, then these needs may follow. If they are not, then it takes us back to the fundamentals of health and unless these girls have better health and education prospects, it is unlikely they will be able to achieve their goals (Bratton, Callinan, Forshaw, & Sawchuk, 2007). Therefore, educating girls may empower them to make informed decisions of sexual and reproductive health issues and its consequences. This is what one participant had to say:

"Certainly one of the possible solutions in my view is that as a country we need to improve on education of girls who will eventually become women. I strongly believe that we have to invest in that as a country [so] that we have an environment where we are getting emphasis on women getting a good, decent education." A 45 year old man, Blantyre

It is encouraging that this man understands the importance of education, particularly given that education has been posited by UNICEF (2008) as a way to empower girls in relation about issues such as sexuality, reproductive health and HIV/AIDS because they have knowledge about better health practices. Education has been shown to lead to a reduction in malnutrition, child mortality, and increased quality care and attention to children (Kasanda, 2005). Education of women further improves their level of understanding on reproductive health and their reproductive health rights (ibid). In addition, a study conducted in Nepal found that education played an important role in women's use of health care services (Furuta & Salway, 2006).

7.3 Community Sensitisation and Civic Education

Once community leaders are informed of the intentions of men getting involved during pregnancy, childbirth and postnatal care, it will be important for leaders to organize and disseminate information about men's involvement to community members. About two-thirds of the participants suggested reaching communities through organized village meetings and using mass media. While these suggestions are insightful, it is important that any health messages be designed to highlight the importance of men's involvement in reproductive health and should also be delivered in culturally acceptable languages. Recall that some communities in this study were much more sensitive to discussing issues about sexual intercourse, reproductive health, and men and women's physiology than others. In specific health issues, such as cholera, family planning, HIV/AIDS, the use of media, drama, comedy, and storytelling has proven successful in Malawi in disseminating messages to the wider public. The quote below from a health worker suggests how community sensitization can be organized.

"They [barriers] can be overcome by going to the community, community dialogue or mobilising the community in drama etc. If we start with the grassroots we will overcome them [the problems] rather than starting from up. We will not overcome them [starting from the top] because ..., these men were born in the same community they have grown up there. They have grown with that culture in their mind; it's difficult to change them overnight. If we go to the community we start with District Executive Committee (DEC) meeting where these Chiefs attend then the Chiefs will go back to their people and tell them, then we will forge ahead." A 59 year woman, Nsanje

One of the health workers talking from his professional experience suggested taking advantage of any social gathering, for example, "sending off parties, women's guild, funeral gathering, or other functions" (a 52 year old man, Mzuzu). While participants suggested these social gatherings, other gatherings may include political rallies and fairs. In addition, both electronic and print media may be used to disseminate information. From my experience as a Malawian and as a civil servant working for Ministry of Health, these avenues have helped get information across to the population. For example festivals, fairs, television, radio, dramas and folklore have been used to disseminate information, health related or political. These modes of information are also in line with what (Food Agriculture Organisation of the United Nations, 1998) suggested.

While participants suggested dissemination of information about male involvement to community members, it may also be valuable to plan dissemination of information to other stakeholders in sexual and reproductive health. These may include non-governmental organisations, civil society groups and government ministries. Building partnerships with other organisations has the potential to complement government efforts in providing services to its population to achieve male involvement in pregnancy, childbirth and postnatal care. This will require commitment, support and inputs from partners. Furthermore collaborative efforts to promote male involvement may show the commitment of the government and stakeholder about how important the issues are and to prevent duplication of efforts. Participants acknowledged that health workers are aware that information cannot reach the community by health workers alone; there is need for concerted and collaborative efforts in order to achieve the required results as this health worker elaborates:

“Ok, I think there should be much of it dealing with the community as we know that if we have to prevent maternal death we cannot do it at the hospital level. We have to start at the communities. So these people we are dealing with they should be able to participate and if we do not go to them and tell them why it is important they will not know. So it is our duty to go to the community, sensitise them, tell them the advantages and then its only then they can come up.” A 38 year old woman, Dowa

Apart from using village meetings and taking advantage of any social gathering to disseminate information, participants suggested “civic education” specifically “to all men” about male involvement, a 43 year old woman, Nsanje. Media could be used as a powerful tool for behaviour change because some participants spoke about it favourably and recalled ways that it had been combined with other promotional tools to add intensity. For example, this health worker from Blantyre said:

“Ok, I think there are already programmes that do address men I remember there is something that is done by Banja la Mtsogolo (BLM) [...] The other thing you may use [is] the mass media. The radios just tell people that it’s & for you to go to antenatal with your wives. I think if I remember safe motherhood... [Used] T shirts that are showing the man carrying his wife to the hospital so you just need to intensify on things like those.” A 44 year old woman, Blantyre

Although the radio is used widely to reach people in the most remote areas, some participants suggested targeting men in venues where they congregate in large numbers or where they can easily be reached. These may include places like pubs and workplaces.

Even though the participants advocated community sensitisation and civic education, other participants cautioned that the media or meetings should not be used to coax people that are not ready to get involved. Rather, the media should allow them to digest the information so that they make informed decisions on what course of action to take. There are fears that the community may be rushed into participating in projects that they may not understand. Therefore, education should not be a onetime activity, but continuous in order to achieve the expected results.

“[As] men we should also be careful because you can’t push things on people who are not ready. I mean you can’t push a PhD on a person who is not ready to take a PhD! So what we need to do is to be careful to start with intensive civic education and allowing those who are enthusiastic and leave the men who are not willing or who are sissies. Others may just have psychological problems.” A 52 year old woman, Blantyre

7.4 Change Policy

Participants suggested that another way to overcome barriers is to change hospital policy to allow men to get involved in pregnancy, childbirth and postnatal care.

“I think it’s the policy that we have talked about that they should be in place. So we need them so that they have room to go and be with their wives during antenatal. I think the other thing will go to infrastructure ... that may be new hospitals that are coming up should they have that provision that male partners can go in and be with their wives if that is what they want.” A 44 year old woman, Blantyre

Such policy changes may instill and increase a sense of responsibility for men (C. P. Green, et al., 1995). Participants suggested that perhaps new hospitals are needed which may overcome these privacy issues. The design may include private rooms for couples who would like to be together during antenatal and childbirth. Hospitals could also articulate the rights of the couples to be together in the antenatal clinic and labour ward. This may also help health workers, who have negative attitudes about male involvement, see male involvement through a more positive lens.

As a more immediate way to achieve change, other participants suggested renovating current labour rooms using cardboards to provide privacy. Although this may not provide the ideal privacy, particularly where noise is concerned, it may provide temporary solutions to public wards which are congested and lack the means to undertake costly renovations.

For others, policy change should include a change of curricula used to instruct health workers and midwives to include issues of male involvement during pregnancy, childbirth and postnatal care. For example:

“I think the curriculum; already when we produce midwives and doctors and those who attend deliveries and who provide reproductive health services to say that this is a family thing there is no child without father as much as there is no child without mother. So we have to get away from the idea of maternal health to parental health I think that is very important. That we also try at least to say to mothers bring your husband maybe he wants to learn and see the fundus rising and learn about the problems you might have.” A 55 year old man, Lilongwe

The participants contend that health workers should be sensitized by the time they qualify from medical, clinical or nursing institutions to allow couples to be together. The training may provide a foundation for health workers to be aware and understand male involvement in reproductive health and thereby encourage men to get involved. Curricula may take time to be reviewed in order to incorporate issues related to male involvement. However, hospitals and training institutions might collaborate to conduct in-service education for health workers so that they are aware of what is expected of them. The orientation may also include all other non-medical staff that comes into contact with the patient when she comes to the antenatal clinic and the labour ward. This may be done to prepare health workers for change of policy in order to create an atmosphere of respect and recognition of men as important partners in reproductive health.

One participant suggested that hospital policy should include incentives for women that come with their husbands to the antenatal clinic, such as giving the couple first priority to be seen by the midwife or doctor. However, incentives may not be a long term solution for men’s encouragement to their being involved. But they need to understand why it is important for them to get involved and make informed decisions of their action.

“We should be well stipulated in the policy that may be during the first antenatal visit the man should accompany the woman because now we are talking of the four targeted visits. So, on the first visit we do a lot of things. So if they can be able to participate on that it should be well stipulated in the policies.” A 37 year old woman, Lilongwe

Some of the participants proposed that there should be a legal framework that is binding and that addresses the problems of both the man and the woman. They suggested that this legal framework should not be seen to be biased towards women but to all concerned parties so that men and women feel they are part of the process of promoting a healthy life of the family. Such legal framework may be a medium for carrying the policy through into action. Participants explained that policy changes must coincide with a change in attitude. A civil society representative explained:

“It’s to change the attitude of the people to try and persuade the communities around to change the attitude towards issues of reproductive health through sensitization [and] awareness, and also to put in place legal framework that would direct support that kind of change of attitude... you can’t just change people. There has to be something binding that they should look at and say, „well I am bound to this even if I...am not supposed to.” So, I feel that...awareness will be the right thing, but putting policies in place and also may be [a] supporting legal framework would also address the issues.” A 57 year old woman, Lilongwe

When this civil society representative was asked what she meant about this legal framework, the response was that:

“What I mean is drafting laws, acts, there has to be a provision. We have a very progressive constitution. Malawi is a signature to most of the UN and some other International and Regional Convention on reproductive rights. So looking at these kind of principles calls for domestication of these international laws into our own national laws so they can be interpreted into our own laws according to Malawi situation, and come up with an act that will work for the Malawi situation. In that way, people will appreciate that it’s within our context of our cultures and tradition. But it also addresses the problem of male reproductive health that can involve men and women together.” A 57 year old woman, Lilongwe

The examples above indicate that participants saw policy change in the hospital as a necessary step to accommodate those couples that would like to be together. This may not be possible in the current hospital structures where labour wards are separated by a screen or curtain, but future plans could consider the wishes of the community to have privacy during delivery. For private wards in the current hospitals, consideration may be made to allow husbands to be present.

Available tools for communicating with the community could be used to sensitise them as much as possible. These channels are the electronic and print media, which have been used by Ministries and non-governmental organisations in alerting the population about other health problems such as Ebola, Cholera, and HIV/AIDs and in the recent times, the swine influenza and other infectious diseases. The Ministry of Health in Malawi has used these channels to sensitise the population about these diseases with success. Other channels could be man to man programmes provided by Banja la Mtsogolo (BLM) which may be directed at organised groups such as prisons, police force and military groups. Such groups offer a “captive audience” of men that can be reached directly (C. P. Green, et al., 1995). For the provision of a legal framework for male involvement during pregnancy, childbirth, and postnatal care, advocacy with policy makers and politicians may be necessary for laws to be enacted or revised. Enacting laws may not be enough, but also translating them in ways that people can understand and be able to implement.

7.5 Motivational Factors for Male Involvement

The previous section presented how to overcome barriers to male involvement. Respondents also discussed motivational factors as ways of overcoming barriers so that men get involved during pregnancy, childbirth and the postnatal period (see figure 3 below). Motivational factors discussed in this chapter are internal drives within an individual that make them achieve their needs (Bratton, et al., 2007). According to Bratton et al., these drives are intrinsic in nature. Motivational factors may influence men and women in changing their behaviours and social interactions with one another. Additionally, motivational factors may impact the degree to which community members accept policy change when it occurs.

Behaviour change theorists have suggested that for a specific behaviour to be performed or modified, there are two determinants. This “relies on the assumption that behaviours -including health behaviours operate under volitional control and that a person’s intention to perform a particular behaviour is both the immediate determinant and single best predictor of that behaviour” (Sutton, 2001, p. 6503). According to Sutton (2001), the first determinant of this is the attitude of the individual in evaluating the benefits of performing the behaviour. The second

determinant is the perceived expectation of performing the behaviour by others (called a subjective norm). For example, if a person believes that performing a particular behaviour will lead to positive personal consequences, he or she will hold a positive attitude towards the behaviour (Sutton, 2001). Thus, for men to get involved in reproductive health issues, they need to evaluate the benefits to themselves and their partners and how this will be viewed by their partners or other peer groups.

Figure 3 summarizes what participants said would motivate men to get involved in pregnancy, childbirth and the postnatal period. These are discussed in detail below.

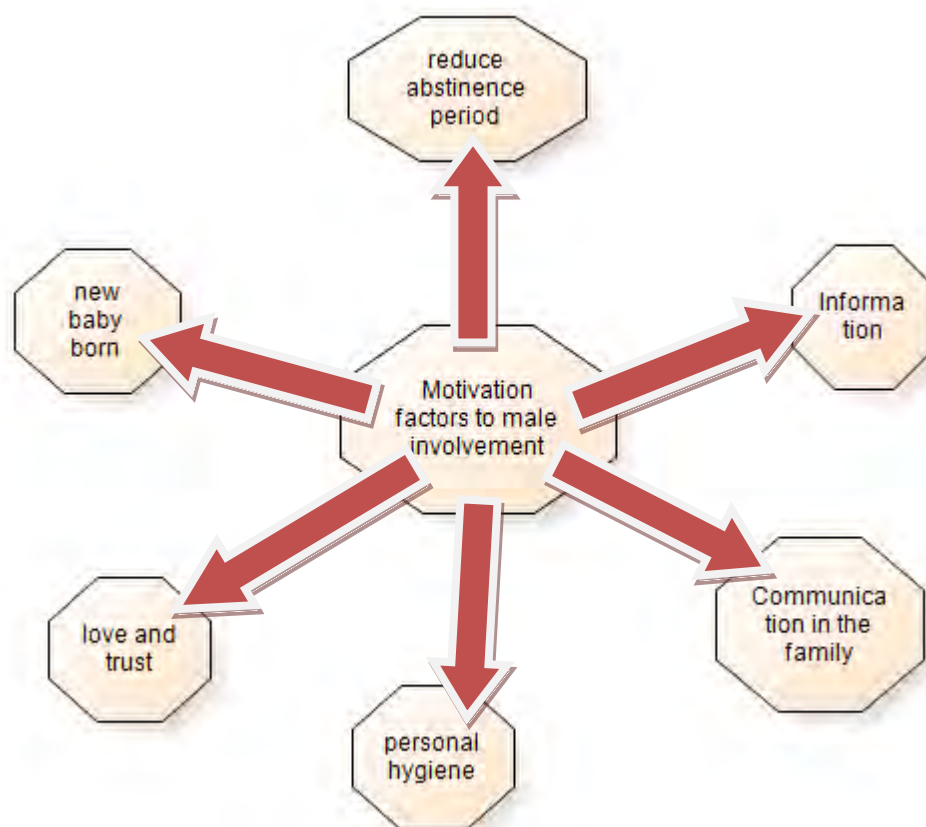


Figure 3: Motivation Factors

7.5.1 *Abstinence Period should be reduced*

A cultural barrier that some participants felt was in need of change was the period of abstinence that is culturally prescribed to men and women after the child's

birth. Even though participants from Mangochi and Dowa did not suggest that couples need to abstain from sex after their child's birth for very long, two districts did: Mzimba and Nsanje. Recall that male participants in Mzimba and Nsanje suggested that they have to wait too long to have sex with their wives. In some cases, men abstain from six months of gestation until the child is 3-4 years of age. It was suggested that this extended period of abstinence leads to men having affairs.

"So if you tell them that I am tired, why? Nine months, is there any reason why I should abstain for nine months? I have body pains. It is better that I continue with someone else." a 49 year old man, Mangochi

The above quote illustrates the frustration that men have to endure to wait for sexual intercourse with their wives for a long period of time. Men express their frustration by "continuing with someone else" because it appears the essence of marriage is lost. In fact, one of the causes of violence and divorces particularly in developing countries like Malawi is refusal of the wife to have sex (Oladeji & Adegoke, 2008). It may be useful for health workers to counsel men and women after childbirth of when it is convenient for couples to have sexual intercourse. This information could be given to couples during discharge of the mother and baby or during postnatal care checkups.

Some participants suggested that men resist this culture of abstaining for over nine months by simply divorcing the wife and marrying another one, practicing polygamy or finding a casual sexual partner because of the belief that there is "no marriage without sex," commented a 49 year old man from Mangochi). This belief is similar with what Sternberg found in Nicaragua. He found that men "value genital activity" which is part of the socialisation process (Sternberg, 2007, p. 91). It is inconceivable for men to have sexual relationship without penetration particularly when "they have bodily problems," as this man commented:

"That was a person who, if he had bodily problems (zanthupi zafika povuta), you had the right to disregard and go to another place because bodily things are what? [They] are troubling you. So these laws were disregarded and [men] start going out with other women. If [men have] a family that were following these laws, the marriages were breaking. But the divorces were done truthfully, just telling her that „Madam, I have failed. „Marriage without sex does not exist because the woman is following the beliefs... of this village." A 49 year old man, Mangochi

Participants suggested that people from the health department should explain to men and women when it is safe to have sex during pregnancy and the postnatal period. This information should be disseminated to the community so that everybody hears the information for themselves from the health workers. It may be that even if couples are informed about when they can have sex during pregnancy and the postnatal period, they may not be courageous enough to inform the elders or challenge the idea that the abstinence period is too long for them to manage because the interest of the group prevails over the interest of the individual (Oladeji, 2008).

7.5.2 *We are Expecting a Baby*

Another motivating factor for male involvement mentioned by participants in all the four districts was the fact that the man is responsible for the pregnancy and expects good outcomes from it. The expected outcomes are the gift of the baby being born, and the excitement of becoming a father. One participant explained:

“The other thing that motivates men to get involved when their wives are pregnant is that this pregnancy, I am the one who has given her, that”s why they seem like motivated to do what? To get involved.” A 20 year old woman, Mzimba

For some participants, the motivation for involvement is demonstrated by being faithful and supporting both wife and baby by doing things such as providing basic essentials in the home. Men and women spoke of how the arrival of the baby created security in the home. One female participant explained how the arrival of the baby may change everything in a couple’s home.

“He is motivated with the baby to take care of it. My baby should grow up. I should give it food... I should rear and take care of my baby so that the baby should grow up very well. So you as a wife also are motivated with the husband that my husband is what? He is taking care of me and my baby, yes.” A 60 year old woman, Mangochi

The arrival of the baby is a motivational factor that may change the way a man behaves towards his wife amid all other worries. During this time after giving birth, it may be especially useful if men and women are counseled together about the timing and practices of healthy sexual relations.

7.5.3 Love and Trust

Throughout the interview, love was mentioned in all the questions that were asked to the men and women. Most of the participants, particularly rural men and women, explained that if a man and woman love each other, they would be able to abstain from sex and he would remain faithful to his wife. Love would ensure that there is no violence in the home and the husband would be able to support the family with food and other necessities in the home.

“...The time that the baby is born, he is very happy indeed. So he does anything that he was thinking of, because when you are sick, the man also if he has love, he thinks, “if my wife delivers, I will do this and that.” So when you deliver, he makes sure that what he promised in his heart should be fulfilled.”
A 38 year old woman, Dowa

According to the participants, love and trust are prerequisites to motivation because the couple has no cause to doubt each other’s behaviour. This is what motivates a man to take care of his family, plan for the coming baby and provide all the support needed to the woman.

“What can make a man to be motivated to get involved with his wife who is pregnant is love? Because if a man has no love for his wife, he cannot look after her, no. He cannot be motivated to look after the woman and the baby because all the responsibility is placed to whom? Upon the man. A man who has love but also trust each other is the one who is very powerful and gets involved by assisting who? The wife ...” A 24 year old man, Mangochi

A lack of love and trust may bring violence, unfaithfulness, and/or quarrels, which affect the health of the woman and the baby. The end result may be divorces or the contraction of diseases such as sexually transmitted diseases or HIV. When men know the facts they may support and love their partners. Public health interventions should look for opportunities which will strengthen husband and wife relationships. Perhaps there is need to have programmes which may promote men and women spending more time together and communicating with each other. This may be a determinants approach.

7.5.4 Personal Hygiene

Participants emphasised that personal hygiene is important for two reasons. First, personal cleanliness removes dirt before pathogens establish themselves on the body and cause diseases. Second, good hygiene allows one to look clean and

presentable. Male participants stated that they would get involved if their wives kept themselves clean, took baths often, and washed their babies' nappies. If women take care of themselves, men are likely to provide the things women need to continue having good hygiene. Poor personal hygiene puts men off, as expressed by this 34 year old man from Mangochi.

"We can get involved if the woman is pregnant until she gives birth. What is required is that we should buy soap for the woman so that she should be taking baths, dress well because there are women, when they are expecting or maybe they have just delivered, they are very filthy. Their clothes are very dirty even the inside clothes, petticoats, you find that they are very dirty (Ziri bii) not well taken care of. Also there are women that after delivery the nappies that you bought for the baby are soiled. You find that they are just being kept without washing them. The following day she will do the same. Two days later the same thing; she just piles soiled nappies. That is also filthiness and so we fail to get involved because of the woman."

Regarding the harsh realities of life for many mothers in Malawi – when their babies are born, women often are overwhelmed with the responsibilities of the home and caring for the baby. A typical day may mean first meeting family obligations by cooking, washing, fetching water and firewood, and caring for the baby. Rarely do women have time to care for and clean themselves. The woman is only relieved if she has a helper, who might be a relative or neighbour, and it may be argued that there are certain chores that even a neighbour or relative cannot perform. But the husband's support may alleviate some of the pressures that women go through and give them time to attend to their own physical and hygienic needs. Because these gender roles are culturally ascribed to women, they have learnt to expect little help from men or their husbands. Situations where women do all of the household chores with little help from their partners may affect the health of the women.

7.5.5 Communication/Information

Other important motivational factors that participants discussed were communication and information. Most of the participants felt that men need information for them to get involved during pregnancy, childbirth and postnatal care. Information may make men understand and give them confidence to participate in issues related to sexual and reproductive health. They may see the importance of playing active roles to achieving and sustaining their health as well as that of their family. Such information may include physiology of pregnancy and its sequelae,

avoiding delays to go to the hospital when the woman is in labour, recognising danger signs, birth preparedness and how to care for the baby. Male participants expressed a desire for information dealing with particular issues:

“What can motivate me when my wife has a baby? The problem is... myself. I have not taken part. I have not been taught about antenatal care at the hospital that I should get involved. We want to be told that we should be involved in some of the parts so that we can stay happily together here at the hospital.” A 34 year old man, Mzimba

Others felt that communication in the home is very important. Participants felt that women need to discuss with their partners of their intentions to start antenatal care. Participants also mentioned that each “time the partner is going to the antenatal clinic,” the women should “ask their husbands to escort them, this includes when the wife is going to the hospital,” (a 58 year old woman, Nsanje). A similar discussion between couples might facilitate men accompanying women to the hospital.

The quote below affirms the importance of couples communicating in the home. Communication may bring couples closer to each other, trust and love each other and therefore they can better understand each other’s attitudes about pregnancy, childbirth and postnatal care. Communication can lead to cooperation. “Cooperation” in this sense refers to the mutual respect and love between the couple to converse with each other with ease. For example, if the couple has no money to prepare themselves for the coming baby, they should discuss how they get the money to support themselves.

“If you cooperate with your husband well, it is something that is not a problem. If indeed you are poor as she is saying, you can agree that, as we have no money, the way you are, how we can prepare ourselves? I have no money. He can go to work on piece work as long as you have both agreed. He will be looking for things that you need. So love that men should be close to us is very important.” A 59 year old woman, Nsanje

The above responses indicate the importance of women having support to find time to care for and keep themselves clean after childbirth. Personal hygiene is one way of preventing infection. Secondly, participants mentioned communication in the home and information from the clinic. Recall that in chapter six one of the barriers for men’s lack of involvement was lack of information. Information is very critical because it raises awareness of what happens at the antenatal clinic, during

childbirth and postnatal care. Equally, communication within families is very important. Couples should learn to communicate to each other, and not only discuss issues related to reproductive health, but everything that concerns the family. They should make responsible decisions together. Available literature has shown that traditional men and women's gender roles discourage couples from communicating with each other particularly on issues related to reproductive health (Drennan, 1998), and yet studies have shown that spousal communication has several advantages. It enables husbands and wives to know each other's attitudes about reproductive health and voice concerns with regard to reproductive health issues and communication (Drennan, 1998). The literature has further acknowledged that interventions that provide clients with information helps empower clients to make appropriate choices and take action (Blanc, 2001). Improving communication in the home where couples traditionally do not communicate about sexual matters may prove to be challenging for this generation, but using available traditional channels of communication such as Chiefs and the media may begin this process.

7.6 Chapter Summary

This chapter has discussed overcoming barriers to male involvement during pregnancy, childbirth and the postnatal period. Men and women have suggested ways in which barriers may be overcome, such as engaging with community leaders, discussing issues that communities need to get involved in, and educating youth. Additionally, participants emphasised the use of available channels of communication for public awareness of male involvement during pregnancy, childbirth and the postnatal period.

Motivational factors to male involvement have also been discussed. Men and women indicated that culturally prescribed abstinence periods are too long for them to wait. This is one of the reasons that drive men to be unfaithful to their wives. Love and trust, spousal communication and personal hygiene are some of the factors that would motivate men to get involved in reproductive health issues. The next chapter, chapter eight, presents information and support that pregnant women need for them to be healthy.

CHAPTER EIGHT: INFORMATION AND SUPPORT

8. INTRODUCTION

Evidence from this research suggests that women's health during pregnancy, childbirth, and the postnatal period would greatly benefit if women were given information and support. Participants in this study were asked to describe the information and support that they believe women need to have a healthy pregnancy and healthy children. A total of forty-eight men and forty-five women between the ages of 20-87 years from the four rural districts of Dowa, Mzimba, Mangochi and Nsanje were asked the following questions:

- What information is required for pregnant women to stay healthy?
- What support do you think women need from others/services during pregnancy, childbirth and postnatal care?

Participants suggested that women should be encouraged to start antenatal classes early; information should focus on birth preparedness and include materials about contraception; resources should be available for women to deliver at the hospital; and neighbours may be a possible source of support for women throughout their pregnancies and after childbirth.

8.1 Early Antenatal Care

The majority of participants said that information about health practices and behaviours should be given to pregnant women early, around three or four month's gestation, or as soon as women know that they are pregnant. The antenatal clinic may be the appropriate place where women and men get information about birth preparedness, the status of their pregnancy and nutrition. Participants specified that information should come from midwives and doctors, and women should be given a physical examination early in pregnancy. These suggestions are interesting in light of the fact that women in rural and urban areas sometimes experience peer pressure to delay attending antenatal clinic because of the assumption that it is too early in the pregnancy to warrant a checkup.

Perhaps husbands are in the best position to encourage their partners to go to antenatal clinic to seek professional advice. The quote below illustrates that this husband is aware of the importance of his wife attending antenatal care early in the pregnancy.

“My views may not be enough but I can encourage her to go to the hospital, to start antenatal at an early stage when she is pregnant because if she goes to the clinic, she is examined to see how she is, how her pregnancy is, how the baby is growing. So when she has problems, whatever the baby is doing in her abdomen, if the baby is not moving well, not well positioned, when she tells the doctors about how she feels, the doctors advise her that if it is like this...it means that she is relaxed and happy.” A 25 year old man, Mangochi

Participants indicated that women should go to antenatal clinic early in the pregnancy so that they can be examined to monitor the growth of the baby and their own health. They should also be given nutrition advice such as eating from all six food groups and good, balanced meals. They should understand the importance of rest after performing household chores, reducing the household workload, and maintaining good personal hygiene. Participants suggested that women be taught birthing exercises and to be prepared with soap, nappies, and clothes ready for both the baby and mother. This kind of information should be given to both men and women because women may be powerless to inform their husbands about the advice given to them from the health workers and changes that might be suggested by the health workers to protect their health during pregnancy, childbirth and the postnatal period. Similar findings were presented by Ringheim about women in India who expressed the need for service providers to equally inform their husbands and mother-in-laws about the advice given from the hospital as the women themselves were powerless to do so (Ringheim, 2002).

Participants’ awareness of the benefits of antenatal care is encouraging as evidence suggests that it remains an important strategy to improving maternal health because it provides an opportunity for women to be in contact with the health care system. Even though safe motherhood literature suggests that maternal deaths cannot be prevented and complications predicted during antenatal period (Maine, 1999), certain conditions can be identified and managed during antenatal period (Nanda, et al., 2005). Therefore, screening and treatment for syphilis, tetanus toxoid immunization, voluntary counseling for HIV and advice on breast feeding options should be part and parcel of the antenatal care package. In addition, treatment of

anaemia, malaria, and recognition of danger signs are other important elements of antenatal care (Graham, et al., n.d.). Antenatal care can provide women with the opportunity to promote healthy lifestyles in order to improve health outcomes for women, children, and their families, and it provides opportunities for women and their partners to establish a birth plan (World Health Organisation, 2005). The provision of antenatal care gives women a chance to be counseled about family planning and for the management of sexually transmitted diseases, hence the need to package cost effective interventions such as pregnancy and delivery care, family planning and management of STIs (World Bank, 1999).

In Malawi, 98 percent of women attend antenatal clinic at least once during their pregnancy. It is generally believed that if a woman does not attend antenatal clinic, she may be ridiculed by health workers for not doing so. Such ridicule may also influence a woman's decision not to deliver at the hospital. Thus, health workers' attitudes not only impact men's level of involvement during labour and delivery (as discussed in chapter six), they also impact whether women seek information and resources about antenatal care before childbirth. Furthermore, even though antenatal attendance is very high in Malawi, it does not necessarily mean that pregnant women start antenatal care early enough in pregnancy. Most women start antenatal clinic in the second or third trimester making it almost impossible to cover information that prepares women for delivery, and not all of them deliver at the hospital. Next, I discuss ways to establish birth preparedness. Then, I explore the factors impacting where women choose to deliver at home or at hospital.

8.2 Birth Preparedness

Another support that women need when they are pregnant is for their partners to prepare for the baby's arrival. Most of the participants, particularly women, voiced the need for their partners to plan for transport to the hospital and to prepare things that women will need while at hospital. For example,

"Before she is due, she should prepare one by one, nappies, put aside. The woman will not cut her cloth. No, she will buy nappies for her baby, little by little, then a basin, put aside. When it is time, she just picks her bag and off she goes. When you go to the hospital and you deliver you just dress it with what? Those things, the parent will keep her worn out pieces of clothes that she was washing [...] Everything is brought from your house, that's what happens." A 59 year old woman, Nsanje

Another respondent acknowledged the need for the couple to prepare in advance for the coming baby.

“The support required for the baby is that, before it is born, you should already buy everything; napkins, clothes ... bath soap, baby oil with a view that when the baby is being bathed, she should apply oil, dress it with clothes and nappies. The people that come to see it, they admire that our friend is really taking care of the baby but also for the baby ... feels good that my parents here love me.” A 35 year old man, Mangochi

Birth preparedness is a strategy that seeks to promote the timely use of skilled maternal and neonatal care during childbirth based on the theory that preparing for childbirth and complication readiness reduces delays in obtaining care (Johns Hopkins Bloomberg School of Public Health Center for Communication, Family Care International, & Maternal Neonatal Health, 2004). These elements include knowledge of danger signs, planning where to give birth, planning for birth attendant, planning for transportation and planning for saving money. Birth preparedness and complication readiness can be applied at individuals, families, communities, providers, facilities and policy makers so that factors arising due to delays in seeking care may be prevented (ibid). It is important to note that all the elements in the birth preparedness and complication readiness may not be applied to all pregnant women. Choices may not be available for pregnant women to choose a birth attendant, for instance in Malawi, due to critical human resource shortages. Therefore, birth preparedness information should be tailored to the individual needs and circumstances of pregnant women in their given situations.

All women and their partners need to be prepared before childbirth so that their lives and that of the newborn babies are saved. Providing men and women with specific information to help them prepare for the birthing process is something that can be covered at antenatal clinic. But, the task of getting women to the clinic early and continuing antenatal clinic visits throughout pregnancy remains an important task to be filled by their partners.

8.3 Deliver at the Hospital

Hospital deliveries have greater advantages than home deliveries particularly in developing countries like Malawi. There are well trained nurses, midwives and doctors to take care of pregnant and labouring women. At hospitals, specialised care

is available in case there are complications during pregnancy and childbirth. Additionally, hospitals are equipped to manage emergency situations better than Traditional Birth Attendants or at a woman's home.

Fifty seven percent of women in Malawi deliver at the hospital while the rest either deliver at home or with a Traditional Birth Attendant (National Statistics Office, 2004). Women choose to deliver at home with a TBA instead of the hospital for a number of reasons. These include differences in reception by health workers (as previously mentioned), the treatment of women during labour, and the availability of relatives as a source of support during childbirth. Another important factor that impacts where women deliver is the availability of financial resources to go to the hospital. Multiple visits to the hospital during pregnancy can be costly and time consuming, and women may not have the resources to attend antenatal clinic and make the subsequent trip to deliver at the hospital (Borghi, et al., 2008). Similar results were found in Nigeria where there was low attendance of antenatal clinic in the first trimester due to the increased costs and time of commencing antenatal clinic before pregnancy is ten weeks old (Nwokocha, 2006).

Participants in this study, most especially males from Mzimba, believed that pregnant women should deliver at the hospital because of greater assistance available as compared with the help women may receive from Traditional Healers in villages. In the other three districts, participants did not discuss women delivering at hospital, perhaps because of participants' perceptions of health workers' attitudes at different hospital sites. This participant echoed the dangers of women going to the Traditional Healer:

"At the herbalist, [women] may not know that this one has little blood so she needs to be given blood...but here at the hospital they would know that the way you are here, your blood is not enough, and you need blood." A 28 year old man, Mzimba

In contrast, other participants recognized the important role that Traditional Healers fill due to a number of factors that may limit women's options for delivering at hospital. Herbalists claim to treat many social and health problems. For this reason, there are people in rural and urban areas who believe that some conditions that the hospital cannot manage, Traditional Healers may manage. For example, there are claims that some Traditional Healers can treat infertility and sexually

transmitted infections. Likewise where a woman has been told by the hospital that she may not deliver vaginally due to previous caesarean sections, others claim that Traditional Healers have managed to help women to deliver vaginally. In addition, if witchcraft is believed to be the cause of any obstetric problems the woman experienced, such as transverse lie, or bleeding during pregnancy, then it is cause for them to seek treatment from the Herbalist (Matinga, 2000). Available evidence further suggests that many people in some African countries will consult them prior to seeking modern medicine or in place of seeking care from modern medicine (Ssali et al., 2005). These are some of the reasons why some women may opt to visit the Traditional Healer. In the absence of scientific evidence, it is difficult to confirm these claims. Nonetheless, they are socially and culturally significant to women and their families in determining where to have their babies.

Distance appears to be another important factor in determining whether or not labouring woman go to hospital to deliver. Some participants suggested that women deliver wherever it is easiest and accessible, regardless of the type of the place, as long as they can be assisted with dignity. This participant explained that when distance cannot be overcome:

“Some do go to the Traditional Healer because they say Mzimba is very far so [they are] afraid of the distance. That’s why they go to the Traditional Healer.” A 42 year old man, Mzimba

Several women expressed a fear of delivering by caesarean section, a procedure done at hospital, because they might be labelled as lazy or weak by other women or their husband’s relatives. In cases where they have delivered by caesarean section for a first or previous pregnancy, women expressed reservation about going to the hospital because they are afraid they may not be given a chance to deliver vaginally. The participant below expressed other fears of delivering at hospital.

“The first thing that women fear coming to the hospital is, they are afraid that they may be operated on. [They think] „Maybe I will die.” So some rush to where? [They go] to the Traditional Healer. Also some women are afraid to come to the antenatal clinic. They say that the month to start antenatal clinic is not yet due, so women are ashamed to go to the clinic because the nurse may scold them.” A 32 year old man, Mzimba.

These sentiments are in line with results from a survey conducted in Chikwawa and Thyolo in Malawi (Matinga, 2000). In that study, women expressed fear that they might die during labour because of previous childbirth history in the family. Many people in rural areas do not understand that if a baby is too big to pass through the woman's pelvis, a caesarean section is medically necessary. This fear of medical intervention leads women to seeking traditional medicine so that they can have a normal vaginal delivery. But given the associated risks to mother and baby's health, there is a real need for information about the benefits of attending antenatal clinic to assess mother and baby's health and to explain the benefits of delivering at hospital.

8.4 Contraceptive Methods

According to the research findings, information that women need to stay healthy includes accessing contraceptive methods. The need for contraception was expressed by both men and women of Mzimba. Participants from this district observed that most of the people in their area lack information about contraceptives. This lack of information may result in unintended pregnancies and disempowers couples from making informed decisions about the number of children they would like to have. Malawi's infant mortality is very high at 76 per 1000 (Mwale, 2004). Because of the high infant mortality rates, couples tend to have more children in case children die. Participants suggested that men and women be given information about what family planning is, its advantages and disadvantages, and options for contraceptive methods.

"They say there is contraception, family planning. Some of us, we don't know very well about family planning. So as you have come, it will be you to teach us about family planning. Sometimes we continue bearing children. We don't even know the problems. We don't know that we are suffering. We just hear that there is family planning, so you are the ones who can teach us since you have come here." A 40 year old woman, Mzimba

Participants emphasised the need to learn more about family planning so that they are able to teach their children to use the methods. By implication, it is too late for the participant quoted above to use contraceptive methods because in her younger years, traditional methods prevailed. She and her partner practiced polygamy as contraception. She explained:

“You are the ones who can teach us how our children can practice family planning because we old ones ... our husbands were marrying two or more wives for us to practice family planning. When one wife has a baby, he was going to the second wife and then if the baby has grown, he goes there.” A 73 year old woman, Mzimba

Among older generations, polygamy was used as a family planning method. Whether polygamy served the purpose as contraception is another debate beyond this research; however, in the older generation, they believed it served such a purpose. When husbands impregnated their wives at different times, this gave new mothers an opportunity to breastfeed and care for their newborns without interference from their husbands. Other traditional methods of the past that were used in rural areas, and those that may also be used today, included lactation amenorrhea (LAM), rhythm or abstinence and coitus interruptus. Lactation amenorrhea refers to the process whereby women avoid pregnancy through exclusive breast feeding (Arevalo, Jennings, & Sinai, 2002). Conversely, rhythm or abstinence refers to avoiding sexual intercourse through observing a woman’s fertile period, while withdrawal or coitus interruptus refers to couples where sexual intercourse is interrupted and the penis is withdrawn from the vagina before ejaculation (ibid). The Malawi Demographic Survey reported that at least 4% of the population in Malawi still use traditional family planning methods (National Statistics Office, 2004).

Knowledge about family planning/contraception is a determinant for practice and use of suitable contraceptive methods (National Statistics Office, 2004). There is substantial evidence to show that knowledge of contraception is a determinant for contraceptive use. For example, in Bolivia the family planning campaign “Let’s Talk Together” has increased the number of users of contraceptives (Family Health International, 1998). Similarly, Ghana’s family planning campaign using different information, education and communication (IEC) approaches for both men and women has recorded an impressive knowledge gain and change of behaviour towards family planning (C. P. Green, et al., 1995). The success of these campaigns points to the fact that people need to have information about family planning in order for them to make informed choices about use of available services.

Even though in Malawi knowledge of modern methods among currently married women is high (99%), (National Statistics Office, 2004) it is evident that there are still places where information about family planning has not reached

everyone. It may be important to evaluate the approach used to inform the population about family planning and the content of the information. If the information is such that the population feels they are being coaxed to practice something that they are not sure of its consequences, then there may be resistance to the use of contraceptives. Women and men of Mzimba expressed the need for health workers to provide them with additional education about family planning. This is where the District Health Office should organize information sessions in order to benefit the population of Mzimba. Additionally, these needs may be in other districts as well.

8.5 Support that Women Need

When men and women were asked about what kind of support women need from others during pregnancy, in all the four districts, men and women observed that women need someone to assist them with household chores. However, none of the participants said that assistance should come from the husband. Nearly everyone mentioned relatives such as mother-in-laws, mothers or sisters, and neighbours. This suggests that gender roles are firmly entrenched in the culture of Malawi (as discussed in chapter four) and that household work is relegated to women's work. It will require a lot of civic education targeting youth and older generations because they influence decisions in the families.

8.5.1 Neighbour's Instrumental Support of Household Labour

"No man is an island," so the saying goes. No matter how much one has, there comes a time that one surely needs a friend for help, resources, or simply comforts. Participants suggested that most people want colleagues or neighbours that they are closely connected with to offer them emotional support in the form of love, caring, sympathy and understanding (Berkman, 2001). As Berkman (2001) notes, individuals may also need instrumental support. For pregnant women in Malawi who bear most of the responsibility for maintaining household chores, instrumental support may come from neighbours.

Participants indicated that a potential benefit from women receiving help from their neighbours could be that they may reciprocate to others in their time(s) of need.

"Maybe her friend sees the sick, but she does not assist. When my friend is like this, I should take at least porridge or ... give her water because it also

depends on the way you are. If you see your friends, it may be a neighbour, who is sick. She just sits quietly, but if you do attend to your friends [they] will follow your work, what you do.” A 38 year old woman, Dowa

If as a family you help neighbours in times of need, you can also expect the same kind of assistance when you need it. What this means is that one good turn deserves another. People will extend a helping hand to a woman once they know she has delivered and she is home. Because of her good neighbour relationship, she may find that all household chores are being performed by her neighbours.

“According to one’s behaviour at the house, some are forthcoming when the woman has delivered. He stops her from doing all the household chores, including farming or any other work. Her responsibility is to sit at home and take care of the newborn baby, but the husband is the one who goes to the garden.” A 77 year old man, Nsanje

If one has good relationships with one’s neighbours, support is not difficult to come by. Some friends in the neighbourhood extend a helping hand and there may not be a need for relatives to come and assist.

“This will show that if you have friends when you are sick...but if you have a hard hand then your friends will not help you. You are like a slave when you go to the hospital, you don’t see anyone coming to assist. You should remember about the past and the future. If I do this, even if you don’t stay together, some are in Lilongwe and others are wherever, but they have their neighbours nearby if they help each other, you feel good [that you have friends who are able to assist in times of need and have a sense of belonging to the community]. You will see that whether you are sick - water, food, nappies, and you will say my good deeds are following me.” A 76 year old woman, Nsanje

Neighbours support each other in different ways such as pounding maize, cleaning the house, cooking, fetching water and firewood. The support may also include social activities, such as participating in women’s groups and other women’s gatherings, which may help new mothers mentally and physically. This assistance may continue:

“Until the baby’s cord is cut or has fallen off, when you are going to the clinic...deliver, they should also wait for you.” A 28 year old woman, Mzimba

Household chores such as sweeping, mopping, and washing clothes are energy draining and for a woman who has delivered this are even more so. After delivery, women should be given ample time to recover and should rest as much as possible to recover from the effects of childbirth.

Pregnancy for most women is a life changing experience. It may be a wonderful experience, but for some it may bring a lot discomfort and suffering. Due to hormonal changes in the body, some women “become short tempered,” (a 20 year old woman, Mzimba) and are easily irritated. It is important that those around her understand her situation by being supportive and consider that her behaviour may only be temporary. When the baby is born, communities celebrate this joyous moment differently. In some cultures, congratulation cards may be sent to mothers or flowers and toys. This kind of celebration is not typical in rural and urban areas in Malawi. Instead, mothers are brought gifts like “clothes for the baby, soap, or firewood, a pail of water and maize meal flour. There [as a family] you have been assisted,” explained a 49 year old man, Mangochi.

Common gifts for the arrival of a new baby may include a basin of flour, perhaps with a live chicken. Neighbours might cook the traditional meal of “nsima” and chicken. Meals with chicken are considered a delicacy and demonstrate a high level of respect between families. These sorts of gifts to the family “show love and joy that the woman has delivered her baby safely and that it is the Grace of God that she is well because childbirth is death,” a 30 year old man, Mangochi.

Men and women emphasized the need to have a good neighbourhood and be helpful towards neighbours. When people move to urban centres, they rarely move along with their relatives. Relatives, not by blood, become those neighbours that they find in suburbs and villages where they reside. People that show each other good attitude, and care for each other have strong relationships. But, if the relationship is poor, neighbours are not likely to support their neighbours, even pregnant women.

8.5.2 Neighbour's Support with Caring for the Baby

Participants stated that sometimes neighbours assist in caring for the baby in order to give space for the mother to perform some household chores and other duties at the house. As some participants contend, neighbours are most likely to assist with the baby if it is well dressed and looks presentable.

“The baby is also looked after by neighbours around where you are living, if you are very interested with the baby, dressing it well, taking good care of it. Do you know that people show interest? Can we carry the baby [neighbours who have come to see the baby] when they see that you have taken good care of it. But if parents have not taken any part in caring for the baby, who can

help? They will just say, just leave them, but if you take good care of the baby, the baby also is loved by many people ...” A 49 year old man, Mangochi

A mother’s care of her baby affects the interaction others have with it. Extreme poverty may limit what is available to a mother to dress her baby and she may not be able to afford to buy diapers or nappies. Sometimes a mother may have to cut an old cloth into pieces to dress the baby. If there is only one piece of cloth for the baby, it is a problem because the mother has nothing else available for the baby to use when the nappy is soiled. As a result, no one is interested in interacting with a baby whose clothes are stained with faecal matter or urine. This is called “chifwenthe” in the local language of Nsanje. This is further exacerbated by the lack of washing soap as this participant describes:

“She needs soap, for her to bathe, to wash nappies. She is washing without soap ... she worries it makes your friends not to carry the baby. They leave it to you according to how the baby is dressed. That’s what they call it ,chifwenthe” [clothes that are dirty, not washed but are still worn] stinking.” A 56 year old woman, Nsanje

Another factor impacting neighbour’s support in helping to care for new babies concerns the level of participation a woman’s partner has in caring for the baby. Generally, cooking, washing nappies, fetching water, and chopping firewood are relegated to women’s roles. But during the focus group discussions, a few men indicated that they could assist women with some of those chores, with the exception of washing nappies.

“When my wife is expectant, I can help with washing her clothes and wash pots, fetching water, yeah, and boiling water for her to take a bath, yes, but not washing nappies.” A 28 year old man, Mzimba

Asked why he cannot help his wife with washing nappies, he responded:

“There are sometimes chores that we divide between each other. One has her chores that suit her. The man also has his own that suits him.” A 28 year old man, Mzimba

The respondent was very emphatic about his views on washing nappies and suggested that this role can only be filled by women. If, for some reason, a woman is unable to wash her child’s nappies, her partner may specifically seek help from relatives or friends rather than do it himself.

“The nappies are supposed to be washed by the woman but not a man, no!” A 28 year old man, Mzimba

These cultural beliefs about the roles of men and women suggest that women can be supported in many ways during pregnancy and after delivery. Currently, women maintain responsibility for most of the day to day tasks that keep the household running and these are often the least valued or appreciated. When women are unable to manage doing all of the household labour and caring for their babies, they may be fortunate to find support from neighbours. Unfortunately, strict gender roles operate to place the burden of work and childcare solely on women while men share little to no responsibility for these tasks and women have no power to influence men to share responsibilities for care and nurturing children and household chores (United Nations Population Fund, 1994).

Surprisingly, only a few men mentioned caring for the baby as a way to help women. Some men during the study mentioned that small babies are difficult to carry around. This view is corroborated in a study conducted in Vietnam. This study found that men did not like to take care of small children because they cry a lot. Some men in the same study admitted to lacking skills to cradle, feed or even to sooth the baby (Efroymson, et al., 2006). That is, men said they *could* help their partners, but did not say that they *would*. They distanced themselves from these activities but felt that neighbours or relatives (who are female) should assist women.

This kind of thinking raises serious questions of gender equality in the home. Such strict gender roles may explain why female participants in chapter four of this study strongly voiced the need for men to assist them with household chores and felt that men were cruel to let them work at home and in the gardens when they are pregnant. Programmes should address these inequalities in order to influence and change attitudes on gender roles. Available evidence shows that gender-based attitudes cannot be influenced with one approach such as the media, but more robust interventions are required if people’s attitudes are to change (Mehta, et al., n.d.). For men to change their attitudes towards the care of their babies, they need to have knowledge and skills of how they can support women to take care of the baby.

8.6 Chapter Summary

This chapter has focused on the information and support needs of women during pregnancy, childbirth and postnatal care. Men and women have suggested several ways to meet the needs of pregnant women: to provide information early in women's pregnancy, to encourage pregnant women to deliver in hospitals and to provide information about contraception and family planning. Birth preparedness can help men and women to be ready when women deliver and return home to care for their new baby. Neighbours may be an important source of support. In the next chapter, I summarise the results of this research, provide recommendations for ways to promote and implement male involvement, discuss limitations of this study, and provide suggestions for future research.

CHAPTER NINE:

SUMMARY OF RESEARCH, RECOMMENDATIONS AND CONCLUSIONS

9. INTRODUCTION

In light of the perceptions and beliefs that men and women in Malawi have about male involvement during pregnancy, childbirth, and postnatal care, what steps should be taken to ensure that women's and their babies' health are improved? What sorts of policies need to be implemented in order to promote male involvement? Who needs to take action to ensure that men are given the opportunity to assist and support their partners? This chapter answers these questions. First, I summarize the research findings focusing on key themes espoused by participants. Then, I provide recommendations for ways to facilitate male involvement and implement it. Finally, I conclude with a discussion of limitations of this research and suggestions for future research.

9.1 Summary of Research

This study has presented the perceptions and beliefs of men and women in four rural districts of Dowa, Mzimba, Mangochi and Nsanje and two urban districts of Blantyre and Lilongwe in Malawi. Participants indicated that male involvement is a new idea in Malawi. To date, no programmes related to male involvement in pregnancy, childbirth or postnatal care exist. Activism in Malawi has raised awareness of gender-based violence, democracy and human rights but has not yet done so with regard to reproductive health issues. Participants explained that movements like these can also be used to raise awareness about male involvement in reproductive health issues.

Male and female participants felt that men should be involved during pregnancy by accompanying pregnant women to the hospital, listening to health education talks at the antenatal clinic, and reminding women of their subsequent antenatal visits but also that men should provide nutritious food to women during pregnancy. However, there were mixed views of male involvement during childbirth. Participants' support for male involvement during childbirth varied by district and

gender. Most of the women in Mzimba, Nsanje and Mangochi were of the view that men should not be present during childbirth because they fear their marriage will end but seemed to have an open mind to support men being involved during childbirth. Women in Dowa were more conservative of men being present during childbirth. They were of the view that if men were present during childbirth they would affect their relationships in a number of negative ways. Men in all districts, on the other hand, were cautiously interested in being involved during childbirth, specifically in situations where they are asked by the health workers to be present during childbirth. Additionally, age was an important factor. Older men were resistant to the idea of men participating in childbirth, particularly in the Muslim district of Mangochi, while younger men and women were much more supportive. Those who supported men's presence in the labour ward suggested that men's presence requires two key changes: 1) for government to allow men to be present during childbirth, and 2) for cultural barriers to be removed. Participants suggested private hospital rooms for couples as part of hospital policy change, and that health worker curriculum should include issues related to male involvement during pregnancy, childbirth and the postnatal period. Furthermore, participants felt that there was need to change the period of abstinence culturally prescribed to men and women during pregnancy and after childbirth. Participants also identified potential pathways for social change via Traditional Leaders and Village Elders.

Participants identified several benefits to men being present in the labour ward during childbirth. These include emotional, psychological, and physiological support to women. If present during labour, participants argued, partners may develop greater value and respect for women. They also suggested that men's presence during childbirth may enhance relationships between couples at an early stage of the baby's life. In addition, one other interesting benefit identified by participants was that maternal deaths could be reduced because men may recognize danger signs related to pregnancy.

Finally, male and female participants felt that men should be involved during the postnatal period by helping out with household chores and caring for the baby. In particular, male and female participants felt that men should help with those chores that are physically laborious such as farming, collecting and chopping firewood, fetching water and helping out with care of the baby. However, some men felt that

changing nappies was still a woman's job and refused to help with this task. Women felt that men need to contribute more to household labour and that being pregnant was enough work in itself.

In addition to the benefits of men's involvement during pregnancy, childbirth and the postnatal period, participants felt that there were also disadvantages. Many men suggested that witnessing childbirth would inflict guilt on men and they may blame themselves for causing women pain. Secondly, there were fears that men may get emotionally involved and interfere with the labouring process. These fears were expressed by health workers. Other health workers were concerned that men may become violent if they feel their partners are neglected by health workers. In contrast, female participants thought that women may feel ashamed and embarrassed after childbirth because of their behaviour during the labouring process.

Participants discussed barriers to male involvement which need to be overcome if men are to be involved during pregnancy, childbirth and the postnatal period. These barriers were mainly with regard to the health workers' attitudes in the way they communicate and relate to the men in hospitals, the infrastructure which provides no privacy for couples to be together and financial barriers because most men in rural areas are subsistent farmers or depend on piece or casual work. This type of employment is either seasonal or available as opportunities arise, and it does not guarantee a continuous flow of income, thereby making it difficult for men to support their families financially. In addition, other barriers included policy which is restrictive and discriminatory in nature, prohibitions of men beyond certain points in the maternity wing further makes it difficult for them to become involved. Cultural beliefs related to abstinence during pregnancy, childbirth and the postnatal period are too long for both men and women. Abstaining for seven to nine months and in some cases for few years presents a significant risk factor of HIV to both men and women. Furthermore, baby cleansing rituals that dictate to men what kind of contact they can have with their baby are significant factors contributing to men's lack of involvement after the baby is born.

Men's lack of knowledge about reproductive health issues was another contributing factor to their lack of involvement. Participants suggested that one way to overcome these barriers is to invest in young people's education to prepare them as future parents so that they are knowledgeable about male involvement in

reproductive health issues. Participants observed that due to socio-cultural factors that determine gender roles for boys and girls, for change in attitudes about male involvement to take place, girls and boys should be educated about male involvement at a young age. Furthermore, participants explained that programmes aimed at male involvement should emphasize the impact on women and men's welfare, rather than involving men only when problems arise.

The participants felt that the results of the research should be shared with government, non-profit organizations, and other stakeholders to stimulate action. Participants indicated that in the past, other researchers have collected data but failed to provide feedback to government and organizations about their research findings. In some cases, this has resulted in the community feeling mistrustful. Providing feedback about this study to organizations is important in order to ensure participation and support during implementation.

Men and women, civil society representatives and health workers also suggested that health workers engage with local leaders about issues related to pregnancy, childbirth and the postnatal period. Engaging with local leaders would have far reaching effects to wider groups of people due to their positions in the community. However, engaging local leaders alone was not considered sufficient in itself, but required other forms of communication. It was suggested that print and electronic media be used for civic education so that knowledge about women's reproductive health could be disseminated widely, especially in remote areas. Dissemination may not only take the form of broadcasting but also involve the use of local communication channels or networks like village meetings which are useful for rural areas in Malawi. Other forms of local communication to reach rural Malawians may include storytelling, dramas and structures similar to what are used for development activities such as District Executive Committees (DEC). Advocacy was also suggested as an important strategy to reach policy and decision makers about the importance of supporting male involvement in pregnancy, childbirth and the postnatal period.

Lastly, some participants showed concern that they have no say about issues concerning health that affects the lives of community members. They were critical of a top-down approach, whereby community waits for whatever government plans for them, and indicated support for a bottom-up approach. A bottom-up approach

involves the government consulting with and including community members in programme design and implementation. Evidence suggests that involving the community and giving them responsibilities for health related issues creates a sense of ownership and ensures that their needs are addressed (C. P. Green, et al., 1995). Such kinds of programmes are likely to succeed.

The remaining chapter focuses on recommendations for facilitating male involvement in reproductive health during pregnancy, childbirth and the postnatal period. First, I provide general recommendations for male involvement. Additionally, I identify the benefits of these changes to improve women's health. Then, I focus my discussion on recommendations concerning gender, cultural practices, health policy, and reproductive health rights, changes that are necessary at a macro or structural level. I explain how these recommendations might be best implemented in the context of Malawi. I conclude with a discussion of research limitations and provide suggestions for future research.

9.2 General Recommendations for Male Involvement during Pregnancy, Childbirth and Postnatal Period

There are many ways in which men should be involved in pregnancy, childbirth and the postnatal period. They should be involved in escorting or accompanying women to the antenatal clinic and participating in discussions related to their partner's pregnancy, her health and that of the unborn baby. Men's presence may improve relationships with their partners because they may better understand what pregnancy is, its physiology, women's health and the danger signs associated with pregnancy. In this way, antenatal care can be an opportunity to promote healthy life styles that improve health outcomes for women and their unborn children (World Health Organisation, 2005). It is important to educate men on the importance of preparing for the baby in terms of clothes, money for transport after delivery, arranging for blood donors, and knowing what kind of action to take in an emergency to save the mother's life (World Health Organisation, 2005).

At the antenatal clinic, men should also be educated about the importance of family planning, immunization for baby and mother, and the health benefits of breast feeding. In this era of HIV, this is an opportune time to counsel men and women as a couple (as opposed to only counseling women) on the prevention of this disease.

Men's involvement would likely improve the communication between couples and facilitate joint decision-making for the benefits of women, babies, and the whole family. Involvement of men during childbirth may reduce the labouring time for women because of their support (Mullany, 2005).

Furthermore male involvement may help men to understand what women go through during labour (Mullick, Kunene, & Wanjiru, 2005). This is not to say that male involvement will solve all reproductive health problems, but rather it will be a step in the right direction for men as decision makers in the home. Therefore, providing them with this type of information does not require education in the sense of formal schooling, rather fostering men's willingness to learn and obtain information on promoting women's and baby's health which may help them to make informed decisions and be involved with their partner's care. As Isiugo-Abanile (2006) puts it, every culture possesses the potential for transformation. Men's involvement can lead to a transformation of traditional birth practices and better treatment of women antenatally and postnatally.

During childbirth, if men invest their time and energy in supporting their partners by doing things such as rubbing their partner's back, encouraging them during difficult times, and supporting the whole process of childbirth until the baby is delivered, they would "communicate a positive message of a sense of caring and concern" (Simkin & Bolding, 2004). Women may feel comforted by the fact that their husbands are present as it indicates they are loved and respected (Campero, et al., 1998). Men may be in a better position to recognize danger signs and avoid delays in taking women to the hospital. These actions would likely save many women who die at home because of waiting for the whole clan to decide when the woman can go to the hospital. There is stark evidence suggesting that delays in recognizing a developing problem, delay in seeking care, identifying and reaching a medical facility, receiving adequate and appropriate treatment at the medical facility have resulted in maternal deaths (World Bank, 2006). Couples should be encouraged to do their part in reducing the first three delays while health facilities must deal with the fourth. This process can be facilitated by couples and the community being knowledgeable about pregnancy, and hospitals having the necessary supplies and equipment to deal with emergencies.

The postnatal period is critical. Evidence shows that of women who die of pregnancy related conditions, 61 percent die during the postpartum period (Gay, Hardee, Judice, Agarwal, Fleming, & Hairston, 2003) caused by puerperal sepsis and post-partum haemorrhage. These conditions may appear after the mother has been discharged from the hospital. In Malawi, follow up of postpartum care is non-existent, even though mothers are advised to go for a checkup after one to six weeks after delivery. Most mothers do not see the need to go back for check up after a normal delivery. In fact, only those mothers that delivered through caesarean section had vacuum extraction, or an episiotomy, typically return for a checkup. Lack of postpartum care has been acknowledged in the literature as a significant health problem, particularly in developing countries. Although less than one developing country in three reports national data on postpartum care, countries with data show that coverage is very low about 5 percent (AbouZahr & Berer, 1999). This is worrying considering that most maternal deaths occur during the first week of delivery (ibid). There is therefore the need to consider institutionalized postnatal care, particularly within the first week postpartum so that life threatening problems can be identified and be managed to save women's lives.

Mothers who seek to have their babies immunized are likely to return to a hospital or clinic. This begs the question, why are women more likely to return to hospital or clinic for immunizations but less likely to return for postnatal check up? One possible explanation is that immunizations for children in Malawi are well publicized with clear information provided on which immunizations are needed and why and also when babies should be vaccinated. Mothers may also clearly understand the benefits of immunizing children. This is in sharp contrast to postnatal care; services are not well developed and there is no publicity of why it is important for women to go for check up after delivery. What this may mean is that postnatal care, though seen as a life saving strategy for women after delivery, may not be a priority in Malawi. There is need to revamp the current services and give it a new face. Given that this service is important in saving women's lives after delivery, interventions such as information, education, and communication about postnatal services must be disseminated, and men be made aware of the significance of postnatal visits to ensure their partners are healing after childbirth without problems.

In addition, midwives need to be equipped with life-saving skills so that they are competent to manage clients when they come for postnatal services.

Mothers who do return to hospital for check-ups have expressed disappointment in the response of health workers who may sometimes question women why they have returned to the hospital when there is “nothing wrong with them.” In addition to emphasizing the need for postnatal checkups to women and their partners, the benefits of these checkups need to be communicated to health workers so that the services are better developed and publicized efficiently. These conflicting messages of women being told to return for postnatal checkups and later being questioned about why they have returned creates confusion and discourages them. If husbands and family members are knowledgeable about the signs and symptoms of complications after delivery, they can monitor women during this period and if there are complications, they will know of the steps to take to prevent long term problems or death to mother or baby. The postnatal period is a risk period for other complications such as vaginal discomfort, breast infection, fatigue, dizziness, insomnia and depression (Gjerdingen & Bruce, 2003), hence the need for both health workers and women’s partners to be alert to these conditions.

9.3 Gender Inequality in Pregnancy, Childbirth, and Postnatal Period

Both men and women in this study believed that pregnancy and childbirth are women’s issues. This is a view that has been discussed in several other studies (Draper, 1997; Greene, et al., 2006). Because it is women who bear the risk and burdens of reproductive health problems, services related to reproductive health components are mainly offered to women instead of men (Drennan, 1998). Men have accepted that they are left out of the equation. The gender socialization process (as discussed in chapter two) has led women and men to believe that women are solely responsible for making reproductive health decisions (in the context of very limited resources, this may not be a choice), that men should not be part of the birthing process, and that women should bear the responsibility for household chores. Furthermore, in Malawi men are culturally socialized to be strong, respected by their wives and command obedience from their wives, a determinant of hegemonic masculinity. This kind of thinking suggests that decision-making is the domain of

men. As Wusu and Isiugo-Abanihe (2006) suggest, “African men enjoy supremacy over decision-making on important issues.”

The results of this study indicate that men rarely, if ever, assist women with household chores. Some men refuse to help care for the baby out of fear that men who assist women with child care may be looked at as “sissies” or “bumpus” and be ridiculed by other men. Men who assist with household and family are viewed as having lost control of their families. They are no longer considered men because they have succumbed to women’s demands. In most cultures in Malawi, men have the view that women cannot give advice to them. Similar results have been found in India, where men mentioned that women cannot give advice including on contraception (Khan & Patel, 1997). Similarly in developing countries like Malawi, it is believed that only men can make decisions that affect the family (Toure, 1996). In the present study, most women were less educated than men placing them in a weaker position to make decisions about their reproductive health. Women’s education will enhance their understanding of reproductive health issues and their reproductive rights (Kasanda, 2005) and also empower women with knowledge, skills and self-confidence in decision-making in the area of sexual and reproductive health (United Nations Population Fund, 1994). Empowerment that women are looking for is the ability to freely, knowledgeably and autonomously to decide when their partners can assist them with household chores, when they need to rest when they are pregnant and after delivery but also when they are comfortable to have sexual intercourse. In addition, women’s understandings of their own health may improve their health-seeking behaviours, particularly in maternal and child health services which are important for their own survival and that of their children.

Change needs to happen and men need to facilitate this lengthy process. Targeting youth with messages that change the gender dynamics between men and women may result in more positive attitudes towards women. Messages may include explanations of what gender is and how gender operates to create differences in gender roles for men and women in Malawi. These kinds of messages may help youth take a different stance on gender equality and be open to gender-equitable masculinities (Esplen, 2006). Currently, women are given little authority about decisions regarding their own bodies when they are pregnant. For example, in some communities women are not permitted to leave their home to obtain care unless

accompanied by a male family member (Greene, et al., 2006). This is a message that must be changed so that women have freedom to act on their own without consulting their husbands or male relatives to receive health care (Greene, et al., 2006).

Changing old habits may not be easy for men and women; some men may seek to safeguard their power. However, there will be some men who are receptive to shifts in gender divisions and harmful versions of masculinity, because “masculinity is not a fixed entity embedded in the body...masculinities are configurations of practice that are accomplished in social action and therefore can differ according to the gender relations in a particular social setting (Connell & Messerschmidt, 2005 p. 836).” Younger men who are more receptive to change in gender roles (such as those young men in this study who supported men participating during childbirth) may be helpful channels to communicate to other men the benefits of male involvement during pregnancy, childbirth, and the postnatal period.

9.4 Cultural Factors Hindering Male Involvement

The findings of this study have highlighted the cultural barriers to male involvement and the challenges in overcoming them during pregnancy, childbirth and the postnatal period. The major barrier is the culturally prescribed period of abstinence from sexual intercourse between men and women. Recall that abstinence is “enforced” by beliefs that illness and harm will come to a couple’s new born baby and the partner if they have intercourse before approval by the village elders. According to participants, this is the driving force behind polygamy and multiple sexual partners, which may have serious consequences for both men and women’s health. None of the participants are willing to challenge this cultural practice for fear of being bewitched. Some participants claimed that this cultural belief has existed for a long time and therefore will always be accepted. To challenge this long held attitude of cultural beliefs requires mobilizing men to be part of the solution to these problems. Providing men and women with information about when it is safe to resume copulation may also be a way of challenging this cultural belief.

A primary reason for men not getting involved in pregnancy, antenatal or the postnatal period is the belief that marriages may end because men’s presence during delivery may deter future sexual relationships with their partners. In addition, men are concerned about fluids such as blood, amniotic fluids, and sometimes faecal

matter discharged during delivery, making women “dirty.” Cultural beliefs enhance this fear as many participants explained that traditional laws suggest that if men stay close to their partners or have sexual intercourse too soon after delivery, they will become “infected” or sick. Even worse, if men do not reveal to Village Elders that they have engaged in intercourse with their partners after delivery, they may not receive the appropriate medicines to “cure” them of any subsequent illness. These are some of the complex and deeply embedded cultural systems which will require equally complex strategies for change. The initial step in overcoming these cultural barriers is to engage with Traditional Leaders on the best strategy to deal with deeply rooted cultural systems.

There is great need to educate men and women about the reproductive physiology of pregnancy, childbirth and postnatal care so that they are equipped with information that will enable them to manage their families and make informed choices. However, it should also be noted that information or education should not compete with beliefs reinforced by religion and superstition. What may be important when planning for information, education and communication sessions about these cultural beliefs is that they are recognized, acknowledged, and addressed before material is provided that dispels these beliefs.

Perhaps the most significant cultural barrier is the baby cleansing rule that dictates that a father cannot spend time with his baby until its umbilical cord has fallen off. This denial may bring resentment to both the baby and the mother, leading to feelings of neglect and isolation. The concepts of intimate relationship, family togetherness, and father-infant attachment may be lost (Early, 2001). Evidence suggests that when fathers are not involved with their infant early in the postpartum period, bonding may be delayed (Barclay & Lupton, 1999). This is typically denying a man his right to be with his family, to show his love to the baby and wife, and to be there for them. This is the time that he should help out with bathing, comforting the baby, and changing nappies (de Montigny & Lacharite, 2004). Changing nappies was one task that Mzimba men argued was entirely the woman’s domain. This is when significant interaction and care takes place. It can also, according to de Montigny and Lacharite (2004) bring support to mothers by relieving them of some of the responsibilities of childcare. It is therefore important that men be encouraged to interact with their new born babies after delivery. The men clearly suggested that if

they were to be involved in the reproductive process, cultural barriers had to be removed. This may require involving community leaders, as the custodians of culture in discussions of these issues.

9.5 Policy Change for Male Involvement

Hospital policies in Malawi prohibit husbands to be anywhere near the maternity ward, let alone being present during childbirth. Men accompany their wives to the hospital but do not enter the labour ward; they wait outside or in their homes for the delivery outcome. According to the participants in this study, the labour wards lack privacy as the beds are only separated by curtains or hospital screens providing little noise insulation. The labour ward is made up of several beds and sometimes there may be more than one woman labouring. Most of the participants in the study argued that reproductive health policies only catered for women and several authors have also documented this concern (Toure, 1996; Haile du Guerny & Shoukal, 2000; Greene et al., 2006).

For men to be involved during antenatal, childbirth and the postnatal period, the environment must be conducive and enabling to their presence. Privacy for couples is needed during labour so that women may receive support from their partners or relatives without worrying about people other than the health workers hearing women's noises during labour. This is their right to privacy. Clearly, hospitals need designated rooms for each couple to share during antenatal, childbirth and the postnatal periods.

In addition, men and women highlighted that the absence of paternal leave deters working men from being present during childbirth. It is difficult for policy-makers to consider providing a policy on paternal leave when they are not knowledgeable of the benefits of men being present during childbirth and involved in the whole reproductive process. It is the same culture that looks at men as sissies and views pregnancy and childbirth as women's issues. What may be necessary is to have supportive legislation that includes paternity leave for responsible fatherhood.

Legislation may also facilitate men's involvement in their children's lives and their inclusion in the birthing process if their wives or partners are supportive (Greene, et al., 2006), in the form of paternal leave. The legislation should in no way be seen as coaxing men into getting involved. But provisions should be made for

those that may be interested to do so. Laws and regulations are needed to enact appropriate policy (Greene, et al., 2006). First, the mindset of policy makers needs to change to allow a male friendly policy that encourages men to be with their partners during antenatal, childbirth and the postnatal period. It must also be realized that some policy makers and companies or government departments may be receptive to men getting involved.

Poverty represents another significant factor that contributes to men's lack of involvement. Women living in poverty are often seriously limited in their access to maternity services because of distance to the nearest hospital, lack of equipment and supplies, and shortage of human resources, and yet these are critical tenets to attaining reproductive health rights (Bueno de Mesquita & Hunt, 2006). Societal expectations dictate that men fill the role of "providers" and when they cannot provide things such as draw sheets, paraffin lamps, and other necessary items for their partners' labour and delivery, hospitals need to accommodate these situations. Changing health policy to ensure that hospitals and clinics are accessible, staffed, and stocked with the equipment and resources necessary to function is critical. In situations where men cannot provide material resources for their pregnant wives, good health policy must create opportunities for women to deliver in safe, clean, and supportive environments. Having this kind of accessibility can alleviate some of the burden many poverty stricken men face and promote their involvement in pregnancy, childbirth, and the postnatal period in other ways, beyond just filling a provider role.

The attitude of health workers is another barrier to male involvement. It is imperative for health workers to respect the policy changes which encourage men to get involved and these changes should be incorporated in their nursing or midwifery training. Such changes may include counseling of both men and women in preparation of women for labour and arrival of the baby and motherhood. These changes may not need a separate module but these messages could be expounded in the existing midwifery competencies. Health workers need to be informed of the benefits of men getting involved during pregnancy, childbirth and the postnatal period. Male involvement may allow more time for health workers to provide health services to women, and over time may lessen their work load. For example, women who are supported and receive proper care throughout their pregnancies are much

less likely to suffer complications that will require greater resources, time, and intervention during delivery.

9.6 Achieving Reproductive Health Rights

Some Malawian men are abusive to their partners in that they expect their pregnant partners to maintain the household during pregnancy and the postnatal period, and much of this work is physically challenging and difficult to perform. This work compromises the health and well-being of women and their unborn children. The United Nations Population Fund's Programme of Action of 1994 stipulated the need and importance of "full participation and partnership of both men and women to include shared responsibilities for the care, and nurturing of children and the maintenance of the household" (United Nations Population Fund, 1994 par 4.2). As interventions are planned for male involvement, comprehensive strategies need to be developed to include roles of men in household care. The information, education and communication strategies should incorporate these tasks.

Reproductive health rights include freedom from discrimination, harmful practices, and violence (Bueno de Mesquita & Hunt, 2006). These rights appear to be violated by the elders in the four districts of Dowa, Mangochi, Mzimba and Nsanje. By imposing traditional laws on the couple, elders may not be aware that they increase the chances of couples being infected with HIV and other sexually transmitted diseases by driving men into polygamous relationships. According to Thompson (1999), meeting these rights in developing countries including Malawi is a challenge; however, states have an obligation to their citizens to ensure that services, reproductive health, and sexual rights are observed. Civil society groups, which are the eyes and the voices for the poor, could be in a better position to monitor the progress of male involvement and hold the state accountable.

Overcoming these barriers requires working with communities at different levels. One way of contextualizing (Nanda, et al., 2005) how to involve men is through the conceptual framework in figure 4. The framework proposes: identifying socio-cultural barriers, engaging with community leaders, advocating with the community, providing civic education, implementing and overcoming barriers. In line with a public health approach it is imperative that gaps are identified if strategies are to be developed to address these problems. In this conceptual model, barriers

have been identified which inhibit men from getting involved in reproductive health issues particularly during pregnancy, childbirth and the postnatal period. Since these barriers are deep rooted in the cultural beliefs of the participants in this study, it is important to ensure that the solutions come from community members themselves with guidance from skilled health workers, local leaders (Traditional Authorities, Group Village Headmen, and Village Headmen), and leaders in government. These groups of people influence decisions that are made at community level. Leaders will need assistance from government and non-governmental organizations, including civil society groups, to advocate for male involvement in the community, to raise awareness of the importance of male involvement and the communities' role in promoting it, and to ensure that the government and partners provide the required resources to advance the male involvement agenda. It is important that key players work together in a coordinated manner to ensure success in the cause.

Civic education is also an important aspect of this conceptual framework if success is to be accomplished. Greater public knowledge and understanding of male involvement can be harnessed by use of multiple approaches of communication in the country. These include mass and electronic media, (and consideration can also be made to use cell phones as a communication medium even though this mode of communication may not be appropriate in the remotest areas of the country), organized groups such as workplaces, police, military, and churches. Use of traditionally available modes of communication such as use of flyers, storytelling, dramas, dances, songs, festivals and village meetings may be effective in communicating to people in rural areas. Once the public is aware of the problems and proposed solutions, it is important to ensure that the hospital policy is receptive of men to be present during antenatal, childbirth and postnatal care and those health care workers have been oriented about accepting men in the antenatal and labour wards. In any new programmes, human and financial resources need to be mobilized to ensure that implementers are prepared to provide services to the public. Plans should be managed through meetings or public gatherings to monitor progress.

This strategy would require the Ministry of Health to work in partnership with other government agencies, civil society groups and non-governmental organisations (NGO). Collaboration with other partners is important in order to garner support and commitment for male involvement services. But also to

complement government efforts in promoting male involvement in pregnancy, childbirth and the postnatal period through resources and service provision (Nanda, et al., 2005). What may be required is to ensure that each organization is clear of their responsibilities, particularly in the areas of their expertise. These approaches may not be implemented in a linear form but would depend on the situation and needs at the implementation level. Therefore, the proposed framework should guide policy makers, opinion leaders and health workers in developing culturally sensitive strategies to promote effective male involvement for improving maternal birth outcomes and hopefully reducing maternal mortality.

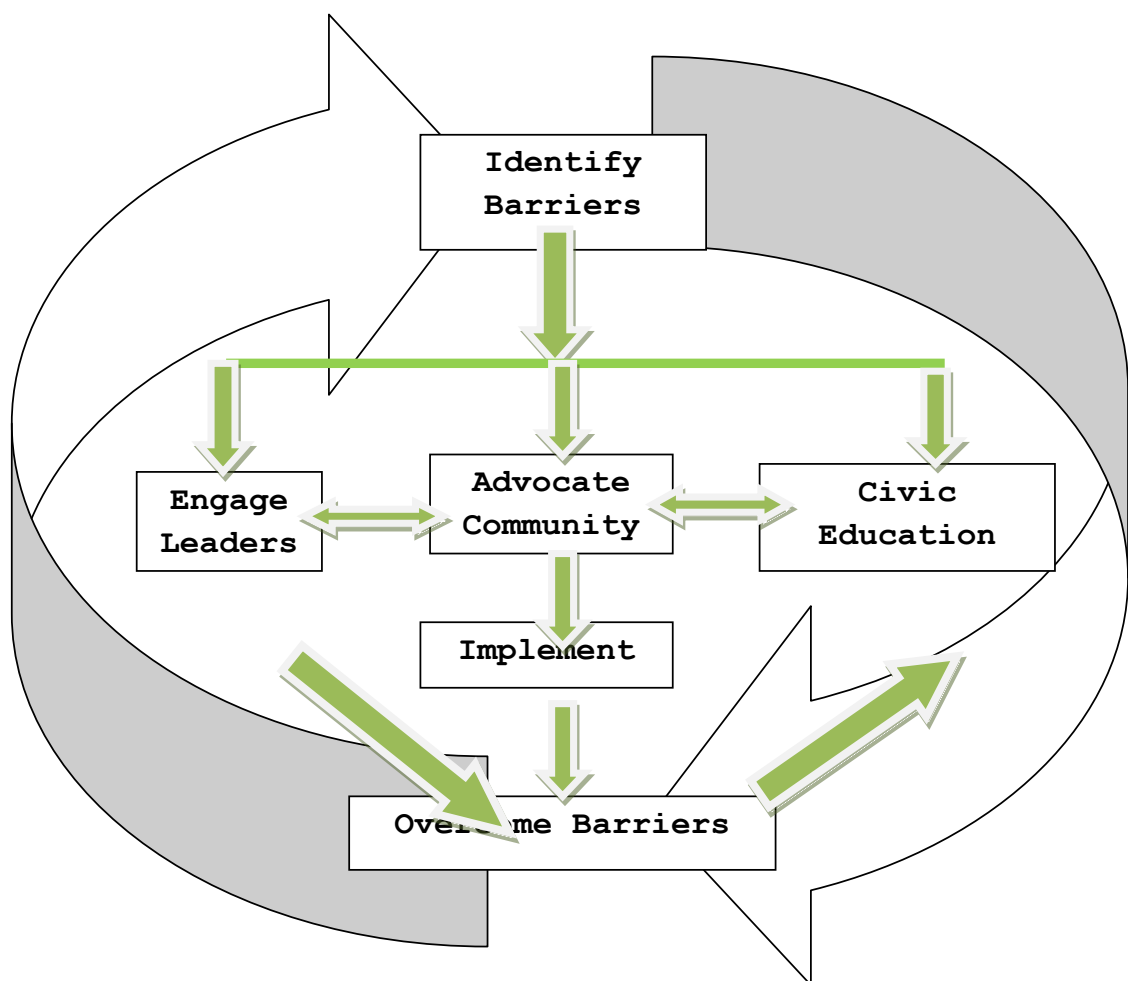


Figure 4: Conceptual Framework for Male Involvement

9.7 Implementation to Overcome Barriers

The Programme of Action (POA) adopted at the International Conference on Population and Development (ICPD) has emphasized the need for programmes to promote male involvement (C. P. Green, et al., 1995) as part of a broader reproductive health agenda (Greene, et al., 2006). The approach is grounded in public health, human rights and gender equality principles answering the questions: what can be done to involve men in reproductive health; how can they be involved; why do they need to be involved; and who should be the key actors for their involvement to be effective? This recognizes the role that men can play in supporting women's reproductive health and in shaping the social roles that restrict reproductive health and rights (Greene, et al., 2006). In order to realise this goal, the interventions discussed below are to provide men the opportunity to be involved in pregnancy, childbirth and the postnatal period.

9.7.1 Policy Environment

The Ministry of Health in Malawi 2002 developed a reproductive health policy which recognised the need to involve men in reproductive health. This policy may be seen as a health sector policy and therefore other sectors may not feel obliged to participate in operationalising it. If this policy is to receive clout nationally, the policy should be included in the Poverty Reduction Strategy Papers (PRSP), which in Malawi is a government blue print. The PRSP, according to Greene et al., (2006), set the tone for government programmes and donor contributions. These policies should be followed with supportive legislation such as paternal leave to include the rights of men to be involved in childbirth process (Greene, et al., 2006). The roles of men during pregnancy, childbirth and the postnatal period should be defined to legitimise their presence (Early, 2001). Hospitals need to organize themselves to ensure that men feel welcomed and accepted. This will require orientation of staff including support personnel who receive patients before they are admitted.

9.7.2 Information, Education and Communication (I E C)

Information, Education, and Communication (IEC) strategies should be designed that are culturally sensitive to the needs of the communities in Malawi. These strategies will require advocacy to policy makers, politicians and donors,

fundraising by stakeholders, for the successful management and deployment of intervention resources.

Drawing from the principle of participation, “involving people to identify their own needs, set their own priorities and goals and plan their own programmes is necessary at the individual, organizational and national levels” (L. W. Green & Ottoson, 1994, p. 5). This may be a way of getting support from each stakeholder and ensure that all work towards the goal of getting men involved in pregnancy, childbirth, and the postnatal period. In the planning for the I E C strategy, consideration should be made to move beyond the I E C strategy (Toure, 1996). Moving beyond I E C strategy may mean planning for services that respond to men’s needs (Food Agriculture Organisation of the United Nations, 1998). This may be a long term goal.

Initial services could be provided first to the most remote, poverty stricken areas on a pilot basis to assess the acceptance level, taking into consideration the cultural factors mentioned in the study. Then, results can be evaluated and replicated in other districts. In establishing service delivery for male involvement, lessons can be learnt from other male involvement projects such as in South Africa where men in maternity study was conducted (Mullick, et al., 2005), and projects supported by Engender Health in Nepal, Pakistan and Bolivia called “Men as Partners” (Mehta, et al., n.d.). As EngenderHealth noted in their MAP project, men are capable of playing a positive role in the health of their partners and families if given the opportunity (ibid). It is hoped that these suggestions and recommendations will make a sustained difference in the reproductive lives of both men and women in Malawi. It is only when the community is knowledgeable and understands why it is important that men be involved in pregnancy, childbirth and the postnatal period that they may be able to act in the best interest of their families.

9.8 Study Limitations and Future Research

Given the paucity of research concerning male involvement in reproductive health in Malawi, this research is exploratory in nature and provides a basis for additional studies on the nature of men’s involvement and the outcome of their involvement during pregnancy, childbirth and the postnatal period. Because this study is largely descriptive in nature, and that the results of this research may not be

generalized, future studies could evaluate the effectiveness of the interventions suggested from this research to document their impact on pregnancy outcomes and maternal mortality. This would entail a case control or longitudinal study that monitors the implementation and success of educating and including men in antenatal, childbirth and the postnatal period. A comparative approach could be taken to explore how successful particular interventions are within specific cultural contexts. For example, given that some districts of Malawi are populated by large Muslim populations, future research could consider ways of promoting male involvement with these specific groups of people. Tracking and monitoring reproductive health outcomes among youth who are among the first to participate in male involvement interventions may help identify aspects of programmes in need of adjustment, as well as guide future research questions. In addition, it would be important to replicate this study in the remaining 21 districts to see if the rest of the population of Malawi has similar views regarding male involvement. Conducting nationwide research would eventually help to generalize the results of this research.

Language was a limiting factor in this research. Participants spoke multiple languages across districts. This complexity in languages made it difficult to obtain first hand information directly from the participants. Data collection had to be conducted in local languages to which the primary researcher was not fluent, particularly languages from Mzimba and Nsanje. It was necessary to use translators who may have been biased in the ways in which questions were asked and also responses from the participants.

In conclusion, this research explored factors influencing male involvement in reproductive health, specifically during pregnancy, childbirth and the postnatal period in four rural districts of Malawi. Strategies to promoting male involvement between men and women through their partners, and changes at the institutional level in hospital training and government policy have been identified. The results of this study have lead to the development of the conceptual framework to overcome barriers and explained potential ways of implementation. It is hoped that Malawi and other countries will benefit from the results of this research for better maternal and neonatal outcomes.

References

- AbouZahr, C. (2003). Global burden of maternal death and disability. *British Medical Bulletin*, 67, 1-11. doi:10.1093/bmb/ldg015
- AbouZahr, C., & Berer, M. (1999). When pregnancy is over: Preventing post-partum deaths and morbidity. In M. Berer & T. K. S. Ravindran (Eds.), *Safe motherhood issues* Retrieved from Google database Available from <http://www.rhmjournal.org.uk/publications/safemotherhood>
- Afsharipour, A. (1999). Empowerment Ourselves: The role of women's NGOs in the enforcement of the Women's Conventions. *Columbia Law Review*, 99(1), 129-172.
- Ahmad, S. M. (1997). *Seminar on female empowerment and demographic process: Moving beyond Cairo* (Seminar report). Lund: International Union for the Scientific Study of Population.
- Allendorf, A. (2006, March-April 2006). *He said, she said, they said: Couples reports of women's autonomy and health care in Nepal (Draft)*. Paper presented at the Population Association of America 2006 Annual Meeting Program, Los Angeles, California. Retrieved February 21, 2007 from <http://paa2006.princeton.edu/sessionviewer.aspx?sessionId=1401>.
- Arevalo, M., Jennings, V., & Sinai, I. (2002). Efficacy of a new method of family planning: the Standard Days Method. *Contraception*, 65, 333-338. Retrieved from http://pdf.dec.org/pdf_docs/PNACQ416.pdf
- Bahai International Community. (1996). Beijing conference approves "an agenda for women's empowerment". *One Country*, 7(2). Retrieved from <http://www.onecountry.org/oc72/oc7204as.html>
- Banda, T. (2004). *Infant feeding and children's and women's nutritional status*. Zomba, Malawi: National Statistics Office.
- Bangster, M., Gumodoka, B., & Berege, Z. (1999). A comprehensive approach to vesico-vaginal fistula: A project in Mwanza, Tanzania. In M. Berer & T. K. S. Ravindran (Eds.), *Safe motherhood initiatives* (pp. 157-163). London: Blackwell Science limited.
- Barclay, L., & Lupton, D. (1999). The experiences of new fatherhood: A socio-cultural analysis. *Journal of Advanced Nursing*, 29(4), 1013-1020.

- Barker, G., & Das, A. (2004). Men and sexual and reproductive health: The social revolution. *International Journal of men's health*, 3, 147-153. Retrieved from <http://0-find.galegroup.com.library.ecu.edu.au/>
- Basu, A., & Das Gupta, M. (2001). Family systems and the preferred sex of children *International Encyclopedia of the Social & Behavioral Sciences* (pp. 5350-5357). Oxford: Pergamon.
- Baum, F. (2008). Research for new public health *The new public health* (Third edition ed., pp. 138-181). Oxford: Oxford University Press.
- Berer, M. (1996). Men. *Reproductive health matters*, 7, 9-15.
- Berer, M., & Ravindran, T. K. S. (1999). Safe motherhood initiatives: Critical issues. In M. Berer & T. K. S. Ravindran (Eds.) Retrieved from Google database Available from <http://www.rhmjournal.org.uk/publications/safemotherhood>
- Berhane, Y., Gossaye, Y., Emmelin, M., & Hogberg, U. (2001). Women's health in a rural setting in societal transition in Ethiopia. *Social Science and Medicine*, 53, 1525-1539.
- Berkman, L. F. (2001). Social integration, social networks, and health. *International Encyclopedia of the Social and Behavioral Sciences*, 14327-14332.
- Bernal, L. C., & Mehta, M. P. (2002). Men as partners in reproductive health. *Sexual Health Exchange* 2. Retrieved from http://www.kit.nl/exchange/html/men_as_partners_sexual_health.asp
- Bhasin, K. (2001). Gender workshops with men: Experiences and reflections from South Asia. In C. Sweetman (Ed.), *Men's involvement in gender development policy and practice: Beyond rhetoric*. Oxford, UK: Oxfam. Electronic version retrieved from <http://www.bradford.ac.uk/acad/dppc/gender/mandmweb/kbhasintext.html>.
- Blaikie, N. (2007). *Approaches to social inquiry* (second edition ed.). Cambridge: Polity press.
- Blanc, A. K. (2001). The effects of power in sexual relationships on sexual and reproductive health: An examination of the ...more. *Studies in family planning*, 32(3), 189-213.
- Bloom, S. S., Tsui, A. O., Plotkin, M., & Bassett, S. (2000). What husbands in northern India know about reproductive health: correlates of knowledge about pregnancy and maternal and sexual health. *J Biosoc Sci*, 32(2), 237-251.

- Borghi, J., Storeng, K. T., & Filipi, V. (2008). Overview of the costs of obstetric care and the economic and social consequences for households
- Bratton, J., Callinan, M., Forshaw, C., & Sawchuk, P. (2007). *Work and Organisation: Understanding the workplace*. London: MacMillan.
- Bueno de Mesquita, J., & Hunt, P. (2006). International Assistance and Cooperation in Sexual and Reproductive Health: A human rights responsibility for donors. Retrieved from www.2.essex.ac.uk/human_rights_centre/
- Bunch, C. (1995). Transforming Human Rights from a feminist perspective In J. S. Peters & A. Wolper (Eds.) Available from http://books.google.co.uk/books?id=Vabnl-FM5nEC&pg=PA11&lpg=PA11&dq=transforming+human+rights+from+a+feminist+perspective&source=bl&ots=ywk4HbVtvD&sig=tHGOOT4Wvsz_vh2GVnBDU4QWMYQ&hl=en&ei=IYNvS8DnBI_g7AObxN30BQ&sa=X&oi=book_result&ct=result&resnum=1&ved=0CAcQ6AEwAA#v=onepage&q=transforming%20human%20rights%20from%20a%20feminist%20perspective&f=false
- Bunch, C., & Fried, S. (1996). Beijing 1995: Moving women's human rights from margin to centre. *Signs. Journal of women in culture and society*, 22(1), 200-204.
- Burman, P. (1994). *Interviewing Qualitative Methods in Psychology: A research guide*. Burkingham: Open Press University.
- Campero, L., Garcia, C., Diaz, C., Ortiz, O., Reynoso, S., & Langer, A. (1998). "Alone, I wouldn't have known what to do": a qualitative study on social support during labor and delivery in Mexico. *Soc Sci Med*, 47(3), 395-403.
- Carlson, M. (2006). Family structure, father involvement, adolescent behaviour outcomes. *Journal of Marriage and Family*, 68(1), 137-154. Retrieved from ProQuest database.
- Carter, M. W. (2002). Because he loves me: husbands' involvement in maternal health in Guatemala. *Culture, Health and Sexuality*, 4(3), 259-279.
- Chakwana, C. D. (2004). Domestic violence *Malawi demographic and health survey 2004*. Zomba, Malawi: National Statistical Office.
- Chapagain, M. (2006). Conjugal power relations and couples' participation in reproductive health decision making: Exploring the links in Nepal. *Gender, Technology and Development*, 10, 159-189. Retrieved from <http://0-gtd.sagepub.com.library.ecu.edu.au/cgi/reprint/10/2/159>

- Chapman, L. (1991). Searching: expectant fathers' experiences during labor and birth. *J Perinat Neonatal Nurs*, 4(4), 21-29.
- Clark, J., Yount, K. M., & Rochat, R. (2008). Men's involvement in family planning in Bangladesh. *Journal of Biosocial Science*, 40, 815-840.
- Clift, E. (1997). Reinventing macho: Men as partners in reproductive health. *Perspectives in Health*, 2(2). Retrieved from http://www.paho.org/English/DPI/Number4_article4.htm
- Cohen, S. I., Gudkovsky, A., & Poshtaruk, A. (2003). *Ukraine: HIV/AIDS Prevention in the Armed Forces* (Project document): Ministry Of Defence, Ukraine.
- Connell, R. W., & Messerschmidt, J. W. (2005). Hegemonic Masculinity: Rethinking the concept. *Gender & Society*, 19 (6), 829-859.
- Conner, M. (2001). Health behaviours. *International Encyclopedia of the Social and Behavioral Sciences*.
- Coombes, Y. (2001). *Sexual and health behaviour in Malawi: A situational analysis for the behaviour change interventions strategy on HIV and sexual and reproductive health*. Lilongwe: Ministry of Health and National AIDS Commission and Department for International Development.
- Cornwall, C., & Molynux, M. (2006). The politics of rights-Dilemmas for feminist praxis: An Introduction. *Journal of Third World Quarterly*, 27(7), 1175-1191.
- Courtenay, W. H. (2000). Constructions of masculinity and their influence on men's well-being: a theory of gender and health. *Journal of Social Science and Medicine*, 50(10), 1385-1401.
- Creswell, J. W. (1998). *Qualitative inquiry and research design: Choosing among five traditions*: Sage publications.
- Creswell, J. W. (2007). *Qualitative inquiry and research design: choosing among five approaches* (second edition ed.). Thousand Oaks: Sage.
- Crocker, J. (2001). Self-esteem in adulthood. *International Encyclopedia of the Social and Behavioral Sciences*, 13822-13826.
- Crotty, M. (1998). *The foundations of social research*: Allen and Unwin.
- Cusson, M. (2001). Control: social. *International Encyclopedia of the Social & Behaviour Sciences*, 2730-2735.
- Dangor, Z. (2006). Raising awareness on the interface between gender based violence and HIV/AIDS, in South Africa: The experiences of Zubeda Dangor of Nisaa. *Exchange on HIV/AIDS, sexuality and gender*, 2, 5-7. Retrieved from www.exchange-magazine.info

- de Montigny, F., & Lacharite, C. (2004). Fathers' perceptions of the immediate postnatal period. *Journal of Obstetrics and Gynaecology*, 33(3), 328-339.
- Department of Women's Health, World Health Organisation. (2003). *'En-gendering' the Millennium Development Goals (MDGs on Health)* (No. WHO/FCH/GWH/03.1). Geneva: Department of Gender and Women's Health, World Health Organisation.
- Dixon-Mueller, R. (1998, June 16, 2007). Female empowerment and demographic process: moving beyond Cairo. *Policy and Research Paper No. 13*, from http://www.iussp.org/Publications_on_site/PRP/prp13.php
- Do Thi Ngoc Nga, & Morrow, M. (1999). Nutrition in pregnancy in rural Vietnam: Poverty, self-sacrifice and fear of obstructed labour. In M. Berer & T. K. S. Ravindran (Eds.), *Safe motherhood initiatives: Critical issues* (pp. 137-145). London: Blackwell Science Limited.
- Draper, J. (1997). Whose welfare in the labour room? A discussion of the increasing trend of fathers' attendance. *Midwifery*, 13, 132-137.
- Draper, J. (2003). Blurring, moving and broken boundaries: men's encounters with the pregnant body. *Sociology of Health and Illness*, 25(7), 743-767.
- Drennan, M. (1998). Reproductive health. New perspectives on men's participation. *Popul Rep J*(46), 1-35.
- Dudgeon, M. R., & Inhorn, M. C. (2004). Men's influences on women's reproductive health: Medical anthropological perspectives. [Journal]. *Social Science and Medicine*, 59(7), 1379-1395.
- Early, R. (2001). Men as consumers of maternity services: A contradiction in terms. *International Journal of Consumer Studies*, 25(2), 160-167.
- Edouard, L., & Bernstein, S. (2006). Seeking equity in maternal health. *Lancet*, 367(9507), 279-281.
- Efroymsen, D., FitzGerald, S., & Jones, L. (2006). *Promoting male responsibility for gender equality* (Summary report of research from Bangladesh, India and Vietnam): HealthBridge.
- Esplen, E. (2006). Engaging men in gender equality: Positive strategies and approaches. *Bridge Development gender*, 15, 1-51. Retrieved from <http://www.bridge.ids.ac.uk/reports/BB15Masculinities.pdf>
- Family Care International. (2006). Male involvement in reproductive health: International Conference on Population and

- development. Retrieved from
www.europrofem.org/contri/2_04_en/en-masc/53en_mas.htm
- Family Health International. (1998). Male responsibility for reproductive health. *Network*, 18(3), 183.
- Fathalla, M. F., Sinding, S. W., Rosenfield, A., & Fathalla, M. M. F. (2006). Sexual and reproductive health for all: a call for action. *World Health Organization Journal paper, Sexual and reproductive health* 6,
- Fontana, A., & Fray, J. H. (2008). The interview from neutral stance to political involvement. In N. K. Denzin & Y. S. Lincoln (Eds.), *Collecting and interpreting qualitative materials* (Third edition ed., pp. 115-152). Los Angeles: Sage.
- Food Agriculture Organisation of the United Nations. (1998). Male involvement in reproductive health: Incorporating gender throughout the cycle. Technical support service system. *Occasional paper number 1*. Retrieved from
www.fao.org/docrep/x0257e/x0257e00.htm
- Food Agriculture Organization of the United Nations. (1998). Male involvement in reproductive health: Incorporating gender throughout the life cycle. *Technical Support Service System: Occasional Paper Series Number 1*. Retrieved January 22, 2007, from <http://www.fao.org/DOCREP/x0257e/x0257e00.htm>
- Fuller, T., & Loogma, K. (2008). Constructing futures: A social constructionist perspective on foresight methodology. *Futures methodologies*, 41(2), 71-79. Retrieved from
http://www.sciencedirect.com/science?_ob=ArticleURL&_udi=B6V65-4T4J876-4&_u. doi:10.1016/j.futures.2008.07.039
- Furuta, M., & Salway, S. (2006). Women's position within the household as a determinant of maternal health care use in Nepal. *International Family Planning Perspectives*, 32(1), 17-20.
- Gable, L., Gostin, L. O., & Hodge, J. G. (2008). HIV/AIDS, reproductive and sexual health, and the law. *American Journal of Public Health*, 96(10), 1779-1786.
- Gay, J., Hardee, K., Judice, N., Agarwal, K., Fleming, K., & Hairston, A. (2003). What works: A policy and programme guide to the evidence on family planning, safe motherhood and STI/HIV/AIDS interventions *Module 1: Safe motherhood training training manual*. Retrieved from
www.policyproject.com/pubs/generalreport/SM_WhatWorksps2.pdf

- Gay, J., Hardee, K., Judice, N., Agarwal, K., Fleming, K., Hairston, A., et al. (2003). What works: A policy and programme guide to the evidence on family planning, safe motherhood and STI / HIV / AIDS interventions - Module 1: Safe motherhood (Training Manual). Retrieved 2007, March 9, from http://www.policyproject.com/pubs/generalreport/SM_WhatWorks2.pdf
- Gecas, V. (2001). Socialization. *International Encyclopedia of the Social and Behavioral Sciences*, 14525-14530.
- Gergen, K. J., & Gergen, M. (2003). *Knowledge as socially constructed*. London: Sage.
- Ghorayeb, F., Ladjali, M., & Villarreal, M. (1998, 9-13 November). *Technical support services (TSS) thematic workshop on male involvement in sexual and reproductive health*. Paper presented at the SD dimensions people: Gender and development, Rome, Italy.
- Gibbs, L., Kealy, M., Willis, K., Green, J., Welch, N., & Daly, J. (2007). What have sampling and data collection got to do with good qualitative research? *Australian and New Zealand Journal of Public Health*, 31(6), 540-544.
- Gijima, M. (1999). *Reproductive health operational research programme*. Harare: United Nations Population Fund.
- Gjerdingen, D. K., & Bruce, A. (2003). First time parents' prenatal to postpartum changes in health, and the relation of postpartum health to work and partner characteristics. *JABFP*, 16(4), 304-311
- Glasier, A., Gulmezoglu, M., Schmid, G. P., Moreno, C. G., & Van Look, P. F. A. (2006). Sexual and reproductive health: A matter of life and death. doi:10.1016/S0140-6736(06)6978-6
- Gracia, E., & Herrero, J. (2006). Public attitudes towards reporting partner violence against women and reporting behaviour. *Journal of Marriage and Family*, 68(3), 759-768.
- Graham, W. J., Cairns, J., Bhattacharya, S., Bullough, C. H. W., Quayyum, Z., & Khama, R. (n.d.). 26. Maternal and Perinatal conditions. *Disease Control priorities Project in developing countries*, 499-529. Retrieved from <http://www.dcp2.org/pubs/DCP/26/section/3617>
- Green, C. P., Cohen, S. I., & El-Ghouayel, H. B. (1995). Male involvement in reproductive health, including family planning and sexual health. *Technical report 28*. Retrieved from http://whqlibdoc.who.int/hq/2002/WHO_FCH_RHR_02.3.pdf

- Green, L. W., & Ottoson, J. M. (1994). *Community Health* (Seventh Edition ed.). Baltimore: Mosby.
- Greene, M. E. (2000). Changing women and avoiding men: Gender stereotypes and reproductive health programmes. *IDS Bulletin*, 31(2), 49-59.
- Greene, M. E., Mehta, M., Pulerwitz, J., Wulf, D., Bankole, A., & Singh, S. (2006). Involving men in reproductive health: Contributions to development. *Millennium Development*. Retrieved from http://www.unmillenniumproject.org/documents/Greene_et_al-final.pdf
- Guba, E. G. (Ed.). (1990). *The Paradigm dialogue*. Newsbury park: Sage publications.
- Guerrina, R., & Zalewski, M. (2007). Negotiating difference/negotiating rights: The challenges and opportunities of women's human rights. *Review of International Studies*, 33(1), 5-10.
- Haile, S., du Guerny, J., & Shoukal, L. (2000). Provision of reproductive health services in Sub-Saharan Africa: Lessons, issues challenges and the overlooked rural majority. Retrieved January 30, 2007, from <http://www.fao.org.sd/wpdirec/wpan0044.htm>
- Halcomb, E. J., Gholizadeh, L., DiGiacomb, M., Phillip, J., & Davidson, P. M. (2007). Literature review: Considerations in undertaking focus group research with culturally diverse groups. *Journal of Clinical Nursing*, 16(6), 1000-1011. Retrieved from http://www3.interscience.wiley.com/cgi-bin/fulltext/118513879/main.html,ftx_abs
- Haralambos, M., & Holbon, M. (1995). *Sociology: Themes and perspectives* (Fourth ed.): Collins Education.
- Harouel, J. L. (2001). Culture, Sociology of. *International Encyclopedia of the Social and Behavioral Sciences*, 3179-3184.
- Hoga, L. A., Alcantara, A. C., & de Lima, V. M. (2001). Adult male involvement in reproductive health: an ethnographic study in a community of Sao Paulo City, Brazil. *J Transcult Nurs*, 12(2), 107-114.
- Huberman, A. M., & Miles, M. B. (1994). *Qualitative data analysis* (Second edition ed.). Thousand Oaks: Sage.
- Huberman, A. M., & Miles, M. B. (2002). *The qualitative researcher's companion*. London: Sage publications.
- Huque, Z. A., Leppard, M., Mavalankar, D., Akhter, H. H., & Chowdhury, T. A. (1999). Safe motherhood programmes in Bangladesh. In M.

- Berer & T. K. S. Ravindran (Eds.), *Safe motherhood initiatives: Critical issues* (pp. 53-59). London: Blackwell Sciences Limited.
- Interactive Population Center. (n.d.). Reproductive health and violence. *Women's empowerment and reproductive health: Links throughout the life cycle*. Retrieved January 30, 2007, from <http://www.unfpa.org/intercenter/cycle/violence.htm>
- International Planned Parenthood Federation. (2004). Youth, sexual health and HIV/AIDS in the Balkans: Prevention - protection - provision. Retrieved January 31, 2007, from http://www.forumi.org/common/docs/aids_project_en.pdf
- International Population Centre. (n.d.). Effects on the economics of the reproductive and family service delivery, violence against girls and women. Retrieved from <http://www.unfpa.org/intercenter/violence/effects3a.htm>
- Isiugo-Abanihe, U. C. (2006). Interconnections among changing family structure, childbearing and fertility behaviour among ogu, southwestern Nigeria: A qualitative study. *Demographic Research*, 114(8), 139-156.
- Johns Hopkins Bloomberg School of Public Health Center for Communication, Family Care International, & Maternal Neonatal Health. (2004). *Monitoring birth preparedness and complications readiness: Tools and indicators for maternal and newborn health*. Baltimore: Johns Hopkins Bloomberg School of Public Health.
- Johns Hopkins Program for International Education in Gynaecology and Obstetrics. (2004). *Maternal and Neonatal Health: Best practices: The traditional Birth Attendants linking communities and services*. Baltimore: JHPIEGO.
- Johnson, M. P. (2005). Domestic violence: It's not about gender - or is it? *Journal of Marriage and Family*, 67(5), 1126-1131. Retrieved from ProQuest 5000 International
- Kamal, I. T. (2002). *Field experiences in involving men in safe motherhood: Programming for male involvement in reproductive health*. Paper presented at the World Health Organisation Regional Advisers in reproductive health. Retrieved from http://whqlibdoc.who.int/hq/2002/WHO_FCH_RHR_02.3.pdf
- Karim, D. R. (2003). *Reproductive health including family planning*. Paper presented at the Fifth Asian-Pacific population conference.
- Kasanda, P. L. (2005). *Empowerment of women of African descent*. Paper presented at the Fifth session of the working group of experts on people of African descent, Geneva.

- Kasturirangan, A., Krishnan, S., & Riger, S. (2004). The impact of culture and minority status on women's experience of domestic violence. *Trauma, violence & abuse*, 5(4), 318-332. Retrieved from <http://tva.sagepub.com/cgi/content/abstract/5/4/318>. doi:10.1177/1524838004269487
- Khan, M. E., & Patel, B. C. (1997). Male involvement in family planning: A KABP study of Agra district, Uttar Pradesh. Retrieved January 28 2007, from http://www.popcouncil.org/pdfs/frontiers/OR_TA/Asia/India_ML.pdf
- Kim, S. (2006). *Social, cultural and humanitarian affairs*. Paper presented at the Social humanitarian and culture committee.
- Kim, Y. M., & Kols, A. (2002). *Programming for male involvement in reproductive health*. Paper presented at the World Health Organisation Regional Advisers in reproductive health. Retrieved from http://whqlibdoc.who.int/hq/2002/WHO_FCH_RHR_02.3.pdf
- Kitzinger, J. (1995). Qualitative research. Introducing focus groups. *BMJ*, 311(7000), 299-302.
- Koenig, L. J., Whitaker, D. J., Royce, R. A., & Wilson, T. E. (2006). Physical and sexual violence during pregnancy and after delivery: A prospective multistate study of women with or at risk for HIV infection. *American Journal of Public Health*, 96(6), 1052-1060.
- Kowal, S., & O'Connell, D. C. (2004). The transcriptions of conversations (B. Jenner, Trans.). In U. Flick, E. Von Kardoff & I. Steinke (Eds.), *A companion to qualitative research* (pp. 248-251). London: Sage.
- Kruske, S., & Barclay, L. (2004). Effects of shifting policies on traditional birth attendant training. *Journal of Midwifery and Women's Health*, 49(4), 306-311. Retrieved from http://www.sciencedirect.com/science?_ob=ArticleURL&_udi=B6W6R-4CS8B6H-R. doi:10.1016/j.jmwh.2004.01.005
- Lauglo, M. (1999, September 1999). *Gender, reproductive health and reproductive rights*. Paper prepared for Adapting to Change Core Course. Retrieved January 31, 2007, from <http://info.worldbank.org/etools/docs/library/48447/m1s5lauglo.pdf>
- Lazo, L. (1993). *Reflections on the empowerment of women. In women education and empowerment*. Paper presented at the Women education and empowerment: Pathways towards autonomy. Retrieved from

http://eric.ed.gov/ERICDocs/data/ericdocs2sql/content_storage_01/0000019b/80/15/8d/48.pdf

- Lettenmaier, C., Langlois, P., Kumah, O. M., Kiragu, K., Jato, M., Zacharias, J., et al. (1994). Focus group research for family planning: lessons learned in Sub-Saharan Africa. *Health Transition review*, 4(1), 95-102.
- Liamputtong, P., & Ezzy, D. (2005). *Qualitative research methods*: Oxford.
- Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*. Los Angeles: Sage.
- Liow, M. L. (2002). Putting men on the agenda. Men and reproductive health. Retrieved from <http://www.icomp.org.my/Resources/Gender%20and%20RH/inn4/inn4cl.htm>
- Lule, E., Ramana, G. N. V., Oomman, N., Epp, J., Huntington, D., & Rosen, J. E. (2005). *Achieving Millennium Development Goal of Improving Maternal Health: Determinants, interventions and challenges*. Washington: World Bank.
- Lupton, D., Short, P. M., & Whip, R. (1992). *Society and gender: An introduction to sociology*. South Melbourne: Macmillan Education.
- Maholtra, A., Schuler, S. R., & Boender, C. (2002). Measuring women's empowerment as a variable in international development. Background paper prepared for the World Bank workshop on poverty and gender: New perspectives. Retrieved from <http://www.aed.org/LeadershipandDemocracy/upload/MeasuringWomen.pdf>
- Maine, D. (1999). What's so special about maternal mortality. In M. Berer & T. K. S. Ravindran (Eds.) Retrieved from Google database Available from <http://www.rhmjournal.org.uk/publications/safemotherhood>
- Mandala, E. C. (1990). *Work and control in a peasant economy: A history of the Lower Tchiri Valley in Malawi 1859-1960*. Madison, WI: University of Wisconsin Press.
- Mardorossian, C. M. (2003). Labouring women, coaching men: Masculinity and childbirth education in the contemporary United States. *Hypatia*, 18(3), 113-134.
- Marshall, C., & Rossman, G. B. (1995). *Designing qualitative research*. London: Thousand Oaks.

- Marsiglio, W., Day, R., Braver, S., Evans, V. J., Lamb, M., & Peters, E. (n.d.). *Social fatherhood and paternal involvement: Conceptual, data and policy making issues*.
- Mason, K. O., & Smith, L. H. (2001, March 2001). Thinking about, measuring, and analysing women's empowerment/autonomy: Lessons from a cross-country comparative study. *Presentation at the annual meeting of the Population Association of America*. Retrieved February 28, 2007, from <http://swaf.pop.upenn.edu/papers/MasonSmithPAA2001.pdf>
- Matinga, P. U. (1998). Improving quality and access to maternal health services for Malawian women: a participatory needs assessment for Blantyre and Nsanje districts. Blantyre District Health Office.
- Matinga, P. U. (2000). Qualitative needs assessment (3) Chikwawa, Mangochi and Thyolo. Blantyre District Health office.
- Matinga, P. U., & McConville, F. (2003). A review of cultural beliefs and practices influencing sexual and reproductive health and health seeking behaviour in Malawi.
- Mays, N., & Pope, C. (1995). Education and debate, qualitative research: rigour and qualitative research. *British Medical Journal*, (311), 109-112. Retrieved from <http://www.bmj.com/cgi/content/full/311/6997/109>
- McBride, R., & Schostak, J. (1994). Qualitative research and introduction. Retrieved from <http://www.enquirylearning.net/ELU/Issues/Research/Res1ch1.html>
- Mehta, M. (2002). *Communicating with men to promote family planning: Lessons learned and suggestions for programming*. In *programming for male involvement in reproductive health*. Paper presented at the World Health Organisation Regional Advisers in reproductive health. Retrieved from http://whqlibdoc.who.int/hq/2002/WHO_FCH_RHR_02.3.pdf
- Mehta, M., Peacock, D. M., & Bernal, L. (n.d.). Men as partners: Lessons learned from engaging men in clinics and communities. Retrieved from http://www.infoforhealth.org/search_results_single.php?start_num=9&fullreco
- Merry, S. E. (2003). Constructing a global law-violence against women and the human rights system. *Journal of Law and Society enquiry*, 28, 941-977.

- Minichiello, V., Aroni, R., Timewell, E., & Alexander, L. (2004). *In-depth interviewing: Principles, techniques, analysis* (Second edition ed.). Melbourne: Longman.
- Ministry of Gender, Youth and Community Services. (2000). *National gender policy*. Lilongwe: Ministry of Gender, Malawi.
- Ministry of Gender and Community Services. (2002). *The National strategy to combat gender based violence*.
- Ministry of Health. (2002). *Reproductive Health Policy*. Lilongwe: Ministry of Health.
- Ministry of Health. (2005a). *Draft report for the Malawi 2005 HIV and syphilis sero-survey and national HIV prevalence*. Lilongwe: Department of Clinical Services, Ministry of Health, Malawi.
- Ministry of Health. (2005b). *Emergency obstetric care services in Malawi*.
- Ministry of Health. (2005c). *Roadmap for accelerating the reduction of maternal and neonatal mortality and morbidity in Malawi*. Lilongwe: Department of Clinical Services, Ministry of Health, Malawi.
- Ministry of Health. (2006). *Human resources in the health sector: Towards a solution*. Lilongwe, Malawi: Ministry of Health.
- Ministry of Health, & Chancellor College. (1986). *The value of children and childspacing practices in Malawi: UNFPA/Ministry of Health project MLW/85/PO1/1987, report of a workshop*. Zomba: Demographic Unit of Department of Geography and Earth Science.
- Ministry of Health, & National Family Planning Council. (1996). *Family planning and contraceptive guidelines*. National family planning council, Malawi.
- Ministry of Health, & National Family Planning Council of Malawi. (1996). *Family planning and contraceptive guidelines*. Lilongwe: Author.
- Mocumbi, P., & Amaral, E. (2006). *Reproductive rights and HIV/AIDS Best Practices and Research Clinical Obstetrics and Gynaecology*, xx(xxx). Retrieved from <http://www.bestpracticeobgyn.com/article/PIIS1521693406000186/pdf>
- Morisky, D. E., Nguyen, C., Ang, A., & Tiglao, T. V. (2005). HIV/AIDS Prevention among the male population: Results of a peer Education Programme for Taxicab and Tricycle Drivers in the Phillipines. *Health Education and Behaviour*, 32(1), 57-66.

- Morse, J. M., Barrett, M., Mayan, M., Olson, K., & Spiers, J. (2002). Verification strategies for establishing reliability and validity in qualitative research. *International Journal of Qualitative Methods*, 1(2), 1-19. Retrieved from <http://www.ualberta.ca/~ijqm/>
- Muia, E., Olenja, J., Kimani, V., & Leonard, A. (2000). *Intergrating men into the reproductive health equation: Acceptability and feasibility in Kenya*. Nairobi: Population council.
- Mullany, B. C. (2005). Barriers to and attitudes towards promoting husbands' involvement in maternal health in Katmandu, Nepal. *Soc Sci Med*, 62(11), 2798-2809.
- Mullany, B. C., Becker, S., & Hindin, M. J. (2006). The impact of including husbands in antenatal health education services on maternal health practices in urban Nepal: results from a randomized controlled trial. *Health Educ Res*, 22(2), 166-176.
- Mullick, S., Kunene, B., & Wanjiru, M. (2005). Involving men in maternity care: Health service delivery, a gender special focus. *A gender special focus*, 124-135. Retrieved from http://www.popcouncil.org/pdfs/frontiers/journals/Agenda_Mullick05.pdf
- Murphy, E. M. (2003). Being born female is dangerous for your health. *The American Psychological Association*, 58(3), 205-210.
- Mwale, M. W. (2004). *Infant and Child mortality. In Malawi Demographic Survey*. Zomba: National Statistics Office.
- Namasasu, J. (2004). Fertility regulation *Malawi demographic and health survey 2004* (pp. 96-119). Zomba, Malawi: National Statistical Office.
- Nanda, G., Switlick, K., & Lule, E. (2005). Accelerating progress towards achieving the MDG to improve maternal mortality: A collection of promising approaches. *Health, Nutrition and Population discussion papers*, 1-79. Retrieved from <http://siteresources.worldbank.org/HEALTHNUTRITIONANDPOPULATION/Resources/281627-1095698140167/NandaAcceleratingProgresswithCover.pdf>
- National Statistics Office. (2004). *Malawi Demographic Health Survey*. Zomba, Malawi: National Statistics Office.
- National Statistics Office. (2008). *The Population and Housing Census 2008*. Zomba, Malawi: National Statistics Office.

- Nejad-Modarres, A. (2005). Couples' attitudes to the husband's presence in the delivery room during childbirth. [Journal]. *Eastern Mediterranean Health Journal*, 11(4).
- Ntabona, A. B. (2002). *Involving men in Safe motherhood: The issues*. . Paper presented at the Programming for male involvement: Report of the meeting of WHO Regional Advisers in Reproductive Health. Retrieved from http://whqlibdoc.who.int/hq/2002/WHO_FCH_RHR_02.3.pdf
- Nwokocha, E. E. (2006). Pregnancy outcomes among the Ibani of rivers State of Nigeria. *Bioline International*, 21(1), 93-118. Retrieved from <http://www.bioline.org.br/request?ep06006>
- Nyasa Times. (2009, June 19, 2009). In defence of the voiceless traditional birth attendants (TBA). *Nyasa Times*. Retrieved from <http://www.nysatimes.com/education/in-defence-of-thevoiceless-traditional-birth-att...>
- Oladeji, D. (2008). Socio-cultural and norms factors influencing family planning choices among couples in Ibadan, Nigeria. [Electronic Article]. *European Journal of Science*, 23(2), 212-218.
- Oladeji, D., & Adegoke, T. G. (2008). Personal, situational and socio-cultural factors as correlates of intimate partners abuse in Nigeria. [Electronic Article]. *Journal of Social Science* 16(1), 57-62.
- Olds, D., Kitzman, H., Cole, R., & Robnson, J. (1997). Theoretical foundations of a program of home visitation for pregnant women and parents of young children. *Journal of community psychology*, 25(1), 9-27.
- Oparkhurst, J., & Rahman, S. A. (2007). Non-professional health practitioners and referrals to facilities: lessons from maternal care in Bangladesh. *Oxford Journals*, 22(3), 149-155.
- Osakue, G., & Van Beelen, N. (2006). Violence against women and girls: breaking the culture of silence. *Exchange on HIV/AIDS, sexuality and gender*. Retrieved February 6, 2007, from www.kit.nl/smartsite.shtml?ch=FAB&id=10669
- Otto, H. A. (1962). What is a strong family? *Journal of Marriage and Family*, 24(1), 78-80.
- Pan American Health Organization. (n.d.). Involving men in sexual and reproductive health. *Fact sheet, women, health & development program*. Retrieved from <http://www.paho.org/genderandhealth>
- Pantelides, E. (2002). *Male involvement in prevention of pregnancy and HIV infection*. . Paper presented at the programming for male involvement in reproductive health: Report of the meeting of

- WHO Regional Advisers in Reproductive Health. Retrieved from http://whqlibdoc.who.int/hq/2002/WHO_FCH_RHR_02.3.pdf
- Pascali-Bonaro, D., & Kroeger, M. (2004). Continuous female companionship during childbirth: a crucial resource in times of stress or calm. *Journal of Midwifery and Women's Health*, 49(4), 19-27.
- Patton, M. Q. (1990). *Qualitative Evaluation and research methods* (Second edition ed.): Sage publication.
- Paulson, S., & Bailey, P. (2002). Culturally constructed relationships shape sexual and reproductive health. [Journal]. *Culture, Health and Sexuality*, 5(6), 493-498.
- Petersen, A., & Lupton, D. (1996). *The New Public Health: Health and self in the age of risk*. Sydney: Allen & Unwin
- Piet-Pelon, N. J., & Ubaidur, R. (1998). Male involvement in the Bangladesh family planning and reproductive health program. *International quarterly of community health education*, 17(2), 195-206.
- Piotrow, P. T., & Rimon, J. G. (1996). *In their own words: a qualitative study*. Amman: Johns Hopkins Center for Communication Programs, Baltimore, Maryland.
- Poedjastoeti, S., & Phoya, A. (2004). Adult and maternal mortality *Malawi Demographic and Health Survey 2004* (pp. 265-270). Zomba: National Statistical Office.
- Pollack, S. (2000). Reconceptualizing women's agency and empowerment: Challenges to self esteem discourse and women's lawbreaking *Women and criminal justice*, 12(1). Retrieved from www.haworthpress.com/store/E-Text/View_EText.asp?a=3&fn=J012v12n01_05&i=1&s=J012&v=12
- Pope, C., Ziebland, S., & Mays, N. (2000). Analysing qualitative data. *British Medical Journal*, 320(7227), 114-116.
- Population Council. (n.d.). Gender and family dynamics: Gender based violence. Retrieved from <http://www.pocouncil.org/genfam/violence.html>
- Potts, M. (2002). Family planning programmes: Development and outcomes. *International Encyclopedia of the Social and Behavioral Sciences*, 5332-5336.

- Rani, M., Figueroa, M. E., & Ainsle, R. (2003). The psychosocial context of young adults sexual behaviour in Nicaragua: Looking through the gender lens. *International Family Planning Perspectives*, 29(4). Retrieved from <http://www.guttmacher.org/pubs/journals/2917403.html>
- Reeve, H. (1998). health and wellbeing: Raising gender awareness among policy makers and practitioners. *a quarterly update from BRIDGE*, Retrieved February 6, 2007, from <http://www.bridge.ids.ac.uk/dgb7.html>
- Reproductive Health Outlook. (2006). Men and reproductive health: Overview. Retrieved from http://www.rho.org/html/menrh_overview.htm
- Richard, F., Witter, S., & De Brouwere, V. (2008). *Reducing financial barriers to obstetric care in low-income countries: The need for action*. Antwerp: Institute of tropical medicine.
- Ringheim, K. (2002). When the client is male: Client-provider interaction from a gender perspective *International Family Planning Perspectives*, 28(3). Retrieved from <http://www.guttmacher.org/pubs/journals/2817002.html>
- Rosen, P. (2004). Supporting women in labor: Analysis of different types of caregivers. *Journal of Midwifery and Women's Health*, 49(1), 24-31.
- Sandberg, J. (2006, March-April 2006). *The effects of individual level autonomy and community context on the desire for additional children and contraceptive use in the 1998/1999 India DHS*. Paper presented at the Population Association of America 2006 Annual Meeting Program, Los Angeles, California. Retrieved June 25, 2007 from <http://paa2006.princeton.edu/sessionviewer.aspx?sessionId=1401>.
- Schwandt, T. A. (1996). Three epistemological stances for qualitative inquiry: Interpretism, Hermeneutics, Social constructionism. 189-212. Retrieved from www.uky.edu/~addesa01/document/schwandt.pdf
- Schwandt, T. A. (2007). Expanding the conversation on evaluation ethics. *Eval Program Plann*, 30(4), 400-403.
- Sciortino, R. (1998). The challenge of addressing gender in reproductive health programmes: Examples from Indonesia. *Reproductive Health Matters*, 6(11)(11), 33-43. Retrieved from

<http://www.hshp.harvard.edu/grhf-asia/suchana/0310/sciortino.html>

- Seale, C., & Silverman, D. (1997). Ensuring rigour in qualitative research. *European Journal of Public Health*, (7), 379-384
- Semper, J. (n.d.). The value of including husband/partner pregnancy and labour massage therapist. *Well mother*. Retrieved from <http://www.btinternet.com/~wellmother/projects/junesemper.htm>
- Sharma, A. (2003). Male involvement in reproductive health: Women's perspective. *Journal of Family Welfare*, 49(1)(1), 1-9
- Sheans, J. (2007). Debating women's human's as a universal feminist project: Defending women's human rights as a political tool. *Cambridge Journals: Review of International journals*, 33(1), 11-27.
- Shears, K. H. (2004). To integrate or not to integrate. *Network: Integrating Services*, 23(3), 6. Retrieved from <http://www.fhi.org/NR/rdonlyres/e2byv25obqy52ayuijohph2f22usesdcc2pk6sgy2vy4a5srbfp7drekitvn2wmvif5bugjuiguwl6k/networkrk233enrh.pdf>
- Shefner-Rogers, C. L., & Sood, S. (2004). Involving husbands in safe motherhood: Effects of the SUAMI SIAGA campaign in Indonesia. *Journal of Health Communication*, 9, 233-258.
- Sherratt, D. R. (1999). Why women need midwives for safe motherhood. In M. Berer & T. K. S. Ravindran (Eds.), *Safe motherhood initiatives: Critical issues* (pp. 227-244). London: Blackwell Science Limited.
- Silverman, D. (2001). *interpreting qualitative data: Methods for analysing talk, text and interaction* (Second edition ed.). London: Sage.
- Silverman, M., Ricci, E. M., & Gunter, M. J. (1990). Strategies for increasing the rigor of qualitative methods in evaluation of health care programs. *Journal of Evaluation Review*, 14(1), 57-74.
- Simkin, P., & Bolding, A. (2004). Update on nonpharmacologic approaches to relieve labour pain and prevent suffering. *Journal of Midwifery and Women's Health*, 49(6), 489-504.
- Singh, S., Darroch, J. E., Vlassoff, M., & Nadeau. (2003). Adding it up: The benefits of investing in sexual and reproductive health care. Retrieved April 19, 2007, from <http://www.guttmacher.org/pubs/addingitup.pdf>

- Sjoblom, I., Nordstrom, B., & Edberg, A. K. (2006). A qualitative study of women's experiences of home birth in Sweden. *Midwifery*, 22(4), 348-355.
- Snow, D. A. (2001). Interactionism: Symbolic. *International Encyclopedia of the Social and Behavioral Sciences*, 7695-7698.
- Solar, O., & Irwin, A. (2007). *A Conceptual Framework for Action on the social determinants of health*. Geneva: World Health Organisation.
- Sonfield, A. (2004). Meeting the sexual and reproductive health needs of men worldwide. *The Guttmacher report on public policy*, 7(1). Retrieved from <http://www.guttmacher.org/pubs/tgr/07/1/gr070109.html>
- Ssali, A., Butler, L. M., Kabatesi, D., King, R., Namugenyi, A., Kanya, M. R., et al. (2005). Traditional healers for HIV/AIDS prevention and family planning, Kibonga district, Uganda: Evaluation of a program to improve practices. *Aids and Behaviour*, 9(4), 485-493. doi:10.1007/s10461-005-9019-9
- Sternberg, P. (2000). Challenging machismo: Promoting sexual and reproductive health with Nicaraguan men. *Gender and Development* 8(1), 89-99. Retrieved from <http://dx.doi.org/10.1080/741923418>
- Sternberg, P. (2007). Challenging machismo: Promoting sexual and reproductive health with Nicaraguan men. *Gender and Development*, 8(1), 89-99.
- Strauss, A. L., & Cobin, J. (1990). *Basics of qualitative research: Grounded theory, procedures and techniques*. Newsbury: Sage.
- Stromquist, N. P. (1993). *The theoretical and practical bases for empowerment*. . Paper presented at the Women's Education and Empowerment: Report on the international seminar. Retrieved from http://eric.ed.gov/ERICDocs/data/ericdocs2sql/content_storage_01/0000019b/80/15/8d/48.pdf
- Sutton, S. (2001). Health behaviour: Psychosocial theories. *International Encyclopedia of the Social and Behavioral Sciences*, 6499-6506.
- The Johns Hopkins School of Public Health. (1999). Population reports: Women's response to abuse. *Chapter 2.3: Population reports series, L, XXV11*,(4). Retrieved from http://info.k4health.org/pr/111/111chap2_3.shtml
- The Manager's Electronic Resource Centre. (2001). Managing reproductive health services with a gender perspective. *The*

- Manager's Electronic Resource Center*. Retrieved February 2, 2007, from http://erc.msh.org/staticpages_printerfriendly/2.2.8_chs_English.htm
- The Millennium Development Goals. (2005). The Situation in the Region: Overlapping Inequalities. *A Latin America and Caribbean perspective: Chapter IV, gender equality and women's empowerment* Retrieved February 16, 2007, from www.bvsde.paho.org/bvsacd/CD29/perspective/040665-04.pdf
- Thomas, D. Q. (2000). We are not the world: US activism and human rights in the twenty-first century. *Signs. Journal of women in culture and society*, 25(4), 1121-1124.
- Thompson, A. (1999). Poor and pregnant in Africa: Safe motherhood and human rights. *Midwifery*, 15, 146-153.
- Toro, H., Jato, M., & Baro, S. (1998a, 9-3 November). *Research findings for male involvement in Africa and Asia: In Male involvement and reproductive health programmes and services*. Paper presented at the Thematic Workshop on Male Involvement in Sexual and Reproductive Health Programmes and Services, Rome, Italy.
- Toro, H., Jato, M., & Baro, S. (1998b). *Research findings for male involvement in Africa and Asia: In male involvement and reproductive health programmes and services*. Paper presented at the Thematic Workshop on male involvement in sexual and reproductive health programmes and services.
- Toroitich-Ruto, C. (1999). *The relationship between reproductive health and family nutrition in Africa*. Paper presented at the Regional workshop on Wmen's reproductive health and household food security in rural Africa organised by East, Central Africa Food Security and Sustainable Divison.
- Toure, L. (1996). Male involvement in family planning: A review of the literature and selected programme initiatives in Africa. Retrieved from http://sara.aed.org/publications/reproductive_health/family_planning/html/male.htm
- UNICEF. (2008). *Report card on maternal mortality* New York: UNICEF.
- United Nations. (2005). Population, reproductive health and the millennium development goals. *Message from the UN Millennium projects report* Retrieved June 6, 2007, from www.unmillenniumproject.org:+Involving+men+in+reproductive+health:+contributions+to+development&hl

- United Nations. (2009). *The Millennium Development Goals report*. New York.
- United Nations AIDS. (2008). *Report on Global AIDS epidemic*. New York: United Nations.
- United Nations Economic and Social Council. (2000). The right to the highest attainable standard of health. *Economic and Social Council*. Retrieved from <http://www.unhchr.ch/tbs/doc.nsf/0/40d009901358b0e2c1256915005090be?opendoc>
- United Nations Economic and Social Council. (2002). *Sexual and reproductive health of young people in the Asia-Pacific Region* (No. E/ESCAP/PRUD/SAPPC/8). Bangkok, Thailand.
- United Nations Population Fund. (1994). *Programme of Action of the International Conference on Population and Development* New York: United Nations Population Fund.
- United Nations Population Fund. (1997). *UNFPA Evaluation report: Support to Traditional Birth Attendants* (No. Evaluation report number 12). New York: United Nations Population Fund.
- United Nations Population Fund. (1999). Reproductive health and rights. United Nations Population Fund state of the world. Retrieved from <http://www.unfpa.org/swp/1999/contents.htm>
- United Nations Population Fund. (2000). UNFPA state of world population: Men, reproductive rights and gender equality. Retrieved from <http://www.unfpa.org/swp/2000/english/>
- United Nations Population Fund. (2001). *Integrating socio-cultural research into population and reproductive health programmes*. Kathmandu.
- United Nations Population Fund. (2002). UNFPA state of world population: Population, development and the Millennium Development Goals. Retrieved April 18, 2007, from <http://www.unfpa.org/swp/2002/english/ch1/index.htm>
- United Nations Population Fund. (2005). UNFPA State of World Population: The promise of equality: Gender equity, Reproductive Health and the Millennium Development Goals. *State of World Population*, 2-128. Retrieved from http://www.unfpa.org/swp/2005/pdf/en_swp05.pdf
- United Nations Population Fund. (2009). *Healthy expectations*. New York.

- University of Essex. (2008). *Reducing maternal mortality: The contribution of the right to the highest attainable standard of health*. Brighton: Human rights centre, University of Essex, UK.
- Vlassoff, M., Singh, S., Darroch, J. E., Carbone, E., & Bernestein, S. (2004). Assessing costs and benefits of sexual and reproductive health interventions. *Occasional report No. 11*, 10-19. Retrieved from <http://www.synergyaids.com/documents/costbenefitsSRH.pdf>
- Walston, N. (2005). Challenges and opportunities for Male Involvement in Reproductive health in Cambodia. Retrieved January 22, 2007, from www.policyproject.com/pubs/countryreports/MaleInvolv_cam.pdf
- Wang, Y. F. (2000). Male reproductive health research needs and research agenda: Asian and Pacific perspective. *International Journal of Andrology*, 23(2), 4-7.
- Wardlaw, T., & Maine, D. (1999). process indicators for maternal mortality. In M. Berer & T. K. S. Ravindran (Eds.), *Safe motherhood initiatives: Critical issues* (pp. 24-30). London: Blackwell Science Limited.
- Webster, J., Stratigos, S. M., & Grimes, K. M. (2001). Women's responses to screening for domestic violence in a health-care setting. *Midwifery*, 17, 289-294.
- Wegner, M. N., Landry, E., Wilkinson, D., & Tzanis, J. (1998). Men as partners in reproductive health: From issues to action. *International Family Planning Perspectives*, 24(1). Retrieved from <http://www.guttmacher.org/pubs/journals/2403898.html>
- Women's Commission for Refugee, Women and Children. (2005). Masculinities: Male involvement in the promotion of gender equality A resource packet Retrieved January 28, 2007, from http://www.womenscommission.org/pdf/masc_res.pdf
- Women's Commission for Refugee Women and Children. (2005). Masculinities: Male roles and male involvement in the promotion of gender equality, a resource packet. Retrieved from http://www.womenscommission.org/pdf/masc_res.pdf
- Women Deliver. (2009). *FOCUS: women's health and the millennium goals*. New York: Women Deliver.
- Wood, W., & Eagly, A. H. (2002). A cross-cultural analysis of the behaviour of women and men: Implications for the origins of sex

- differences. *Psychological bulletin*, 699-727. doi:10.1037/0033-2909.128.5.699
- World Bank. (1994). *Enhancing women's participation in economic development: a World Bank policy paper*. Washington D.C: WB.
- World Bank. (1999). *Safe motherhood and The World Bank: Lessons from ten years of experience*. Washington D.C: World Bank.
- World Bank. (2004). Integrating Gender issues into HIV/AIDS programmes: An operational guide Retrieved May 15, 2007, from <http://worldbank.org/INTGENDER/Resources/GenderHIVAIDSGuideNov04.pdf> -
- World Bank. (2006). Maternal mortality. *Public Health at a Glance*. Retrieved from <http://web.worldbank.org/WBSITE/EXTERNAL/TOPICS/EXTHEALTHNUTRITION...>
- World Health Organisation. (2002). *Programming for male involvement in reproductive health: Report of the meeting of WHO Regional Advisers in Reproductive Health WHO/PAHO, Washington DC, USA, 5-7 September 2001* (No. WHO/FCH/RHR/02.3). Geneva: World Health Organisation. Retrieved March 9, 2007 from: http://whqlibdoc.who.int/hq/2002/WHO_FCH_RHR_02.3.pdf.
- World Health Organisation. (2003). *'En-gendering' the Millennium Development Goals (MDG on Health)*. Geneva: WHO.
- World Health Organisation. (2005). Realizing the potential of antenatal care. *World health report*. Retrieved from <http://www.who.int/whr/2005/chapter3/en/index2.html>
- World Health Organisation. (2006). *Making a difference in countries: Strategic Approach to improving maternal and newborn survival and health. Ensuring skilled care for everybirth*. Geneva.
- Yerudian, P. P. (2004). Impact of women's empowerment, autonomy and attitude on maternal health care utilization in India. *Global forum for research*
Retrieved February 21, 2007, from <http://www.globalforumhealth.org/Forum8/Forum8-CDROM/OralPresentations/Yesudian%20P%20F8-327.doc>
- Zanera, D. (2004). *Introduction. In Malawi Demographic Health Survey 2004*. Zomba, Malawi: National Statistics Office.
- Zanera, D., & Miteka, I. (2004). *HIV/AIDS and other sexually transmitted infections. In Malawi Demographic Health Survey 2004*. Zomba, Malawi: National Statistics Office.

Appendix A:

FOCUS GROUP INTERVIEW GUIDE – WOMEN

Form 1

Moderator introduces the research team and the reasons for focus group discussion

Date.....

Village.....TA.....District.....

Name of moderator.....

Language of discussion.....

Start time.....end time.....

1. Can you tell me what you understand by reproductive health?
2. What do you see as the main reproductive health problems affecting women?
3. I'd like you to discuss your thoughts about involving men in reproductive health specifically during pregnancy, childbirth and postnatal care?

Prompts

- What are your role/ the role of men now during pregnancy, childbirth, postnatal care (ask for examples)
- What do you see your role/the role of men to be in future during pregnancy, childbirth, and postnatal care (ask for examples)

4. What do you consider, if any, are barriers to you/men being involved in pregnancy, childbirth and postnatal care (if not discussed previously)

Prompts

- Socio cultural (ask for examples)
- Financial (ask for examples)

- Systemic - e.g. no male friendly health services; attitudes/beliefs of health care professionals (ask for examples)
 - Physical factors
5. What do you consider, if any are motivating factors to you being involved in pregnancy, childbirth and postnatal(if not discussed previously)
 6. What information is required for pregnant women to stay healthy?
 7. What support do you think women need from others/services during pregnancy, childbirth and postnatals

Prompts

- Household chores, (ask for examples)
- Care of the baby (ask for examples)

At the end of the discussions ask for comments on the subject discussed

5/05/07

Appendix B

FOCUS GROUP INTERVIEW GUIDE FOR MEN

Form 2

Moderator introduces the research team and the reasons for focus group discussion

Date.....

Village.....TA.....District.....

Name of moderator.....

Language of discussion.....

Start time.....end time.....

1. Can you tell me what you understand by reproductive health?
2. What do you see as the main reproductive health problems affecting women?
3. I'd like you to discuss your thoughts about being involved in reproductive health specifically during pregnancy, childbirth and postnatal care?

Prompts

- What are your role/ the role of men now during pregnancy, childbirth, postnatal care (ask for examples)
- What do you see your role/the role of men to be in future during pregnancy, childbirth, and postnatal care (ask for examples)

4. What do you consider, if any, are barriers to you/men being involved in pregnancy, childbirth and postnatal care (if not discussed previously)

Prompts

- Socio cultural (ask for examples)
- Financial (ask for examples)

- Systemic - e.g. no male friendly health services; attitudes/beliefs of health care professionals (ask for examples)
- Physical factors

5. What do you consider, if any are motivating factors to you being involved in pregnancy, childbirth and postnatal (if not discussed previously)

6. What information is required for pregnant women to stay healthy?

7. What support do you think women need from others/services during pregnancy, childbirth and postnatals.

Prompts

Household chores, (ask for examples)

Care of the baby (ask for examples)

At the end of the discussions ask for comments on the subject discussed

5/05/07

Appendix C:

IN-DEPTH INTERVIEWS

FORM 3

Key questions for in-depth interview

The PhD student introduces herself and explains the reasons for the interview

Date.....

Village.....TA.....District.....

Dept/ Organisation.....

Name of the person interviewed.....

Place of the interview.....

Date.....

Start time.....end time.....

1. What do you understand by the term „male involvement?
2. What are do you think are advantages and disadvantages of male involvement?
3. I'd like you to think about issues surrounding involving men in reproductive health specifically during pregnancy, childbirth, postnatal care. What do you think are potentially, barriers to male involvement in this area?

Prompts

- Barriers to male involvement
- Cultural (+ ask for specific examples)
- Financial (ask for examples)
- Policy (ask for examples)

4. We've just talked about barriers to involving males in pregnancy, childbirth and postnatal care. I'd now like you to think about and describe to me ways that you think these barriers could potentially be overcome.

Prompts:

- Education (ask for specific examples)
- Access to health services
- Community support for involvement

Ask for any comments on the subject discussed

Appendix D: CONSENT FORM



Consent form

SOCIO-CULTURAL FACTORS INFLUENCING MALE INVOLVEMENT IN REPRODUCTIVE HEALTH: DURING PREGNANCY, CHILDBIRTH AND POSTNATAL PERIOD IN RURAL DISTRICTS OF MALAWI

The aim of this study is to understand how best to involve men in reproductive health and explore barriers to this involvement – specifically during pregnancy, childbirth and postnatal periods. This is a new area of research in Malawi.

I.....have read the information provided to me and any questions I have about the research have been answered to my satisfaction. I understand that I will be participating in a one-off focus group which will be audio taped and the results of the research may be published. Data, information and audio tapes will be stored in a locked cabinet during the study and for a period of 5 years after the completion of the study, after which they will be destroyed.

I agree to participate in this research on the understanding that all records will remain confidential and I will not be identified. My participation is also subject to my being able to withdraw from the research at any time without consequences.

Participant's signature/ thumbprint

Date

Researcher's signature

Date

Researcher's Name _____

Appendix E:

PARTICIPANTS INFORMATION



Participants Information

Research Title: Socio-cultural factors influencing male involvement in reproductive health, during pregnancy, childbirth and postnatal period in rural districts of Malawi

The aim of this study is to understand how best to involve men in reproductive health and explore barriers to this involvement – specifically during pregnancy and postnatal periods and during childbirth. This is a new area of research in Malawi.

I would like to ask your input and participation in this research. Your participation is entirely voluntary and you may withdraw from the research at anytime without any explanation.

If you agree to participate, you will be involved in an interview which will be audio taped with your consent. It is expected that the interview will take 45 minutes to 90 minutes. Information collected for this research will be held in confidence.

Participants will not be identified by their names in the report. Results of the research will be written up in the form of a thesis. The results may also be presented in conferences or workshops and they may also be published.

Data collected as part of this research project will only be available to the researchers and the research supervisors. After completion of the project records will be stored in a locked filing cabinet in the Centre for Public Health at Edith Cowan University, Joondalup Western Australia for a period of five years. After this time, the records will be destroyed.

Should you agree to be involved in this research project, I ask that you sign or thumb print the consent form which is attached for your information. If you require any further information about the research, please do not hesitate to contact the researcher or her supervisor whose details appear below:

Jane Namasasu

PhD Student

Edith Cowan University

E-mail: jnamasas@student.ecu.edu.au

Dr Colleen Fisher

Senior Lecturer

Edith Cowan University

E-mail: c.fisher@ecu.edu.au

Or

Jane Namasasu

Ministry of Health