

## ORIGINAL RESEARCH ARTICLE

# Male Involvement in Maternity Health Care in Malawi

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## Abstract

This study was conducted in Mwanza district in southern Malawi with the aim of investigating the individual's, community's and health workers' perception of male involvement in maternal health care. In-depth interviews and focus group discussions were the methods used for data collection. The participants' responses generated two main themes namely male involvement in health facility care and outside the health facility. The participants' perception of male involvement in facility care concentrated around six sub-themes describing male involvement as; couple HIV counselling and testing; a government law; a strategy for fast services for women; unfair programme for women without partners; a foreign concept; an act of love. We conclude that male involvement in the health facility care was fragmented and associated mainly with first antenatal care; couple HIV counselling and testing; suggesting poor integration of male involvement into the existing maternal and child health programmes and that there is need to engender maternal health care services (*Afr J Reprod Health* 2012; 16[1]:145-157).

## Résumé

**La Participation des hommes au soin de santé maternelle au Malawi :** L'étude exploratoire a été menée dans le district de Mwanza au Malawi en vue d'examiner la perception de l'individu, la communauté et du personnel de sante du rôle des hommes a l'égard du soin de sante maternelle. Pour collecter les données, nous nous sommes servis des interviews a profondeur, des discussions a groupe cible et de l'observation non participante. L'étude a révélé que l'on perçoit le rôle des males dans deux dimensions. D'abord, comme la participation des hommes dans le cadre du soin des établissements de santé et deuxièmement la participation de hommes en dehors du cadre des établissements de santé. Nous avons dégagé six sous-thèmes de l'étude : la participation comme les analyses et le conseil à l'égard du VIH chez des couples ; une loi gouvernementale ; une stratégie pour les services rapides pour femmes ; un programme injuste pour les femmes sans partenaires ; un concept étranger ; un acte d'amour. Nous concluons que la participation des hommes au soin des établissements de santé était fragmentée et liée principalement au premier soin prénatal ; le conseil et des analyses à l'égard du VIH chez des couples indiquent une mauvaise intégration de la participation des hommes dans les programmes actuels de la santé maternelle et infantile et qu'il y a la nécessité de créer des services de soins de santé maternelle (*Afr J Reprod Health* 2012; 16[1]:145-157).

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**Keywords:** Gender roles, maternal health care, social norms, perception

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## Introduction

Male involvement in maternal health care has been described as a process of social and behavioural change that is needed for men to play more responsible roles in maternal health care with the purpose of ensuring women's and children's well-

being<sup>1</sup>. The concept of male involvement in maternal health is now being advocated as an essential element of World Health Organization (WHO) initiative for making pregnancy safer<sup>2</sup>. The impetus for the initiative was as a result of the 1994 International Conference on Population and Development (ICPD) held in Cairo, Egypt,

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which urges that special efforts should be made to emphasize men's shared responsibility and promote their active involvement in responsible parenthood, sexual and reproductive behaviour including family planning; prenatal, maternal and child health; prevention of sexually transmitted diseases, including HIV; prevention of unwanted and high-risk pregnancies; shared control and contribution of family income, children's education, health and nutrition; recognition and promotion of the equal value of children of both sexes. Male responsibilities in family must be included in the education of children from the earliest ages. Special emphasis should be placed on the prevention of violence against women and children (ICPD, POA: paragraph 4.27) <sup>1</sup>.

Maternal health is viewed as a gender issue<sup>3</sup>, and gender may influence the way men may get involved in maternal health care. It has been postulated that men and women have distinct roles that are important for survival of the family and society<sup>4(p.343)</sup>. The most basic division of labour is biological, men are physically strong, and women are the only ones able to bear and nurse children. Gendered belief systems foster assumptions about appropriate behaviour for men and women and may have an effect on the type of work women and men perform. Gender systems are social institutions that ascribe the social characteristics of men and women, which provide meaning and guidance with regard to their roles, rights and obligations over the life course <sup>3</sup>. Gender norms have been attributed to lack of male involvement in maternal health care<sup>5</sup>. For instance, men are not expected in some cultures to accompany their wives to the clinic. If they do, this is perceived by their peers as a demonstration of weakness. On the other hand, male involvement in maternal health care has been perceived as loss of women's right to make decisions regarding pregnancy issue<sup>6</sup>; therefore, men should not encroach in their territory.

As a contrary to this, there has indeed been a steady move to more male involvement in pregnancy and childbirth in countries in the west. Since the 1970s, men in the UK have been participating in maternity care.<sup>7</sup> In Sweden, the value of the father's involvement in pregnancy, parent education, childbirth and the care of the

newborn baby is emphasized in legislation<sup>8</sup>, and so is Norway<sup>9</sup>.

The traditional approaches to maternal health care taken by health systems in most developing countries portray the gendered belief system. The services are female oriented thereby discouraging male involvement<sup>5</sup>. However, it has been argued that individuals are not born with certain behaviour and personality characteristics, but learn role expectations (gender roles) imposed by a particular society through processes such as modelling, imitation and applications of rewards and punishments<sup>10</sup>. Therefore, people can learn and unlearn behaviour.

Male involvement in maternal health care is a relatively new approach in Malawi. Traditionally, maternal health care services have focused on women, with very little male involvement. Given that male involvement in maternal health care is a relatively new approach, and it touches on the sensitive nature of gender roles related to culture, social norms, values and beliefs; understanding people's perceptions about the programme is critical for its success. In addition, introduction of a new health or social and behavioural change activity, as is the case with male involvement in Malawi, is a fundamental step in designing appropriate interventions<sup>11</sup>. Understanding the differential meanings of male involvement to men, women and health care providers may lead to better predictions of future male participation. This study, therefore, aimed at exploring the perceptions of men, women, and health care providers towards male involvement in maternal health care in rural communities in Mwanza district, Malawi.

## Methods

### Setting

Data was collected from two health centres and their catchment areas in Mwanza District, southern Malawi, namely Kunenekude and Tulonkhodo health centres. According to 2008 Malawi Population and Housing Census, Mwanza District has a population of 92,947 consisting of 44,679 males and 48,268 females. Literacy rate in the district is 59%, while 65% and 53% are males and

females, respectively <sup>12</sup>. The total fertility rate in the district is 6.3 and antenatal attendance is estimated at 98%. Delivery in a health facility is at 74.5% and delivery by a health professional is at 74.8%. Postnatal check up by a skilled personnel is at 40.9% <sup>13</sup>.

Kunenekude Health Centre is 19 km north of the district hospital and it served an estimated population of 15,800, while Tulonkhondo Health Centre is 17 km south of the district hospital and served an estimated population of 14,500. The health centres provided basic emergency obstetric care (BEmOC). Each health centre had two deliveries and ten postnatal beds. Two midwives at each health centre provided maternal health care services. Male involvement programme was launched in Mwanza District in 2004. Men were encouraged to accompany their wives to antenatal clinics where services such as prevention of Mother-to Child Transmission (PMTCT) of HIV were offered.

Ngoni is the main ethnic group in terms of numbers and political influence. The Ngoni tribe is based on a matrilineal and matrilocal system although some married couples may have lived in either the husband's or wife's village. The majority of the people practised Christianity. Most people were peasant farmers who grew maize, beans, and pigeon peas for home consumption. However, the locals do grow citrus fruits such as tangerines, lemons and oranges for sale. Women's access to resources is mainly through men as fathers, husbands, brothers, uncles and sons.

## Participants

One hundred and eight participants were selected to represent a rural population and health care providers who worked in rural health facilities. Six key informants consisting of community leader such as village headman, traditional birth attendants, traditional counsellors, village health committee members and elderly women and men participated in the study. These key informants were chosen because of their socio-cultural influence in the communities and were interviewed individually. Ten groups of men and women were formed by purposive sampling

format to represent different segments of the population by gender, age, marital status, educational level and occupation. The following was the inclusion criteria: age of 18 years and above, currently married, divorced or in union and had given birth within the past 2 years. Two health care providers were also interviewed individually and were nurse/midwife technicians who had worked in the MCH department for not less than 6 months.

## Recruitment

Purposive sampling technique was employed to select the two health centres as focal points. This enabled the researchers' easy access to community members for interviews and FGDs. The selection was based on accessibility to the facilities and the advocacy for male involvement initiative that was being conducted in the communities around the two health facilities. Mwanza District has three health centres. However, only two were selected for the study. The third one, Thambani, was left out because of difficulties to access the facility due to poor roads and bridges.

Recruitment of participants was done through locally acceptable procedures. Firstly, permission was sought from Mwanza District Commission and the district's health office. The officer's in-charge of the health centres and group village headmen/women were consulted as entry points into the community. The approval and cooperation of the group village headmen/women allowed greater trust in the communities. Once this general approval was secured, village headmen/women and health surveillance assistants (HSAs) helped the principal investigator (PI) to identify and mobilize those who qualified to be participants. Once the potential participants were identified, interviews and FGDs were scheduled. One health care provider from each health centre was asked to be interviewed and both agreed to participate in the study.

## Ethical consideration

The study was approved by Malawi College of Medicine Research and Ethical Committee and the Regional Committee for Medical and Health Research Ethics in Norway. In addition, permission to collect data was obtained from

Mwanza District Commissioner and Mwanza District Health Officer. A written informed consent was obtained from individual participants.

### **Data collection**

The PI and a research assistant conducted the focus group discussions while individual interviews were conducted by the PI. The village headmen selected the location for the FGDs while individual participants selected location and time for individual interviews. Interviews and FGDs were scheduled a week before in consultations with the participants. This was done to allow people plan for their activities.

A semi-structured questionnaire was administered to all individuals that consented to participate in the study. The structured part collected participants' demographic data and the open-ended part captured qualitative data. The FGD and individual interview guide included open-ended questions about male involvement in maternal health care.

### **Interviews**

Eight in-depth interviews were conducted with individual key informants that included health care providers, community leaders and influential individuals. Two health care providers, one from each health centre were interviewed at the respective health facilities in a private office. Six key informants from the communities were interviewed either at a private room in the health facilities or a place convenient for the participants. The interviews were held in Chichewa and lasted 40 to 60 minutes. All interviews were audio-recorded. The research assistant took notes during each interview to supplement the transcripts. The participants were given a soft drink and a snack after the interviews as a gesture of appreciation.

### **Focus group discussions**

Ten FGDs were conducted, 4 groups with men and 6 groups with women. Each FGD had ten participants. The group size was purposively chosen as literature indicates that an adequate group size is between 4 and 12 participants, with

an optimal size being between five and ten individuals<sup>14-17</sup>. The purpose of the study was explained to participants before starting each FGD session in order to confirm their acceptance and gain their informed consent. The PI moderated the discussions while the research assistant took notes. All the discussions were audio-recorded. At the end of each FGD session, the research assistant read out a summary of the discussion to the participants. This was done in order to verify if what was recorded was a true representation of what the participants said. This also gave the participants an opportunity to clarify any areas that were not clear. Each session lasted one to one and half hours. The participants were given a soft drink and a snack after the discussions as a gesture of appreciation.

### **Data analysis**

Data analysis was undertaken simultaneously with data collection in order to identify and correct errors during next interviews and focus group discussions. The taped information was transcribed verbatim and translated from vernacular language into English. Observational field notes were incorporated into the data for analysis. Thematic content analysis guided data analysis<sup>18</sup>. The transcripts were read repeatedly and words with similar meanings were grouped into categories using Nvivo 9 software. Similar categories were grouped into themes and sub-themes which are presented as results. The results contain direct quotes from participants and the narrations are reported as were spoken by participants without editing the grammar to avoid losing meaning. Expressions in vernacular language are presented in parentheses and fictitious names are used in the quotes to maintain anonymity of the participants.

## **Results**

### **Participants' demographic characteristics**

A total of 60 women and 40 men participated in the focus group discussions distributed among the catchment areas of the two health centres, Kunenekude and Tulonkhondo. Participants

represented Ngoni, Chewa and Lomwe ethnic groups. The age range of the men was 22 to 55 years and 18 to 39 years for women. Education level ranged from none to form 4 for both sexes and most of them were peasant farmers except for three men whose occupations were carpentry, security guard and primary school teacher. The parity of the participants ranged from 1 to 5 births. The eight key informants' age ranged from 28 to 90 years and two of them were male. The educational level ranged from none to form 4. Two male health care workers participated in the study and were nurse-midwife technicians. Their experience in MCH ranged from 1 year 4 months to 2 years respectively.

The participants' responses generated two main themes namely male involvement in health facility care and male involvement outside the health facility. The participant's perceptions of male involvement in facility care concentrated around six subthemes; male involvement as couple HIV counselling and testing; male involvement as a government law; male involvement as a strategy for fast services for women; male involvement as unfair programme for women without partners; male involvement as a foreign concept; male involvement as an act of love.

### **Male involvement as couple HIV counselling and testing**

The data showed that men felt being pressurized to attend antenatal care with their wives purely for HIV counselling and testing and PMTCT counselling, interventions whose goal is to promote the health of the mother and child. The participants reasoned that couple HIV counselling and testing gave them the opportunity to know their status and to prepare for the future and how to take care of the coming baby if found positive. The participants further said that the couple counselling helped to strengthen the couples relationship and faithfulness to each other when found negative. The male expressed the feeling of being ignored by the health care providers because they were not allowed in the examination room even in facilities where privacy was guaranteed. As such, the men lingered outside the clinic waiting for their wives. The exclusion of men from

the examination room was seen as part of antenatal care tradition that it was a women's issue and nothing for the men. It also reinforced the views that antenatal care is for women and men are being invited only for the HIV test. The data also showed that some health care providers had a woman-centred approach to maternal health care such that they portrayed some resistance to involve men in antenatal activities that men could easily participate in. Such practice demonstrates that men are not taken as beneficiaries of the services but as a means to get women to maternal health care services:

*"When men come to the antenatal clinic they are involved in activities such as health talk, as we start the clinic with group health talk. Then as individual couples we counsel them on HIV and PMTCT. Then blood test is done followed by post counselling. After that the woman goes for physical examination."* (Health care worker).

### **Male involvement as a government law**

The collaboration between the District Health Management Team, the District Commission Office, the health care providers at the health centres and the community leaders to reinforce male involvement initiative was perceived by the community participants as a government law. The collaborating partners met and agreed on a strategy to motivate men to participate in safe motherhood. However, 'the grass root' community members were not consulted but were informed about the programme and had no power to question the authorities.

The data showed that the need for men to participate in maternal health care emerged from the health sector authorities and neither from the men nor women. This top to bottom approach was perceived as punitive in the sense that men were denied the freedom of whether to participate or not. In addition, the men were forced to comply with the directives from the authorities or else their spouses would be denied antenatal care services. The punitive measures were mainly practiced in the rural health centres. The village authorities stipulated hard rules that every couple had to follow in order to access antenatal care

services. If a woman's husband/partner was away, the woman had to get an approval letter from the village chief in order to access services at the clinic. This practice portrayed a culture of looking down upon women and rendering them helpless in such a way that they could not access services freely on their own, the services that are meant for them, unless a man is there. The practice also reflected the societal value placed on men. A woman being victimized because of the absence of a man:

*"..... The village head man announced about men going to the hospital with their pregnant wives during a village public meeting. The village headman said that the programme would assist in reducing maternal deaths in the village if men would participate in safe motherhood. According to our custom it is not polite to ask a village headman question at a public meeting. So we just kept quiet although we had so many questions in our minds. The other thing was that during the meeting we agreed that when a husband is going away and that he would not be present during the day that his wife was supposed to go for antenatal care, the husband was supposed to report to the village headman about his absence. So when the woman is going for antenatal care she has to get a stamped letter from the village headman to give to the doctors at the hospital saying that the husband is away." (FGD male participant).*

The top-down model of implementing the male involvement programme in maternal health focused on the desired outcomes and overlooked the local beliefs, values and practices associated with pregnancy and childbirth. The approach did not consider the needs of the local people in relation to the objectives of the programme. As such, the local people perceived the male involvement programme as a programme for the health authorities and not as their own. Lack of perceived need for the programme led some men to go away during the period their spouses were due to start antenatal care, rendering the women to take the long route of seeking approval from the village chief and spend more time at the clinic in

order to pave way for couples to be served first before being attended to.

### **Male involvement as unfair programme for women who do not have husbands**

The data revealed that women who went to the clinic without a husband/partner were attended to last. However, the practice of attending first to women who came with their husbands stigmatized those women who may not have come with their husbands or who may not have had husbands. The practice reinforced a cultural norm that 'men are more important than women' even at antenatal clinic. Being alone at the clinic could also have denoted being in unintimate relationship or pregnancy outside marriage:

*"When a woman goes to the antenatal clinic together with her husband she is allowed to go in first than the one who comes alone. Even if a woman comes at 12 noon with her husband and the other one came early in the morning but without a husband, she is told to wait for the woman who came with her husband to be helped first. Just because it is the law that the government put in place to promote male involvement in this program." (FGD male participant)*

### **Male involvement as a strategy for fast service for women**

The data also revealed that male participation in subsequent antenatal care is constructed as a means for getting fast service. This practice portrayed the picture that 'women have all the time' and for men, 'time is money'. It also demonstrated the respect men are accorded in a feminine environment such as the antenatal clinic:

*"Even though men are encouraged to attend only the first antenatal visit, they are free to attend the subsequent visits. These visits help to reinforce what they had learnt during the first visit. However, some men do accompany their wives for the subsequent visits just because they want to be attended to first." (Health care worker)*

*"When men accompany their wives for maternal health care services, the couple is served first and fast. So that they do not*

*spend along time at the clinic. I have heard men telling each other that if you want your wife to be attended to fast at the clinic, escort her.” (Health care worker)*

### **Male involvement as a foreign concept**

Some of the participants viewed male involvement as a foreign concept as they expressed lack of understanding between husbands/ male partners in maternity care services and the reduction in maternal mortality. The participants expressed the view that pregnancy and childbirth issues are women’s business, however, men do play a supportive role like getting women to the hospital and providing financial and material resources. This notion alludes to the fact that maternal health care services in Malawi have focus on women with little male involvement which is sought when there is a problem and need their decision, reaffirming the opinion that men are decision makers. Childbirth was described as women’s issue and that women would not want husband’s to know the process of childbirth. The women participants gave an impression that, culturally, childbirth is a source of power for women, a territory where they would not want men to invade for fear of losing that power. The power was portrayed in the form of decision making regarding labour and delivery and men are only informed about the decisions or outcomes of the decisions made.

*“... Remember that there are some things for women only. Our tradition is that men should not witness childbirth. Do not bring foreign ideas into our culture.” (Female key informant)*

### **Male involvement as an act of love**

An association between husbands accompanying their wives to the antenatal clinic/hospital and the quality of intimate relationship emerged from the data. A belief was portrayed that a ‘loving’ husband will accompany a wife to the antenatal clinic and escorts her to the hospital for delivery. Thus, accompanying a wife to the antenatal clinic has been constructed as a public statement of intimate relationship between husband and wife. On the contrary, the absence of the qualities

mentioned above denoted lack of love and male involvement:

*“Our group village headman is very much into it. He encourages the men to love their wives and escort them to the hospital.” (Female key informant)*

### **Male involvement outside the health facility**

Male involvement outside the health facility was perceived in the cultural constructed role assigned to men during pregnancy and childbirth. The roles that are assigned to men by the society during the perinatal period were based on the cultural construction of pregnancy, labour and delivery and postnatal period. A pregnant woman was referred to as ‘odwala’, ‘wapakati’ or ‘oyembekezera’, meaning ‘a sick woman’, ‘a woman in the middle of life and death’, and ‘an expectant woman’ respectively. Labour is defined as *matenda* meaning ‘disease’ and delivery is defined as *kuchila* meaning ‘recovery’. The postnatal period is convalescent period. As such a ‘sick person’ is supposed to be cared for. So during the antenatal period the husband assumed the feminine role of providing care, mainly in the absence of a female relation or helper. The husband’s role during the perinatal period was explained by gender-specific reasons – house hold chores were women’s job, men only assist when the woman is pregnant and cannot manage to perform. Men were identified with masculine role of providing - financial support, nutrition, psychological support and birth preparedness in terms of material support and transport arrangements:

*“It means that like in a marriage and when the woman is pregnant the man should be taking care of the woman. When a woman is pregnant she has a craving for different kinds of foods, so it is the responsibility of the man to be providing the woman with such kind of things.” (FGD male participant)*

*“When a woman is pregnant it is obvious that soon she will give birth and there will be a baby. So the man is supposed to buy cloths, a basin to be used at the hospital during delivery and a one metre plastic sheet which is used when the woman is*

*giving birth.” (Female key informant)*

The data revealed that men have the responsibility of making sure that their wives do delivery at a health facility. In the catchment areas of the health centres, a couple is fined for home delivery as well as for a delivery on the way to the hospital. In order to avoid such deliveries and the associated fines, women were advised to await labour at waiting shelters situated near the health centres. Thus husbands assumed the responsibility of escorting the wives to the waiting shelter.

*“During this time the husband’s role is to escort the woman to the waiting house at the hospital after she has been advised at the antenatal clinic that she is almost due. She is supposed to come and wait at the hospital’s waiting house.” (FGD male participant)*

## Discussion

This study has provided insights on how male involvement is perceived by the rural community and health care providers in Mwanza District, Malawi. The insights gained have helped to contextualize the situation of the study area by “unpacking” power relations and agendas which are often hidden in language, everyday life activities, labels and names, local customs<sup>19</sup>, in order to understand the social and cultural factors that shape the behaviour and practices of men in relation to male involvement. The contextualizing of male involvement is very crucial as it relates to social and behaviour change.

### Male involvement as couple HIV counselling and testing

Data from this study indicated that male involvement in maternal health care is perceived as couple HIV testing at antenatal care clinic. This perception is in line with the recent upsurge interest in involving men in HIV prevention, mainly PMTCT. Currently, PMTCT is receiving much attention both from local and international organizations<sup>20</sup>, and antenatal care services are widely recognized as one potential entry point for reaching out HIV prevention to the large population groups in low-resource settings where

HIV prevalence is high, but most women attend ANC<sup>21</sup>. However, research in this area has shown that pregnant women who accept HIV testing, a substantial number never return for results, interventions for PMTCT, or antiretroviral treatment<sup>22-24</sup>. Furthermore, most women refrain from testing and disclosure of their HIV-positive status to their partners. The reasons for refraining from testing and disclosure are cited as fear of partners’ reactions, like accusation of infidelity, divorce, and violence<sup>23,25-28</sup>. Therefore, both researchers and practitioners are advancing the notion of involving men in antenatal couple HIV counselling and testing as one of the avenues to improve access to HIV prevention interventions including PMTCT<sup>29-33</sup>.

Couple HIV counselling and testing has been demonstrated in previous studies as a key to success in antenatal HIV prevention interventions<sup>27,28,34</sup>. However, Farquhar et al<sup>27</sup> assert that integrating men into ANC and PMTCT programmes is a challenging endeavour. ANC has a long tradition of representing a female realm, and where couple routine counselling and testing (RCT) is offered in the frame of ANC, the participation rates of male partners often remain negligible. Chinkonde et al<sup>22</sup> also argue that the approach of linking PMTCT services to maternal and child health units, although logical, excluded women’s partners, who viewed antenatal care as well as PMTCT programmes as “women’s spaces”. Inviting men to participate in ANC and PMTCT programmes was seen to jeopardize their masculinity, and precluded them from accepting advice or information from their partners<sup>22</sup>. Similarly, in a Tanzanian study it was pointed out that poor utilization of STD and HIV tests by men were attributed to the fact that they were conducted in ANC clinics<sup>35</sup>, which is considered women’s place. However, it can be argued that poor utilization of ANC by men in rural health facilities is not necessarily caused by a bias on gender, but by environmental and structural factors and the space in which ANC services are conducted that do not provide a conducive environment for men to be involved.

It was observed during this study that men are left out in most of the antenatal care activities. Men who accompany their wives to antenatal



clinics are only offered an HIV test as part of the PMTCT interventions. On the other hand women would get a physical examination, including blood pressure and weight checks. This is done as routine antenatal care for the women while the men are waiting for the health care provider to be through with the women. This practice may discourage the men, especially those who may not want to have an HIV test and those who already know their HIV status. Similar findings were also reported by Finnbogadottir<sup>36</sup> in a study done in a multicultural industrial town in southern Sweden whereby men felt being marginalized and excluded in their contact with maternal and child health services. One of the reasons as to why fathers felt left out, despite the fact that they took part in parent groups, is that childbirth or parent education classes tend to focus exclusively on women and motherhood, and seldom address the fathers' concerns and their situation. Kaila-Behm<sup>37</sup> argues that parents' groups most often only focus on how the man can best support the woman. It is therefore proposed that the health care sector should develop SRH services that should be offered to men while they are attending the antenatal clinic with their partners. Such services would promote family health as well as increase demand and utilization of ANC by men, and thereby increasing male involvement.

### **Male involvement as a government law**

Literature has portrayed men as reluctant users of health care, and engaging men in health services has been highlighted as a problem for those working within the health field<sup>38</sup>, and getting men in maternal health care which is dominated by women could be even harder. In view of the foregoing, the health sector in the study area used traditional leaders to promote male involvement in maternal health care. The engagement of traditional leaders by health professionals is not uncommon in Malawi<sup>39</sup>. Traditional leaders are custodians of culture and command high respect within their communities. Therefore, traditional leaders are seen as important channels through which social and cultural changes can be realized. Involvement of chiefs and village headmen/women in public health interventions

demonstrates the importance of the issue and therefore motivates greater participation of other community members. Yamba et al<sup>40</sup> posit that community activities that have the full support of a traditional leader attract broader participation and are less challenging; and that traditional leaders are key in spearheading efforts to change some cultural practices that are of public health interest. The power position of traditional leaders in the initiation of male involvement programme in the study area, seem to have worked in promoting male involvement. For instance, the evaluation report of 'Male Champion Initiative' in Mwanza district indicated that the engagement of traditional authorities as role models had helped encourage male involvement in PMTCT<sup>20</sup>. Thus the engagement of traditional leaders in promotion of public health programmes is viewed by community members as government law, and no one is above the law.

### **Male involvement as a strategy for fast services for women**

When a couple is attended "to first" was reported as a strategy that promotes male participation in antenatal care. Similarly, Byamugisha et al<sup>31</sup> describe a similar practice, by antenatal staff in Uganda at Mbale Regional Referral Hospital, of attending to couples first before attending to the mothers who came alone, as one way of encouraging couple attendance. This practice shows that traditional women-centred services in the first place are not organized in a way that the waiting time issue is addressed. However, the time issue is only address when men are involved. This may reflect the notion that ANC clinic is a women's space such that the health care workers would want to attend to the man as fast as possible and free him from the feminine environment. In addition, the concept of men accompanying wives to the ANC clinic is not yet an accepted gender role norm in this community. Myburgh<sup>41</sup> posits that men view the clinic as women's space, as many clinics were run mainly by women and attended primarily by women and children. As such men may find visiting the clinic cumbersome and embarrassing, as it challenges traditional and hegemonic notions of masculinity.

The concept of male involvement in maternal health care could be based on the assumption that pregnancy and childbirth occurs within marriage realms or the woman has a male partner. However, there is a possibility that a woman can be pregnant before marriage, separation and divorce or death of a spouse. Some studies have found decreasing relevance of marriage for pregnancy in sub-Saharan Africa<sup>42,43</sup>. Therefore, giving preferential service to women who are accompanied by husbands could act as a discrimination against those women that come alone to the clinic.

### **Male involvement as a foreign concept**

Traditionally, pregnancy and childbirth are seen as women events and husbands do not take part. Older women in the community, like mothers, grandmothers and mothers-in-law were trusted and perceived knowledgeable about childbirth issues<sup>44</sup>. The introduction of western maternal health care in Malawi mirrored the traditional practices. Men were excluded from maternal health care services. Even the information, education and communication messages (IEC), which are part of the services in this setting, also targeted women. As such it could be implied that even the formal health care sector mirrored the societal views and expectations of women as the consumers of maternal health care services. In addition, the establishment of medical maternal health care services in Malawi may have been based on radical feminism ideology that proposes programmes that exclude men in order to achieve equality<sup>19</sup>.

The introduction of male involvement in Malawi has also been influenced by international conventions, policies and treaties that the government ratified to, such as 1994 ICPD Programme of Action; ICPD +10; Millennium Development Goals; African Union SRHR policy guidelines; the African Union Health Strategy; the Southern Africa Development Community Health Strategy; and the Maputo plan of Action<sup>45</sup>. Much as the rural community may not be aware of the above cited ratifications, their perception is influenced by the view that the practice is new in the area and being initiated by a non-governmental

organization like UNICEF, symbolizes the supposition that the initiative is a foreign concept.

### **Male involvement outside the health facility**

The husband's role during the perinatal period was explained by gender-specific reasons – house hold chores were women's job, men only assist when the woman is pregnant and cannot manage to perform. Men were identified with masculine role of providing - financial support. Similarly, in a study done in Guatemala it was found that the most universal form of male participation during pregnancy was financial support nutrition, psychological support and birth preparedness in terms of material support and transport arrangements<sup>46</sup>. The identification of men with masculine roles affirm the notion that Malawian men are socialized to be superior in terms of decision making and to be financial providers. As such it has proved to be difficult for them to participate in activities that are feminine including health issues concerning their wives. At the same time, although some have desired to support their partners, they have been curtailed by cultural definitions of maleness and roles of masculinity. As a result, they fear being ostracised and ridiculed by other men in the community whom they imagine will call their manhood into question<sup>47</sup>. Similarly, in a study done in western Kenya, Onyango et al<sup>5</sup> observe that gender norms were one of the factors that inhibit male involvement in maternal health care. For instance, men are not expected culturally to accompany their wives to the clinic. If they do, this was perceived by their peers as a demonstration of weakness. In addition, Olayemi et al<sup>48</sup> that argued that men can participate in helping pregnant women stay healthy by making sure that the women get proper antenatal care which may entail providing transportation or funds to pay for her visits, accompany the wife during antenatal visits where the man can learn about the symptoms of pregnancy complications and how to respond to an obstetric emergency. Similar views are also shared by Roth and Mbizvo<sup>49</sup>.

In this study male involvement was also described as act of love. Having a man at an antenatal clinic, a place that is viewed as women's

place, and assisting with household chores which are considered feminine, were seen as big sacrifice on the part of the man and only a loving man could do such a thing. Similar finding were also reported by Carter<sup>46</sup> and Byamugisha et al<sup>31</sup> in studies done in Guatemala and Uganda respectively.

### Limitations

In this study, focus group discussions, in-depth interviews and participant observation were used as data collection methods. One of the limitations to the study is reporting bias arising from participants wanting to provide socially desirable responses rather than a true reflection of the real life situation. Participants especially in focus group discussions may have been uncomfortable to share all information for fear of peer pressure resulting in incomplete and socially biased information. The researchers attempted to address these constraints by using two different data collection methods. This approach enabled the researchers to have a deeper understanding of male involvement in the study area, by bringing together what people said and what they actually do. The study population was largely rural, therefore limiting the application of results to the peri-urban areas of Mwanza district. However, the issues raised could be similar to other settings in the country.

### Conclusion

In this study male involvement was perceived by men, women and health care providers as having two dimensions, male involvement in a health facility and outside health facility. Male participation in the health facility was fragmented and associated mainly with first antenatal care and couple HIV counselling and testing, suggesting poor integration of male involvement into existing MCH programmes. The need for male participation in antenatal care was perceived by the health sector and not a felt need by the community and noncompliance was associated with punishment. This lack of consultation with the community has a bearing on the sustainability of the programme.

Merely accompanying a wife to the first antenatal visit and having an HIV test is not sufficient to change the social and behaviour of men towards maternal health care. This requires information targeted at men, women and health care providers to stimulate debate on cultural issues related to male involvement. In addition, there is need to engender maternal health care services.

### Competing interests

The authors declare that they have no competing interests.

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### Authors' contributions

LIK conceptualized the study, collected the data, led the analysis, and wrote the text of the paper. JS, EC and AM advised on the conceptualization of the study, analysis of the data, and presentation of the results, review and edited the text. All authors read and approved the final manuscript.

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