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Full Length Research Paper

Barriers to husbands' involvement in maternal health care in a rural setting in Malawi: a qualitative study

Lucy I. Kululanga[1,2*], Johanne Sundby[1], Ellen Chirwa[3], Address Malata [3] and Alfred Maluwa[4]

[1]Department of International Health, Section for Health and Society, Faculty of Medicine, University of Oslo, P.O. Box 1130, Blindern, Oslo 0318, Norway.
[2] Department of Community and Mental Health, Kamuzu College of Nursing, University of Malawi, P.O. Box 415 Blantyre, Malawi.
[3] Department of Maternal and Child Health, Kamuzu College of Nursing, University of Malawi, Private Bag 1 Lilongwe, Malawi.
[4]Research Centre, Kamuzu College of Nursing, University of Malawi, Private Bag 1 Lilongwe, Malawi.

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Factors that hinder husbands from participating in maternal health care are well documented. Nevertheless, very little research has been conducted in Malawi to understand the core causes of such barriers. Therefore, this study was conducted in Mwanza District in southern Malawi to examine the core causes of barriers to husbands' involvement in maternal health care in rural Malawian settings. Data was collected through in-depth interviews and focus group discussions. The study revealed two main causes of barriers to husband involvement in maternal health care; gender role norms and health system issues. The prevailing gender role norms influence husband participation in maternal health care, and are also reflected in maternal health care delivery system in the rural health facilities in Malawi, whereby, the services are female focused. Therefore, husbands find it difficult to get involved in their spouses' maternal health care. However, husbands' involvement in maternal health care is possible if the causes of barriers were surmounted. Therefore, it is recommended that maternal health care services need to be de-feminized in order to create the foundations for a more equal access by both women and men.

Keywords: Barriers, gender role norms, male involvement, maternal health care, Malawi.

INTRODUCTION

The concept of husband involvement in maternal health care is not generally accepted in most developing countries including Malawi as it is evident in literature. The benefits of positive husband's involvement in maternal health care are, however, well articulated (Kunene et al., 2004; Mullany et al., 2009; Varkey et al., 2004). (USAID, 2009) defined positive male (husband) involvement in maternal health as the mental and physical participation of males (husbands) in maternal and prenatal health and family planning in such a way as to increase maternal and infant survival rates and improve family planning outcomes. However, in developing countries such as Malawi, husband involvement in maternal health care is very low (Aarnio et al., 2009; Farquhar et al., 2004; Semrau et al., 2005). In addition, maternal, neonatal and child health indicators in Malawi are very poor. According to the 2010 Malawi Demographic and Health Survey (MDHS) maternal mortality ratio is estimated at 675 per 100,000 live births, neonatal mortality rate is at 31 deaths per 1,000 live births, infant mortality rate is at 66 deaths per 1,000 live births and child mortality rate is at

List of abbreviations

ANC, Antenatal Care; BEmOC, Basic Emergency Obstetric Care; FGDs, Focus Group Discussions; HIV, Human Immunodeficiency Virus; HSAs, Health Surveillance Assistants; IEC , Information Education and Communication; MCH , Maternal and Child Health; MDHS , Malawi Demographic and Health Survey; NUFU , Nasjonalt Utvalg for Utviklingrelatert Forskining og Utdanning (Norwegian National Committee for Development-Related Research and Education), PI, Principal investigator; RH, Reproductive Health; SRH, Sexual and Reproductive Health; SRHR, Sexual and Reproductive Health and Rights; VSO, Voluntary Services Overseas

*Corresponding author E-mail: lucykululanga@yahoo.co.uk, Tel: +265888851381

50 deaths per 1,000 live births (National Statistical Office and ICF Macro, 2011).

It is only recently that the Malawi health sector started implementing the recommendations of the International Conference on Population and Development (ICPD) 1994 that stressed the need for male involvement in reproductive health (RH) in order to improve the health of women and children (Ministry of Health, 2009; United Nations, 1995). Furthermore, the HIV pandemic has also facilitated the need for men to participate in sexual and reproductive health (SRH) issues (Walston, 2005). In view of the importance of male involvement in SRH, Malawi Ministry of Health incorporated male involvement policy statements and strategies in its recent sexual and reproductive health and rights (SRHR) policy. The goal for male involvement in SRH is to promote male involvement in all SRHR issues and services and the strategy is to empower men to promote and patronize SRHR services (Ministry of Health, 2009). Despite the foregoing ICPD initiative, HIV pandemic and the SRHR policy, there has been a slow progress in getting men to participate in facility based SRH services especially maternal health care.

Literature has shown a variety of factors that hinder husbands from participating in maternal health care. These factors are at individual, family, community and health facility levels (Byamugisha et al., 2010; Carter, 2002; Mullany et al., 2005; Mullany, 2006; Roth and Mbizvo, 2001). However, negative or absent husband involvement has detrimental effects on maternal and child health (Barker and Das, 2004; Aarnio et al., 2009; Odimegwu and Okemgbo, 2008). This is because of the perceived men's influence on partners' and children's access to health services.

Generally, studies on barriers to male involvement in maternal health care conducted in developing countries have focused on factors that structurally hinder husband involvement at the expense of understanding the core causes of such barriers. In addition, very little research on the barriers to husband involvement in maternal health care has been conducted in Southern African developing countries. There is need to generate evidence for policy formulation as well as designing and implementing male involvement programmes that remove causes of barriers to husband involvement. This study investigated core causes of barriers to especially husbands' involvement in maternal health care in rural settings in Malawi. The aim of this study was to examine and describe the causes of barriers to husband's involvement in maternal health care in rural Malawian settings.

METHODS

Design

The design of the study was a descriptive non experimental approach that utilized qualitative methods. Data were collected using in-depth interviews with individual participants and focus group discussions (FGDs), which allowed in-depth exploration of the under-researched area of the perspectives of rural men (also as husbands), women and health care providers, on causes of barriers to husbands' involvement in maternal health care (Dahlgren et al., 2004). Focus group discussions were conducted to complement individual interviews and to examine from a group's perspective the phenomenon under study. Data were collected from August 2010 to January 2011.The study was part of a larger project that is focusing on male involvement in maternal health care in rural and urban settings in Malawi.

Setting

Data for this paper were collected from two health centres and their catchment areas in Mwanza District, southern Malawi, namely Kunenekude and Tulonkhodo health centres. 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. The setting was chosen because of the male involvement programme that was being implemented in the area. Male involvement programme was initiated in Mwanza District by the Ministry of Health with the support from UNICEF in 2004. UNICEF pioneered a project called 'Male Champion Initiative' and the aim of the project was to get men more involved in their partners' sexual and reproductive health. Men were encouraged to accompany their wives to antenatal clinics where services such as Prevention of Mother-to-Child Transmission of HIV (PMTCT) were offered.

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%, (men 65%, and females 53%) (National Statistical Office, 2008). 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 skilled personnel is at 40.9% (National Statistical Office (NSO) and ICF Macro, 2011).

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 delivery 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.

The 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. They represent the 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 dominant role in these societies and 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.

Recruitment of participants was done through locally acceptable procedures. Firstly, permission was sought from Mwanza District Commission and the district's health office. The in-charges 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 and 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 centres 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 as some of the participants had travelled a long way by foot to get to the interview place.

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 (Beyea and Nicoll, 2000; Gulanick and Keough, 1997; Morgan, 1998; Sim, 1998). 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 as some of the participants had travelled a long way by foot to get to the FGD place.

Data analysis

Data analysis was undertaken simultaneously with data collection in order to identify and correct errors during next interviews and focus group discussions, and to add important issues that may have come up. 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 (Graneheim and Lundman, 2004) . 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.

FINDINGS

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 (the education system in Malawi consists of 8 years of primary and 4 years of secondary education, then, tertiary education). Most of the participants were peasant farmers except for three men whose occupations were carpentry, security guard and primary school teacher. The parity of the female 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 causes of barriers to husbands' involvement in maternal health care. The causes of barriers to husband involvement were gender role norms and health system issues. The gender role norms had four sub-themes namely; pregnancy and childbirth as women's domain; childbirth a shameful process for husbands to witness; jealous; and wives' unwillingness to have husbands' participation. The health system issues had six sub-themes namely: lack of privacy; traditional mode of service delivery; lack of agenda for men; lack of knowledge about male involvement; staff attitude and distance.

Gender role norms

Pregnancy and childbirth as women's domain

The findings show near universal agreement among women and men about the norms related to maternal health care. Both men and women viewed pregnancy and childbirth as the domain of women. The participants expressed that they have been brought up to believe that maternal health services are for women. Although the participants reported that with the introduction of male involvement programme some men accompanied their spouses to antenatal clinic, but were quick to say that it was a taboo for men to enter the labour and delivery room. Even during home deliveries, participants mentioned that husbands are not allowed to be near the birthing hut. The birthing woman is attended to by women only. Culturally, childbirth is a women's business. Men were characterized as resource providers of the family including health care.

"The husband is supposed to accompany the wife to the hospital. He may take her on a bicycle so that they should not delay and the woman deliver on the way. The husband is also supposed to inform the relatives of the woman that the wife is in labour and organize for a female guardian." (Mutu).

In both women's and men's focus group discussions it

was revealed that men are excluded from the traditional instructions that are given to expectant women. The instructions include information related to labour and delivery as well as in the period after birth. The husband is only given information related to nutrition, avoidance of violence, importance of rest for the woman during pregnancy and postpartum period. In addition, men are told to avoid contracting sexually transmitted infections during pregnancy and the period after delivery. Men are advised not to indulge in extramarital sexual relationships in order to avoid infecting the woman and the unborn child. The participants expressed that they believed that extramarital sexual relationships are associated with adverse events like prolonged labour, stillbirths and neonatal deaths. Furthermore, husbands are also advised to avoid having sexual intercourse with their wives during the first three months after delivery. The husbands are told that during this period the women do have a vaginal discharge that is so infectious and it causes a disease called “kanyera”. The participants described the condition as characterized by fever and body wasting. The man who is infected feels very cold even when the weather is hot and may bust in the sun or sit near fire place to make himself warm. These manifestations are indexical signs of non adherence to postpartum instructions.

“When a woman is pregnant the man is not supposed to sleep with other women because he can cause ‘mitulo’ or ‘tsempho’ to the woman so there might be complications when the woman is giving birth. When the woman has given birth, the couple has to abstain from sexual intercourse for three months. If they have sex before the three months period is over the man sucks into his body the vaginal discharge from the woman and the man suffers from ‘kanyera’.” (Maso)

Childbirth a shameful process for husbands to witness

Several women reported that sometimes deliveries are dirty and would not want a husband to witness that. In addition, the stretching of the birth canal would make a husband lose sexual desire for the wife leading to divorce. The female participants also reported that most of their husbands do drink alcohol and talk nonsense in public when they are drunk. The women were afraid that once the husbands were drunk they would talk about what they saw during delivery in public thereby bring shame to the women. Most of the participants reported that childbirth issues are not discussed in public as well as with women who had never given birth, let alone with men.

“The reason why the elderly women do not allow men to witness child birth is that they do not want the men to lose their desire for their wives. The issue is the birth canal stretches in order to allow the baby to come out. So for a man to see the woman disfigured like that, he may no longer have sexual desire for the wife. As such he may want to look for a younger woman who has not given birth before. That is the reason the elders say that men should not be allowed to witness a delivery because that could lead to breaking up of marriages”. (Mwendo)

When the women in the FGDs were asked about their views regarding being attended to by male midwives at the health facilities, they pointed out that they had no problems with that. The women explained that the male midwives were professionals that treated the women with respect and dignity and they did not talk about what they do outside the labour and delivery ward.

Elderly women reported that it was a shameful thing for a husband to witness a wife giving birth. They retaliated that male involvement, especially during labour and delivery was a foreign culture. The elderly women opposed to having men participate in labour and delivery. The health care providers alluded to the fact that culture is one of the main barriers that hinder husband participation in maternal health care in their catchment areas.

“There are some cultures which say that issues to do with childbirth are for women only and the man is not supposed to be at that kind of place. And if you are to take this information to the community most of the men may not agree with that and needs a very strong kind of message to convince them.” (Dzanja)

In the men’s discussion groups it was expressed that sometimes husbands do not actively participate in facility based maternal health care because of shame. In a community where it is not a social norm for men and women to be close together in a common place, most husband feel ashamed to be seen by other people among women at the clinic.

Sometimes men think it is a shameful thing to go to the hospital with their wives because sometimes people would laugh at the men who accompanies their wives to the clinic. So many men started being discouraged to escort their wives but beside that most men just have the mentality that antenatal care is only for women. So it would be better if men were going for antenatal with their wives. It’s okay not to go in the labour ward but to be present during antenatal care because this would help to prevent some other things and problems. (Nkono)

Jealous

Another male involvement barrier that most women in focus groups mentioned was jealous. The women expressed that the husbands would feel jealousy if they were to witness the tender care male midwives provide to the women especially during labour and delivery. The women explained that the male midwives were very kind and took time to do backrub when the labour pains were very intense. The women felt that if husband were to witness such acts of care they might think that their wives were having an affair with the male midwives and that could limit the women’s ability to access MCH services.

Wives' unwillingness to have husbands' participation

In both women's and men's focus group discussions it was revealed that some women are themselves the main barriers to husband involvement. The women that do not want their husband to participate would not communicate to them about male involvement. The women participants explained that the health care providers asked women to come with their husbands during the subsequent antenatal visit. Thus it was up to individual women to choose whether to invite the husband or not. However, they were quick to say that husbands' participation was depended upon the relationship which exists among couples.

"Every woman knows her husband. If the relationship with the husband is not good, then it is difficult to tell him to accompany you to the antenatal clinic. Nowadays at the clinic blood is tested for HIV. So if you are found positive, the husband might say that you are the one that has brought the infection into the family. So to avoid misunderstanding in the home, some women do not tell their husbands that they should come to the clinic." (Khosi).

Health system

Lack of privacy

Infrastructure was one of the major barriers to male participation consistently identified by all the focus groups, key informants and the health care providers. Most of the men expressed that they felt ashamed to be seen by others at ANC, a space that is perceived as women's space. The participants described the MCH clinics and services as gendered, such that men felt unease to be seen in such feminine places. Walking through the health facilities, it was observed by the researchers that antenatal care services were offered in an open space that denied women as well as men the physical and verbal privacy they deserved, except for services such as HIV counselling and testing and physical examination for women. The labour and delivery ward at Kunenekude health centre had two beds separated by curtains. While at Tulonkhondo health centre there were two cubicles in the labour and delivery ward that offered physical privacy but not verbal privacy. In both health centres, the postnatal wards were open halls with ten beds each. Due to this lack of privacy, most men opted not to participate in maternal health care at the health facilities. Some of the male participants explained that they opted not to participate in order to provide respect to the women.

"In the past, our labour ward was not in a condition that would allow men to be on the bed side due to lack of private and space. At present, our labour ward has been renovated with donation from the VSO. We now have cubicles that do provide the privacy that is needed in a labour ward. I feel that we can now allow men to be labour companions to their wives."(Mimba)

Traditional mode of service delivery

The mode of service delivery was also identified as a barrier to male participation. In men's focus group discussions, it was expressed that maternal health services are women centred and oriented in the way services are offered. The male participants mentioned that antenatal and postnatal care service commenced with group health talk whereby the topics under discussion most often focus on the women, ignoring the men. Thereafter, the health care providers lead the women into educational songs about reproductive health and the messages in most of the songs portrayed a negative image of men as perpetrators of poor maternal health and barriers to women's access and utilization of health services. Thus the male participants felt intimidated and out of place as well as being ashamed especially that antenatal and postnatal health talks are conducted in an open place. In addition, the participants expressed that after the group health talk session, men would participate in couple HIV counselling and testing if they were attending first antenatal care visit. However, the participants explained that they did not participate in physical examination of the women and other services unless the spouse had a medical problem that required the husband to be treated as well, such as sexually transmitted infection. Thus men perceived accompanying a spouse for subsequent antenatal and postnatal care visits as a waste of time as there was no service for them.

"They (men) complain that our place is open; they complain that they can't come and sit on this kind of place and be singing songs…. They say that the songs are so feminine because they mostly sing about family planning and all that. So they do not find it interesting to be present there". (Dzanja).

Lack of agenda for men

A perceived lack of agenda for men at the health facilities was one of the barriers for low male participation. Several men in the focus group discussions reported that they would only accompany their spouses to a health facility for maternal health services if they were invited by a health provider. The male participants expressed that it was the women who need the services and not the men; and that there are no services for men. Therefore the male participants reported that they thought it prudent to engage in activities that will bring money into the family than to waste time at the clinic and money for transport for two people just for health education. In addition, male

participants reported that the health system demanded that women should bring supplies for delivery when coming to the health facility for delivery. Thus men felt obliged to buy these supplies and they engaged themselves into income generating activities in order to afford buying the supplies. In both men's and women's focus group discussions it was reported that pregnant women are expected to go to the health facility waiting shelter when the women are 8 months pregnant to await labour. This was done to avoid home deliveries. Therefore, during such periods the husband has to solicit food supplies, firewood and other necessities that the wife and a companion would use at the waiting shelter.

"The husband must also buy the items necessary for the woman to use at the hospital. When they go to the hospital they are told what the woman needs to have for delivery. Things like a basin, a razor blade, zitenje [rappers] and a plastic sheet." (Khutu)

"The husband should escort the wife to the hospital to await labour. The woman might stay there maybe up to tenth month [for two months]. Therefore, man [husband] is supposed to bring supplies such as firewood, maize flour and relish that the wife should use while at the hospital." (Phazi)

Lack of knowledge about male involvement

Most men in focus group discussions mentioned lack of knowledge about male involvement in maternal health care at a health facility as one of the barriers for husbands' participation. The men that missed the sensitization campaigns and whose wives did not communicate with them about the importance of husband involvement expressed ignorance about husband participation in maternal health care. Continuous community sensitization was mention as a way of keep community members informed about the programme.

"He just said that antenatal care is for women only. He said that what he will be doing if he goes there. He is not the one carrying the pregnancy and he is not going to be examined so what is the point of going at the clinic. He also thinks it is foolish to go there because there is nothing for men. I think it is just a mentality with most men that there are only women there at the antenatal clinic so the issues discussed there are for women." (Chala).

In addition both men's and women's focus groups expressed lack of knowledge as to actual activities that the husbands would participate in MCH services apart from HIV counselling and testing and antenatal health education. Both men and women felt that there was nothing for the men especially after the first antenatal visit.

"From the discussion, it seems that there is no actual activity that men can participate in after the first antenatal visit, even in labour and delivery care apart from just observing what is happening." (Tsitsi)

The health care participants mentioned that there were no guidelines as to how men should participate especially during labour and delivery. Thus the midwives were not sure as to what the husband would do in the labour ward. The midwives also expressed that there is need for written guidelines for male involvement in maternal health care and proper orientation to both health providers and the community.

Staff attitudes

The staff attitude is another barrier that was isolated, related to service delivery. The health care providers mentioned that some of the health care workers are so much attached to the idea that MCH is for women such that they do not have an initiative to involve husbands in the care of their wives. One of the health care providers reported that husbands have not been involved in the ANC physical examination of their wives not because of issues of privacy but they have not done it before.

"The man does not enter the examination room, it is only the woman but if there is a problem, then we would call the man to come in and we would explain it to him. But during blood testing they would go as a couple and we would tell them the results as a couple." (Dzanja)

When the participant was asked why husbands did not enter the examination room with their wives? The response was:

"There was no particular reason, only that we have not tried it." (Dzanja)

Distance

Another factor that hindered men to accompany their wives for maternal health care was distance. Walking was the means of transportation for most people in the study sites. The participants estimated that travelling 5kilometres takes one hour. Most of the participants lived further than 5 kilometres from the health centres, as they indicated that they walked 3 to 4 hours to reach the respective health centres. Furthermore, there was lack of consistent transport infrastructure in the areas. The only convenient option was to use privately owned vehicles that are unlicensed for public transportation called 'matola'. These privately operated transports charged exorbitantly such that most rural poor people could not afford. Thus distance to the health facility compounded with lack of financial resources was perceived as one of the major barriers for husband involvement. Most male participants reported that it was prudent for the wife to use the little available financial resources for her to access maternal health care.

"The distance can be one factor. Because for us the hospital is near. But there are people that come from

Chikwawa. So it can be very difficult for them to come at the hospital just to get the education". (Nsana)

It was also reported in both men's and women's focus groups that some men do fail to participate in maternal health care as they were away from the village in search for work in town, leaving a pregnant wife in the village. Others migrate to neighbouring countries in search for employment. By being away from home while the wife is pregnant, the husbands could not participate in maternal health care.

DISCUSSION

The findings of this study indicate that the prevailing gender role norms influence male participation in maternal health care. In addition, the traditional ways in which maternal health care services are implemented play a crucial role in influencing male participation as well as knowledge and appreciation of maternal health issues. These norms and values are so much engraved in people's minds, such that it is difficult for people to break away from them. Witt (1997) however, posited that gender roles adopted during childhood normally continue into adulthood. Consequently, as children learn gender roles within a social context from parents and society, it is suggested that androgynous gender role orientation may be more beneficial to children than strict adherence to traditional gender roles. Therefore, targeting socializing agents such as parents, teachers and the mass media to reinforce androgynous gender role orientation could have an impact on behavior change in the long run. On the contrary, Deutsch (2007) stated that people do not merely internalize gender roles as they grow up but respond to changing norms in society. Therefore, with the changing policies on maternal health care and mainstreaming of gender in sexual and reproductive health care delivery system, people in the study areas would respond to the change and male involvement in maternal health care would become a norm just as in the modern western countries.

The gender role norms that pregnancy and childbirth are feminine and caring for a woman in labour is women's social role are deeply rooted in the study areas. Similar results have been documented in earlier studies done in Africa (Muia et al., 2000; Mullick et al., 2005). The notion of women being care givers is quite common in most societies. Helman (2007) asserted that in almost every culture, the main providers of health care are usually women. Such a notion is not uncommon among professional fraternity. With the view that most health care providers are women, the findings have shown that service providers' attitudes also play a significant role. Whilst health care providers have been receptive to men's participation in ANC and postnatal clinics, they have prohibited men's entry into the labour wards (Kunene et al., 2004; Helman, 2007; Muia et al., 2000). Although male midwives provided maternal health care in the health facilities where this study was conducted, that did not change the perceptions of the community that a labour companion has to be a woman. These findings concur with the assumptions made by Moser (1993) that reproductive work is almost always the responsibility of women and girls. Barker and Das (2004) also expressed the view that reproductive and sexual health has always been the domain of women and that men's concern seem to appear only when sexually transmitted infections and HIV and AIDS or adolescent health are added to the list. A male gendered role norm during the pregnancy, childbirth and postnatal period is to provide emotional, material and financial support to their wives. Men around the world have been portrayed as economic providers and decision makers (Carter, 2002; Muia et al., 2000). However, gender roles and relations and patterns of behavior can be learned and unlearned as evidenced by some men who adopt feminine roles without fear of being ridiculed by peers for instance accompanying a wife for maternal health care services.

The traditional ways in which maternal health care services are implemented in the sites where this study was conducted, play a crucial role in influencing male participation. The information, education and communication messages (IEC), which are part of the services in this setting, target women and

some of the songs that are sung to reinforce IEC, portray men as obstacles for women's access to care. Consequently, it could be implied that even the formal health care sector mirrored the societal views and expectations of MCH services to be for women. Aarnio et al., (2009) found similar results in a study conducted in Malawi that focus on male involvement in antenatal HIV counselling and testing

in some rural areas. Therefore, accompanying a wife for maternal health care services was viewed by most male participants as a waste of time and money as they could not see its importance. Lack of specific activities for men in the MCH services underscored this behaviour. Furthermore, the Malawi SRHR policy on maternal and neonatal health is silent on how men should be involved in maternal health care services. Hence, maternal health care need to be de-feminized in order to create the foundation for a more equal access to services for both men and women.

The entrenched gendered perception of maternal health care services being for women only is indeed reflected in the design of infrastructure for maternal health services in the study sites. This was also another primary source for low male participation. It was observed during the data collection that the architectural design of the facilities could not provide privacy for the clients. Women laboured and delivered babies in a ward that deprived them of privacy. As a result of such lack of privacy, labouring women were only allowed to have a female labour companion. The health care sector needs

to consider seriously the privacy issue in the delivery of maternal health care for male involvement as well as for the dignity of the women.

Health care providers' negative attitude was identified as one of the barriers to male involvement in the study sites. Negative attitudes of health care providers seem to be a major problem in most developing countries (Barua, 2004). There is urgent need to improve the attitudes of health care providers so that husbands' participation in maternal health care can be facilitated.

Distance to the health care facility compounded with lack of financial resources was perceived as a barrier to male participation. This finding is consistent with other similar studies done in Tanzania, Uganda and Bangladesh (Anwar et al., 2008; Mrisho et al., 2007; Tann et al., 2007; Tweheyo et al., 2010) . Thaddeus and Maine (1994) illuminated that long distance to a health facility is one of the most important determinants in the decision not to seek modern health care even when needed. Thus, the health sector should endeavor to invest in community based male involvement and maternal health care approaches that have proved successful elsewhere (Turan et al., 2001).

Men's knowledge about male involvement in maternal health care is a starting point for participation. However, some men expressed ignorance and others did not understand why they had to be involved. Similar findings have been documented by (Aarnio et al., 2009; Theuring et al., 2009). In addition, the social context of the study areas exhibited a culture of silence around pregnancy and childbirth issues. Men were not taught issues related to labour and delivery. This information was given to women only. Men were told how to provide emotional, material and financial support to their pregnant spouses. Thus gender values and norms in the study area acted to ensure that labour and childbirth knowledge was withheld from men. In addition, most men did not attend ANC clinics with their wives where such information was disseminated and this contributed to their lack of knowledge on issues related to maternal health. Similar findings were also documented by Mullick et al., (2005) in a study done in South Africa and (Onyango et al., 2010) in Kenya. The health sector could be the source for maternal health information for men. Therefore, it is very essential that the health sector should be proactive in disseminating maternal health information to both men and women for the benefit of the families. In addition, the health sector should endeavor to invest in IEC strategies that target both men and women for behavior change towards male involvement in maternal health care.

Limitations

In this study, focus group discussions and in-depth interviews 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 information. The researchers attempted to address these constraints by using two different data collection methods, and in addition, took field notes on what was observed at the health facilities in relation to male involvement. 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.

CONCLUSION

The prevailing gender role norms influence male participation in maternal health care. The gender role norms are also reflected in maternal health care delivery system in the rural health facilities in Malawi whereby the services are female focused. Therefore, husbands find it difficult to get involved in their

spouses maternal health care. However, male involvement in maternal health care is possible if the causes of barriers were surmounted. It can be recommended that maternal health care services need to be de-feminized in order to create the foundations for a more equal access by both women and men. In addition, pregnancy and childbirth education need to be given to both men and women so that they are equally knowledgeable and involved in issues pertaining to maternal health.

Competing interests

The authors declare that they have no competing interests.

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. AM advised on analysis of the data, presentation of the results and edited the text. All authors read and approved the final manuscript.

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REFERENCES

Aarnio P, Olsson P, Chimbiri A, Kulmala T (2009). Male involvement in antenatal HIV counseling and testing: exploring men's perceptions in rural Malawi. AIDS Care: Psychological and Socio-medical Aspects of AIDS/HIV. 21: 1537-1546.
Accessed on 12-06-2010 at www.popcouncil.org/frontier/frontiersfinalrpts.html
Accessed on 9-9-2009 at
Anwar I, Sami M, Akhtar N, Chowdhury ME, Salma U, Rahman M, koblinsky M (2008). Inequity in maternal health-care services: evidence from home-based skilled-birth-attendant programmes in Bangladesh. Bull.World Health Organ. 86: 252-259.
Barker G, Das A (2004). Men and sexual and reproductive health: The social revolution. Int. J. Men's Health. 3: 147-153.
Beyea SC, Nicoll LH (2000). Learn more using focus groups. *AORN J. 71:* 897-900.
Byamugisha R, Tumwine JK, Semiyaga N, Tylleskar T (2010). Determinants of male involvement in the prevention of mother-to-child transmission of HIV programme in Eastern Uganda: a cross-sectional survey. Reprod.Health. 7: 12.
Carter MW (2002). 'Because He Loves Me': Husbands' Involvement in Maternal Health in Guatemala. Culture, Health and Sexuality. 4: 259-279.
Dahlgren L, Emmelin M, Winkvist A (2004). Qualitative Methodology for International Public Health. Umeå University publication, Umeå.
Farquhar C, Kiarie JN, Richardson BA, Kabura MN, John FN, Nduati RW, Mbori-Ngacha DA, John Stewart GC (2004). Antenatal couple counseling increases uptake of interventions to prevent HIV-1 transmission. J Acquir Immune Defic Syndr. 37: 1620-1626.
Graneheim UH, Lundman B (2004). Qualitative content analysis in nursing research: concepts, procedures and measures to achieve trustworthiness. Nurse education today 24(2), 105-112.
Gulanick M, Keough V (1997). Focus groups: an exciting approach to clinical nursing research. Prog.Cardiovasc.Nurs. 12: 24-29.
health equation: acceptability and feasibility in Kenya. The Council's Robert H. Ebert
Health in Cambodia. United States Agency for International Development (USAID).
Helman CG (2007). Culture, Health and Illness. (5th edition ed.) London, UK: Hodder Arnold.
http://www.policyproject.com/pubs/countryreports/MaleInvolv_Cam.pdf
Involving men in maternity care in India Washington, DC: Population Council.
Kunene B, Beksinska M, Zondi S, Mthembu N, Mullick S, Ottolenghi E, Kleinschmidt I, Adamchak SE, Janowitz B, Cuthbertson C (2004). Involving Men in Maternity Care: South Africa Durban, South Africa: Reproductive Health Research Unit in Durban, Department of Obstetrics and Gynecology, University of the Witwatersrand. Accessed on 10-03-2010 at http://www.k4health.org/toolkits/igwg-gender/involving-men-maternity-care-south-africa
Ministry of Health (2009). National Sexual and Reproductive Health and Rights policy Lilongwe, Malawi: Republic of Malawi.
Morgan DL (1998). Practical strategies for combining qualitative and quantitative methods: applications to health research. Qual.Health Res. 8: 362-376.
Moser C (1993). Gender Planning and Development: Theory, Practice, and Tranining. London: Routledge.
Mrisho M, Schellenberg JA, Mushi AK, Obrist B, Mshinda H, Tanner M, Schellenberg D (2007). Factors affecting home delivery in rural Tanzania. Trop.Med Int Health. 12: 862-872.
Muia E, Olenja J, Kimani V, Leonard A (2000). Integrating men into the reproductive
Mullany BC, Hindin MJ, Becker S (2005). Can women's autonomy impede male involvement in pregnancy health in Katmandu, Nepal? Social Science and Medicine. 61: 1993-2006.
Mullany BC, Lakhey B, Shrestha D, Hindin MJ, Becker S (2009). Impact of husbands' participation in antenatal health education services on maternal health knowledge. J Nepal.Med.Assoc. 48: 28-34.
Mullany BC. (2006). Barriers to and attitudes towards promoting husbands' involvement in maternal health in Katmandu, Nepal. Social Science and Medicine. 62: 2798-2809.
Mullick S, Kunene B, Wanjiru M (2005). Involving men In Maternity Care: Health Service Delivery Issues. Agenda: Special Focus on Gender, Culture and Rights (special issue). 124-135.
National Statistical Office (2008). Population and Housing Census Results Zomba, Malawi.
National Statistical Office (NSO) and ICF Macro (2011). Malawi Demographic and Health Survey 2010 Zomba, Malawi, and Calverton, Maryland, USA.
Odimegwu C, Okemgbo C (2008). Men's Perceptions of Masculinities and Sexual Health Risks in Igboland, Nigeria. Int. J. Men's Health. 7: 21-39.
on 09-09-2010 at www.popcouncil.org
Onyango M, Owoko S, Oguttu M (2010). Factors that influence male involvement in sexual and reproductive health in Western Kenya: A Qualitative study. Afr. J. Reproductive Health. 14: 33-43.
Programme on critical Issues in Reproductive Health, Population Council. Accessed
Roth DM, Mbizvo MT (2001). Promoting safe motherhood in the community: the case for strategies that include men. Afr. Journal of Reproductive Health. 5: 10-21.
Semrau K, Kuhn L, Vwalika C, Kasonde P, Sinkala M, Kankasa C,Shutes E, Aldrovandi G, Thea DM (2005). Women in couples antenatal HIV counseling and testing are not more likely to report adverse social events. AIDS. 19: 603-609.
Sim J (1998). Collecting and analysing qualitative data: issues raised by the focus group. J Adv.Nurs. 28: 345-352.
Tann CJ, Kizza M, Morison L, Mabey D, Muwanga M, Grosskurth H et al. (2007). Use of antenatal services and delivery care in Entebbe, Uganda: a community survey. BMC Pregnancy Childbirth 7: 23.
Thaddeus S, Maine D (1994). Too far to walk: Maternal mortality in context. Social Science and Medicine. 38: 1091-1110.
Theuring S, Mbezi P, Luvanda H, Jordan-Harder B, Kunz A, Harms G (2009). Male Involvement in PMTCT Services in Mbeya Region, Tanzania. AIDS and Behavior. 13: 92-102.
Turan JM, Nalbant H, Bulut A, Sahip Y (2001). Including expectant fathers in antenatal education programmes in Istanbul, Turkey. Reproductive Health Matters. 9: 114-125.
Tweheyo R, Konde-Lule J, Tumwesigye NM, Sekandi JN (2010). Male partner attendance of skilled antenatal care in peri-urban Gulu district, Northern Uganda. BMC Pregnancy Childbirth. 10: 53.
United Nations (1995). Report of the International Conference on Population and Development (Rep. No. A/CONF.171/13/Rev.1). Cairo, Egypt.
USAID (2009). Country health statistical report: Nigeria. Washington DC.
Varkey LC, Mishra A, Das A, Ottelenghi E, Huntington D, Adamchak S et al. (2004).
Walston N (2005). Challeges and Opportunities for Male Involvement in Reproductive
Witt SD (1997). Parental influence on children's socialization to gender roles. Adolescence, Summer . Accessed on 10-01-2012 at http://gozips.uakron.edu/~susan8/PARINF.HTM