INVOLVING MEN IN SAFE MOTHERHOOD: A STUDY OF MEN AND WOMEN IN KAFUE DISTRCT, ZAMBIA

BY

NAMASIKU INONGE NAKAMBOA

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LUSAKA

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DECLARATION

I declare that that this dissertation was written and submitted in accordance with the rules and regulations governing the award of the Masters of Arts Degree of the University of Zambia. I further declare that the dissertation has neither in part nor in whole been presented as substance for the award of any degree, either to this or any other university. Where other people's work has been drawn upon, acknowledgements have been made.

Signature of Author: _____

Signature of Supervisor: _____

Date: 26/06/08

APPROVAL

This dissertation by Namasiku Inonge Nakamboa is approved as fulfilling of requirements for the award of Master of Arts degree in Gender Studies by the University of Zambia.

Examiner's Signature:

1. ..... Date: 26/06/08

2. Nawani Date: 26/06/0

3..... Date:.....

ABSTRACT

In Zambia, maternal mortality rate is estimated at 649 women per 100, 000 per live births. Such deaths are not only deeply rooted in the provision of poor quality health services, but also gender in relations between men and women. Both men and women make important contributions to the production of children yet, demographic studies of fertility and family planning in the past have tended to focus on women alone. Men play important often dominant roles in decisions crucial to women's reproductive health. This study examines the levels and patterns of male participation and seeks to identify the obstacles men face in safe motherhood.

The sample comprised of thirty married women and men of ages between 18 and 49 and interviewed were four medical personnel. Data were collected through focus group discussions and an in-depth discussion with medical personnel at Kafue Mission in Kafue district.

The study established that the decision–making privileges are enjoyed by men and fundamentally affect women's health status. It further revealed that there was a high level of knowledge of the types of Family planning available. However, there was a discrepancy in knowledge and use of family planning methods. It was also established that lack of proper spousal communication led to the gap in men's knowledge leading to their lack of positive participation. The most prominent barriers to male involvement in maternal health included low levels of knowledge, social stigma, shyness and embarrassment and job responsibilities. Though medical personnel also foresaw some obstacles, primarily in the forms of hospital policy, manpower and space problems, they unanimously felt the option of couples-friendly maternal health services would enhance the quality of care and understanding of health information given to pregnant women, echoing attitudes expressed by most pregnant women and their husbands.

However, it is widely recognized that men are often marginalized by maternal health services and are provided with limited access to basic information and knowledge to help them make informed choices and decisions in order to protect and promote their own health as well as that of their families. As a result men tend to get second hand information from their wives after they visit family planning and antenatal clinics. Due to this, it was found that information that men should know is not known to them for example risks of pregnancy and their planning for delivery.

Men's participation in safe motherhood is a promising strategy for addressing some of the country's most pressing reproductive health problems. The study concludes with recommendations to service providers and agencies to include men as partners by adopting a life cycle approach which identifies and services their needs in a way that is both cultural and gender sensitive. Men, starting at an early age when they are still secondary school going children, must be targeted through education to share sexual, contraceptive and parenting responsibilities so to plan their children.

DEDICATION

This thesis is dedicated to my parents who have supported me all the way since the beginning of my studies.

Also, this thesis is dedicated to my daughter, Cecilie and my husband, Peder, who has been a great source of motivation and inspiration.

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CHAPTER 1

INTRODUCTION

1.0 Background to the Problem

Safe motherhood as defined by World Health Organisation is a process of achieving conception, going through pregnancy and childbirth safely, this resulting in the birth of a healthy baby. The woman's ability to have a safe and healthy pregnancy and delivery implies that pregnancies should be planned for while the woman is in the best of health. Safe motherhood is of importance because women's lives are saved. Unsafe motherhood causes millions of women to die due to maternal related conditions. It has been estimated that at least 600, 000 women worldwide die annually as a result of pregnancy and childbirth. More than 90% of them are in sub-Saharan Africa. In Zambia, maternal mortality rate is estimated at 649 women per 100 000 live births. Such deaths are not only deeply rooted in the provision of poor quality services, but also gender in relations between men and women (Nsemukila, 1998).

Historically, most reproductive health programmes focused on family planning and in turn most family planning programmes offered their services exclusively to women. Most programmes, viewed women as the target group and paid little attention to roles that men might have with respect to women's reproductive health decision-making and behaviour. In recent years, a number of family planning and women's health programmes began to acknowledge that family planning and women's health must be viewed in the broader context of reproductive health and the involvement of men in Safe Motherhood Programmes. For instance, the 1994 International Conference on Population and Development's statement that 'Special

efforts should be made to emphasise men's shared responsibility and promote their active involvement in responsible parenthood and sexual and reproductive behaviour including family planning; prenatal maternal and child health; including HIV: prevention of unwanted and high-risk pregnancies.

Men are an important focus for family planning and reproductive health services, not only because they have their own concerns in this area, but also because their participation and behaviour affect women's reproductive health. Research has identified that involving men in reproductive health has a positive impact on women's health in a number of ways, including improving maternal and child health care, preventing or reducing sexually transmitted diseases and AIDS transmission. Studies have shown that involving men can increase contraceptive adoption, contraceptive use effectiveness and contraceptive continuation.

Discussions on the involvement of men in reproductive health also included recognition that gender inequalities between women and men have a significant influence on sexual health. There is a number of growing awareness and debates to testify the importance of men's participation in reproductive health and the process of bringing about gender balance in men's and women's reproductive rights and responsibilities. The involvement of men in maternal health is low in Zambia. According to a study carried out by Centre for African Family Studies in urban and rural areas of the Copperbelt Province in Zambia in 1999, men were found to be marginally involved in child health and maternal care. Therefore, the problem is that there are still obstacles that men face in participating in safe motherhood. To increase male involvement and participation in reproductive health efforts particularly on safe

motherhood, there is need to gain in-depth knowledge and understanding of the participation level of male involvement in safe motherhood.

1.1 Statement of the Problem

There is growing awareness and debate to testify the importance of men's participation in reproductive health and the process of bringing about gender balance in men and women's responsibilities in safe motherhood. Since men play an important role in reproductive health, it is important to examine any obstacles that may hinder their involvement in safe motherhood programmes.

1.2 General Objective

The study investigated the involvement of men in Safe motherhood in Kafue Mission, Zambia. The study came up with recommendations on how to improve men's participation by addressing the various obstacles that they face.

1.3 Specific Objectives of the Study

The first objective of the study is to examine the levels and patterns of male participation in safe motherhood. The second objective is to identify the various obstacles to men's involvement in safe motherhood.

In order to realise the above objectives, the study set forth the following:

i. Determine the role of men in women's health.

ii. Determine the level of men's participation in Children's health.

iii. To establish the dynamics of decision making in Family planning.

iv. Determine the level of family planning knowledge and use.

v. To elicit strategies on obstacles men face in safe motherhood.

1.4 Research Questions

1. What are the levels and patterns of male participation in safe motherhood?
2. What are the various obstacles to men's involvement in safe motherhood?

In order to realise the above research questions, the study set the following:

i. What is the role of men in women's health?

ii. How are the levels of men's participation in children's health?

iii. How are the dynamics of decision making in Family planning?

iv. What is the relationship between knowledge and use of family planning?

1.5 Significance of the Study

If family planning and reproductive health programmes are to reach out to more men, a better understanding of their reproductive intentions is imperative. Increasing male participation may also help improve women's programmes because more men would understand and be likely to support better reproductive health care for women as well as themselves. The new knowledge gained will be added to the field of reproductive health by documenting the practices and obstacles to men's involvement in safe motherhood. The knowledge gained may assist in solving some of the major safe motherhood problems such as unwanted and high-risk pregnancies.

1.6 Limitations of the Study

The study did not include all the population in the reproductive age group of 18 to 49. Only those that were currently married were included. This was because focus of the researcher was on currently married men and women and that the couple level approach involved direct comparison of preferences of two individuals who matter most in reproductive health decision-making.

CHAPTER 2

LITERATURE REVIEW

2.0 Introduction

This chapter was about literature related to the involvement of men in safe motherhood. The study focused on the levels and patterns of male participation in safe motherhood and the various obstacles to men's involvement in safe motherhood.

2.1 Levels and Patterns of Male Participation in Safe Motherhood

2.1.1 Defining Male Involvement

Male involvement is used as an umbrella term to encompass the various ways in which men relate to reproductive health problems and programmes. Male involvement has two major facets: The way men accept and indicate support to their partner's needs, choices and rights in reproductive health; and men's own reproductive and sexual behaviour. The other terms, which are used in this context, are male responsibility and participation. The term responsibility stresses the need for men to accept the consequences of their sexual and reproductive behaviour. Participation refers to men's supportive role in their families, communities and workplace to promote gender equity. Participation also suggests a more active role for men in altogether decision-making with their partners, supporting their partner's choices and using contraception and / or periodic abstinence (Green, 1995).

In the last few years more attention has been focusing on the issue of male involvement in reproductive health. Since its importance is widely acknowledged, programmers and planners are trying to incorporate it as one of the main components of women's reproductive health. However, existing programmes that address men's

reproductive needs tend to share potentially problematic aspects. Firstly, programmes dealing with men's reproductive roles and fertility are usually limited to male methods of family planning, the only element of reproductive health. Secondly, existing programmes tend to address men only in a similar manner as the old programmes addressed women only without taking into account their gender relations (Guerny, 1998). A focus on either men or women alone is inadequate as it fails to take into account the way in which many decisions are made and the context that influences them. Thirdly, they tend to be grounded on negative premises, that it is men's irresponsibility rather than a positive one of promotion of men's rights (Guerny, 1998).

These problematic aspects of men's participation in safe motherhood also emanate from: a female bias in gender literature, and the consequent lack of knowledge of the male side of gender (Guerny, 1998). The traditional inability to set up programmes on the understanding of gender relations, disregarding the power relations and the gender roles that influence decision making related to reproductive health is another factor (Guerny, 1998). Finally, the way in which programmes were traditionally institutionalised through maternal and child health facility of the Ministry of Health, focused on women and barred men from access to services. Men were inhibited from exercising a number of responsibilities in the area of reproductive health of their wives and the health of their children. This was also highly due to the commonly held myths and erroneous assumptions about men's views about family planning and health. There is also lack of data to understand male perspectives and the extent of their involvement in reproductive health issues (Guerny, 1998).

2.1.2 Gender and Decision-making

Gender refers to the roles that men and women play in society and also the rights and responsibilities that come with these roles (CEDPA, 1996, Green C. 1997). Gender roles and relations are reflected in virtually every social institution including family structures, household responsibilities, labour markets, schools, health care systems laws and public policies. The different roles that men and women play in society and the benefits that come with these roles differ tremendously from culture to culture and have different values attached to them (Family Health International, 1998).

Gender stereotypes of submissive females and powerful males may restrict access to health information, hinder communication, and encourage risky behaviour among women and men in different, but equally dangerous, ways. Ultimately, they increase vulnerability to sexual health threats such as violence, sexual exploitation, unplanned pregnancy, unsafe abortion, and sexually transmitted infections (STIs), including HIV (Family Health International, 2002)

From an early age, people are socialized to believe that gender roles are "natural," which contributes to beliefs that risky sexual behaviour is unavoidable

Gender has a powerful influence on reproductive decision-making and behaviour (Mccauly et al 1996). The knowledge of gender relations in a culture or between husband and wife will help the decision-making and establish the role men play in safe motherhood and their level of participation (Riley, 1997).

2.1.3 Male Involvement In Family Planning

Family planning often encompasses two distinct concepts: Contraceptive use and family planning services. Contraceptive use is exercised by an individual or couple as a means to avoid pregnancy. (Population Reports, 1994). There is a lot known about what women think about family planning services but very little about what men think. Yet men's knowledge, perceptions and concerns about family planning methods are likely to influence their behaviour. (Rutenburg, 1999). In virtually all surveys of adult men, a large majority (90%) of them can identify at least one contraceptive method. In Niger, for example, 85% of the men surveyed knew at least one method compared with 77% of women. In other countries the percentage is as follows: Egypt 97%, Tanzania 93%, and Uganda 98%.

In Zambia, knowledge levels are almost identical between women and men. According to the 2001-2002 Zambian Demographic Health Survey, in general 98% of all men and women know at least one method of contraception. Modern methods are more widely known than traditional methods. The data shows that 98% of all women know of a modern method compared to 72% who know of a traditional one. Three in four married women and four in five married men indicated that they have some knowledge about a traditional method. The most widely known methods by both men and women are the contraceptive pill (94%) and condom (93%) known by about 94% of married men and women (ZDHS 2001-2002). Another difference in the knowledge of any contraceptive methods known between currently married women and currently married men is 99% and 98% respectively. According to a study carried out in 1998 about factors associated with maternal mortality in Zambia, the overall knowledge of family planning among men in 1998 was 96%. The

percentage has since then risen to 98.0% in the 2001-2002 Zambian Demographic Health Survey (Nsemukila, 1998, ZDHS 2001-2002).

Men can be fully involved in family planning by showing their approval of using contraception and the actual use of contraception. The Population Council findings indicate that a man's views on family planning can influence his partner's attitudes and her access to services, thereby determining the timing and number of pregnancies she may have (Population Council 1998).

When couples have a positive attitude toward family planning, they are more likely to adopt a family planning method. In the 2001-2002 ZDHS survey, it was found that 65.1% of the currently married couples both approve of family planning. The data also indicate that 70% of currently married women reported having discussed family planning with their husbands. About 29% never discussed family planning with their husbands. This is a great improvement from the 1996 ZDHS survey which found that out of the 85% of husbands that approved of family planning; only 31% discussed the subject with their wives (ZDHS 2001-2002, ZDHS 1996). The question remains what about the 69% of men? Why do they not discuss family planning?

Urban men with higher levels of education are more likely to approve family planning than urban men with lower levels of education (Roudi and Ashford, 1998). This is partly because of the differentials in access to information between rural and urban areas (Rutenburg, 1999). Men in rural areas are disadvantaged in that they have limited access to information about family planning. The issue of lack of access to information is related to approval because in earlier days, family planning methods

were mostly for women and not men and people have developed a culture thinking that family planning is just women's issue (Roudi and Ashford, 1996).

This view is supported in a study conducted in Cameroon, which found that only 20% of men with no education approve of family planning, but 75% of men with secondary or higher education approve. In the 2001-2002 DHS of Zambia, it was found that the largest differentials in current use of contraception are found among educational groups. Contraceptive use increases steadily with increasing level of education from 23% among married women with no education to 55.5% of women with secondary or higher education (ZDHS, 2001-2002).

2.2 Obstacles of Men's Involvement in Safe Motherhood

2.2.1 Rationale for Male Involvement

During the last two decades or so demographic literature has been preoccupied with men's participation in reproductive health. The Cairo declaration reiterates that men need to be more responsible and participate more in reproductive health issues. Some changes in this direction have been documented- men are becoming more supportive in family planning and men's access to reproductive health services is improving (Lazarus, 1999).

When we think of reproductive health or safe motherhood, we think of women – their concerns, their issues and the need to empower them to make decisions. However men's lack of participation undermines women's health. Many women cannot ensure their own sexual and reproductive health without the availability of services and education for men (WHO, 1998). In particular the use of contraception

is often dependant on male participation or acceptance. Men can help slow the spread of HIV/AIDS and other sexually transmitted diseases, prevent unintended pregnancies and reduce unmet need for family planning; foster safe motherhood and practise responsible fatherhood (Drennan, 1998).

Involving men increases their awareness, acceptance and support to their partner's needs, choices and rights. Awareness in this case refers to men being alert on how they affect women's reproductive health because they make decisions that affect women and their health. Gender awareness affects sexual behaviour, reproductive decision-making and reproductive health (UNFPA, 1999).

In terms of contraception, for example, it means encouraging men to give more support to their partners who use female dependent methods. In terms of HIV prevention, all methods except for the female condoms are male controlled. Therefore, there is need to involve men in this domain (Guerny, 1998).

The challenge of involving men in Reproductive Health interventions is simply not a matter of overcoming feelings of shame and embarrassment but must also address cultural traditions associated with seeking health care. The public system suffers from limited staff and poor capacity. Many health centres, particularly in rural areas, are under stuffed and under equipped and operate at inconvenient hours. Financial constraints, loss of income through lost work time or the inability to arrange transport are all factors that prevent men from either accompanying their wives to reproductive health appointments or keeping their own appointments. (Walston, 2005).

2.2.2 The Role of Family and Gender Roles

The high degree of male involvement and in certain age groups, male control of reproductive decision-making maybe explained by two cultural factors: the importance of the family , particularly of parents and older relatives in the transfer of ideas and attitudes to young couples and the persistence of traditional beliefs about primary roles of men and women within the marriage. Strongly held traditional belief and responsibilities and roles of husbands and wives have influenced the range and control of reproductive decision-making. (Mihira, 1997).

Men in Africa, who are the heads of their households, are often key figures in domestic decision making particularly about fertility behaviour and preferences (Isiugo- Abanihe, 1994), and that authority is supported by tradition. In addition, they are the main link between family planning and the prevailing culture (Toure, 1996). They are also the major players in bringing development to the home and thus referred to as the main link (Fapohunda and Tadaro, 1998). Fapohunda and Tadaro observed that African structure shapes spousal perceptions of fertility and that, men and women do not necessarily have the same views about family planning and reproduction. This is because their interests are shaped by expectations which are determined by the social structure of their households and community.

According to a study conducted by Ezeh et al 1996, evidence of men's participation in reproductive health is shown in a study on Nigerian couples where men and women were asked who makes the final decision on issues such as family size, when to have sex and how long periods of sexual abstinence should last. It was found that close to 60% of the men said they decide and 40% to 50% of the women agreed that

men decide on issues such as family size, and the period of abstention (Ezeh et al 1996).

Fapohunda and Rutenburg, 1998, argues that understanding men's perspectives on reproductive health could provide more insights than are possible by studying women alone because men have more power than women in reproductive decision making including determining the number of children and whether or not to use family planning. This is substantiated in a survey carried out in Malawi to examine the relative roles of men and women in making decisions regarding childbearing and the use of traditional and modern methods of family planning. Using quantitative and qualitative data collected, contrary to what many other studies have suggested, the results show that men have traditionally played a limited role in making decisions relating to initiation of child-bearing and the use of traditional methods of contraception (Population Council, 2001).

2.2.3 Gender Roles and Communication

In many countries traditional female gender roles deter couples from discussing sexual matters, condone risky sexual behaviour, and ultimately contribute to poor reproductive health among both men and women (Danforth and Jezowski, 1994). The traditional roles normally assigned to women and men are through the socialisation process, which inculcate ideas of male power and female subordination (Hollander, 1997). Concepts of womanhood emphasise a secondary subsequent and supportive rather than a leadership role. On the other hand, concepts of manhood, which emphasise dominance, power, authority and entitlements, are inculcated in men. In other words the man is the head and the woman the tail. It has been found

that because of these roles of superiority, many women around the world may have trouble talking about sex and reproductive health issues (Blanc, 1996). In addition, in many developing countries men are the primary decision makers about sexual activity, fertility and contraceptive use (Danforth and Jezowski 1994, Bryant et al 1998). This leaves women utterly powerless to make reproductive health decisions. Women end up having an undesired number of children and sometimes even difficult pregnancies as the husbands dominate reproductive decision making, whether regarding contraceptives use, family size, birth spacing or extra marital sexual partners (Bryant et. al., 1998)

It is the inequalities in power that often make women vulnerable to men's risky sexual behaviour and irresponsible decisions. Little is known about the dynamics of couples' sexual and reproductive decision-making or about how gender roles affect these decisions. Such decisions can include when and how to have sexual relations, breastfeeding, and seeking prenatal care (Beckam, 1993). One aspect of the shift in gender issues is the necessity to encourage and facilitate corresponding changes in traditional male perceptions of men's roles and identities. Talking of female alone or male alone is not an adequate approach to reproductive health issues. Many of the decisions regarding reproductive health and family planning are made within a set of gender relations that affect them or their implementation. In addition, all methods of family planning and most of STIs and HIV prevention are traditionally labelled either as male or female methods. More attention should be paid in identifying to what extent each one of the methods requires cooperation and support of both sexes and its implication on the health partners (Guerny, 1998).

2.2.4 Contraceptive Use

Research found that in regions where men favour family planning, there is a strong influence on the use of contraception (Rinmon, 1996). A study conducted by Ezeh et al, 1997, suggests that contraception is two or three times more likely to be used when husbands rather than wives want to cease child bearing (Dodoo, 1998).

In the 2001-2002 ZDHS, almost 70% of currently married women report having used a method of contraception at some time. Currently, married men who have ever used contraception are 80.9%. On average, according to the 2001-2002 ZDHS, 16% of the married women with unmet need for family planning cite husbands' disapproval as the principal reason for not using contraception. 2001-2002 DHS findings indicate that 34% of currently married women are using contraceptives. This is a positive indicator as in the last ZDHS survey it was only 25.9%. Furthermore, qualitative studies among married women with unmet need for family planning demonstrate the powerful role that their husbands lay in determining whether they use contraception. A key question is why they do not apply their knowledge? In Utter Pradesh 87% of women with unmet need said the decision to use contraception ultimately rests with the husband. Meaning that if the husband is not positively involved, the woman suffers the consequences of not using family planning which include unwanted pregnancies (Yinger, 1998).

At present there is little choice of male methods of contraception available, and men have fears and concerns about the methods that are available. The exclusion of men from education regarding sexuality, fertility, contraception and the prevention of

STIs will lead to their lack of involvement (Guerny, 1998). Can this be applied to Zambia?

Some studies have shown that men are willing to participate in safe motherhood and general family planning activities. Yet, not much has been achieved in encouraging them to play a much bigger role. Therefore it is imperative to try identifying the prevailing obstacles that have been seen to deter the active participation of the male folk and at the same time identify strategies that would help to check the trend. This study examines the relative roles of men and obstacles they face in safe motherhood with the aim of finding strategies that can overcome the obstacles.

CHAPTER 3

METHODOLOGY

3.0 Introduction

This chapter first elaborated on methodological approach used and the choice of techniques used to collect data. It also gave a description of the data analysis process. This chapter described the researcher's experiences of the fieldwork during the data collection and the participants who were involved in the study and how the data was collected from the study site.

3.1 Research Design

The study used qualitative methods and a short questionnaire was used to gather basic demographic and socio-economic information including the level of education, place of work, income status, personal and household assets. Focus Group Discussions (FGDs) were used so as to get an in-depth understanding of the level and patterns of men's participation in safe motherhood and the obstacles men face in safe motherhood. In total 6 FGDs were conducted with both women and men. A few days before data collection the facilitators went out to publicise the study and elicit community participation.

The FGDs was the principal method used to gather information from the community. This was a participatory valuable tool for studying the people's varying perceptions in factors hindering men's participation in safe motherhood. Keeping the objectives of the study in mind, the FGDs systematically provided answers to research questions through unstructured interviews with groups of men and women respectively. FGDs engage participants in active comparisons of their opinions and experiences and in so doing creates lines of communication that connect the

participants to one another and to the research team (Kruger 1998). A team of two field assistants of the same sex as the participants and a moderator facilitated each FGD. In addition to the notes, all discussions were recorded on an audiotape.

3.2 The Study Area

The study was conducted in Lusaka district in a small town called Kafue, Kafue Mission, which lies about 35 kilometres from the capital Lusaka. It has a growth rate of 3.2 percent and 11 percent of people in Lusaka province live here. Since the main objective of the study was to examine the levels, patterns and obstacles men face while participating in safe motherhood in relation to family planning, it was felt that such a study would be more meaningful when conducted in a semi-rural area as it represents characteristics of both an urban and rural area. Another condition kept in mind in the selection of the area was the availability of data from a research in 1998 conducted by Nsemukila Bullet on factors affecting Maternal Mortality, which ranked Kafue as the forth-highest district with high maternal mortality at 38.2 percent. This figure makes it the highest in Lusaka Province (Nsemukila 1998).

3.3 Selection of Respondents

The sample used was from women who attended the antenatal and postnatal clinics. These were sampled using the purposive sampling. This means that the researcher selected those members of the community who she thought would provide her with the best information.

Most male and female surveys in reproductive behaviour undertaken in Africa have tended to focus on the age group from 15 to 54 this marking the onset of puberty and

the end of childbearing (Ezeh et. al, 1996). In this study, the age group considered was between 18-49 years because it represented the most sexually active age group and was most likely to be in a marital relationship. Participants in the focus group discussions were selected with the help of community facilitators, including personnel from the Health Centre. The medical personnel at the clinic also helped with the informing of the women that attended antenatal and postnatal clinics of the forthcoming discussions.

The sample consisted of currently married couples living together. The choice of currently married couples came from the understanding that couples as a unit of analysis add a different perspective and enhances the understanding of reproductive health and decision making with regard to safe motherhood. In the same vein, the criterion of living with the husband became necessary as the decision making power of the wife and husband were given stress in the study. Sampled also were the medical personnel involved in offering family planning and antenatal services at the safe motherhood clinic.

3.4 Data Collection

Data collection was carried out using focus group discussions to encourage participation by the respondents. Firstly, background data was collected through a structured interview with the participants before the sessions began. This was to have an insight of the basic demographic and socio–economic information including education, age, occupation, income status and head of the household. The participants consisted of married women and married men of ages 18 to 49.

The groups were stratified by age and sex to enable participants to discuss freely in their groups. Each discussion had about 6 persons and took one hour and in some instances one hour thirty minutes. The FGDs were held with separate groups for men and women. Altogether six FGDs were held with the participants. Data from the FGDs were also recorded using a tape recorder. In-depth interviews were held with key personnel from the clinic, which offered safe motherhood services.

3.5 Data Analysis

Analysis of data was done manually along major themes. The qualitative data from this study was analysed as well using the tally sheet method. Tally sheets are specially prepared sheets that show all possible responses and are useful for comparing, summarising and analysing qualitative information. Broad categories were developed to describe the ideas, opinions and attitudes that emerged were noted and related to the objectives. Comparison and critical analysis of ideas led to findings and interpretations. As an initial step, the data was classified on the basis of different characteristics. Correlation analysis was done to find the association between variables. Cross tabulations were also used to examine the variables between the Socio-economic variables and knowledge, attitude and behavioural variables.

Information collected using questionnaires was firstly edited for consistency. Open-ended responses were edited and assigned codes before being entered in the computer. As for the FGDs, the scripts were typed and analysed according to the groups of investigation. The key themes that emerged from the discussion and fell under each of the guide headings were identified and grouped together.

3.6 Limitations of the Study

An obstacle met during the data collection was the lack of eagerness of the participants to discuss sexual matters with a stranger, especially the men. This resulted in respondents giving very brief responses to the questions asked. Probing had to be done very delicately. Another drawback was that the respondents expected to be paid for participating in the discussions and when they discovered that they would not be paid, some of them were not willing to participate. They wanted to be given something for imparting their knowledge to the researcher and said when NGOs ask them to participate in such things they are given something to take back home. However, an incentive of light snacks and refreshments was offered to the participants which helped to relax the throughout the session.

CHAPTER 4

PRESENTATION OF FINDINGS

4.0 Introduction

Among reproductive health programmes, family planning is the one in which the fieldwork has the most experience in involving men. Including men in programmes and services has become increasingly common and important in the past decade. This study investigated different dimensions of levels and patterns of male participation as well as the obstacles of men's involvement in safe motherhood. These dimensions included male involvement in family planning, spousal discussion of family planning and STIs/HIV/AIDS infections, and notification of infection. Each of these dimensions is crucial to understanding of the dynamics of spousal negotiation and decision making about family planning and fertility. The findings of the study are presented in two parts: Levels and patterns of men's involvement in Safe motherhood and obstacles to men's participation in Safe motherhood

4.1 Levels and Patterns of men's involvement in Safe Motherhood

4.1.1 Background Information

The majority of the male respondents fell between 29 and 40 years old, whereas the women were 18 to 37 years old. The male respondents outnumbered the females in ages above 30 years while the females were more than males in lower ages.

The highest concentration of men, 75% had received secondary education only 16% of the women had received secondary education whereas 83% of the women had received primary education.

84% of the women were engaged in some form of employment. All the male respondents were engaged in either formal or informal employment. The dominant occupation was farming. 34% of the male respondents were government employees. Among the women, farming and trading ranked highest with 34% of the women engaged in either. 16% of the women respondents were not involved in any form of income generating activities.

4.1.2 Differential in Family Planning Knowledge

Family planning was defined as a method of spacing children and planning the number of children to have. Data revealed that awareness of family planning was high among both men and women. Almost all of the participants knew at least one modern and traditional method of family planning. The following were the most common: contraceptive pill, male condoms and female condoms, injectables, Norplant, female and male sterilisation, withdrawal, rhythm, periodic abstinence and what was termed as African family planning. African family planning was described as a method where one tied a string around the waist with a tube filled with one's blood mixed with some herbs.

4.1.3 Family Planning Practices

Family planning practices seem widely spread and used. The methods which were currently used included: the contraceptive pill commonly referred to as *"family planning"* and the injectable also referred to as *"Injeleti"* which was widely used by both age groups of women in the study. *"Injeleti"* means injection in the local language spoken. Surprisingly, the injectable was most common for the ages between

18 and 29 years old. The condom was not a favourite among men as can be derived from the following responses.

> *'Me, I can't use a condom with my wife. Why? She is my wife. What am I afraid of? There is nothing to be afraid of. I would rather she swallows the contraceptive pill and we do not use the condom,'* 25-year-old man.

> *'Condoms are for girlfriends not wives. What will she think if I used a condom with her? Obviously she will suspect me of being unfaithful or worse that I have an illness which I do not want to pass on to her,'* 22-year-old man.

On the traditional methods, the rhythm and periodic abstinence use in marriages was not common, as the husbands did not cooperate although the women were willing to use them. The withdrawal method was considered as wasting *"pouring out seeds,"* according to a 29- year- old man.

From the discussions with the female and male groups, there was a discrepancy in the use of male condoms as the men recorded more than 50% use while none of the women used male or female condoms. This could indicate that the men might have used male condoms with partners who were not their wives. Table 4.1 summarises the findings on levels of knowledge of contraceptive methods as discussed in the preceding sections.

Table 4-1 Knowledge of types of Family Planning

Age Group	Pill	Injectable	Implants	Male condom	Traditional family planning	African family panning
Women 18-29	100%	100%	100%	100%	100%	0%
Men 18-29	100%	100%	16.7%	100%	33.3%	0%
Women 30-49	100%	100%	100%	100%	100%	16.7
Men 30-49	100%	50%	50%	100%	100%	0%

Source: Primary data

As can be seen from the table, Knowledge of methods of family planning is quite high. The most common methods were: Contraceptive Pill, Injectable, Male condom and Traditional family planning which includes rhythmic and periodic abstinence. The least known was the African family planning which none of the men knew and only the women in the age group of 30 to 49 could site.

4.1.4 Non-Use of Family Planning Methods

The common reasons for non-use of family planning methods among both men and women were infrequent sexual relations with spouse, breast-feeding, high failure rates and fear of side effects, especially with the contraceptive pill. Among the female participants who used contraception, one woman revealed that she had been using the contraceptive pill when became pregnant.

> *'Some women do not use because they are afraid of side effects of the contraceptive pill. You know, women get really fat when they take the family planning. I know one woman who was slim before she started taking it. When she was put on the contraceptive pill, she got disfigured and her husband was not happy with her. Others I have heard do not get their monthly period. Now, why take the family planning when you cannot be a normal woman?'*
> 28-year-old woman.

Desire for children, especially those in the younger age group seemed to be another reason for non-use. Cultural and religious practices contributed to non use of family planning methods.

4.1.5 Reasons for use of Family Planning Methods

Four broad reasons were derived from the data for the use of family planning methods, which included prevention of unwanted pregnancies, child spacing, economic stability and health status. Participants argued that family planning offer some economic advantages with the high cost of living. The fewer children one had

the easier it was to send them to school, give them shelter, clothe and feed them. This was one of the responses given,

> *'This time one cannot afford to have so many children. What will you feed them? How will you take them to school? At the same time they have to dress properly. Even "salaula" that was cheap is now expensive. No we have to use family planning so that we do not have too many children whom we cannot take care of,'* 32- year- old woman.

4.1.6 Decision Making/Male Involvement in Fertility Decisions

Inter spousal communication on family planning related matters is associated with a number of issues including contraceptive use, antenatal and postnatal attendance, number of children to have and when to have them.

50% of the women's husbands approved contraceptive use while the other half did not. Those whose husbands approved said that there were considerable disagreements why they should both use birth control methods. For the other 50%, in spite of non-approval, they secretly adopted a family planning method without their partners' consent. None of the women were accompanied by their husbands to the family planning counsellor. These were the main reasons given:

> *'It is my responsibility, my husband says. After years of being together I know I have to use the contraceptive pill. If I do not, I am the one who suffers. He has other things to worry about which he considers important.'* 32- year- old woman.

> *'Husbands prefer the woman to use family planning not him to use but with their girlfriends they use condoms which they do not want to use with us. That is why, when you come to the family planning clinic there are only women and not men,'* 35-year-old woman.

All the men in the 30 to 49 years FGDs said they approved family planning mostly because their wives kept on talking about it. Discussion of family planning was mainly initiated and done by their wives and then a decision was reached together.

Although the men did not hesitate to say they had the final say in the matter meaning that they had the authority. The main reason given for not encouraging their wives was that it was women's responsibility. The men also expressed fear of their wives becoming promiscuous. Table 4.2 shows the percentage of the participants using the various types of family planning methods.

Table 4-2 Type of Family Planning being used.

Contraceptive Method	Women	Men
Pill	63%	56.7%
Injectable	81%	50%
Implants	50%	0%
Male condom	0%	75%
Female Condom	0%	0%
Withdrawal	0%	50%
Rhythm /natural family planning	16.7%	16.7%

Source: Primary data

The results show that the use of female oriented methods was higher that male oriented methods. As might be expected like other surveys men have reported a higher use of the male condom than the women. Traditional methods were not commonly used. From the percentages there is inconsistence in the spousal reporting the usage of family planning, which could indicate lack of proper communication.

4.1.7 Ideal Number of Children

There were various reasons given for having children. These tended to be the same general ideals from family planning surveys. Children were regarded as a gift and blessing from God. At the same time having children was a fulfilment of being a

woman. Fertility was of high importance and a woman who is infertile is at risk of being divorced.

In this study, both men and women were asked about the number of children they already had and the number of additional children they desire, and their ideal number of children. The response to the above showed that in the women's younger group of ages between 18 and 29, which had just entered the child-bearing age and marriage, 2 out of the 6 women discussed with their husbands the number of children to have and how to space them. Three years seemed to be the preferred age difference. The number of ideal children had not been discussed with their husbands but they said that they would like to have enough children depending on their husbands. Fifty percent of the women desired more children citing that they had just started bearing children and would like to have more. The other 50% said they did not desire more children as they had already borne the desired number.

The younger men, on the one hand, when asked about discussing the number of children, a third of the participants responded that they did whereas two thirds did not. However, when probed, there seemed to be no clear indication on the discussion on the number of children to have. However, one man said he already had three male children and he wanted to have a female child. He was ready to have as many children as possible until his wife gave him a female child. The number of children desired ranged from 2 to 4 and the preferred age difference given was from 2 to 3 years. The men intimated that they were ready to listen to their wives' suggestions about family planning but the final say lay in the man's decision.

4.1.8 Men's participation in Women's Health

When asked if the husbands accompanied them to the clinic, all the women stated that their husbands did not accompany them to antenatal clinics and were not reminded by their husbands to go for antenatal clinic. They said the husbands told them it was their duty to go to the clinic and not the men's. The women added that in spite of the men not attending antenatal clinics they helped them stay healthy by sometimes assisting in household chores and going through the clinic card. Though on doing the household chores there was a debate, as men did not like to be seen as weak by doing household chores, which have been labelled as women's work.

Most husbands, according to the women, did not arrange for skilled care during delivery or before. They had never at any given time gone to the clinic to discuss delivery with the medical personnel. However, the couples did discuss which clinic to deliver from and the wives choose the place because the husbands had no idea about the status of the health centres.

The men reported that they rarely took part in antenatal activities. It was common for the men to accompany their wives to the antenatal clinic during the first pregnancy. The one man that accompanied his wife to antenatal did it only once and according to him he felt out of place, as he was the only man present. The men instead preferred to go through the card records and ask their wives how the clinical sessions went. Almost all the men did help with the first baby but with the subsequent ones they did not. The statistics of the responses are given in Table 4-3.

The men were also asked if they helped their partners stay healthy while expecting a baby, they said they did. They helped with the household chores. The men also said they helped their wives stay healthy by providing both transport to the clinic and funds to pay for visits to the clinic. 90% of the respondents did not arrange for skilled care during delivery. The men were not aware how many times a woman was supposed to attend antenatal or postnatal clinics. The responses varied from monthly to every three months until delivery.

> *'Monthly? But I am not sure. These things our wives would know better,'* 29- year-old man.

> *'You guys you do not listen to your wives. It is changes as the pregnancy develops. First it is every month then every fortnight and then every day until she delivers,'* 29- year- old man who seemed to have an idea about antenatal and postnatal gave the most accurate response.

However, the men knew the benefits of antenatal clinics and when asked how they knew without attending the clinics they said that their wives told them. The following were some of the benefits of antenatal care given, advice on food to be taken, pregnancy care, monitor progress of baby, check mother for diseases, check blood pressure, proper assistance to be given during labour.

The men were also asked about the causes of miscarriages and their responses varied. The men in the younger age group gave more responses to this question than the older ones. The FGDs with the 30 to 49 could only give two responses and said their wives knew better. The men were not sure whether their wives attended postnatal care.

Table 4-3 Inter spousal Communication

Age	Discuss FP	Do not discuss FP	Partner's opinion on FP			Encourage partner to use FP	Desire more children	Discuss no. of children	Accompany wife for FP
			Not sure	Approves	Not approve				
Women 18-29	50%	50%	16.67%	33.33%	33.33%	N/A	100%	66.67%	N/A
Men 18-29	100%*	0%	0%	100%	0%	100%	75%	66.67%	0%
Women 30-49	50%	50%	-	66.67%	33.33%	N/A	-	100%	N/A
Men 30-49	100%*	0%	0%	100%	-	33.33%	-	-	0%

Source Primary Data

Communication between couples regarding family planning is important as can be seen from the findings that there are some discrepancies between men and women on issues such as approval for family planning or the type of method to adopt. The 100% recorded for men is usually reached because of insistence and persistence from the women. In some instances there are no figures because the partners did not know what their partners views were as they had not talked about it.

4.1.9 Men's participation in Children's Health

When asked who was responsible for the immunisation and taking children to the under five clinic, the men said that task was left to their wives. According to the responses given, men felt that Under Five Clinics were meant for women, as they did not feel welcome because the place was full of women who stared at them suspiciously. The men could only take a child for immunisation when the wife was very ill or not available. Often the question asked by the medical personnel is where the wife was for the man to bring the child to the clinic.

4.1.10 Men's Awareness of Pregnancy Risks

Prompt recognition and immediate care seeking when faced with any life threatening circumstances is considered one of the most life-saving behaviours in pregnant women. However, men seemed surprised when they were asked whether they discussed risks of pregnancy with their wives. It was obvious from the responses that they did not take into account the risks involved.

4.1.11 Gender Relations and STIs, HIV/AIDS

The discussion results on STIs and HIV/AIDS were almost same, although it was not easy for the men to talk about. The initiative came from the women most of the time as they said it was inevitable because they were at more risk than the men. In addition, both men and women were asked whether they would tell their partner if they found themselves with an STI or HIV. The purpose was to determine how men and women perceive their responsibility for their spouse's health.

There was a universal agreement among the men that it is not easy for a spouse to tell the other spouse about having an STI because revealing such information was an admission of unfaithfulness. This in turn brought disharmony to the household. If they were able to get treatment privately, then they would go ahead without informing the wife. In contrast, if they contracted HIV/AIDS it was a different matter. They would inform their wives but with great difficulty due to fear of being rejected and divorced as can be concluded from the following selected responses:

> *'Myself I think I would tell her but I will have to prepare her first. I like to think I am a good counsellor. I will talk to her and ask her to go for an HIV test. But for STI no ways would I tell her,'* 40-year-old man.

> *'On that one, in the end I have to tell her but I would rather not tell her as I am admitting that I have girlfriends and I am unfaithful to her. If I can get treatment for*

the STI then I would do so, without her knowledge. For HIV/AIDS that is a serious issue which has to be discussed,' 37-year-old man.

Looking at the similar responses given by both men and women in assuming that men were the ones responsible for bringing the infection in households, the men were asked to explain why they assumed so. There was a chorus response that it could not be the women bringing the venereal diseases in homes because the men are the ones that have affairs outside marriage. A 40-year-old man stated clearly:

'It cannot be our wives. Impossible, we are the ones that have girlfriends not them. We, men, have girlfriends even us sitting here cannot deny it. But bringing the illness into the home then you are stupid! That is why we use condoms with our girlfriends,'

However, if by any chance the women found out that they had an STI they insisted they would inform their husbands as they (husbands) were the ones who brought the illness in the home as can be seen from the following responses:

'Yes definitely, I will tell him, because he gave me the disease he must know. And I will also inform my relatives and his so that he is punished. It will not be me to bring the disease in our home but him. These men, you can give them all they want but they still go to prostitutes!' 30- year- old woman.

'I would tell him, there is nothing to hide because it eventually comes out. And I have to tell him so that he would not say I brought the illness while it is him who did so,' 26-year-old woman.

4.1.12 Interview with Key Informants

The average number of people who attended antenatal and postnatal clinics per month was 395 and not one of them were men. The clinic offers family planning sessions for both men and women on a daily basis. On average 5 men and 186 women attend the sessions in a month. Out of that number, 2 couples came together to the family planning clinic.

The clinic has 4 members of staff out of which 1 is a man. Already the composition of staff shows an imbalance of gender. This could serve as an obstacle to men visiting the clinic. The centre does not have any programmes to encourage men's participation in safe motherhood.

The staff acknowledged the importance of male participation by citing ways in which it would benefit the couple: Good planning and implementation of health education, Early family planning, Men would know the health status of women; Men would learn the risks of pregnancy. Men thought children were supposed to be under the care of women, cultural beliefs that do not allow men to discuss issues like child bearing, fear of stigma and lack of knowledge were some of the reasons the staff thought men did not fully participate in safe motherhood

Challenges should be taken up in order to establish strategies for male involvement in safe motherhood. The sister-in-charge was of the view that the government should come up with a mandatory policy for men to be involved in such programmes. Certain programmes should be put in place to empower the community to carry out sensitisation programmes or sessions. There should be added efforts to sensitise men from both the government and Non Governmental Organisations through the media. More reproductive health education should be given to the community through health care providers, community workers, chiefs, headmen and even the church leaders. Men should be encouraged to attend antenatal and post natal sessions with their spouses.

4.2 Obstacles to Men's Participation in Safe Motherhood

This section introduced the obstacles men faced when participating in safe motherhood. The participants were asked to give examples of the obstacles men face. The responses came from both the women and the men's point of views. Because the responses were similar, they were grouped according to the type of obstacles: personal, cultural and institutional.

4.2.1 Personal Obstacles

These were obstacles that men faced in participating in safe motherhood as men because of their sex. It included their emotions, fears, confidence, courage and their motivation as fathers and husbands.

The first obstacle found was that men simply lack motivation to be involved in maternal health. This is attributed to the way maternal health is perceived as being for women only and men had no major role to play. As can be read from the following responses,

> *'It is considered as women's business or matters. The hospital personnel think we are ignorant for example, the nurses will not allow me in the labour ward when my wife is delivering. They say it is only for women,'* 37-year old man.

Lack of support to share or discuss maternal or family planning with spouses was the second obstacle found. Because family planning was left to women in earlier programmes, men feel left out especially when they wanted to discuss family planning because they felt that women knew better than them as they attended the clinic sessions.

Low priority toward family planning or maternal health among men was another reason. Men being the head of the households have not prioritised contraception as they see it as the responsibility of women. They look at women's maternal health as something normal that does not warrant their involvement.

The men were afraid of being rebuked at the health centre by the nurses why they do not take care of their children and wives. The male folk seemed to have this idea that the service providers at the hospital would not be amused with their attitude towards the family. This view came out from a 29-year- old woman and was supported by the rest of the group.

Fear of being laughed at by friends for getting involved in women's issues was the fifth personal obstacle. This seemed to be one of the largest and common obstacles because of gender. In society men and women are given gender roles. Looking after children and attending antenatal clinic is seen as a woman's job. If a man was seen to be doing that work he was perceived as weak.

> *'I cannot help with household chores or be seen sharing mothering duties like going to under five clinic or go with my wife to ante natal or postnatal. Even if she is not pregnant I will not do it what will my neighbours say? 'Look at him he has been given love portion and he is under petticoat government!'* 40-year-old man.

Finally, men had no time to attend family planning sessions and antenatal clinic because they are the breadwinners. They had no time to attend the sessions as they are out working and most of the time the sessions take place at the clinic.

4.2.2 Cultural Obstacles

Men held a number of beliefs and misconceptions regarding family planning, which were obstacles for them adopting it or support their wives use family planning. For example, men believed that contraception is women's business and that women are not supposed to suggest the use of condoms as it reduces sexual pleasure and that some methods make women unresponsive during sexual intercourse.

The belief that women talked too much and if a woman saw you at the clinic, everyone in the neighbourhood would hear about it and the man will be a laughing stock in the community. Closely connected to the above belief is that society frowns upon a man who accompanies his wife for antenatal, family planning and under five clinics. He might be considered that he is very possessive if he follows her everywhere.

4.2.3 Institutional and Policy Obstacles

The findings in this section agreed with earlier studies on the way in which programmes were traditionally institutionalised through Maternal and Child Health that focused on women and children barred men from access to services and from exercising a number of responsibilities in the area of reproductive health of their wives and the health of their children. One 32-year-old man said:

> *'When I take my wife to the clinic they won't allow me to enter the labour ward. They won't allow me. They will tell me to wait out side. They won't allow me.'*

> *'It would be nice if we went the centre and there is a section where someone will teach us about what is expected of us! Instead of just letting us line up with a lot of women who stare at us all the time!'* 28-year-old man.

There were no special programmes for men but services were only offered to couples or women only. Thus men felt left out and unimportant. Men would like at times to visit the health centres on their own without their partners to discuss their sexual health but the facility is not offered to them. The programmes that were in place, were directed at mothers and not fathers. A 39-year old man pointed out,

> *'They should not just put posters and pictures at the clinics. They should talk to us how to look after the baby and mother. However, we are now old maybe the younger ones still in school should be taught some life skills how to look after the baby, bath and feed him! Tell the young men the importance of attending antenatal clinics with their wives.'*

Men were not allowed to enter certain wards at the hospital like the labour ward. This simply consolidated that reproductive health is for women not men as they cannot witness the birth of their children. It should be left as a choice to the men whether to attend the birth or not. In addition, the times set were inconveniencing because men wanted flexible hours so that services were available when they needed them.

4.2.4 Strategies for Overcoming the Obstacles

To elicit greater participation from the male folk, the participants were asked to give strategies for overcoming the obstacles cited above.

The first major strategy proposed was that antenatal and postnatal clinics should be more male friendly. This can be done by adding more masculine dimension to their reproductive health services. However, a first step had been taken by changing the name of Maternal and Child clinic to Safe motherhood clinic. The original name excluded men totally from the services as it indicated that it was for only women and children. There should be efforts to integrate men's reproductive health care into the

existing approaches since they have had little opportunity to learn bout reproductive health or reproductive health programmes.

Setting up the same clinic for men and women is the best way to carter for the needs of couples, especially if the care being sought requires that both be treated. Married couples should show a good example to the youth by going together for family planning, antenatal without fear or shame. In addition services could be offered to either men or women alone if necessary.

Society must also change their attitudes towards men and women. The macho concept should be removed and this can only be achieved by working to remove the socio cultural barriers. The barriers include that all decisions must be made by men and that men must not be seen as weak by doing women's duties, which include visiting antenatal clinics and family planning clinics.

Reproductive health education should be introduced in schools so that as the young ones grow up being aware of their reproductive responsibility. There was also a cry from men that there was need to have sensitisation on men's role in safe motherhood. To overcome the lack of information for men, programmes should provide information directly to men, train service providers, improve quality of service and integrate services for men into existing health care particularly at community level where services are offered. Information, education, communication could play a greater role in increasing men's participation in safe motherhood if the cultural, financial, political and technical obstacles standing in the way of IEC could be overcome.

CHAPTER 5

DISCUSSION OF FINDINGS

5.0 Introduction

This chapter is summarises the major findings of the study of involvement of men in safe motherhood in Kafue mission, Zambia. The findings were grouped under the levels and patterns of male participation in safe motherhood and the various obstacles to men's involvement in safe motherhood.

5.1 Levels and Patterns of Male Participation in Safe Motherhood

Men play an important role in safe motherhood as they are involved in decision making even if they do not physically visit the family planning and antenatal clinics. The findings in this study revealed that men get second hand information on women's maternal health from their wives. This indicates that the men are interested in the maternal health of women only that something is holding them back to be in the limelight. The earlier focus of primary health care facilities meant that men were excluded from the health care services. However from the study, it has been found that men are involved in the health of their families either directly or indirectly.

The level of participation of men in their children's health and antenatal clinics needs to be improved. A pre- requisite for male involvement in under five clinics, antenatal and postnatal activities is adequate knowledge about the clinics and safe motherhood. We know a lot about what women think about antenatal and postnatal activities but not what men think. In spite of this oversight men's knowledge, perceptions, concerns and level of participation are very vital for safe motherhood. This is

important because men are normally the heads of the household and thus make or influence the decisions made in the home.

There is a high level of awareness of both family planning and knowledge of types of family planning available to the couples. This is consistent with an earlier study carried out by Nsemukila (1998) who found out that 99% of currently married women and 98% currently married men were knowledgeable of family planning methods. However, there was a discrepancy in knowledge and use of them between men and women as most men did not care to use contraception or were against it. A lesson emerges here that challenges the assumption that knowledge of family planning will lead to adoption of a method. This is entirely dependant on the dynamics of couple communication and amount of information dispersed. In addition, failure of some methods suggests that counselling on correct and consistent use of a family planning method need to be addressed. Lack of information about methods side effects has also tended to discourage use, especially the contraceptive pill.

Collected data revealed that awareness; knowledge of family planning, STIs, HIV/AIDS with all the participants was universal. However, the use of family planning methods and attendance to the family planning clinics depended on the dynamics of couple communication. Studies by Biddlecom revealed the lack of men's participation in reproductive health undermines women's health; the findings of this study are similar in that women's reproductive health choice depends on the involvement of men. Due to non-approval of use of contraceptives, some women

have resorted to secretly using some female oriented methods, which indicates that men need to be educated on women's health and family planning.

5.2 Obstacles to Men's Participation in Safe Motherhood

The study showed that men hardly discussed risks associated with pregnancy, they only did so after their wives under went pregnancy complications. The men were able to give a few risks of pregnancy but there is need to educate men on the issue. Discussion of the risks faced must be part of spousal communication if men's involvement has to be improved.

The study had a component of key informant interviews with the relevant stakeholder. The key informant interviews had two objectives. One was to establish the importance of men's participation in safe motherhood and second based on the responses given by the members of staff, an analysis of the level of participation of men in safe motherhood was to be done. High-quality health services are safer and responsive to clients ensuring individual rights and dignity. The attitudes and knowledge of medical staff is a key issue to the involvement of men. "Involving men" often means including them in counselling sessions, either alone or with their female partners. However, it has to be done in a way that does not undermine women's confidence as Ringheim explains in his works.

The provider must therefore consider the existing gender and social inequalities between men and women that affect reproductive health, as well as how to meet men's needs for information and services in a way that does not diminish attention to women. It is a complex process. High-quality client-provider interaction with male

clients endeavours to ensure that programs promote gender equity to benefit both men and women. It meets men's needs while focusing primarily on a woman-centered agenda. Although couple counselling may stimulate positive communication within the relationship, there are circumstances in which both men and women are better served by individual interactions with a provider (Ringheim, 2002).

Another important finding is the role gender plays. There are the traditional stereotypes that reinforce the macho concept and the gender roles. Tradition does not allow men to be seen as weak by doing women's chores. Men want to make decisions and be leaders of their households and this has greatly contributed to the hindrances of participating fully. Reproductive health roles seem as women's issues and responsibilities. This result confirms what Hollander (1997) argued that traditional roles normally assigned to women and men are through the socialisation process, which inculcate ideas of male power and female subordination.

The question Guerny (1998) had asked whether the exclusion of men from education regarding sexuality, fertility, contraception and the prevention of STIs will lead to their lack of involvement an if it could be applied to Zambia has been answered. Some of the obstacle men faced were insufficient information about the importance of men's participation in safe motherhood. There are gender gaps in access to resources, poor male access to reproductive information and services. This includes a range of services provided: lack of choice, space, privacy, convenience, confidentiality and poor provider behaviour.

CHAPTER 6

SUMMARY OF FINDINGS CONCLUSIONS AND RECOMMENDATIONS

6.0 Introduction

This chapter gives a summary of findings of this study, draws conclusions and makes recommendations to family planning programmes, policy makers for them to effect decisions and strategies towards eliminating the obstacles men face in safe motherhood and therefore increasing their participation.

6.1 Summary of Findings

The findings of this study suggest that male involvement in safe motherhood is very important and that men are interested but that there is something that is standing in their way to be actively involved. Men play significant roles in decisions relating to family planning. All the men in the focus group discussions knew family planning methods and 50% percent approved of the usage. However, there is a gap between approval and use; the men would prefer their wives to use contraception but not them.

Couples who used family planning methods relied predominantly on female oriented methods except the female condom, which is not used at all. The most common methods used were the contraceptive pill and injectables. The male condom seemed to be stigmatised among the married couples. However, some men used the male condoms with partners who were not their wives.

Irrespective of educational background, type of occupation, male attendance of antenatal and family planning clinics was almost nil. This can be traced back from

the programmes which offered maternal and child clinics thus bypassing men's involvement. This exclusion of men from family planning programmes contributes to low levels of men attending the sessions.

However, on average women would like to have men accompany them to antenatal clinics and family planning sessions. They felt that it would help the men understand the condition of their wives and the care due to the women. At the moment the trend is that men get second hand information from their wives. This gap resulted in most men being unaware of life threatening or serious conditions during pregnancy that they should be alert of and seek medical attention.

Couple communication was found to be still a problem. Discussion of family planning or child spacing took place because of insistence and persistence from the women. In most cases the wives initiated the discussions but the final say still came from the husband being the head of the house. There was not much communication between couples during pregnancy in relation to antenatal care, especially on when to start and where to have it, the place of delivery and who would assist the woman to deliver.

Traditional conceptions of gender roles often isolate men from becoming actively involved in their own sexual and reproductive health and in that of their partners. It is apparent that in order to work with men to promote gender equality and improve both men's and women's sexual and reproductive health, service cannot address these issues in isolation; programmes must treat men particularly this idea of masculinity enshrined in society's values.

6.2 Conclusions

Male involvement in sexual and reproductive health has become a topical issue since the concept of reproductive health and rights was adopted at the ICPD in 1984. While implications of this initiative are deeply rooted in the way society defines gender roles and responsibilities, progress in the involvement of men in safe motherhood specifically, i.e. in matters directly related to ensuring the wellbeing and survival of mothers during pregnancy might take more time. According to the majority of men in most societies, this area is traditionally seen as the domain of women shrouded in mystery. Given that the aim is to promote mutually supportive male-female relationships during this critical period of women's life, this subject could be internalized more rapidly through relevant educational opportunities offered to young people (Ntabona, 2001).

There are strong indications that involving men to promote safe motherhood is a worthwhile approach that promises positive results which can contribute towards improving the status of women. Reaching out to men as partners may improve spousal communication and may help in early decision making for seeking care if complications arise and may also help define couples' sexual and reproductive behaviour, goal and perceptions and services for men can be improved.

Involving men in safe motherhood could help Zambia achieve some major developmental goals such as decreased maternal mortality and increased contraceptive prevalence rate. Involving men could also help reduce the overall prevalence of HIV/AIDS – a result which will be possible if men are involved as partners, service providers, policy markers, teachers and programme mangers..

The findings have clearly demonstrated that in general at least more than half of the men were not aware of their wives' health status or prenatal care services or the risks associated with pregnancy. It is not easy to conclude whether this indicates a lack of concern towards the health and care of their wives or reflects the social segregation of roles and responsibilities of men and women in reproductive process in which antenatal care is left to women. However, men can help reduce maternal related deaths by recognising symptoms that require immediate action by assuring their partners get medical attention they need. This can only be possible if men have the right information and knowledge.

The study found that there were several obstacles men faced in the participation of safe motherhood, which ranged from personal to institutional. Masculinity like gender is socially constructed and influenced by society. Men are expected to live by certain ideals and not be involved in certain issues, which are deemed to be women's territory. This is a major obstacle as gender roles are internalised and boys learn to divert themselves from what they identify as feminine, which includes active involvement in women's reproductive health.

Society also frowns upon a man visiting a family planning or antenatal clinic with his wife saying that he is very possessive. The men that actually visit the clinics find them not so male-friendly. Thus they get intimidated. There is also a lack of male staff at the clinic to deal with men and make them feel at home. The male counsellor will play a very important role as it will be through him that men are made aware of

reproductive health issues. Programmes must be set up to show the importance of men's participation in safe motherhood.

Gender differences in society appear to have a profound effect on male involvement which is usually assumed to be a woman's concern at the household. Cultural expectations also make it difficult for women to discuss reproductive health issues with men. Overcoming social and cultural obstacles requires more educational efforts in particular towards the youths and their parents. Research should be carried out to identify the specific traditional attitudes that need to be addressed as they differ from community to community. Present husbands and wives in close communication suggesting that the husband's family health decisions result in discussions with his wife. Such an image can help develop the idea that men, who are interested in the well being of their families, are the more respected in the community.

Given the sensitive nature of gender roles and relations in many cultures, understanding the context of a particular setting, potential barriers, and attitudes towards a new intervention are necessary first steps in designing services that include men. In preparation for a male involvement in antenatal care intervention, this study revealed that it is important and necessary to: (a) understand the barriers to male involvement in maternal health and (b) explore men's, women's, and providers' attitudes towards the promotion of male involvement in antenatal care and maternal health.

6.3 Recommendations

Based on the findings from the study, it is important to increase men's positive participation in safe motherhood. Men can support their partners use contraception or use contraceptive methods themselves, and they can help prevent the spread of sexually transmitted diseases. It is necessary to allow them to come out of the closet to actively and openly participate instead of interrogating their wives for information. Failure to involve men in family planning and safe motherhood programmes can have serious implications. Even if women are educated and motivated to practice contraception, they may not do so as seen from the findings of this current study because of opposition from their husbands. This could be achieved by the following:

1. The service providers to make sure that there is a serious campaign involving both rural and urban areas to fill the information gap. More qualitative research is needed on male participation in safe motherhood on the factors that may influence their attitudes and practices both in urban and rural areas.
2. A set of guidelines to mainstream male involvement needs to be developed and distributed. Male involvement in safe motherhood programmes must be introduced and implemented by the Ministry of Health through the health centres. Assess infrastructure of clinics and maternity wards in hospitals and their accessibility to men.
3. There should be a couple level approach to focus on couples as a unit rather than one at a time. Couple oriented counselling stresses an equal responsibility in maternal health. These programmes must be designed carefully so that neither the men nor the women's autonomy is jeopardised. In relation to the preceding recommendation, it would be

imperative for the family panning clinics to consider flexible hours for couple counselling taking into account men's work schedule.

4. Antenatal and postnatal clinics should introduce a Father's Day where it is mandatory that a couple attend one session together. This will act as a platform to increase male participation. It will also afford men to get first hand information from the medical personnel on the health status of their wives and what they should do to safe guard their health.

5. Current educational campaigns need to be reviewed in the context of male involvement and should not, for example reinforce gender inequalities or the notion that condom use is restricted only to high-risk situations. Emphasis should be placed on involving men as partners in maternal and child health and at the same there should be clear cut guidelines.

6. Improving interpersonal skills of the health care providers using information about how community (women and men) defines care. There may be need for closed sessions among the male leaders and community leaders when discussing cultural or traditional issues that infringe on reproductive health.

7. Safe motherhood programmes should increase men's access to information and benefits of antenatal and postnatal care. A responsive policy would reduce gender disparity in access to resources and opportunities both productive and reproductive. This would eliminate obstacles to spousal discussion of reproductive health matters.

8. Existing services should be made more "male –friendly," with service providers undergoing additional training and engaging in effective outreach activities.

9. Programmes for young men and women should be a high priority among reproductive health programmes and secondary schools. These programmes might be able to change attitudes, behaviour, and increase knowledge of importance of male involvement in reproductive health.

10. Finally, document the experiences with male involvement in promoting safe motherhood and develop a mechanism for evaluating the long term impact of male involvement in not only safe motherhood but other aspects of women's lives as well.

Research Agenda

The researcher feels that further study should be undertaken on the role of Government in Safe motherhood programme implementation.

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APPENDIX 1 BACKGROUND CHARACTERISTICS

Question No	Questions, Instructions & Filters	Responses		
	Sex of the Respondent	Male.....1 Female..... 2		
	In what month and year were you born? (	Month _____ Year_____		
	How old were you at your last birthday?)	Age in completed years_____1		
	How old is your partner?	Age _____		
	How long have you been married?	No of years _____		
	Who is the head of the household?	Husband.....1 Wife 2		
	Have you ever attended school?	Yes .....1 No 2		
	What is the highest level of school you attended?	Primary.....1 Secondary..... 2 Tertiary 3		
	What is the highest level of education that your partner has attended?	Primary.....1 Secondary..... .2 Tertiary 3		
	What is your occupation i.e. what kind of work do you mainly do?	Teacher.....1 Nurse..... .2 Medical Officer..... ...3 Peasant Farmer..... ....4 Fisherman.....5 Other Specify_____		
	How much money do you earn per month?	ZMK_____		
	Does your household have: Electricity A radio A television A refrigerator A bicycle A motorcycle A car A stove	Yes 0 0 0 0 0 0 0 0	No 1 1 1 1 1 1 1 1	

APPENDIX 2 FOCUS GROUP DISCUSSIONS FOR WOMEN

Target population: married women aged 18-29, 30-49

i. Safe Motherhood has been defined in many different ways one of them is a woman's ability to have a safe and healthy pregnancy and delivery. It has also been suggested that men have a role to play in safe motherhood one of them being the:

- ✓ Provision of money for necessities and ensure that their pregnant partners are health.
- ✓ Safe guarding women's health during ante natal care and their nutrition.
- ✓ Arranging for skilled care during delivery.
- ✓ Seek medical help when need arises.
- ✓ Family planning
- ✓ Decision –making

Do you see your partner participating in other ways?

A. Male Involvement in Family Planning

1. There are various methods by which a couple can delay or avoid a pregnancy:
Have you ever heard of family Planning?
Probes: Modern, Traditional methods?

2. Which family planning ways and methods have you heard about?
Probes: Contraceptive pill, Male condom, natural family planning?

3. Have you and your partner ever used family planning methods?
Probe: Which is the most common method used? Contraceptive pill, condom, natural family planning?

4. If yes, which methods to prevent pregnancy are you using?
Probes: Contraceptive pill, Male condom, natural family planning?

5. If no what is the main reason you are not using contraception to avoid pregnancy?
Probes: Men do not want to use contraception?

6. What is your partner's opinion about using birth control method?
Probe: Approve, disapproves?
7. Do you discuss the use of contraception or the type of contraception to use?
Probe: Who takes the decision?

8. Does your partner accompany you to the family planning counselor?
Probe: How often? Never Sometimes, Frequent

9. Does your partner encourage you to use family planning?
Probe: Yes, No?
Probe: Which methods?

B. Decision Making /Male Involvement in Fertility Decision

10. Do you discuss the number of children to have?
Probe: How many children do you have?
Probe: Who decides on the number of children?

11. Do you also discuss how to space your children. That is the number of years between pregnancies?
Probe: How many years would you prefer in between the children?

12. What according to you is the ideal number of children?
Probe: Number of male or female children?

13. Do you desire more children?
Probe: Number of male children? Number of female children?
Probe: Total Number of children?

14. Is your partner ready to listen to your suggestions and new ideas about family planning?

15. Have you been able to discuss sexual issues freely with your spouse, including issues relating to STDs HW/AIDS and Condoms?
Probe : If no what are the hindrances stopping you?
16. If you found you had an STD or HIV/AIDS, would you tell your partner?

C. Male Involvement in Antenatal and Postnatal Activities:

17. Does your partner accompany you to the antenatal clinic?
Probe: Always, Sometimes, Never?

18. Does your partner try to help you stay healthy when pregnant by helping with heavy household chores?
Probe: In which ways?

19. Does your partner help with the immunization of children?
Probe: Who takes the children for immunization? You? Husband? Both?

20. Has he ever tried to avoid delays in seeking medical care for you when pregnant?
Probe: Keeping money aside for emergency?

21. Does he arrange for skilled care during delivery?
Probe: like organising before hand so that there are qualified personnel at the clinic?

22. Have you ever discussed with him which clinic to deliver from when pregnant?
Probe: Did he give a preference clinic delivery? Home delivery?

23. The last time you delivered who choose the place of delivery?

Probe: Did he suggest a certain clinic?

24. Has he ever reminded you to go either to antenatal or post antenatal clinics?
Probe: Ask you when you have to go?

25. Where did the last delivery take place?
Probe: Home? Clinic? Hospital?

26. Have you ever-experienced abuse when pregnant from partner?
Probe: Mental, physical, wife battering?

2 Looking at the answers you have given to the first question we would then like to discuss with you the obstacles you think men face in participating in safe motherhood. A number of issues have been raised as the obstacles to men's involvement we would like to have more opinions and discussions of the obstacles faced by men in participating in Safe Motherhood. Some of them are as follows:

- Negative attitudes toward reproductive health care.

Probe: Men simply do not favour family planning clinics

- Lack of knowledge of contraceptive methods

Probe: They do not know how contraceptives work?

- Lack of enthusiasm to share reproductive health roles with wives

Probe: Men do not want to do women's work?

- Reproductive health roles seen as women's business.
- Cultural stereotypes against male contraception methods.

Probe culture does not permit men to use contraception?

- Traditional masculine stereotypes which reinforce stereotypes against about male decision making

Probe : For example men are always right.

- Existing reproductive health programs have never developed specific interventions for men.

Probe: There is nothing at clinics that encourage men to go there.

Are there any other obstacles you think men face and we have left them out

Probes: Do they have a bias towards family planning clinics and antenatal clinics for example that is a woman's place?
Probes: Do they not understand their roles in maternal health?
Probes: Are there no channels at various levels for men to follow?
Probes: Or perhaps there is very little literature on male participation?

3 Looking at the answers you have given to the second question we would like to have more opinions and discussions of how you would like your partners to be involved in Safe Motherhood. This simply means what measures do you think should be put in place to improve safe motherhood and diffuse the obstacles men face in participating in safe motherhood. One would say that the government should provide sufficient information about safe motherhood and the role men play. The following are some suggestions what do you think about them?
Probes:

- Staff at health centres should be educated about their negative attitudes towards male clients
- Antenatal and postnatal clinics should be more male friendly
- Add masculine dimension to reproductive health programs
- Provide at various levels to reinforce reproductive health messages
- The macho concept should be squashed – work to remove the socio cultural Barriers.
- Advocate for men's reproductive health among decision makers and opinion leaders
- Motivate religious and traditional leaders to actively encourage men to accept and use contraceptive methods
- Convince educators, parents and opinion leaders of the need for family life and sex education for young people so that they grew up aware of their responsibility
- Introduce reproductive health education programs in school and university programs
- Work to remove the socio cultural barriers

Are there any more suggestions that you can come up with which will ease male participation in safe motherhood?

APPENDIX 3 FOCUS GROUP DISCUSSIONS FOR MEN

Target population: married men aged 18-29, 30-49.
1 Safe Motherhood has been defined in many different ways one of them is a woman's ability to have a safe and healthy pregnancy and delivery. It has also been suggested that men have a role to play in safe motherhood to help women stay healthy. These are some of the ways suggested that a man can participate in safe motherhood:

A. MALE INVOLVEMENT IN FAMILY PLANNING

There are various methods by which a couple can delay or avoid a pregnancy. Have you ever heard of Family Planning?

1. Have you ever heard of Family Planning?
Probe: Modern, Traditional methods?

2. Which family planning ways and methods have you heard about?
Probe: Contraceptive pill, Male condom natural family planning?

3. Have you and your partner ever used family planning methods?
Probe: Which is the most common method used? Contraceptive pill, Male condom, natural methods?

4. If yes, which methods to prevent pregnancy are you using?
Probe: Contraceptive pill, Male condom natural family planning?

5. If no, what is the main reason you are not using a method of contraception to avoid pregnancy?
Probe: As men we do not want to use condoms?

6. What is your partner's opinion about using birth control method?
Probe: Approves or disapproval?

7. Do you discuss the use of contraception or the type of contraception to use?
Probe: Who takes the decision?

8. Do you encourage your partner to use family planning?
Probe: Which methods?

Probe: Do you accompany your partner to family planning clinics?

B. Decision-Making / Male Involvement in Fertility Decision

9. Do you discuss the number of children to have?
Probe: How many children do you have?

10. Do you also discuss how to space your children that is the number of years between pregnancies?
Probe: How many years in between the children?

11. Are you ready to listen to your partner's suggestions and new ideas about family planning?
Probe: Do you allow her to say out what she feels? Probe: Discuss which clinic to go to?

12. Have you ever discussed with your spouse which clinic to deliver from when pregnant?
Probe: For example naming the clinics and discussing how efficient they are?

13. Do you discuss the risks of pregnancy?
Probe: Yes, No,
Probe: What are the risks involved? If no, why do you think not?

14. If you found you had an STD or HIV/AIDS, would you tell your partner?
Probe: Would you discuss with her what type and possibly suggest that you go to the clinic together?

15. Have you been able to discuss sexual issues freely with your spouse, including issues relating to STDs HIV/AIDS and Condoms?
Probe: If no, what are the hindrances stopping you?

C. Male Involvement in Antenatal and Postnatal Activities:

16. Do you accompany your partner to the antenatal clinic?
Probe: Always, Sometimes, Never?

17. During the last delivery did you help with the baby?
Probe: Bath the baby and dress him up?

18. Do you help with taking the children for immunization?
Probe: Who takes the children for immunization? You? Wife? Both?

19. During the last pregnancy did your wife attend antenatal care?
Probe: Often, Sometimes Never?
Probe: Not sure?

20. How many times are women supposed to attend antenatal?
Probe: Monthly?
Probe: Fortnightly?
Probe: Weekly?

21. What are the benefits of antenatal care?
Probe: Advise on food to be eaten and not to be taken.
Probe: Take care of oneself when pregnant.
Probe: Monitor the progress of the baby.
Probe: Check the mother for any diseases.
Probe: Checking & correcting abnormalities.
Probe: Treating pregnancy & related problems.
Probe: Providing pregnancy education to women.
Probe: Checking blood pressure weights of mothers?

22. After delivery did your wife visit antenatal care?
Probe: How often?

23. What causes miscarriages?
Probe: Promiscuous behaviour of both men and women.
Probe: Not going for antenatal care.
Probe: Doing heavy household work.
Probe: Eating the wrong foods.
Probe: Lack of proper care.
Probe: Medical complications.

WOMEN' S HEALTH

24. Do you try to help your partner stay healthy when pregnant by helping with heavy household chores?
Probe: In which ways?

25. Do you arrange for skilled care during delivery?
Probe: Like organising before hand so that there are qualified personnel at the clinic?

26. The last time your partner delivered who choose the place of delivery?
Probe: Did you suggest a certain clinic?

27. Where did last delivery take place?
Probe: Home? Clinic? Hospital?

2 Participating in safe motherhood is often influenced by a number of factors including Socio-cultural factors. For example perceptions on family planning and decisions in the usage of types of family planning methods depend on the social-cultural environment in which a couple is placed. Research in other areas has indicated that men face obstacles in participating in safe motherhood. One of them being insufficient information about men's reproductive health needs. The other being the branding of "Safe Motherhood as being women's business." There are many other reasons given which ones do you face personally:

- **Personal Obstacles**
  Probe: Lack of knowledge of contraceptive methods.
  Probe: Lack of enthusiasm to share reproductive health roles with wives.
  Probe: Do not want wife to use contraceptives.
- **Cultural Obstacles**
  Probe: Going to the family planning clinics seen as women's business.
  Probe: Cultural prejudice against male contraception methods.
  Probe: Traditional masculine attitudes which reinforce bias against about male decision making.
- **Institutional Obstacles**
  Probe: Health workers inadequately trained to serve men, as they are unfriendly.
  Probe: Problem of accessibility and availability of family planning clinic, which respond to men's needs.

Probe: Too much emphasis on maternal and child health and family planning.
Probe: Negative attitudes toward reproductive health care.

- **Policies**
  Probe: Existing reproductive health programs - have never developed specific interventions for men.
  Probe: Weak coordination of men and women' issues at various levels.

3 After giving such brilliant responses to question two what measure should be taken in order to remove or reduce the obstacles to men's participation in safe motherhood. What would you like to see happening? This simply means what measures do you think should be put in place to improve safe motherhood and diffuse the obstacles men face participating in safe motherhood. One would say that the government should provide sufficient information about safe motherhood and the role men play. Other reasons include:

Probes:

- Staff at health centres should be educated about their negative attitudes towards male clients.
- Antenatal and postnatal clinics should be more male friendly.
- Add masculine dimension to reproductive health programs.
- Provide at various levels to reinforce reproductive health messages.
- The macho concept should be squashed - work to remove the socio cultural Barriers.
- Advocate for men's reproductive health among decision makers and opinion leaders.
- Motivate religious and traditional leaders to actively encourage men to accept and use contraceptive methods.
- Convince educators, parents and opinion leaders of the need for family life and sex education for young people so that they grew up aware of their responsibility.
- Introduce reproductive health education programs in school and university programs. Work to remove the socio cultural barriers.

Do you have any other reasons, which you think will improve positive male participation in safe motherhood?

APPENDIX 4 INTERVIEW GUIDE FOR KEY INFORMANTS

Topic guide for Key Informants

Age..... Sex.....

Education.....

What is the number of people who attend Antenatal and Postnatal clinics? .....

Out of the number of people who attend Antenatal and Postnatal clinics how many are men? .....

Is it important that men participate in Safe Motherhood? .....

Give reasons for your answer?

.....

.....

Give reasons why you think men do not participate in safe Motherhood?

.....

.....

Do you have programmes in place for men to encourage them to participate in Safe motherhood?

.....

.....

What challenges must be taken up in order to establish strategies for involvement in safe motherhood?

.....

.....

.....