

Review Article

Cultural and Institutional Barriers to Male Involvement in Pregnancy, Delivery and Postnatal Care in Rural Districts of Malawi

Jane Namasasu*

Department of Sexual and Reproductive Health, Malawi Ministry of Health, Malawi

Abstract

The land mark for male involvement in reproductive health matters was recognized at the International Conference for Population and Development (ICPD) held in Cairo in 1994 and called for the inclusion of men in all spheres of sexual and reproductive health through the promotion and encouragement of equal participation of men and women in matters of family, household, and childrearing. Male involvement was seen as central to sexual and reproductive health outcomes and gender equality. However, more than 20 years since ICPD male involvement has been given lip service in most developing countries.

In this research I examined men and women's knowledge of reproductive health issues to identify barriers to male involvement during pregnancy, childbirth, and the postnatal period in rural districts of Malawi. Data were collected from one hundred twenty-one participants using focus group discussions and in-depth interviews. Results indicated two main obstacles: cultural barriers and institutional barriers as primary reasons for men's lack of involvement in reproductive health issues. I advocate for policy changes in the design and practices of administration in maternity care units to overcome these barriers and increase men's involvement in pregnancy, childbirth and postnatal care.

Keywords: Cultural barriers; Institutional barriers; Male involvement; Pregnancy; Childbirth; Postnatal care

Introduction

The land mark for male involvement in reproductive health matters was recognized at the International Conference for Population and Development held in Cairo in 1994. The Program of Action (POA) from the conference called for the inclusion of men in all spheres of sexual and reproductive health through the promotion and encouragement of equal participation of men and women in matters of family, household and childrearing. It was further emphasized that men should be actively involved in all elements of sexual and reproductive health such as family planning, child health, and unwanted and high risk pregnancies [1]. Male involvement was identified as central to sexual and reproductive health outcomes and gender equality.

More than 20 years since the ICPD, male involvement has been given only lip service in most developing countries yet men continue to witness most of the reproductive health problems that women go through [2]. Men are in a position of power, making decisions for their partners' and families' welfare. In addition to men's lack of inclusion, the high maternal mortality further provides the impetus to

identify reproductive health interventions that will improve maternal and neonatal outcomes. Davis et al. [3] assert that if men are involved use of clinic services and support for practices that promote Maternal and Child Health will improve. Several reports have shown that involving men in matters of fertility regulation, sexually transmitted infection and HIV prevention have yielded positive results [4,5]; however we lack an understanding of male involvement in pregnancy, childbirth, and the postnatal period in low income countries like Malawi. Nor do we know how male involvement may improve women and infants' health.

The research that currently exists suggests that socio-economic factors shape men's inclusion in reproductive health matters male involvement is low in low income countries [6-8]. Additionally, obstacles to male involvement may be rooted in cultural practices based on religion and gender roles within the family [9-11]. Discussions of sex are often taboo within communities across Malawi and in other countries in Sub-Saharan Africa and Asia [11,12]. Pregnancy entails strict observations of cultural practices by both the husband and wife, and sometimes the entire family. These practices perpetuate the segregation of men and women into separate spheres, and hinder male involvement in pregnancy, delivery, and the postnatal period.

In Malawi, social and cultural norms and practices around pregnancy dictate that women are not allowed to eat certain foods, similarly in some Asian cultures, certain foods are avoided during pregnancy, childbirth and postpartum period [13], are expected to take a subordinate role (for example giving respect to their partners/husbands by kneeling), not talking back to their husbands and elders, or raising their voices to men [14]. In addition, the dominant construction of masculinity values strength, respect and control in heterosexual relationships [15]. These culturally constructed norms lower women's status. What has yet to be considered is how these practices

Citation: Namasasu J. Cultural and Institutional Barriers to Male Involvement in Pregnancy, Delivery and Postnatal Care in Rural Districts of Malawi. *J Reprod Med Fam Plann.* 2018; 1(1): 1004.

Copyright: © 2018 Jane Namasasu

Publisher Name: MedText Publications LLC

Manuscript compiled: October 13th, 2018

***Corresponding author:** Jane Namasasu, Department of Sexual and Reproductive Health, Malawi Ministry of Health, Lilongwe, Malawi, E-mail: jnamasasu@yahoo.com

undermine the health of men and women in Malawi. Other cultural practices that impact a woman's reproductive health during pregnancy and childbirth vary by region and religion. For example, in some districts of Malawi, women who experience prolonged labor while delivering at home are expected to confess to infidelity to facilitate labor [16]. While in Asia, women experiencing prolonged labour or difficult births will require a magical healer to conduct rituals [13]. In Nepal, it is also believed that if the husband is present during childbirth, the spouse would experience birth difficulties [4]. Elsewhere, the husband's family encourages the woman to deliver at home, particularly with the first pregnancy, due to the belief that infidelity of the woman leads to a difficult birth. Additionally, if a pregnant woman delivers by caesarean section, it means the husband or the wife had extramarital sexual relationships when birth complications are experienced [16]. These cultural beliefs often mean that referral to a health facility is delayed which results in maternal deaths [11,17].

Institutional aspects of reproductive health care including unfavorable health policies that guide the operation of clinics (such as opening hours, clinic set up, service costs, and transportation to clinic), and health workers' attitudes towards male involvement also impact the inclusion of men in reproductive health matters [5,18]. These practices are exacerbated in health care systems which lack the infrastructure to provide the necessary resources or supportive hospital staff to advance male involvement and improve women's reproductive health. In Malawi, a maternal mortality reduction strategy known as "The Malawi Road Map" was developed from the Emergency Obstetric Assessment (2005) with the goal of "empowering communities to ensure continuum of care between households and health facility by strengthening the capacity of women and their partners to ensure self care in the home and to seek and reach health care facilities in a timely manner for improved pregnancy outcomes" [19]. The 2012 Road Map went a step further to ensure that maternal and neonatal community health interventions were scaled up and existing ones strengthened [20]. Despite these government health policies, male involvement is still low.

Several organizations have responded to the call for male involvement by instituting different projects. A community empowerment project in Mchinji is focusing on women and community to reduce maternal mortality [21]. Another project in three districts in Malawi focuses on community mobilization through women groups, and maternal and neonatal task forces [22]. A project in two districts in central region of Malawi focused on understanding aspects of the community system and health care providers' initiatives to get men involved in the health of their partners and children [7]. Despite these steps, a significant gap remains-cultural barriers, institutional policies and practices continue to limit men's involvement in pregnancy, delivery, and postnatal care. It is in this context that I seek to identify the factors that limit or increase men's involvement in reproductive health matters in rural Malawi.

Methodology and Study Design

A qualitative design utilizing both in-depth interview and focus group discussions were used for this research. For focus group discussions, participants were recruited through the district health offices which were provided with guidelines for selecting the participants. Two gender segregated focus groups, one for women and the other for men, were conducted in each rural district making a total of eight focus groups. Each focus group discussion comprised 12 participants. Data were collected from traditional chiefs, traditional

birth attendants, health professionals, and representatives of civil society using in-depth interviews.

Study participants

The study population for this research was women and men age 20 years to 87 years and living in Malawi. The sample consisted of 93 men and women (45 men and 48 women) from rural areas who participated in focus group discussion. A seven question interview guide was used for focus group discussions. Additionally, 28 (11 men and 17 women) from urban areas participated in in-depth interviews, each of whom had knowledge and expertise in women's reproductive health, including: four Traditional Leaders, four Traditional Birth Attendants (TBA), four civil society members, ten health workers working in the maternity unit of district and central hospitals, four lecturers at College of Medicine and College of Nursing (two from each institution) and also those at policy level working for the Ministry of Health. A four question English interview guide was used to collect data from all the health professionals and the civil society groups. The interview guides were in participants' native languages of Chichewa, Tumbuka and Sena.

Participants were purposefully drawn from four rural districts (Dowa, Mzimba, Mangochi and Nsanje) and two urban districts (Blantyre and Lilongwe) based on variability in the tribal and religious groups residing in each district. Mzimba and Nsanje are both rigidly patrilineal and residents speak different dialects, while Dowa and Mangochi districts are matrilineal. Collecting data from these diverse groups helped to capture variability and complexity in multiple viewpoints and experiences.

Topics that are related to sexuality and reproductive health are taboo in some of the districts of Malawi where this research was based. Women were interviewed separately from men because, in my past research experience, women will not contribute much to discussions about reproductive health when men are present. Oftentimes, women may fail to respond to interview questions because culturally this is how women have been socialized to behave in the presence of men. Furthermore, because men are culturally seen as superior to women, it may be assumed that they know more about reproductive health issues than women.

As one writer reported, even if men do not know about reproductive health issues, they may not wish to show their lack of knowledge in the presence of their partners [23]. In addition, women depend on their husbands for most decision making about reproductive health issues [24], so it is not likely that women's responses will be independent of men's if they are interviewed at the same time.

Results

Cultural barriers

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

Abstinence

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

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

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

Baby cleansing

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

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

In addition to influencing when men may have contact with their babies, specific cultural beliefs and practices also influence women's behavior. For example, once the baby's cord has fallen off, a woman can start cooking and resume adding salt to her food. Women stop putting salt in food during pregnancy because it is believed that if they put salt in the food and the family eats the food they have prepared, they will "jump" the baby. The "jumped baby" may show visible veins on the face, faint, or fall ill. These beliefs play an important role in dictating what women can do and suggest that if women do not follow these culturally prescribed practices, there will be physical evidence (i.e., damage to the baby) of their deviant behavior.

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

Couples do not question why they must perform baby cleansing rituals or subsequent ceremonies in order to resume intercourse; rather they accept that their parents and elders of the village know best. This kind of social pressure to conform to what the elders want does not give the couple freedom to exercise their sexual right and freedom to choose when they can "accommodate" the baby. One participant summarized such practices "This issue [baby cleansing] is valid because old cultural beliefs are just too many. How do we care for it? Isn't it that when you are taking the baby so that she is in the village? There are others who take the baby and lay her in between the parents. They take it while having sexual intercourse and the baby is where? In the middle; some do take the baby while having sexual intercourse. After they have finished, they take the baby and make it jump the fire" (An 87 years old man).

Female participants were apprehensive about these cultural barriers imposed by their forefathers because "the children are just advised that when a woman is pregnant...you should not touch the baby, this is one of the cultural belief that is preventing men from getting involved" (A 67 years old woman).

Gender segregation

Societal expectations about the type of social interaction that men and women can have and gender roles within the household represent another barrier to men's involvement in pregnancy, childbirth, and the postnatal period. Women are expected to carry out all household chores such as nursing children and husbands, gardening, cleaning, cooking, fetching water and looking for firewood while men are expected to be breadwinners and provide for their families. Through socialization, the segregation of men and women from interaction with each other and in the household culminate over time, leading to men's lack of involvement. One participant, a health worker, commented on gender segregation and its occurrence early among young boys and girls.

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

It is considered inappropriate for women and men to be together in each other’s physical presence or to interact if they are not married, and a girl cannot claim to have a boy as a “friend”. Relationships are not seen as platonic, rather sexual in nature.

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

Men socialize with each other, separately from women. Men drink beer to socialize with their friends or to deal with problems related to lack of employment or financial problems. Women who were interviewed explained that men go out to drink beer and eat very good meals like roasted meat which is called “kanyenya” while the family is left at home starving. For example, one woman expressed concern about men’s behavior and stated: “As he comes home he is drunk, has eaten roasted meat (kanyenya) at the bar. He deliberately comes [home] late so that when a woman shouts he should go away looking for other women. It is worse during hunger periods then they just go to their parents homes looking for food” (A 67 years old woman).

Another aspect of gender segregation that relates to men’s lack of involvement concerns information. A consequence of boys and girls, men and women being socialized to fill different roles in a rigid division of labor is that they receive different types of information. While women may be taught about aspects of reproduction, men lack this information. Most men in this study observed that information about reproduction is hidden from them. They are excluded from the process in many ways, particularly when their wives are in labor. One male participant explained: “When a woman is giving birth, like in my village, they hide things from men, they don’t tell us quickly, no! They just come and collect your wife and maybe tell you to go away... until you hear about finished business, that she has a newborn baby. So as a man you cannot get involved in anything because they don’t inform you, no! These are women’s issues and men should not what, they should not know” (A 25 years old man).

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

“An example would be in certain cultures, an uncle would be a gatekeeper...deciding whether the woman is taken to a hospital or not. So in those grouping within Malawi...the setting that we have in Malawi where women deliver, are settings where culturally...they form a barrier in the sense that it’s not acceptable that where a group of women are gathered, that a man should show their face in such a

place. Well, people would say that this man is uncultured if he finds himself among a group of women” (A 45 years old man).

All of these societal expectations shape the way men behave. From social constructionist perspectives, men think and act the way they do because of ideologies of masculinity [25]. Some men may assist their wives in private, but when they are in public they want to show that they fit with normative definitions of what it means to be a man.

Attitude of health workers towards men

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

Most male participants noted that health workers are disrespectful to them and send husbands home before assessing the needs of women in labor. An assessment conducted by the Ministry of Health found that factors contributing to health workers’ negative attitudes towards men are lack of transportation and communication, lack of electricity, low salaries and heavy workloads [26]. These are realities on the ground; however the frustrations of health workers are often directed towards men with the effect of alienating men from assisting their wives with labor and delivery. This is what this 58 year old woman said: “Sometimes, at the hospital when the woman goes into the labor ward, the doctor tells the man to go home....If they were told to stay near or get them into their offices when the woman is in labor, it would have been nice. But they tell them to go home and then the woman has no what? [She has] no blood”.

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

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

Health workers further observed that midwives are not receptive to men who fail to bring new clothes for the baby or wife. During

the antenatal period, pregnant women are advised to prepare for the baby by bringing clothes, basins to bath the baby, razor blades to cut the cord, and in this era of HIV their own draw sheets. In some cases, health workers and hospital servants take advantage of poverty stricken women that do not bring these things to the hospital and ask women to buy from them. It should further be noted that most of the health centers in the rural areas don't have electricity. In these areas, "women are asked to bring paraffin" (a 59 years old woman) with them when they are in labor. They use paraffin lamps at night to conduct deliveries and this is a big challenge.

In this study, the majority of the female participants had concerns with the way health workers treat them as patients in the labor ward. Some women reported workers yelling, swearing, scolding, slapping or treating patients poorly. Similar results were also found in a study conducted [16] and other studies conducted in Gambia and Uganda respectively [2,27]. One man stated that health workers say bad words that discourage men to get involved such as "When you were getting pregnant was I there?" (A 46 years old man) (This statement from the health worker was poignant given that sex is a sensitive subject rarely spoken of in public).

These sentiments were expressed in all the four districts including the two urban districts. "Sometimes when women go to the hospital to deliver, the nurses ill-treat us. They are violent, and it is a problem that we face!" (A 20 years old woman). "I was pushed around, pricking so I thought that this was violence. Yes, I had a lot of luggage, so I wanted to leave some of it outside. But they did not speak to me well, it was violence" A 20 years old woman.

Nurse's attitudes towards patients and their partners are a barrier to women accessing services, and also for men getting involved during childbirth.

Institutional barriers

Participants also highlighted the lack of privacy at hospital, inaccessible hospitals and hospital policy as institutional barriers to male involvement. More than half of the participants noted that the hospital environment at the maternal health services is not male friendly in a number of ways.

Lack of privacy

Over half of those interviewed reported that there is no privacy in the labor ward. They argued that most of the labor wards are only separated by a screen and therefore not conducive for men to be present. They stated that if men were to be present, they would clearly see the other women admitted in the labor ward and hear them as they give birth. This is the case in non-paying wards as opposed to private or paying wards. Overcrowding was another barrier that was cited. Therefore, health workers felt that men may not be comfortable to accompany their partners in those crowded places. These findings are corroborated in a study conducted in Gambia where partners could not escort their wives in the labor ward due to limited space and lack of privacy [27]: "Here it's the infrastructure....It's like it's overcrowded, so men...don't feel comfortable to be among the women The way our labor ward is built, there is no privacy. It's like... labor beds are demarcated by curtains so if a man has accompanied the woman in the labor ward to watch a delivery it will be easy for that man to be able to hear whatever is happening with another woman on the other side" (A 37 years old woman).

Other participants expressed concern for the way "women may compare their circumstances, especially in cases where one has been

accompanied by her husband and one has not, 47 years and 55 years old men". The women laboring alone may be psychologically affected by the presence of another woman's husband. She may feel isolated and neglected by her partner for his lack of involvement. She may fear the midwives may not be able to take care of her. Additionally, the way the labor ward is structured does not provide privacy. Beds are lined up next to one another and women are not given private rooms. As one participant explained "At the hospital men cannot be involved. In the labor ward there is a bed here, a bed here, and a bed here. All these women are giving birth, so if a man comes in, looking at them each one looking after his...If each woman had her own room, then men can come in. If they are there...[lined up] on the beds, can a man come in?" (A 58 years old lady).

Non-accessibility to the hospitals

Most participants explained that the hospitals were very far away and that such distances were a risk to women's health. "For our health, what we want is that the hospital should be near but not far away, no, because our life...depends on the hospital. Just imagine from Saiti Village to Tibutibu, the only hospital is Nankumba. So for us to walk with a person who may be pregnant, going to Nankumba, she may lose her life because of the distance to the hospital" (A 49 years old man).

In some cases, laboring women have to travel 20 km to 100 km from their home to the hospital. In most rural areas, transport is unreliable and even if transport is available, it takes significant time to get to the hospital because of the terrain. Some roads are impassable during the rainy season. These problems have consequences for the pregnant woman who might bleed to death or deliver on the way to the hospital and sustain injuries. "Women face a lot of problems. They face difficulties during childbirth the hospital the way it is, Mzimba is very, very far. Sometimes transport is a problem. Women sometimes die because the hospital is very far in Mzimba" (A 29 years old man).

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

"It is very true that the location of health facilities is another critical factor that has got to be looked into seriously...Geographically, yes, there are some places which are very, very bad. People have to climb several hills before they reach the facilities. They deter people they cannot go to such facilities" (A 50 year old man).

Several studies have shown that distance to health centers, lack of transport, and lack of privacy are barriers to accessing health services and this appears to be the case in this study [4,11,26].

Hospital policy

Participants from rural areas also suggested that hospital policies are a barrier to male involvement because they are restrictive. Most participants felt that the policies regarding the design of the labor ward were discriminatory as they only favor women. In some hospitals, sign posts say "no men allowed beyond this point" (A 55 years old man). This it suggests hospitals perceive labor and delivery only as a woman's issue. While participants did recognize the need to have security and protection for laboring women, they suggested that

male family members do not represent any threat during delivery. This participant explained:

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

Most hospital policies allow only one guardian per patient. Because the patient is in the labor ward, the relatives often decide which guardian will be with the laboring woman. The guardian’s job is to wait outside of the labor ward unless the laboring woman is not co-operative, “Things are that only women are the ones that are found there. They [midwives] say a patient should only have one person. So we say [to the midwives], do you want to stay with her yourself? Or maybe you should go in there? “So I wanted to ask, how can we go in there us as men”? (A 65 years old man).

Other participants, particularly health workers, argued that policy problems are at the implementation level. It could be that policy is misinterpreted at the implementation level or that health workers are themselves influenced by their own culture, especially gender roles, thereby affecting their decision to send men away from the labor ward.

“As far as the policies are concerned, I do not think that [they] in themselves are barriers to male involvement. I think the lack of male involvement is something that happens at the level of implementation. So the unit that is offering the services themselves that’s where I think the problem is. So that if we were to address at that level, I don’t think there would be any policy that would be against male involvement” (A 45 years old man). It is evident that policies in the health facilities are not male friendly. Another factor is that policies may require explanation at the implementation level. Health policies may not stipulate details of how each hospital should manage its own affairs but it is up to the hospital management to determine the needs of the patients or clients.

Discussion

The focus group discussions, in-depth interviews of men and women of child bearing age group and over, helped to identify cultural and institutional barriers about involving men during pregnancy, childbirth, and the postnatal period. The simple construction of a clinic can provide cultural cues and symbols about male involvement the labor wards are only separated by screens therefore not conducive for men to be present during childbirth. Even where men accompanied their spouses to antenatal or childbirth, men stayed outside due to lack of space [2]. Similarly a study conducted in Tanzania found that there was no privacy in the labor wards for men to get involved [28]. This has reinforced men’s lack of involvement in pregnancy and childbirth issues. Health policies of the hospitals, according to the participants, were restrictive and discriminatory in nature on whether men should accompany their spouses to the hospital for childbirth or not. These findings are consistent with a study conducted in Ghana that found unfavorable policy as one of the limiting factor to male involvement [18]. While participants observed that the hospital policy is restrictive in nature, health workers argued that the hospital policy is not a barrier but implementation is a problem for men to be involved in issues of pregnancy and

childbirth. Each hospital should orient their hospital staff to ensure they understand the hospital policy and ensure consistency in interpretation and implementation by all.

Results of this research have shown that cultural barriers limit men’s involvement in pregnancy, childbirth, and postnatal care. These cultural barriers were related to abstinence and baby cleansing. Baby cleansing rituals occur after the first child is born and involve the elders giving instructions to men and women about how to behave with one another. This cultural practice is based on beliefs about ways that men and women can protect the health of their baby. Each of these cultural practices represents barriers which may result in men’s lack of involvement with their partners and newborn babies. Female participants were apprehensive about these cultural barriers imposed by their forefathers because “the children are just advised that when a woman is pregnant...you should not touch the baby, this is one of the cultural belief that is preventing men from getting involved” (A 67 years old woman).

Societal expectations about the type of social interaction that men and women can have and gender roles within the household represent another barrier to men’s involvement in pregnancy, childbirth, and the postnatal period. Through socialization, the segregation of men and women from interaction with each other and in the household culminate over time, leading to men’s lack of involvement. Socialization process also contributes to men’s lack of involvement in household chores. For example, a study in Gambia found that women carried out heavy domestic chores such as pounding, ferrying water, and chopping firewood even when the pregnancy was advanced [12]. Results in our study were similar where women stated that they are expected to carry out household chores such as cooking fetching water and collecting firewood, while men are expected to be breadwinners and provide for their families. They are supposed to maintain gendered division of labor in the household as the cultural norms dictate. In general in Malawi, interaction among men and women is considered acceptable, but it is unacceptable for a woman to be present with a group of men, and for a man to be present with a group of women. If for some reason a woman is in the presence of a group of the opposite sex, she is seen as being promiscuous. Women receive considerable scrutiny and such behavior is considered uncultured while men are not scrutinized because of the societal belief that it is their right to behave so [14].

The study further reported that health workers and domestic staff were a barrier to men’s involvement in maternal health. Men stated that most health workers are disrespectful and do send away husbands before assessing the needs of women in labour. Several studies have reported about the poor attitudes of health workers in resource limited settings [5,18]. Nurse’s and midwives’ attitudes towards patients and their partners are a barrier to women accessing services, and also for men getting involved during childbirth. Similar results were also found in Gambia and Uganda where midwives used abusive language or very unfriendly language [2,27]. Surprisingly, even the health workers interviewed acknowledged that health workers’ attitudes prevent men from getting involved.

Drawing on from these findings, I can conclude that men are deterred from getting involved in pregnancy, childbirth, and postnatal care due to cultural and institutional barriers. It is clear that men lack information on pregnancy, childbirth and postnatal care, they don’t understand what is going in the women’s bodies when they are pregnant, men do not know their roles during pregnancy, childbirth

and during the postnatal period, and they feel isolated in issues of maternal health. When they accompany their spouses to the hospital they either remain loitering outside the maternity ward or sent away without been given proper information about the condition of their partners or wives. Then the pregnant women are moved to their relatives' home or their mothers or sisters whom they felt would support them during pregnancy and childbirth. How can men be fully involved in matters of childbirth when the environment is not male friendly? Men perceive the attitude of health workers as disrespectful to men. Policies alone are not enough to motivate them to get involved. There is need to consider these barriers when designing maternal health programs. The programs should ensure that men have been sensitized enough by conducting focused education and communication campaigns, and hospital designs should be male friendly. These education campaigns should be implemented within all levels of health care from village elders who are the custodians of cultural practices to health workers who provide health care services to patients. Such changes require a systematic effort.

The research results discussed here have provided a foundation for future program designs. Socio-cultural factors should be considered in programming of service delivery for men to be involved in maternal health. As the results of this research have shown, barriers to male involvement during pregnancy, childbirth and the postnatal period exist at community, family, as well as hospital level [29,30]. For these barriers to be removed there will be need for transformational change in terms of gender ideology about men and women's roles in the household, family and village in terms of the attitudes of health workers who may facilitate or hinder male involvement. Health interventions should target the family, community and hospital and this will require concerted effort from the traditional leaders, government and civil society groups. Some of the health interventions could include but not limited to, group education, civic education, and building planners should ensure that future labor ward designs should be male friendly. Since there is paucity of information on the impact of men's involvement to reduce maternal mortality, future studies should focus on this and evaluate the effectiveness of existing and newly developing interventions involving men in maternal health.

Acknowledgement

This research was made possible with financial support from United Nations Children Fund (UNICEF) Malawi office. I wish to extend my special vote of thanks to the translators/transcribers, the district health officers, the district administrators and the chiefs, the women and men of Dowa, Mzimba, Mangochi, Nsanje, Blantyre and Lilongwe for without them this research would not have been possible. I wish also to thank most sincerely, my supervisor, Sarah Chivers for her valuable comments.

References

1. United Nations. Programme of Action of the International Conference on Population and Development. New York: United Nations Population Fund; 1994.
2. Kaye DK, Kakaire O, Nakimuli A, Osinde MO, Mbalinda SN, Kakande N. Male involvement during pregnancy and childbirth: Men's perceptions, practices and experiences during the care for women who developed childbirth complications in Mulago hospital, Uganda. *BMC Pregnancy and Childbirth*. 2014;14:54.
3. Davis J, Vyankandondera J, Luchters S, Simon D, Holmes W. Male involvement in reproductive, maternal and child health: A qualitative study of Policymaker and Practitioner perspectives in the Pacific. *Reprod Health*. 2016;13(1):81.
4. Lewis S, Lee A, Simkhada P. The role of husbands in maternal health and safe childbirth in rural Nepal: A qualitative study. *BMC Pregnancy and Childbirth*. 2015;15:162.
5. Nyondo AL, Chimwaza AF, Muula AS. Stakeholders perceptions on factors influencing male involvement in prevention of mother to child transmission of HIV services in Blantyre, Malawi. *BMC Public Health*. 2014;14:691.
6. Aborigo RA, Reidpath DD, Oduro AR, Allotey P. Male involvement in maternal health: Perspectives of opinion leaders. *BMC Pregnancy Childbirth*. 2018;18:3.
7. Manda-Taylor L, Mwale D, Phiri T, Walsh A, Matthews A, Brugha R, et al. Changing times? Gender roles and relationships in maternal newborn and child health in Malawi. *BMC Pregnancy and Childbirth*. 2017;17:321.
8. Maluka SO, Peneza AK. Perceptions on male involvement in pregnancy and childbirth in Masisi District, Tanzania: A qualitative study. *Reprod Health*. 2018;15:68.
9. Nanjala M, Wamalwa D. Determinants of male partner involvement in promoting deliveries by skilled attendants in Busia, Kenya. *Glob J Health Sci*. 2012;4(2):60-7.
10. Olugbenga-Bello AI, Asekun-Olarinmoye EO, Adewole AO, Adeomi AA, Olarewaju SO. Perception, attitude and involvement of men in maternal health care in a Nigerian community. *J Public Health Epidemiol*. 2013;5(6):262-70.
11. Story WT, Burgard SA, Lori JR, Taleb F, Ali NA, Hoque DME. Husbands' involvement in delivery care utilization in rural Bangladesh: A qualitative study. *BMC Pregnancy and Childbirth*. 2012;12:28.
12. Lowe M, Chen DR, Huang SL. Social and cultural factors affecting maternal health in Rural Gambia: An exploratory qualitative study. *PLoS One*. 2016;11(9):e0163653.
13. Withers M, Kharazmi N, Lim E. Traditional beliefs and practices in pregnancy and childbirth and postpartum: A review of the evidence from Asian countries. *Midwifery*. 2018;56:158-70.
14. Oladeji D, Adegoke TG. Personal, situational and socio-cultural factors as correlates of intimate partner abuse in Nigeria. *J Soc Sci*. 2008;16:57-62.
15. UNESCO. Role of men and boys in promoting gender equality: Advocacy brief. Bangkok, Thailand: UNESCO; 2009.
16. Matinga PU. Improving quality and access to maternal health services for Malawian women: a participatory needs assessment for Blantyre and Nsanje districts. Blantyre District Health Office: 55. 1998.
17. Coombes Y. Sexual and health behaviour in Malawi: A situational analysis for the behaviour change interventions strategy on HIV and sexual and reproductive health. Lilongwe, Ministry of Health and National AIDS Commission and Department for International Development. 2001.
18. Craymah JP, Oppong RK, Tuoyire DA. Male involvement in maternal health care at Anomabo, Central Region, Ghana. *Int J Reprod Med*. 2017.
19. Ministry of Health. Emergency obstetric care services in Malawi. MoHM. Department of Clinical Services. Lilongwe, Government print: 45. 2005.
20. Ministry of Health. Roadmap for accelerating the reduction of maternal and neonatal morbidity and mortality in Malawi, Reproductive Health Unit, Lilongwe: Non-Published no. 53. 2012.
21. Mai Mwana project, (no date) Motivational women's project, Mchinji. www.pachimalawi.com.

22. Mai Khanda Trust, (no date). Community mobilizations centering on Women's groups and maternal and neonatal health task forces, Lilongwe. www.maikhandatrust.net and www.ihf.org.
23. Ringheim K. When the client is male: Client-provider interaction from a gender perspective. *Int Fam Plan Perspect.* 2002;28(3):170-5.
24. Bloom SS, Tsui AO, Plotkin M, Bassett S. What husbands in northern India know about reproductive health: Correlates of knowledge about pregnancy and maternal and sexual health. *J Biosoc Sci.* 2000;32(2):237-51.
25. Courtenay WH. Constructions of masculinity and their influence on men's well-being: A theory of gender and health. *Soc Sci Med.* 2000;50(10):1385-401.
26. Ministry of Health. Human resources in the health sector: Towards a solution. Lilongwe, Malawi. 2006.
27. Secka E. Men's Involvement in Care and Support during Pregnancy and Childbirth. Gambia: University of Oslo; 2010.
28. Peneza AK, Maluka SO. Unless you come with your partner you will be sent back home: Strategies used to promote male involvement in antenatal care in Tanzania. *Glob Health Action.* 2018;11:1449724.
29. Dumbaugh M, Tawiah-Agyemang C, Manu A, Ten Asbroek GH, Kirkwood B, Hill Z. Perceptions of, attitudes towards and barriers to male involvement in newborn care in rural Ghana, West Africa: A Qualitative analysis. *BMC Pregnancy Childbirth.* 2014;14:269.
30. Kumar A. Role of Males in Reproductive and Sexual Health Decisions. *Acad.* 2007.