

**MOTHER'S SOCIAL CONSTRUCTIONS OF MALE  
INVOLVEMENT IN MATERNITY CARE IN CHINSALI DISTRICT**

**By**

**Michael Kani**

**A DISSERTATION SUBMITTED TO THE UNIVERSITY OF  
ZAMBIA IN PARTIAL FULFILLMENT OF THE REQUIREMENTS  
FOR THE DEGREE OF MASTERS IN GENDER STUDIES**

**The University of Zambia**

**2013**

© 2013 by Michael Kani. All rights Reserved

## Declaration

“Mother’s Social Constructions of Male Involvement in Maternity Care in Chinsali District” is original work and that all sources that have been used or quoted have been indicated and acknowledged by means of complete references.

Signature.....

*Michael Kani*  
(Candidate)

Dated this 18<sup>th</sup> day of October 2013

Signature.....

*Jason Mwanza*  
(Supervisor)

University of Zambia

Dated this 18<sup>th</sup> day of October 2013

## Certificate of Approval

This dissertation by **Michael Kani** is approved as fulfilling part of the requirements for the award of the degree of Master of Arts in Gender Studies by the University of Zambia

Names of Examiner:

.....

Signature

.....

Dated this 18<sup>th</sup> day of October 2013

Names of Examiner:

.....

Signature

.....

Dated this 18<sup>th</sup> day of October 2013

Names of Examiner:

.....

Signature

.....

Dated this 18<sup>th</sup> day of October 2013

## **Dedication**

To my Son, Mulenga Kani. I thank the Almighty God for bringing you into our life to fill us with so much love for you. God Bless You.

## **Acknowledgments**

I am greatly indebted in my thanks to my parents *ba Kani na bana Kani* for financing my Master's Degree Programme at UNZA. May God continue to bless you.

Special thanks go to Mr. Jason Mwanza for supervising my research work. Had it not been to his desire to create from students a master through scholarly advice and critique, this work could not have come out in the end.

I thank the lecturers in the Department of Gender Studies with whom I had contact before embarking on this important exercise especially Prof. Mubiana Macwan'gi, Dr. Anne N. Phiri, Dr. Thomas Kusanthan, and Mr. Patrick Sakala. Thank you all for shaping and assisting me.

My other thanks go to Dr. Peter Mwaba, the Permanent Secretary, Ministry of Health and the then Muchinga Acting Provincial Medical Officer, Dr. Charles Chungu for granting me authority and facilitating the execution of my research respectively at Location Clinic and Lubwa Rural Health Centre.

## Abstract

**Background:** There have been gaps in research on male involvement in maternity care. The views of women regarding what they consider to be the roles of men in maternity care have largely been neglected.

**Purpose:** To explore mother's social constructions, from their lived experiences, regarding male involvement during antenatal, labour and postnatal care.

**Methodology:** An exploratory cross sectional qualitative research design informed by the abductive research strategy was chosen to ground this study. Data was collected from two health centres. Theoretical purposive sampling interleaved with maximum variation sampling was used to enlist respondents. Ninety (90) women attending antenatal, labour and postnatal health care services were in turn enlisted. Thirty Four in-depth interviews and eight focus group discussions with women numbering six to ten were conducted.

**Results:** Men were involved in the care from antenatal to postnatal and seemed to be involved more in activities outside the health centre than activities inside the health centre. Men were involved more in the activities that required less effort or time than more effort and time. Women' views regarding male involvement have dual motives and these relate to past experiences and what they envisage presently and into the future. The motives for agreeing or disagreeing with male involvement were based on women' experiences focusing on benefits or threats of male involvement.

**Conclusions:** Women do not seem to be eager to have husbands attend physical examinations and the birth of a child. A wide gender gap exists that no men may be fully involved in the whole mothering experience from antenatal to postnatal care in Chinsali.

**Research Policy Implications:** The study recommends undertaking a quantitative survey with a larger number of women to solicit their positions. There is need to develop advocacy programmes that could reach out to both men and women in Chinsali. Women groupings like Alangizi, Bana Fimbusa and Traditional Birth Attendants could be reached out to by way of community mobilisation strategies. The Office of the Provincial Child Development Coordinator (also known as Gender Focal Point) within Chinsali should be involved in reproductive matters by changing the strategy of merely voicing out gender inequities and inequalities.

## Table of Contents

Declaration .....	iii
Certificate of Approval .....	iv
Dedication .....	v
Acknowledgments .....	vi
Abstract .....	vii
Table of .....	viii
List of Tables .....	xi
List of Appendices .....	xii
CHAPTER ONE – INTRODUCTION .....	1
1.0 Background .....	1
1.1 Problem Statement.....	4
1.2 Research Questions .....	5
1.3 Overarching Research Question .....	5
1.4 Specific Research Questions.....	5
1.5 Main Objective.....	6
1.6 Specific Objectives .....	6
1.7 Definition of Key Terms .....	6
1.8 Structure of Dissertation .....	7
CHAPTER TWO – LITERATURE REVIEW.....	8
2.0 Introduction.....	8
2.1 The Justifications of Male Involvement in Reproductive Health.....	8
2.2 Level of Male involvement in Maternal and Child Health .....	10
2.3 Socio-demographic characteristics.....	11
2.4 Traditional Viewpoints on Maternity.....	13
2.5 Male involvement in maternity care .....	14
2.5.1 Male involvement in Family planning.....	15

2.5.2 Male involvement in Labour.....	16
2.5.3 Male involvement in postnatal care .....	17
2.6 Mother’s empowerment, status, autonomy and health outcomes.....	17
2.6.1 Mother’s views on Male involvement in Reproductive Health .....	18
2.6.2 Mother’s desires about spouses’ involvement in Reproductive Health ..	19
2.7 Paternity leave and Male involvement.....	20
2.8 Gender mainstreaming of Male involvement in maternal and child health	20
2.9 Theoretical Framework.....	21
2.9.1 Maternal and Child Health/Gender Studies .....	22
2.10 Research designs used in gender studies.....	22
CHAPTER THREE – RESEARCH METHODOLOGY .....	26
3.0 Introduction.....	26
3.1 Research Strategy and Design.....	26
3.2 Research Site .....	27
3.3 Study Population .....	28
3.4 Sampling and Sample Size .....	28
3.6 Interview Process .....	31
3.7 Focus Group Discussion Process.....	31
3.8 Data Analysis.....	32
3.8.1 Step-by-step guide to doing thematic analysis .....	33
3.9 Ethical Considerations.....	34
3.9.1 Voluntary Participation.....	35
3.9.2 Minimizing Risk to Participants .....	35
3.9.3 Informed Consent .....	35
3.9.4 Confidentiality & Anonymity .....	35

3.9.5 Scientific Honesty .....	36
3.9.6 Permission to Conduct Research .....	36
CHAPTER FOUR – PRESENTATION OF FINDINGS .....	37
4.1 Introduction.....	37
4.2 Participants’ Demographic Characteristics .....	38
4.3 Areas men are involved in and not involved .....	38
4.3.1 Theme I: Male involvement outside health facility .....	41
4.3.2 Theme II: Male involvement within the health facility.....	46
4.4 Desired and undesired areas that mothers consider men could be involved .....	50
4.4.1 Theme III: Non Birthing Expectations .....	50
4.4.2 Theme IV: Birthing Expectations .....	56
4.5 Motives for the Desired and Undesired Areas of Male Involvement .....	58
4.5.1 Theme V: Because Motives.....	58
4.5.2 Theme VI: In Order to Motives.....	59
CHAPTER FIVE – DISCUSSION OF FINDINGS .....	61
5.0 Introduction.....	61
5.1 What The Study has Found.....	61
5.2 Meaning of The Study (Lessons learnt).....	63
5.2.1 Limitations of the Study .....	65
5.3 Conclusion.....	67
5.4 Research Policy Implications.....	68
REFERENCES.....	70

## **List of Tables**

Table 2.7.1 Research Designs used - male involvement in Reproductive Health Studies .....	24
Table 4.3.1 Dos Don'ts And Expectations Of Male Involvement .....	40

## **List of Appendices**

Appendix I – Informed Consent Form .....	79
Appendix II - FGD and In-depth Interview Guide.....	82
Appendix III – Research Proposal Approval Letter.....	83
Appendix IV – Ethical Approval Letter.....	84
Appendix V – Authourity to Undertake Research .....	85

## CHAPTER ONE – INTRODUCTION

“It’s not natural for a man to be present” Dr. Odent, renowned French obstetrician, January 2000, in response to rising trend of men’s attendance at their partners’ births in most western industrialized countries (Williams, 2000:5).

### 1.0 Background

The quotation above sets the theme of this study. This study assumes interest in examining the roles of men in pregnancy, delivery and post-delivery periods. It is motivated by the increasing realization within the arguments in critical theory that strengthening male involvement in maternity care is cardinal not only to meeting gender needs of pregnant and nursing women but also to reducing maternal mortality, (Mullick et al, 2001; WHO, 2002). Such thoughts that bring men into what could have been the preserve of women have been advanced and emphasized by upper-middle-class elitist women (Freedman, 2002; Tong, 2009) who espouse critical theory. Pierre Bourdieu (Bourdieu and Passeron, 1977) for instance argued that the knowledge of the upper and middle classes are considered capital and are valuable to a hierarchical society. This kind of thinking, which is embedded in critical theory focuses on leveling male and female inequality in society. As the new millennium unfolds, the human species is undergoing one of the most dramatic technological revolutions and transformations in history, one that is changing everything from the ways that people work to the ways that they communicate with each other and spend their leisure time. This great transformation poses tremendous challenges to health care providers to rethink their basic tenets, to deploy the emergent thinking about sex, sexuality and reproduction to respond constructively and progressively to social changes now encompassing the globe.

Linking the arguments within critical theory, male involvement in maternal health care has been vogue for a few decades now. Male involvement, defined as men’s active

acceptance of, and support for, their female partners' needs, choices and rights in reproductive health (Drennan, 1998). Maternity care is the life-saving care that a woman requires during pregnancy, at delivery and in the post natal period (CSO et al, 2007).

There has indeed been a steady move to more male involvement in pregnancy and childbirth in countries in the West. Since the 1970s, men in the UK have been participating in maternity care. The state of California was the initial state to offer a paid out paternity leave in 2004 (Rutter, 2011). In 2005, the British Government approved of a paid paternity leave of \$200 a week. In Sweden, the father's involvement in maternal and child health care is emphasized in legislation. Fathers have also been invited to participate in antenatal classes, preparing them for the experience of birth. In Australia, over 90 percent of fathers attend the birth of their baby (Hanson et al, 2009; McKellar *et al.*, 2008).

In many developing countries however, maternity care continues to be viewed as a mother's affair and men are not expected in some cultures to accompany their wives to the clinic and are mostly absent during labour and delivery. In some quarters, male involvement in maternity care has been perceived as limiting mother's rights to make decisions regarding pregnancy as was indicated in a study in Mwanza District, Malawi (Kululanga et al, 2012). The end result is that there is very low male involvement in maternity care in developing countries. Eighteen years ago, the 1994 United Nations International Conference on Population and Development (ICPD) stressed "male responsibilities and participation" in sexual and reproductive health. The conference's 20-year Programme of Action advises that:

Efforts should be made to emphasize men's shared responsibility and promote their active involvement in responsible parenthood, sexual and reproductive behavior, including family planning; prenatal, maternal and child health; prevention of sexually transmitted diseases, including HIV; [and] prevention of unwanted and high-risk pregnancies (ICPD, POA: paragraph 4.27).

Following the ICPD, a growing body of qualitative research has echoed these recommendations, examining closely the impact of men, as individuals, as social gatekeepers, financial controllers of their families, and as powerful family members who enforce cultural practices, often to the detriment of mother's reproductive health (Ntabona, 2002). From this background therefore, involving men in maternity care is perceived as leading to improved maternity care utilization by women (Tsui et al, 1997). It is for these reasons that international agencies like the World Health Organization (WHO) have advocated for male involvement in maternity care as an essential element in the global initiative for making pregnancy safer. Surveys around the world increasingly are interviewing men and reporting on their contraceptive use, reproductive preferences, attitudes toward family planning, and sexual behaviours (Ntabona, 2002).

For Green et al (2001), the AIDS crisis particularly in Sub-Sahara Africa has made the need to address men in reproductive health policies and programs clear and urgent in terms of preventing sexually transmitted infections and improving maternal and child health. It has been reported that anti-AIDS interventions such as Prevention of Mother to Child Transmission (PMTCT) of HIV are largely dependent on male partner participation to be successful (Farquhar et al, 2004; Theuring et al, 2009; Akarro et al, 2011). In this regard, men have been encouraged to accompany their partners to antenatal clinics for couple HIV counseling and testing. It was upon this realization that the Ministry of Health, Zambia introduced male involvement as a minimum component of the PMTCT of HIV in 1997 (Kankasa et al, 2002). In a bid to encourage men to be involved in maternity care, several African countries, including Zambia, have initiated talks about integrating paternity leave in their employment acts (Rutter, 2011).

The increased emphasis on male involvement in maternity care has subsequently resulted in many studies having been conducted, mostly focusing on decision making and social economic factors as justifications for involving men. Assessing the impact of husbands' involvement on mother's health outcome is a basic question driving much work/research on male involvement. (Thaddeus & Maine, 1994; Robey et al., 1998; Drennan, 1998; Kumar, 1999; Ntabona, 2002; White, et al, 2003; King et al., 2006). The

gap in these studies is that the views of women regarding what they consider to be the roles of men and the extent to which they would want men to be involved have largely been neglected.

However, given that male involvement in maternity care touches on the sensitive nature of gender roles related to culture, social norms, values and beliefs (Kululanga, 2012), efforts to involve men in reproductive health must remain sensitive to the needs of women (White Ribbon Alliance for Safe Motherhood, 2011). Moreover, none of the studies conducted in Zambia on this subject (Tshibumbu, 2006; Nakambo, 2008; Phiri, 2011) has explored and documented what women consider to be the roles of men in and the extent to which they want men to be involved in antenatal, labour and postnatal health care.

### **1.1 Problem Statement**

In Zambia as in other developing countries, maternity care has traditionally been considered exclusively as a women's issue and yet there has been so much advocacy by health practitioners and feminist advocates for men to be involved (Godlove et al, 2010). Evidence from research suggests that maternity care is not only a woman's issue but it is also a man's issue (Drennan, 1998). There has been so much research done relating to male involvement elsewhere and these studies have highlighted the significance of involving men in maternity care focusing mostly on decision making and social economic factors (Thaddeus & Maine, 1994; Robey et al., 1998; Wegner et al., 1998; Mullick et al, 2001; King et al, 2006). The gap in these studies is that the views of women regarding what they consider to be the roles of men in maternity care have largely been neglected. The voices in available studies have been coming from health workers and feminist advocates of male involvement (Tsui et al, 1997). Further, in Zambia, the views of women regarding male involvement in maternity care have not been documented. It would also be ideal to understand from the point of view of postnatal mothers what they see or feel to be the roles of men in the whole reproductive phase – from antenatal into labour and into postnatal care. The intent of this study

therefore, is to explore the unknown views of women in respect to what they see or feel to be the roles of men in maternity care in the specific context of Chinsali District. This in essence is within the thinking of critical theory building on a constructivist as well as an interpretivist picture of women regarding male involvement in the reproductive issues.

## **1.2 Research Questions**

In general, research questions are “specific questions that researchers seek to answer” (Creswell, 2005: 117). According to Maxwell (2005:69), “research questions state what you want to learn”. In this study, the researcher opts to use the research questions model and this is because research questions are the essence of most research conducted and act as the guiding plan for the investigation (Mertler and Vannatta, 2001). Therefore, this study sought to answer the following research questions as enunciated by gaps in the literature:

## **1.3 Overarching Research Question**

What are the social constructions of mothers regarding male involvement in antenatal care, labour and postnatal care?

## **1.4 Specific Research Questions**

- 1) In what areas do mothers say men are involved when the women are attending antenatal care, labour and postnatal care?
- 2) What roles do mothers expect or not expect men to perform in antenatal care, labour or postnatal care?
- 3) Based on the selected areas that mothers say men could be involved, why do women have particular decisions regarding male involvement in antenatal, labour and postnatal care?

## 1.5 Main Objective

To explore the mothers' social constructions, from their lived experiences, regarding male involvement during antenatal care, labour and postnatal care.

## 1.6 Specific Objectives

- 1) To document what men do and do not do in antenatal care, labour and postnatal care.
- 2) To describe desired and undesired areas in antenatal care, labour and postnatal care that mothers consider men could be involved.
- 3) To understand using the mothers' own words, the motives regarding the selected and deselected areas of male involvement in antenatal care, labour and postnatal care.

## 1.7 Definition of Key Terms

**Gender** – refers to a theoretical construct in the social sciences and humanities that refer to a set of social and behavioural norms that, within a specific culture are widely considered to be socially appropriate for individuals of a specific sex. It usually refers to a set of characteristics that are either seen to distinguish between male and female, one's biological sex and one's gender identity (Holmes, 1998: 203).

**Social Construction** – refers to realities (physical or abstract) whose existence depends on contingent aspects of our social selves. According to Hacking (1999), social construction talk is often applied not only to worldly items – things, kinds, facts – but to our beliefs about them. In this study, social construction refers to a collection of postnatal mother's views, beliefs and attitudes regarding male involvement in maternity care within the specific context of Chinsali District.

**Men involvement-** refers to the active participation of men in pregnancy, labour and post-delivery activities and not only the financial or material support to the wellbeing of the mother or the unborn child.

## **1.8 Structure of Dissertation**

This dissertation is divided into five chapters. Chapter One introduces the study, the problem and the objectives and definition of key terms. Chapter Two reviews the literature related to the study. Chapter Three provides the research methodology which indicates the research strategy and design, sources of data, sampling procedures, sample size and characteristics of the study sites and participants. Chapter Four presents an analysis and discussion of the findings of the study. Chapter Five considers the findings of the study based on the research questions to clearly show what the research outputs are in relation to the problem we had at the onset. The chapter further outlines the limitations and strengths of the study as well as the research policy implications based on the findings.

## **CHAPTER TWO – LITERATURE REVIEW**

### **2.0 Introduction**

Literature review is a key step in the research process and refers to an extensive, exhaustive and systematic examination of publications relevant to the research project (Basavanthapa, 2007). In this study, literature was reviewed for the following reasons:

- i. To investigate or examine what exists on the subject and determine the strength and weaknesses of the appropriate scholarly publications.
- ii. To show the gaps in knowledge in order to generate questions for this inquiry.
- iii. To familiarize with methods of enquiry in earlier works including their success and shortcomings (Basavanthapa, 2007) in order to select the method appropriate for this study.

The literature review therefore, is thematised to show what is in practice on the subject.

### **2.1 The Justifications of Male Involvement in Reproductive Health**

The importance of involving men in reproductive health has gained increased recognition in the literature, especially after the 1994 Cairo and 1995 Beijing consensus documents, which agree that men are crucial to bringing about changes in mother's health status (Lee, 1999). The International Conference on Population and Development was one of the first international conferences to recognize men's role in reproductive health. The ICPD program of action notes,

Given that men play a significant role in women's sexual and reproductive health outcomes, engaging men as partners in programs adds value to women's health (ICPD; POA, 1996).

The 1995 World Conference on Women in Beijing re-enforced the same message

Shared responsibility between men and women in matters related to reproductive and sexual behaviour is essential to improving women's health (Ntabona, 2002).

Accordingly, there are two justifications for this gradual programmatic shift. First is that men also have their own sexual and reproductive health problems, and second is that men – owing to their privileged positions and dominant roles in their families, communities and organizations – are influencing women's health in markedly negative ways. However, between the two, the latter carries more weight and serves as the guiding principle for pushing men's program participation (Ntabona, 2002).

In the same vein, Carter (2002a) asserts that male involvement in reproductive health matters promotes better partnership between men and women in the household and community, leading to improved health of their families through the added social support. For the World Health Organization, women cannot ensure their own sexual and reproductive health without the availability of services and education for men (WHO, 2002). Therefore, men should be involved.

According to several studies undertaken in a number of developing countries, men have significant influence over women's access to health services through their control over economic resources as well as mother's decision making including reproductive decision making. Men have been found to be the ultimate decision makers regarding contraceptive use and family size in studies conducted in Zimbabwe, Kenya, Cambodia and Zambia (Piotrow et al, 1992; Tsui et al, 1997; Toure, 1996; Green, 2001; Population Council, 2005; Nakambo, 2008; Phiri, 2011). Lee (1999) calls this the 'Gate Keeping' authority of men. This realization too forms part of the justifications for male involvement.

In her study in Urban Nepal, Mullany (2006) established that male involvement in antenatal health education improved mother's postpartum care utilization. Further, women whose husbands attended ANC were more likely to report their husband's

assistance in reducing their workload during pregnancy. In a Uganda study, educating fathers about childbirth discouraged unsafe home deliveries and increased the mother's chance of obtaining life-saving care (USAID, 2002). Singh and Ram (2005) similarly observed that male involvement increased mother's likelihood of having a safe institutional delivery in their study in Maharashtra.

The rapid spread of the HIV/AIDS pandemic has also been said to further necessitate the involvement of men as defined by the ICPD and Beijing Conferences. The importance of male involvement in this regard has been emphasized in the success of HIV/AIDS interventions such as the prevention of mother to child transmission PMTCT of HIV/AIDS. It has been established that men are an important factor in women's adherence to HIV/AIDS prevention and treatment regimens (Kumar, 1999; Rutenberg et al, 2002; Akarro et al, 2011).

## **2.2 Level of Male involvement in Maternal and Child Health**

According to Lee (1999), the meaning of male involvement in women's health programmes varies from source to source. When viewed from program perspectives, male involvement may mean men supporting choices and rights of their female partners or men doing something about their own reproductive and sexual behavior in order to protect their partners. For Rutenberg et al (2002), the meaning of male involvement is relative to individual couples and communities; some men may choose to accompany female partners to clinic, get involved in counseling and HIV testing, while many choose to support their partners in other ways such as paying for health care and/or providing transport for their partners to reach the clinic.

Consequently, studies conducted in many locales around the world have reported various levels of male involvement. For example, a study in Maharashtra found that majority of husbands accompanied their wives to the first antenatal checkup; but women generally either went alone or with other female members of the family for subsequent visits (Singh and Ram, 2005).

In Mwanza District Malawi, it was found that male involvement in health facility care was associated mainly with antenatal (ANC) couple HIV counseling and testing during the first ANC visit. It was further established that husbands ignored wife's health care during pregnancy except their awareness of the need for antenatal registration and nutritious diet (Kululanga et al, 2012).

Delivery and post-delivery periods have been found to be exclusively women's affairs. For instance, only a small proportion of men were found to be present at the time of delivery of their children in Maharashtra (Singh & Ram, 2005). In Guatemala, men were found to be less likely to decide the place of delivery and the type of assistance to be provided during delivery of their children despite being involved in decision making, (Carter, 2002a).

### **2.3 Socio-demographic characteristics**

According to Carter (2002a), the analysis of male involvement in maternal matters entails three main dimensions namely: husband's availability for being involved; nature of involvement and why; and couples' views about the level or form of involvement. Husband's availability during pregnancy, labour and postnatal periods has been cited as determining the nature of male involvement. For example, a Maharashtra study established that whether a husband lives in the household with his wife and family and is therefore available to provide assistance was affected by the gendered forces of job opportunity and migration and this affected the nature of male involvement (Singh and Ram, 2005).

Similarly, women interviewed in a Guatemala study attributed husband's absence at home during labour to their work demands (Carter, 2002a). The presence of men during antenatal care has also been shown to differ slightly by residence. In a study in Jammu and Kashmir-India, three fourth of men in urban areas and two-third in rural areas were

present during at least one antenatal check-up received by the child's mother (Green et al, 2001).

The other factors often said to influence the nature of male involvement include among others: union status; birth order; economic status; and men's lack of understanding of pregnancy risks. Regarding union status, a study on factors influencing male involvement in prevention of mother to child transmission PMTCT of HIV in Mambwe District, Zambia revealed that formally married women were twice more likely to receive male support than women in consensual unions (Tshibumbu, 2006). Similar findings were recorded in a study in Kathmandu Nepal and in Maharashtra by Mullany (2006) and Singh and Ram (2005). Considering birth order, it has been shown that first and higher order births seem to elicit different levels of male involvement. For example, married women with their first birth were twice more likely to be accompanied by their husbands than women with higher birth order in Malawi (Kululanga et al, 2012). Similar findings were reported in a study in Jammu and Kashmir-India, where men with one child ever born were more likely to attend antenatal care than those with four or more children (Green et al, 2001).

With regard to economic status, the possession of control over some economic resource such as money or medical advice determined the nature of male involvement in Guatemala, (Carter, 2002a). Relatedly, and Waltson (2005), cited financial constraints, loss of income through lost work time or inability to arrange transport as other factors preventing some men from either accompanying their wives to maternity care appointments or keeping their own appointments.

Further and according to Carter (2002a), maternal health emergencies may supersede the basic guidelines for behavior that gender provides; most people would do what they could to get a woman to the hospital if her life were knowingly threatened, regardless of social barriers to doing so. Some researchers like Pachauri (1997), have blamed men's poor involvement on the nearly entirely women-oriented reproductive health service delivery systems; a situation which they consider as leading to men's lack of

understanding of the risks of pregnancy and their responsibilities. For example, around one-half of the men in Maharashtra could not correctly identify a symptom of serious pregnancy complications. In the same study, the majority men were aware of the need for antenatal, delivery and postnatal care, few and fewer husbands knew details and accompanied their wives for care respectively (Singh & Ram, 2005).

## **2.4 Traditional Viewpoints on Maternity**

Research so far conducted in developing countries suggests that maternity care is both a man's and woman's issue. From one end, the activities surrounding pregnancy, childbirth and postnatal care continue to be viewed as women's affairs in many developing countries. Men rarely accompany their partners to antenatal care, and it is still unthinkable in many communities for a man to accompany his companion to the clinic for delivery (Drennan, 1998).

In Maharashtra, husbands were found to ignore their wives' health care during pregnancy despite their awareness of the need for antenatal care and nutritious diet. Delivery and post-delivery periods were also found to be exclusively women's affairs. For example, only half the men who said that husbands should accompany their wives for antenatal and postnatal care actually did so. The proportion fell to one-third for delivery (Singh & Ram, 2005).

Research conducted in several African countries reveal that women do not want men to be involved in issues surrounding childbirth. For example, in Mwanza District, Malawi, issues surrounding childbirth were culturally considered to be a source of power for women, a territory where women would not want men to be involved for fear of losing that power (Kululanga et al, 2012). Similar findings were established in Cameroon where a common objection to male involvement in maternity care was that it was a foreign idea that limited women's right to make decisions regarding pregnancy issues (Godlove et al, 2010). In Zambia, and according to a study by Nsemukila et al (1998), most communities regarded delivery as a woman's issue and men including the spouse

were denied entry into the delivery room. Women made most decisions regarding labour and delivery and men were merely informed about the outcomes of the decisions made.

On the other end however, the traditional husband's role seems to be that of assisting when the woman is pregnant. Financial support arrangements has often been cited as the most common form of male participation during pregnancy, labour and postnatal care. For example, in Malawi, women argued that pregnancy and childbirth issues were mother's business but expected men to get them to hospital and to provide financial and material resources (Kululanga et al, 2012). In Guatemala, apart from participating in other activities, husbands seemed to specialize in transportation and communication arrangements (Carter, 2002a). In the same line, the most universal form of male participation during pregnancy in Ecuador were financial support, nutrition, psychological support and birth preparedness in terms of material support and transport arrangements (Roy & de Vargas Pinto, 1999).

## **2.5 Male involvement in maternity care**

According to Ntabona (2002), strategies for involving men in maternal health care services should aim at raising their awareness about emergency obstetric conditions, and engaging them in birth preparedness and complication readiness. The current consensus is that men need to take part in efforts to reduce maternal mortality and improve women's reproductive health through being enabled to recognize symptoms that require medical attention and ensuring that women get proper nutrition and rest (Ntabona, 2002; Kumar, 1999).

Male involvement in pregnancy has been emphasised by several studies and the areas where men can contribute for their pregnant/nursing partners have been identified including:- (a) plan their families, (b) support contraceptive use, (c) stress and participate in acquiring maternity care (d) ensuring nutritious food for their wives during

pregnancy (e) arrange for skilled care during delivery (f) avoid delays in seeking care and (g) help after baby is born (Drennan, 1998; Ntabona, 2002).

However, it has also been reported that men's desire to help does not necessarily translate into action. In Turkey for example, husbands wanted a closer relationship with their children in the post-partum period than their fathers had had with them, yet said they did not know how to help. In Baroda District India, men indicated an interest in accompanying their wives to ante- and postnatal checkups yet only half were aware whether their wife had had such care during her last pregnancy. In Maharashtra State India, husbands of adolescent wives advised them to lighten their loads during pregnancy but rarely took over the domestic chores themselves. Similar findings were reported in a Kenya study, where most men felt positive about getting involved in reproductive health services, yet only two-thirds of women said their partners were aware of their visits (Blanc, 2001).

### **2.5.1 Male involvement in Family planning**

According to the Population Council (2005), male involvement in family planning is not just promoting the use of male methods of contraception, but men's supportive roles in their families, communities and workplaces to promote gender equity, sharing of child rearing and caring and women's empowerment. It (male involvement) also suggests the importance of responsible, respectful and non-coercive sexual behavior and of shared reproductive decision making. Additionally, Shore (2011), posits that with regard to family planning, male involvement may mean men accompanying their partners to the clinic for family planning counseling, helping partners use the method of choice correctly and encourage women to seek help from a health provider or use a male method themselves or practice periodic abstinence as a couple.

Lasee & Becker, (1997) argue that beyond men's involvement in choosing to use male contraceptive methods of vasectomy or condoms, they should also be included in family

planning discussions and counseling generally to encourage or facilitate mother's contraceptive choice.

### **2.5.2 Male involvement in Labour**

Male involvement in labour may mean many things depending on the couple and community; some men may choose to accompany their partners to deliver at the hospital while many choose not to visit the clinic, but instead support their partners in coping with labour in other ways, pay for their partners' health care and/or provide transport for their partners to reach the clinic (Ntabona, 2002).

According to McKellar et al (2008), a man can be of enormous help to his partner during childbirth simply by being present; offering encouragement, support and love. For Ntabona (2002), men may give active assistance during childbirth by simply being present during their partners' labour or by coaching during childbirth.

The involvement of men in labour has been established as adding value to women's health. A study in rural Maharashtra for example, established that the likelihood of delivering in a medical institution was much higher in cases where the husband decided the place of delivery compared to those cases where the other members of the household decided. In other words, women were more likely to have a safe delivery in cases where husbands decided the place of delivery compared to the cases where other members of the household decided (Singh and Ram, 2005).

While the benefits of men's involvement in labour seem to be indisputable, some childbirth specialists like Michel Odent have objected to men's involvement in labour. Odent's argument in Williams (2000), is that the ideal birth environment involves no men in general. The presence of men during their partner's labour may make the woman tense and slows her production of the hormone vital for birth; thus labour becomes longer, more painful and more difficult. Odent further argues that men witnessing childbirth can ruin the sexual attraction between a couple and lead to them becoming just good friends and then getting divorced. For Hanson et al (2009), although men's

presence during childbirth now accepted in the West, some men felt under pressure to attend their child's birth because of cultural expectations. For Hanson et al (2009), although it is not men's right to witness childbirth, the most important thing is that the woman feels safe, secure and supported; so if she wants to have her partner around instead, that is fine.

### **2.5.3 Male involvement in postnatal care**

Ntabona (2002) refers to postnatal period – a period up to six weeks after childbirth (Koblinsky, 2005) – as a critical period during which the mother needs attention and support from family members, including men, to recover from the effects of pregnancy and return to non-pregnancy state. Tsui et al (1997), observes that it is often family members and not the woman alone, who make decisions about obstetric care and in many cases, women's decision makers are men who are either their husbands or relatives. Tsui et al (1997) observe that most women are poor and it is this lack of money to meet costs of accessing health care services that often may be a barrier to the utilization of such a service.

In this regard and according to Drennan (1998), men whose partners have had a recent delivery can support them financially in terms of transport and other costs or accompany their partners to postnatal sessions. Men can play vital roles during the postnatal period such as assisting in household chores to ensure that their partners have enough rest.

### **2.6 Mother's empowerment, status, autonomy and health outcomes**

According to Malhotra et al (2002), empowerment, though often used synonymously with autonomy, essentially refers to a process, requiring change over time or a progression from one state to another (i.e., from gender inequality to gender equality). The other important distinguishing feature of empowerment is that it is rooted in the idea of self-efficacy and...the realization by individual women that they can be the agents of

change in their own lives (Malhotra et al, 2002). While the measurement of empowerment as an outcome may represent the ideal, its dynamic nature makes such measurements difficult. Alternatively, the more static nature of women's status and autonomy lend themselves better to investigation. Measuring women's status and autonomy can also be problematic, however, due to the wide range of attitudes and practices that these concepts potentially encompass.

Women's status has traditionally been measured using education and employment status variables. In a study of female autonomy in India, Dyson and Moore (1983) stated that autonomy represents the capacity to manipulate one's personal environment, and that equality of autonomy between the sexes...implies equal decision-making ability with regard to personal affairs. Autonomy has thus increasingly been defined as a woman's 'ability or lack thereof to make decisions in the household (Hindin, 2000). Higher levels of women's autonomy, though context-specific and therefore measured slightly differently in different studies, have been associated with nutritional status, maternal health care utilization and fertility behaviors and contraceptive use (Beegle et al, 2001; Bloom et al, 2001).

### **2.6.1 Mother's views on Male involvement in Reproductive Health**

Several studies on male involvement in maternity care (Mullick et al, 2001; Tshibumbu, 2006; Theuring et al, 2009; Kululanga et al, 2012) have indicated that both men and women are interested in male involvement. In a Guatemala study, women thought men should be involved in maternity care because they are the ones with the money (Carter, 2002b). In Katmandu Nepal, women considered the provision of nutritious foods and the purchase of delivery requirements as men's duty (Mullany, 2006).

The same was reported in a South Africa study where women responded positively to their male partners accompanying them to antenatal and postpartum visits. However, more women were less likely to want their partners at delivery. A study in Malawi found

that women considered childbirth as a preserve for women and not an area for men to be involved (Kululanga et al, 2012).

Similar findings are reported by studies conducted in Kafue and Chilanga, where women have generally expressed interest in their partners' involvement in clinic-based activities except during childbirth due to traditional culture in which only women are allowed to support during labour and childbirth (Nsemukila et al, 1998; Nakambo, 2008; Phiri, 2011).

### **2.6.2 Mother's desires about spouses' involvement in Reproductive Health**

It is evident in studies conducted so far that women desire men to be involved in clinic based activities such as antenatal and postnatal care services. With regards to family planning, a study in Ecuador indicated that women expressed great interest in their partners' involvement in joint reproductive health decision making. Eighty Nine percent (89%) of women interviewed wanted their partner to accompany them on their next family planning visit and 94% expressed desire to have their partner present during their family planning session (Roy & de Vargas Pinto, 1999; Mehta, 2002). In a Kenya study, 90 percent of women said they desired men's participation in antenatal care, post-partum, and family planning visits. Young mothers in Istanbul, Turkey, expected their husbands to be involved in family planning and child care. In Cochabamba, Bolivia, 90 per cent said that men should support their partner's decision to practice contraception (Blanc, 2001).

Referring to antenatal care ANC, women studied in South Africa, Zimbabwe and Malawi agreed in respect of men accompanying them to antenatal clinic, or providing support in terms of transportation and other related costs (Mullick et al, 2001; Horizon Report, 2001; Kalulanga et al, 2012).

However, it has consistently been found in these studies that women are ambivalent regarding men witnessing childbirth. For example, in a Kenya study, fewer women,

wanted husbands present in the labour ward or during delivery (Blanc, 2001). In South Africa, most women considered men witnessing childbirth as culturally unacceptable while some felt it was important for their male partners to witness their labour pains (Mullick et al, 2001). Similar findings have been reported by studies conducted in Zambia, and Malawi (Kululanga et al, 2012; Nsemukila et al, 1998).

## **2.7 Paternity leave and Male involvement**

Among key themes in the advocacy for male involvement is the need to create an enabling environment for more men to get involved in maternity care. Following the 1994 ICPD, a number of African countries among them Madagascar, Mauritius, South Africa, Tanzania, Mozambique and Zambia have included paternity leave in their employment acts. According to Rutter (2011), paternity leave is the rest a father-to-be takes from work upon the birth of the child. The purpose of paternity leave is to enable men to support and look after their newly delivered partners and born babies, as well as bond with their infants. The provision of paternity leave to new fathers is one example of a step intended to create an enabling environment.

## **2.8 Gender mainstreaming of Male involvement in maternal and child health**

The principle of gender mainstreaming was initially developed by feminist development practitioners in 1970s and launched at the United Nations conference on women in 1995 (Meyer & Prugl, 1999). It is simultaneously intended to revise all mainstream policy areas as a way of improving the effectiveness of mainline policies by making visible the gendered nature of assumptions, processes and outcomes (Beveridge et al, 2000).

The 1994 ICPD drew attention to the historical neglect of men in maternal and child health programs (Green et al, 2001). Since then, maternal and child health agendas have been re-evaluating gender perspectives as one way of promoting men's participation. Accordingly, surveys around the world are increasingly interviewing men and reporting on their contraceptive use, reproductive preferences, sexual behaviours

and attitudes towards getting involved in maternity care. Underlying the increased focus on men's perspectives is the rationale that to have comprehensive understanding of factors influencing men's involvement requires male focused research with men themselves as respondents to understand their attitude better (Tshibumbu, 2006; Theuring et al, 2009).

Consequently, the existing literature and precedents on men's involvement in maternity care have mostly been about how maternity care programs could be adjusted to accommodate more men with emphasis on men's advantage over women in decision making and social economic factors (Thaddeus & Maine, 1994; Robey, et al., 1998; Drennan, 1998; Kumar, 1999; Ntabona, 2002; White et al, 2003; King et al., 2006).

In-depth studies with a primary focus on women supplying evidence of mother's experiences, opinions and attitude regarding male involvement and on participation barriers are rare.

## **2 .9 Theoretical Framework**

This study will be grounded in critical theory focusing on feminist thoughts. Critical theory refers to a style of Neo-Marxist philosophy of the Frankfurt School developed in Europe in the 1930s. It aligns itself with theories of enlightenment, emancipation, and critique of instrumental rationality. Indeed, if some knowledges have been used to silence, marginalise and render women invisible. Critical theory listens to factors that bring about and perpetuate inequality. Therefore critical theory is a framework that can be used to theorize, examine and challenge the ways women domination implicitly and explicitly impact on social structures, practices and discourses. Critical social theory is oriented toward critiquing and changing society as a whole and not testing assumptions (Pratschke, 2003) as all mid-range theories do. In this dissertation, critical theory was chosen in this study for the following reasons:

- 1) To show crude forms of social, ideological or cultural determinism (Carr, 1987).

- 2) To present areas of women oppression or resistance and advance strategies for women empowerment or maintenance of the status quo.

### **2.9.1 Maternal and Child Health/Gender Studies employing Standpoint Feminism**

Most of the studies conducted on maternal and child health in Gender studies have mostly focused on the impact of men's attitude on mother's uptake of maternity care services using either women, men or both women and men as participants (see Mullick et al, 2001; Mullany, 2006; Theuring et al, 2009; Kululanga et al, 2012; Nakamboa, 2008; Phiri, 2011). A few studies have used women only as respondents with the data for the studies largely all from women's points of view. In her study on husband's involvement in maternal health issues in Guatemala, Carter (2002a) examined men's involvement through Guatemalan mother's reports of their spouses' involvement in their latest pregnancy and birth. The data for the study were largely all from mother's points of view.

In their study on male involvement in birth preparedness and complication readiness for emergency obstetric referrals in rural Uganda, Kakaire et al (2011), assessed the level of male participation in the birth plan among women admitted as emergency obstetric referrals in antenatal, labour or the postnatal period. The data were all from mother's points of view.

### **2.10 Research designs used in gender studies**

Research regarding male involvement in women's health especially reproductive issues seems to be predominantly qualitative (population Council, 2005; Mullany, 2006; Theuring et al, 2009; Kalulanga et al, 2012). A few of the studies are quantitative (see table 2.7.1) and mixed studies (Mullany et al, 2006; Akarro et al, 2011; Mullick et al, 2001). The sample sizes in quantitative studies do not go beyond two hundred (200). There seems to be no theory guiding quantitative samples. Qualitative studies tend to

prefer in-depth interviews to focus group discussions. In these qualitative studies sampling has predominantly been purposive (see table 2.7.1).

**Table 2.7.1 Research Designs used - male involvement in Reproductive Health Studies**

<b>Author</b>	<b>Article</b>	<b>Methodology</b>
Mullick et al. (2005)	Involving men in maternity care: health service delivery issues	A structured questionnaire was used. Eleven focus group discussions were conducted with pregnant women, men whose partners were pregnant at that time and couples who had recently had babies.
Theuring et al. (2009)	Male Involvement in PMTCT Services in Mbeya Region, Tanzania	124 Individual interviews and 6 focus group discussions were data collection tools
Kululanga et al. (2012)	Male Involvement in Maternity Health Care in Malawi	In-depth interviews and focus group discussions were the methods used for data collection.
Population Council (2005)	“Men and Women Differ in Expectations About Male Involvement in Pregnancy. Harare, Zimbabwe	The study consisted of 30 focus group discussions and 30 in-depth interviews with pregnant women, men, Community leaders, and antenatal care staff at health centers serving commercial farming communities in Zimbabwe.
Mullany (2006)	Women’s autonomy and male involvement in antenatal care: associations and tensions	In-depth-interviews and focus group discussions were conducted to investigate patterns of household decision-making and the context of male involvement behaviors in Katmandu, Nepal. A questionnaire focusing on household decision-making and husbands’ roles during pregnancy was administered to 592 women receiving antenatal care at a large maternity care hospital. Multivariate regression techniques were used

Author	Article	Methodology
Akarro et al. (2011)	An Evaluation of Male Involvement on the Programme for PMTCT of HIV/AIDS: A Case Study of Ilala Municipality in Dar es Salaam, Tanzania	Structured, administered questionnaires and in-depth interviews were used as data collection instruments.
Nakambo (2008)	Involving men in safe motherhood of men and women in Kafue Mission of Kafue District	In-depth interviews and focus group discussions used as data collection tools. Study sample comprised of thirty married men and women of ages between 18 and 49 and interviewed were four medical personnel
Phiri (2011)	Men's participation in family planning in Chilanga Ward of Kafue District	Cross-Sectional Survey design employing both qualitative and quantitative approaches. Primary data collection using semi-structured questionnaires and FGDs Simple random sampling used to sample 200 people comprising both men and women
Mungaila (2007)	Decision making and reproductive health issues: A case of expectant married mothers at Chainama Antenatal Clinic in Lusaka	Qualitative and quantitative research methods. Structured open and closed interview, and FGDs. The sample constituted 39 expectant married mothers at Chainama Antenatal Clinic
Carter (2002b)	Because He Loves Me: Husbands' Involvement in Maternal Health in Guatemala.	Based on individual interviews and focus groups with men, women, and community health workers in two rural areas of Guatemala, researchers describe the pregnancy-related advice and assistance husbands give, and the reasons men are and are not involved in maternal health.
Carter (2002a)	Husbands and maternal health matters in rural Guatemala: wives' reports on their spouses' involvement in pregnancy and birth	This paper explores the content, prevalence, and determinants of husbands' involvement in two aspects of their wives' maternal health: (1) providing advice and care during pregnancy and (2) attending birth. Using primarily women's reports of their spouses' involvement taken from qualitative and survey data from a sample of rural Guatemalan households,

## CHAPTER THREE – RESEARCH METHODOLOGY

### 3.0 Introduction

This chapter presents the methodology as used in this study and is organized under the following sections: research strategy and design, research site, population, sampling and sample size, research instruments, data collection procedures and data analysis.

### 3.1 Research Strategy and Design

A cross sectional qualitative research design informed by the abductive research strategy was chosen to ground this study. According to Blaikie (2000) this is a research strategy that embraces interpretivism and constructivism. Noting that the ontological assumptions of the abductive research strategy are different from those of induction and deduction, scholars such as Dilthey, Simmel, and Weber who once used abduction, maintained that the human sciences (*geisteswissenschaft*) were fundamentally different from the natural sciences (*naturwissenschaft*) and, as such, could not be studied in the same manner (Erickson, 1986). Recognizing that the ontological assumptions of abductive strategy stem from the inner world of beings and that human beings do not behave in the same manner (constructing or interpreting social action) and assign meaning to situations differently, exploratory qualitative research was therefore befitting. The interpretivists' and constructivists' model of human beings carries with it the notion of choice, free will and individualism. Human beings are seen as active agents capable of monitoring their own behaviour and using their speech to make comment on their performance and plan ahead. Further, human beings are purposive, active and involved with life experiences (Cohen et al., 2007) about things. The things have meaning (at least to a very large extent) in virtue of the fact that people ascribe meaning to them. These ascriptions can be diverse and numerous and can display a multitude of perspectives, motives and biases (Smelser and Baltes, 2001).

Recognising that meanings for the interpretivists and constructivists are not static and that the researcher wanted to show lived experiences of women as they constantly created life and conceptions of motherhood alongside the roles of their husbands, how fatherhood changed from say conception through delivery to postnatal life, and finally how the men modified the life of women, being into the field with women was therefore sought to be the best approach (Kerlinger, 1969); Haralambos, 1985; Kombo & Tromp, 2006).

An exploratory and descriptive design employing a qualitative approach therefore was best suited to elicit the social constructions of postnatal mothers regarding men's involvement in pregnancy, labour and postnatal care. Kerlinger (1969) in Kombo (2006) explains that descriptive research is predominantly exploratory because it takes a case study approach. Descriptive studies involve giving a detailed account of events and the cultural setting where the phenomena are happening (White, 2005).

### **3.2 Research Site**

Data was collected over a period of two months from December 2012 to February, 2013. This data was collected from two health centres and their catchment areas in Chinsali District namely Lubwa Rural Health Centre and Location Clinic. Chinsali District, the provincial capital of Muchinga Province, has eighteen health facilities distributed in peri-urban and rural areas and most of them are in the rural areas.

Chinsali District was chosen for this study because it is one of the districts where an advocacy group for male involvement is said to be active and the sponsors of this study wanted to see what was actually happening on the ground. As such, it was thought to be research prudent to explore the views of women in Chinsali.

For this study, the researcher desired to have view points from women in rural and peri-urban places and as such, Lubwa Rural Health Centre was enlisted purposefully from

among rural institutions and Location Clinic was enlisted to represent peri-urban places. Lubwa Rural Health Centre is 8 kilometers west of Chinsali District Hospital – which makes it the most accessible (nearest) of the rural institutions. It has a catchment population area of 10,373. Location Clinic is within the peri-urban zone and has a catchment population of 28 393. Both health centres provide basic emergency obstetric care including antenatal, delivery and postnatal care services.

### **3.3 Study Population**

According to White (2005), a study population refers to a collection of objects, events or individuals having some common characteristics that the researcher is interested in studying (White, 2005). In this study, the study population comprised mothers attending antenatal, labour, and postnatal care services at Lubwa and Location Clinics in Chinsali District.

### **3.4 Sampling and Sample Size**

The researcher used purposive sampling technique in selecting Lubwa and Location Clinics as study focal points as well as study participants. The selection of these two centers was based on the advocacy for male involvement that the Zambia Prevention Care and Treatment (ZPCT) had rolled out to the two health facilities among other public health institutions in 2010. Further, the two facilities cater for diverse cultures, and this ensured a comparison and applicability of the research findings to create typical phenomena that could be explored further in future. Recruitment of participants was done through locally acceptable procedures as follows:

- a) Permission to conduct research was sought from the Ministry of Health Headquarters, and from Chinsali District health office.
- b) The officers in charge of Lubwa and Location Clinics were consulted as entry points into the health facilities. The approval and cooperation of the district

medical officer and the centre in charges of the health centres allowed greater trust of participants in the two purposively sampled health facilities.

The researcher was helped by staff to draw sample elements from mothers cutting across the three groups (antenatal, labour and postnatal mothers). This is because the staff knew who was in the three phases and when such clinics took place. Postnatal mothers were the best of the three groups among the mothers who were interviewed and who participated in the focus group discussions because they were the only group that had a recent experience with antenatal care, labour and were attending postnatal care.

MacNealy (1999) gives advice on purposive sampling and submits that a researcher, who desires to have sampling units that are necessary and specific to answer questions about a certain matter or product, should consider this type of sampling technique. To recruit mothers for in-depth interviews, the researcher employed theoretical sampling technique as one variant of purposive sampling in selecting sample units or searching for cases or individuals until saturation was attained to cover the spectrum of views and perspectives sought by the research questions.

The theoretical sample is a “well-defined sample” according to Barton (2001: 324,325) and “that is systematically aimed at reaching saturation and not representativeness.” The process of sampling was such that when data from one interview or focus group were analysed, before conducting the next interview or focus group discussion, a grounded theory approach of data analysis was employed to see what categories were emerging. These categories were used as building blocks for the next round of inquiries. Once the categories kept on emerging in subsequent interviews and focus group discussions, the researcher recruited additional participants or conducted more focus group discussions as points of saturation. This is what Glaser (1978) and Strauss and Corbin (1990) consider as theoretical sampling.

This kind of sampling was interleaved with maximum variation sampling, where cases were selected serially, with each adding a different, contrasting element to the overall sample.

A sample of 90 mothers attending antenatal, labour and postnatal health care services at Lubwa and Location health centres informed this study. Eight focus group discussions with mothers numbering six to ten were conducted broken down as follows: two with postnatal mothers, and two with antenatal mothers at each of the two study sites respectively. Focus group discussions were done only with mothers in the antenatal and post natal clusters and this is because it was difficult to have mothers in labour cluster come for focus group discussions. The focus group discussions in essence were composed of homogenous members (Stewart and Shamdasani, 1990), implying that the composition was (a) antenatal attending mothers and mothers who delivered six weeks earlier or just one week after postnatal date. The size of the group was no less than six and no more than twelve as guided by Stewart and Shamdasani (1990) and Krueger (1994). On average, focus group discussions took between one to one and half hours. Fifty Six mothers participated in the focus group discussion.

Thirty Four (34) in-depth interviews were conducted with mothers who were enlisted using maximum variation sampling. Seventeen (15) were from the antenatal cluster, 9 from the labour cluster and 10 were from the post natal cluster. On average, interviews took about thirty minutes to explore phenomena around mothering. No woman was allowed to participate in both the FGD and the in-depth interview. As for mothers in the first stage of labour, only those who were being admitted and were not in incessant pain were enlisted. These two methods were appropriate for exploratory and descriptive research questions that were designed rather than for the formal testing of hypotheses as argued by Stewart and Shamdasani (1990), Peters, (1993) and Rigge (1994)

### **3.6 Interview Process**

The researcher introduced himself and the purpose of the study. Thereafter, and depending on the literacy level of a prospective participant, the researcher either gave her the consent form to read and sign or read the consent form to her for verbal consent. Thereafter, the researcher requested the participant to introduce herself including her age, number of children, number of previous pregnancies, marital status, education, and income. Once a participant had introduced herself and demographic information recorded, the researcher welcomed the participant and begun the interview.

The researcher emphasized confidentiality and the voluntariness of participation in the study and sought the participant's permission to use the voice recorder on condition that the recorded voices would be used for research purposes only.

The researcher then led the participant through a series of exploratory and descriptive research questions that had been designed while constantly ensuring a conducive atmosphere that enabled optimum participation of the participant throughout the interview process. At the end of every interview, the researcher thanked the participant for cooperating and participating in the study.

### **3.7 Focus Group Discussion Process**

At the start of every focus group discussion, the researcher welcomed participants and thanked them for considering being part of the study. The researcher then introduced himself and the research assistant and clarified the question under investigation as well as the kinds of information being sought including their intended use. Thereafter, and depending on the literacy level of the group, the researcher either gave them the consent form to read and sign themselves or read the consent form to them for verbal consent.

The participants were then requested to introduce themselves including their age, number of children, number of previous pregnancies, marital status, education, and income. Once participants had introduced themselves and demographic information collected, the interview begun. The researcher encouraged participants to freely and actively participate, that there was no right or wrong answer, and assured participants of confidentiality.

Before asking the first focus group question, the researcher always inserted an icebreaker, usually a question unrelated to the research questions, to increase comfort and level the playing field. Mothers were then asked about their views regarding what they felt about their male partners getting involved in antenatal care, labour and postnatal care and what areas of maternity care they considered critical for their partners' involvement. The questions elicited describing and understanding experiences of being a mother and allowed the researcher to listen more than talk (Sorrell and Redmond, 1995). A number of discussion points with prompts were used to guide the focus group discussions to encourage participants to elaborate on issues of particular importance or relevance (Van Manen, 1990) to their lives as mothers.

Throughout the process, the researcher ensured that he covered all prepared questions within the given time and also took it upon himself to get all participants to talk and fully explain their answers. Additionally, the researcher remained neutral as much as he could throughout the interview process to enhance credibility of participants' responses. At the end of the focus group, the researcher thanked all participants for participating in the study. Immediately after all participants left, the researcher and the assistant debriefed while the recorder was still running and labeled all recordings and notes with the date, time and name of the group.

### **3.8 Data Analysis**

According to Kombo & Tromp (2006), data analysis refers to the examination of data collected in a study and making logical conclusions and suggestions. There are different

kinds of analysis for qualitative data. Data for this study was analyzed using thematic analysis. Thematic analysis determines the frequency with which certain objects, persons, institutions or concepts are mentioned and could be a credible base for generalization. Thematic analysis minimally organizes and describes a data set in (rich) detail (Boyatzis, 1998). Thematic analysis in this study was used for identifying, analyzing and reporting patterns (themes) within data.

Data analysis was undertaken simultaneously with data collection in order to identify and correct errors during next interviews and focus group discussions. The recorded data was transcribed verbatim and translated from the native language (Bemba) into English. Observational field notes were incorporated into the data for analysis. Thematic analysis guided data analysis as follows:

Transcripts were read repeatedly and words with similar meanings were grouped into categories. Similar categories were grouped into themes and sub-themes which are presented as results. The results contain direct quotes from participants and the narrations are reported as were spoken by participants without editing the grammar to avoid losing meaning.

### 3.8.1 Step-by-step guide to doing thematic analysis

The process of thematic analysis, similar to other processes of qualitative data analysis starts when the researcher begins to notice, and to look for patterns or themes of meaning and issues of potential interest in the data – this may be during data collection. Themes are abstract (and often fuzzy) constructs the investigators identify [sic] before, during, and after analyses (Ryan and Bernard, 2000). The endpoint is the reporting of the content and meaning of patterns (themes) in the data. The following step-by-step guide was adopted in analyzing qualitative data gathered for this study:

### *Step 1: Familiarizing with the data*

The researcher transcribed all data, reading and re-reading the data and noting down initial ideas. The researcher initiated this process during data collection.

### *Step 2: Generating initial codes*

The researcher began coding interesting features of the data in a systematic fashion across the entire data set, collating data relevant to each code.

### *Step 3 Searching for themes*

The researcher started assembling codes into potential themes, gathering all data relevant to each potential theme.

### *Step 4 Reviewing themes*

The researcher started checking if the themes worked in relation to the coded extracts and the entire data set.

### *Step 5 defining and naming themes*

The researcher refined the particulars of each theme, and the overall story the analysis told, generating clear definitions and names for each theme.

### *Step 6 writing the report*

The researcher selected vivid, compelling extract examples, made final analysis of selected extracts, relating back of the analysis to the research questions and literature and produced a scholarly report of the analysis.

## **3.9 Ethical Considerations**

The main ethical issues most considered when conducting research include the voluntary nature of participation, reduction of risk for participants, obtaining of informed consent; ensuring confidentiality and privacy of participants, institutional ethical issues,

which include obtaining authority to conduct research and scientific honesty (Babbie & Mouton, 2001; Bless & Higson-Smith, 1995; Polit & Beck, 2004). The following was done to ensure the above ethical issues were adhered to:

### **3.9.1 Voluntary Participation**

The right of the participants to participate in the research or not, as they chose, was respected. All participants participated freely after receiving information on the study and their right to answer questions or not, right to avoid being made uncomfortable and the right to withdraw at any time during the interview process was emphasised.

### **3.9.2 Minimizing Risk to Participants**

The research was carried out with minimum risk for respondents. The only possible identifiable risk could arise from questions related to male involvement in labour which some participants found embarrassing. Two participants withdrew from the interview process because they were uncomfortable responding to labour-related questions.

### **3.9.3 Informed Consent**

Participants were provided with adequate information on the research before the interview and due to the low level of literacy, the consent obtained from most participants was verbal (oral).

### **3.9.4 Confidentiality & Anonymity**

The right of participants to anonymity and confidentiality was ensured by reporting research findings in a way that would not relate to participants.

### **3.9.5 Scientific Honesty**

Scientific honesty was observed as much as possible in this report by ensuring proper cross-referencing and by listing all scientific sources at the end of this report. The Harvard referencing system was used throughout this report.

### **3.9.6 Permission to Conduct Research**

The research proposal was submitted to and approved by the Research and Ethics Committee of the University of Zambia in November 2012. Authority to conduct research in the two health facilities in Chinsali District was also obtained from the Ministry of Health Headquarters on the 28<sup>th</sup> November, 2012; and from Chinsali District Health Authorities before commencement of data collection.

## CHAPTER FOUR – PRESENTATION OF FINDINGS

### 4.1 Introduction

This chapter presents the data collected for this study based on the themes below:

- 1) Things men do and do not do in antenatal care, labour and postnatal care.
- 2) Desired and undesired areas in antenatal care, labour and postnatal care that mothers consider men could be involved in.
- 3) Mothers' motives regarding the selected and deselected areas of male involvement.

In presenting the findings, the researcher takes a naturalistic point of view. As a model of qualitative research, *naturalism* focuses on the factual characteristics of the object under study (Guba and Lincoln, 1994). The goal is to describe what life (mothering and the role of men) is really like based on what was heard and observed. The observations and narratives are intended to reflect what the researcher saw and heard in this real world of mothering. In this section, the researcher is describing an experience or events and has selected only what is critical to describe what the research questions were demanding and, in the process of featuring certain aspects of what is critical. The researcher presents a personal interactive view and in a number of places uses double hermeneutic phenomenology to transform that experience or event by contextualising it. A double hermeneutic phenomenology necessarily forms part and parcel of *verstehen*. The first hermeneutics that will be presented is Husserlian in nature. This is the original description of phenomena as lived by the social actors and can be called as original meaning. The second hermeneutics is existential in nature. This is because according to Hans Gadamer (1989), there are no original meanings but only original meaning ascriptions which tend to be personalised and may include the researcher's observations and interpretations. To use a double hermeneutics so as to show the

results clearly, the researcher does this by citing past research and adds a personal interpretation. Although no description is free of interpretation, basic or fundamental qualitative description, as opposed to, for example, Husserlian phenomenological or grounded theory description, which is the approach used in this section, entails a kind of interpretation that is low to moderate inference, or likely to result in easier consensus among researchers. This approach borrows heavily from Pearce, (1971) and Wolcott, (1994).

As a rule, demographic characteristics of the respondents are discussed before the main findings.

#### **4.2 Participants' Demographic Characteristics**

A total of ninety (90) mothers attending antenatal, labour and postnatal care services, from the catchment areas of Location and Lubwa Rural Health Centres, participated in the study. Their mean age was 24 and the youngest was 15 whereas the oldest was 46 years of age. Demographic baseline information was obtained from them by examining their antenatal cards and these were confirmed by one to one interviews before being enlisted in the focus group discussions. Their education level ranged from none to tertiary. On average, mothers had been up to primary school. Most of the participants were housewives and petty traders except for a few, 12 in number, who were teachers (9 primary and 3 secondary school teachers). Participants were predominantly married (79 out of the 90 interviewed for the study). Their number of children (parity) ranged from one to eight births with the majority having between one and five children.

#### **4.3 Areas men are involved in and not involved**

Concerning mothers' views regarding male involvement, several points were agreed upon by all mothers during antenatal care, labour and postnatal care. Most of the time, the mothers agreed that their husbands needed to be involved in their care from

antenatal to postnatal so that they can understand the process. However, male involvement was expected to be pronounced during antenatal and in fact men were more involved during antenatal than at any other stage. This is in line with the findings of a study in Mwanza District, Malawi where male involvement was more pronounced mainly in line with antenatal couple HIV counseling and testing (Kululanga et al, 2012). Even though mothers wanted to have their partners involved, not all were enthusiastic especially during labour and post-partum. Men seemed to be involved more in activities outside the health centre than activities inside the health centre and were involved more in the activities that required less effort or time than more effort and time. However, there were more areas men were not involved than they were and more areas mothers expected men to be involved than not. For instance, involvement by men among mothers was not preferred during physical examinations and delivery while men seemed to be involved in providing food and some emotional support. In this study, fifteen themes were generated that are being used to answer the research questions and these themes include:

1. Accompanying partner to antenatal clinic
2. Attending health education and counseling sessions
3. Attending screening sessions/physical examination
4. Helping in household chores
5. Providing food
6. Ensuring birth preparedness
7. Emotional support
8. Providing money
9. Accompanying partner to deliver
10. Attending childbirth
11. Infant care
12. Accompanying partner to postnatal care
13. Decision making
14. Taking baby to under-five clinic
15. Supporting postpartum abstinence

Below is a table summarising male involvement using qualitative content analysis.

**Table 4.3.1 Dos Don'ts and Expectations of Male Involvement in Reproductive Health Care**

<i>Reproductive Phase and Broad Themes</i>	<i>What men do</i>	<i>What men do not do</i>	<i>What is expected of men</i>
	<i>Frequency</i>	<i>Frequency</i>	<i>Frequency</i>
<b><i>Antenatal (Pregnancy)</i></b>			
Provide money	19	7	34
Provide food	21	11	37
Emotional support	9	16	23
Escorting the mother for review to the Clinic	6	18	29
House chores	4	14	26
Attending screening sessions	0	0	7
Attending health education and counseling sessions	2	13	25
<b><i>Intra-partum (Labour)</i></b>			
Provide money	12	19	33
Provide food	3	7	7
Emotional support	15	9	24
Escorting the mother for delivery to the Clinic	7	8	19
Attending the examinations and being present during labour	0	0	2
<b><i>Post-partum (from delivery to six weeks)</i></b>			
Provide money	11	14	18
Provide food	15	10	27
Emotional support	3	12	17
Escorting the mother to the post natal Clinic	3	25	12
House chores	4	16	16
Attending the post-delivery screening session	0	24	5
Attending health education and counseling sessions	0	17	3

There were fewer things mothers reported that men do in pregnancy, labour and post natal care. The things men do and do not do were thematised into male involvement outside the health facility and male involvement within the health facility.

#### **4.3.1 Theme I: Male involvement outside health facility**

Concerning male involvement outside health facility care, majority mothers said their husbands do provide financial support, food, emotional and psychological support. In a number of instances, men offered birth preparedness in terms of material support and transport arrangements. However, not all mothers were enthusiastic about husbands' involvement some said the exact opposite. Several mothers felt husbands only actively provide care in the absence of a female relation or helper. Many mothers felt that household chores were mothers' job, and that men only assist when the woman is unwell and cannot manage to perform.

*My husband is never there for me. If you see him doing something, it is either because my sister has left home.*

*My husband helps me with some work even when I am well.*

*You are joking, men do not want to help at all. Only in some situations when a woman is sick.*

#### *Food Provision*

This is a role men were said to perform very well. However, where a woman was not married, this role was not very well performed. The descriptions below attest to what most men did and few did not do in the three reproductive phases in Chinsali District.

*Men who care know that a woman has a craving for different kinds of foods. Once in a while when he has some chance, he will bring what I say I want. I see that it is not only my responsibility to take care of my health but my husband's too. I speak to him over and over and he will do it but struggling you know...*

*He ensures provision of good food for the good health of both us and the children.*

*This is true when you have a husband. If the man is not your husband, he will not provide good food.*

This finding regarding the influence of union status on the nature of male involvement is not unique to this study. Formally married women were found to be twice more likely to receive male support than women in consensual unions in a study in Mambwe District, Zambia (Tshibumbu, 2006). In Mwanza District, Malawi, married women their first birth were twice more likely to be accompanied by their husbands than any other class of women (Kululanga et al, 2012).

In the postnatal period however, more mothers stated that their husbands became less involved in ensuring good food provision. The man seemed to be more concerned in the antenatal phase. One of the mothers stated that:

*After delivery, my husband has relaxed bringing me good and nutritious foods to enable me regain my strength. He says that I can now fend for myself so he could buy one or two other things.*

### *Money*

The point of having men involved because they were the ones with the money pointed to a responsibility which was culturally approved as a gender role in Chinsali District. Men who had money shared part with their wives as a kind of support throughout the whole phase of mothering. There were men who were stingy and others who were poor and could not perform this noble role.

*I see something different in my husband. He seems to give money liberally. I have also seen it in my neighborhood I mean in the Cell group. May be because my friends have husbands too who love God. The moment you get into labour, they are there running around looking for transport even a bicycle and donate some money....*

*Men possess and control resources in the home and you have to beg to the extent of quarrelling to have some. This makes travelling or buying little things for the baby a bit challenging sometimes. The man will give you in one instance and in the other, he will not.*

*Our husbands as you have seen are just mere fishermen and peasant farmers. The money to run around the family is not enough. This is very hard for very young mothers who are made pregnant or married to young men.*

The illustrations above point to what research elsewhere has shown regarding the influence of economic status on male involvement. Economic status has been found to be a determinant of men's role in reproductive health as a form of direct or indirect support in maternal matters. The possession of control over some economic resource such as money or access to medical advice and treatment or pregnancy related conditions determines the degree of male involvement. This was found in a Guatemala study, *Because he loves me: Husbands' Involvement in Maternal Health in Guatemala* (see Carter, 2002b). Relatedly and Waltson (2005) also cited financial factors like inability to arrange transport and loss of income through lost work time as preventing some men from either accompanying their wives to maternity care appointments or keeping appointments. In a similar situation, in Katmandu Nepal and Guatemala, the most universal form of male participation during pregnancy, labour and postnatal phases was financial support, transport and communication arrangements (Carter, 2002a; Carter, 2002b; Mullany, 2006).

### *Emotional Support*

Mothers expressed various points of view regarding the roles men performed in this domain. Most of the mothers claimed that men were very positively involved in labour than outside labour and that this was the phase in mothering when mothers were supported the most. This is the phase which men thought required psychological support and birth preparedness in terms of material support and transport

arrangements. Three excerpts below show positive emotions and one is actually an indifference.

*My husband seems to be very concerned when it is time to be put to bed (delivery). I see him attached to me and he seems to be in so much thoughts. I personally wonder what goes in his mind...He is able to release money which he would normally withhold.*

*I get much support when I am in labour. We pray together and my husband leads. It is such an electrifying experience. I see him worried but hopeful of the best....Men seem to be ready to help this time than any other.*

One woman gave a contrary testimony in the discussion.

*But others are detached. They see you in pain and that is the time they leave you to fend for yourself. There is actually no attachment.*

Other beliefs about childbirth that shaped mothers' views on male involvement in delivery was that the childbirth process was an emotionally draining experience and that men lacked the stamina and emotional strength required to attend to the needs of mothers as well as childbirth. Similar sentiments to the testimonies below were reported in a study in South Africa where mothers felt that men became weak if they witnessed childbirth (Mullick et al, 2001). Relatedly, childbirth specialists like Michel Odent have argued that it is not natural for men to attend childbirth as this practice can ruin sexual attraction between a couple and lead to them becoming just good friends (Williams, 2000). The illustrations below describe these observations.

*Men are weak when it comes to reproductive issues. We should not just accept the belief that they are stronger than women. I am yet to see a man withstand labour. When you are in pain, ....I mean I have seen some shedding tears too.....birthing is a traumatic process and it is emotionally draining...*

*I feel pity for my husband. This is the fifth delivery and my experience is that he seems not to have the power or strength to go with me the whole way. He will just drop me here and goes home...*

*You think a man is strong. There are instances that they have fainted. Just the mere sight of blood. I remember in the village, a woman failed to give birth and we asked for help. The husband fainted just seeing blood. Other men stood at a distance and you would hear them say birthing is embarrassing and you may just lose your appetite for sex.*

### *Ensuring birth preparedness*

More mothers stated that their husbands played an active role in birth preparedness. Two testimonies assert so and one is at variance from the most common practice.

*It is obvious that a woman who falls pregnant will soon give birth. In our homes, it is usually our husbands who provide money to buy clothes, a basin to be used at the hospital during delivery and a plastic sheet which is used when the woman is giving birth.*

*Yes while this is true, others are the exact opposite. You may go to the hospital with nothing..I mean no nappies, no soap, and no towel. You only have these things at discharge.*

*Nowadays there is need for the husband to put aside some money to be used for transportation to and from the hospital because sometimes the woman may go into labour even before the expected time.*

What is described above is not only specific to Chinsali. Similarly, a study done in Rural Guatemala indicated that financial support, nutrition, and birth preparedness in terms of material support and transport arrangements was the most universal form of male participation from pregnancy through to postnatal period. A study conducted in Ecuador by Mehta (2002) also established that women considered the purchase of delivery requirements as men's duty.

### *Infant care*

In the postnatal period, more mothers said their husbands play a less active role in infant care. It seemed men felt mothers were out of danger after delivery and could then concentrate on child care.

*My husband refuses to participate in most of the child care needs. He can only soothe the baby sometimes when he cries at night.*

*Normally men think this task is for women and no matter how the baby cries at night some men don't even move expecting that the mother will handle it. But there are times when you just have to come in to help instead of just sleeping and leaving everything to the mother.*

### **4.3.2 Theme II: Male involvement within the health facility**

Few mothers indicated that their husbands accompanied them to the clinic. Most of the mothers had husbands accompanying them when in labour than during antenatal and postnatal sessions. The mothers explained that fear of death and blame from relatives was the driver for husbands to escort them when in labour. There were various reasons mothers cited for their husbands to accompany them for care. The excerpts below attest to the situations when mothers were accompanied and when they were not.

### *Accompanying partner*

*My husband accompanied me for the first time because he wanted to know what he could do and to also know our HIV status (First time in pregnancy).*

*My husband is funny you know. He says he has to accompany me to see what is involved in pregnancy....maybe he is jealous I do not know.*

*Mine says it is a waste of time except when I am in labour. He will say go and come and tell me what happened and how you are and my child. Imagine just like that. As for postnatal, forget....he will say I am out of danger so what is the fuss...*

*My Husband has during each pregnancy accompanied me to antenatal clinic. He feels that we both ought to be informed on how to protect the baby in case one of us or both of us have a disease.*

*It is incumbent upon our husbands to accompany us to delivery after all the child being expected is theirs as well but they do not do so most of the times.*

*Sometimes it happens that you get transferred to another distant hospital such as Kasama, Lusaka, Kabwe and so on and husbands are not available so that you can be supported.*

#### *Attending Health Education and Counseling Sessions*

Some participants said their husbands were not willing to attend health education sessions even when they were escorted claiming that the activity was not man like.

*My husband would not like entering the antenatal room. He does desire to learn anything directly from the nurses but not from me.*

*Men are very shy and they would not like to be in a place where there are many women so they shun our sessions.*

*I remember my husband has never failed to support me. When I am up and come to register pregnancy, he is involved in health talk, as we start the clinic with group health talk. Then we are counseled on HIV and PMTCT... our blood is tested and we are counseled again. After that he decides to go out and he does not want to witness the physical examination. I only remember once he stayed on and he said it was rather embarrassing.*

Though slightly different, similar findings were reported by Mullany (2006) in a study in Katmandu Nepal where embarrassment or awkwardness in learning about pregnancy or mixing with women during antenatal health education appeared to be a less significant,

though still important barrier to husbands' involvement in maternity care services within the health facility.

#### *Attending screening sessions*

The majority women in the focus group discussions stated that their husbands often decided to stay away from the screening room because only women were supposed to be found in the screening room during physical examination. They also noted that it was embarrassing and taboo.

*I heard at the clinic one day that my husband could be welcomed to attend my antenatal examination. So dutifully, I asked him to accompany me and he just told me ehhe you seem to be mad. You think I can with your so called doctor (implying a male nurse).*

*In refusing entering the labour room, my husband remarked that the only people who should be present in the screening room are women and the nurse because if I do,...I can misinterpret the screening procedure especially if it is the male nurse conducting it. It is also embarrassing to have others see what you see alone.*

#### *Attending Child Birth*

Almost all the mothers reported that their husbands did not attend any childbirth either at home or at the health centre. Only one woman reported having her husband witness her childbirth once due to a medical condition. It appears that though some men may desire to attend childbirth, a vast majority of mothers would not allow them as they felt that it was a violation of personal rights to allow men attend. The women further claimed that birthing was a virtue for women and as such men were not privy to witness birthing. Below are excerpts attesting to this while one is an exception

*At my age, I do not remember a man witnessing where a woman is giving birth. I would not allow him to come closer to see. To see what? That is exclusively for women. Because it is not men's right to witness a woman giving birth as what happens during childbirth is a mother's secret.*

*It is not right for men to be there and it has never been right for men to witness this secret*

*My husband attended our second birth. He was called in by the doctor to be cautioned that my uterus was weak because we had spaced our first and second pregnancies too close*

These findings are not specific to Chinsali alone. Kululanga et al (2012) in their Malawian Study found that attending childbirth was considered exclusively as a mother's affair. Both the men and women interviewed in this study considered childbirth as a preserve for women and not an area for men to be involved. Issues surrounding childbirth were culturally considered to be a source of power for women, a territory where women would not want men to invade for fear of losing that power. Nsemukila et al (1998) revealed similar findings in Zambia where issues surrounding childbirth were culturally considered to be mother's affairs. According to Nsemukila et al, men including the spouse were denied entry into the delivery room while according to Singh & Ram (2005), only a small proportion of men were found to be present at the time of delivery of their children in Maharashtra.

#### *Taking baby to under-five clinic*

The women were unhappy that husbands seemed to have resigned from many roles. Most of the women wanted their husbands too, to take children to under five clinics.

*My husband has consistently refused to take children to under five clinic because he sees it to be a woman's duty.*

*Mine says the Clinics were designed for women and they are full of women so why men?*

#### **4.4 desired and undesired areas that mothers consider men could be involved**

There were numerous contradictions among mothers in the focus groups regarding what they expected their husbands to do or not do. Individual attitudes and behaviors among women towards male involvement varied enormously in the focus groups with mothers who seemed to have had some education agreeing with the current movement of male involvement. However, in order to show lived experiences and expectations, the researcher points out the most frequent spoken about matters. However, the evidence suggests that many men would not participate in maternity care in Chinsali District. The following sections show that mothers expect men to be available for them on non-typical reproductive matters and not birthing, if they had more opportunity to do so. The themes presented here are grouped under non-birthing and birthing expectations.

##### **4.4.1 Theme III: Non Birthing Expectations**

Non birthing expectations included all activities related to antenatal care as well as postnatal care. There were eight subthemes under this theme and these included: being accompanied to antenatal clinic; attending health education sessions; attending screening sessions; assisting in household chores; provision of desired food stuffs; assisting in infant care; taking baby to under five clinic; and supporting postpartum abstinence and pregnancy.

The descriptions below are therefore about the none-birthing experiences.

##### *Being accompanied to antenatal clinic*

Nearly every mother wanted to be accompanied to the health centre and the reasons were numerous. Below are illustrations.

*He is not ready to come with me at all. I feel that it is necessary that my husband attends health education sessions....In this way, he is likely to be informed of how to care for me during pregnancy.*

*I feel that my husband should accompany me to the hospital so that he sees what is involved in pregnancy because if he does not come and I just report to him what is required, he may think I am lying, exaggerating or simply not saying the truth. He is in fact a very difficult and uncompromising man.*

Similar findings were reported in a qualitative study on factors influencing male involvement in PMTCT in Tanzania by Burke et al (2004), which revealed that men consider themselves traditionally as bringers of health information to the family. If information on maternity care services is first given to women, this information is less trusted by men. Men prefer to receive information directly from health workers and in gender-specific groups, because cultural norms do not encourage mixing of men and women when discussing reproductive health issues.

Relatedly, a study conducted by the Horizon Programme (2001) in Kenya and Zimbabwe on the feasibility and accessibility of Prevention of Mother to Child Transmission of HIV PMTCT found that attempts to involve male partners are most successful when men have firsthand experience and when information about PMTCT is provided directly to men and preferably outside the antenatal clinic setting, which is perceived by men as exclusive to women. In Katmandu, Nepal, majority of both wives and husbands, regardless of parity status or whether the husband was present or absent at the hospital for ANC, expressed favorable attitudes towards having husbands become more involved in pregnancy health, particularly in ANC health education services (Mullany, 2006).

### *Attending screening sessions*

Mothers did not want their husbands to be present in the screening room. Traditionally, women in Chinsali have viewed physical examination as their activity and stated that men needed to just support them.

*As I had pointed out, personally, I would not like my hubby to attend my examination. Even if he knows all about me. The site is not just good I mean...He may actually end up misinterpreting the procedure especially if it is performed by a male Clinical Officer or nurse.*

*When we come to register pregnancy, men are involved in health talk, as we start the clinic with group health talk. Then we are counseled on HIV and PMTCT... our blood is tested and we are counseled again. After that men go out and women remain for physical examination.*

In a Kenya study on the contrary, though based on a small sample, several women wanted their husbands present during physical examinations (Blanc, 2001). Similarly, some women in South Africa felt that nurses would treat them well if their husbands attended physical examinations (Mullick et al, 2001).

### *Assisting in household chores*

This aspect of gender balancing was echoed by almost all mothers. The mothers desired their partners to assist them in performing household chores during pregnancy and even after delivery. They argued that a man should always assess the kind of work his pregnant partner does in order to see how he could help so that the wife works moderately during pregnancy.

*My husband should be helping me in doing household chores because what is often difficult for pregnant women there are tasks like drawing water from distant wells and collecting firewood. It is very helpful if my husband accompanies me or does it for me*

*When the woman is pregnant and the husband does not seem to care, it is very depressing on the woman's part even small problems become big.*

*My husband should assist me in performing household chores because some of us cannot afford housemaids and it is very difficult to care for the baby and perform household chores at the same time*

There were few mothers however, who believed that it was unacceptable or taboo for their husbands to perform household chores unless they were unwell.

*My husband should only assist in household chores when I am unwell. But if I am well I cannot let him because he should be doing work suited for him.*

*It is necessary that the husband assists his partner to perform household chores during pregnancy but the woman should not take pregnancy as an excuse for laziness.*

*Should my husband also be washing baby wear or bathing the baby? No, that is my work he has his own work suitable for him as well.*

#### *Provision of desired foodstuffs*

Traditionally, men are bread winners and women felt strongly that men needed to lead in this area. They argued that it is men who make them pregnant and as such ought to take a leading role. Women who were not married reported being unsupported in this area and spoke strongly about the need for men to be responsible. More women wanted their partners during pregnancy, to provide the desired foodstuffs and not just the desired food stuffs but good and health food for the well-being of both themselves and the unborn baby.

*When a woman is pregnant she has an insatiable appetite and demand for food....Ehhmm a man must show responsibility to provide the woman with food*

*My husband should provide good food to ensure that I am well and the baby inside my womb grows well.*

### *Infant care*

In the postnatal period, some mothers, especially working mothers wanted their husbands to play a more active role in infant care.

*When I come from work, I am tired and I just get bogged up with feeding the baby. I feel husbands should also participate including soothing the baby when he cries when one is doing house chores and even at night. How does one manage everything including the man himself under such circumstances?*

### *Taking baby to under-five clinic*

Some women wanted while others did not want their husbands to take children to under five clinic. Those who did not want saw it to be demeaning to their husbands. These feelings were echoed more by women with low or no education.

*Regarding childcare, my husband can as well take children to under-five clinic*

*My husband should not take children to under five clinic because it is not his role. It is making him look foolish among women.*

*During the early stages of the baby's life, it is women who should be taking baby to under-five clinic until the baby is old enough to be handled by the father*

### *Supporting postpartum abstinence and pregnancy*

Many women expressed desire for their husbands to be co-operative in delaying resumption of sexual activity following delivery to allow them to heal and to protect the baby from malnutrition which may arise from an early post-delivery pregnancy. The assumption of many women that men are uninterested in taking responsibility for family planning has become a self-fulfilling prophecy. Most of the women in the study agreed that family planning programmes have made little effort to involve and actively consider men's reproductive health needs or to reach men. As a result men in Chinsali are brought up to think that family planning or reproductive health is woman's issues. No

wonder they seem to lack information and do not participate fully with their spouses or partners. The relative scarcity of information among men in Chinsali or men's absence in these settings is not new. Research elsewhere has shown the same (Dudgeon & Inhorn, 2004). The excerpts below show mother's attitudes regarding early sex, birthing and examinations.

#### *Time for recovery*

*I have this strong feeling within me that just after delivery, husbands should give wives time to recover. It is not just a matter of sex throughout and making babies as one wishes. Nowadays there is even family planning not only for women alone but for men too. They have to attend some of our sessions to learn about their bodies and their roles.*

#### *Protection of the baby*

*It is not correct to be pregnant shortly after delivery. After delivery, we should all control ourselves especially if the baby is still too young. Sometimes men want to continue doing what you were doing before the baby was born even when there is a tender child who should be protected..... I mean from ill health or just poor growth you know...*

#### *Lacking information*

*You can see for yourself. Where are the men in this session? Our men are brought up to think that reproductive health is a woman's issue. You will hear them discuss their points and they are very negative and ignorant of what takes place. We expect them to attend these sessions either on their own or in our company. No wonder they lack information and do not participate actively with their spouses or partners. It is also time that you health workers found ways of engaging our men without using us to get to them.*

#### 4.4.2 Theme IV: Birthing Expectations

Birthing expectations included all activities related to labour as well as delivery. There were two subthemes under this theme and these included: accompanying partner to delivery, and attending childbirth.

##### *Accompanying partner to deliver*

A vast majority of mothers preferred to be accompanied by their husbands to deliver. A belief was portrayed that if the husband is present, he may be able to assist in making decisions that may be required at various junctures in the childbirth process such as dealing with medical problems and other matters. The excerpt below attests to this.

*During labour sometimes, it happens that you get transferred to another distant hospital such as Kasama, Lusaka, Kabwe and so on. So the husband should be available so that he can accompany you and be supportive wherever you may go.*

##### *Witnessing childbirth*

Husband's primary role during delivery was mainly considered to be to bring wives to the health facility and not to witness childbirth. Accordingly, the vast majority of mothers were against having the husband present in the delivery room. They reported feeling uncomfortable or embarrassed having their husbands witness them giving birth describing that customarily, only females are present in the delivery room. Below are excerpts attesting to this.

*What happens during childbirth is a mother's secret and I submit again that men must not attend it.*

*It is not right for men to be present in the delivery room. Society does not allow men to be there*

The descriptions above rejecting men attending a birth are not new. Williams (2000) quoted Dr. Odent renowned French obstetrician, January 2000, in response to rising trend of men's attendance at their partners' births in most western industrialized countries and said "It's not natural for a man to be present."

However, and contrary to the study by Nsemukila et al (1998), where all communities interviewed opposed to men witnessing childbirth, and atypical of a predominantly traditional setting like Chinsali District, some mothers in this study explained that, if given the option, they would prefer to have the husband present during delivery. They primarily cited two reasons for wanting the husband's presence: witness and support. These mothers described wanting the husband to be present during delivery to witness their pain. Witnessing the suffering of the wife appeared to be an important element in bolstering the husband's appreciation for a smaller family size. For instance, one woman described:

*He will know how women suffer while giving birth. Many men do not understand the problem— I think two children are enough, but men go for four or five children, as they do not know about the pain .....if he is present, he will know the pain*

*Several problems may arise to which he should pay attention. Other people do not know the situation. The husband's presence is important and convenient.*

*I strongly feel that my husband has to attend child birth so that he sees for himself the pain I have to go through during labour.*

A similar but minority view was reported by Mullick et al (2001) in her study in South Africa where several women agreed with the view that it was important for men to be present during delivery so that they can see how women suffer in labour. Related findings were reported in Studies conducted in Katmandu Nepal and Malawi (Mullany, 2006; Kululanga et al, 2012).

## 4.5 Motives for the Desired and Undesired Areas of Male Involvement

The illustrations in the above sections tend to show the points mothers have whether or not men ought to be involved in antenatal, labour and postnatal care. Noting that this inquiry is naturalistic as Gubrium and Holstein (1997) and Miles and Huberman (1994), it is research prudent to establish the motives mothers had for the preferences and expectations. Using Max Weber's approach of interpretive sociology, *verstehen* will be used as a framework to show the motives. This is a description of the first-person participatory perspective that agents and in this case mothers have on their individual experience as well as their culture, history, and society to use in explaining preferences and expectations. Therefore *aktuelles verstehen* will be used to indicate the motives or purposes (teleology) of particular actions or views that mothers have towards men and their involvement in antenatal, labour and postnatal care. Von Wright (1971) submits Max Weber's position on the teleology of *aktuelles verstehen*. Teleology – or purposiveness – is a distinctive feature of human action. Human actions take place in order to bring certain future states of affairs about, not merely because certain past states of affairs happened. Two themes of motives within *aktuelles verstehen* were generated and these are (a) because of motives and (b) in order to motives. *Because of* motives were reasons or actions that had a bearing into the past experiences whereas *in order to* motives were reasons or actions made that had a bearing into bringing certain future states of affairs about. Motives actually are based on experiences or perceived benefits or threats of male involvement. This section will advance illustrations of parts of speech that may have been covered already but this time, the emphasis is to exhibit motives. This is demonstrated by making bold the concepts *because* and *in order to* as well as their synonyms in the descriptions.

### 4.5.1 Theme V: Because Motives

*Because of* motives that appear below have a distinctive feature of actions among mothers that take place in time and space because certain past states of affairs

happened. A motive with a past orientation is given in the following examples embracing **because**.

*Men should also be present during health education sessions to receive the information directly from the health workers because sometimes it feels like we are just making up stories especially if there is money involved.*

*My husband should be present during health education because what is taught concerns both men and women. It does not only concern women.*

*When the baby cries at night, my husband should help me because when the baby cries and I breast feed him but he continues to cry there is nothing more I can do.*

#### **4.5.2 Theme VI: In Order to Motives**

*In order to* motives or *so that* motives that appear below have a distinctive feature of actions among mothers that are expected to take place in time and space to facilitate future states of affairs happening or not happening. A motive with a future or present orientation is given in the following examples embracing **so that or in order to**.

*So my husband should just help me sooth the baby so that I also have time to rest.*

*I feel that my husband should accompany me to the hospital in order to see what is involved in pregnancy.*

*My Husband should accompany me to antenatal clinic so that we are both tested for HIV and informed on how to protect the baby in case we have a disease.*

*My husband should be present in the screening room so that if there is a question that I fell to answer, he can help to answer it*

*During labour sometimes, it happens that you get transferred to another distant hospital such as Kasama, Lusaka, Kabwe and so on. So the husband should be available so that he can accompany you and be supportive wherever you may go.*

*Husbands should be present in order to know how women suffer while giving birth. Many men do not understand the problem – I think two children are enough, but men go for four or five children, as they do not know about the pain... if they are present, they will know the pain.*

## **CHAPTER FIVE – DISCUSSION OF FINDINGS**

### **5.0 Introduction**

This chapter considers the findings of the study outlined in chapter four based on the research questions to clearly show what the research outputs are in relation to the problem we had at the onset. A regional and global context is used to situate the findings to outline what is similar and dissimilar. The chapter outlines the limitations and strengths while at the same time offers implications based on the findings. The implications are policy based and research based (called as recommendations by Blaikie, 2000).

### **5.1 What The Study has Found**

It is prudent that at the end of an inquiry, answers to research questions or for those using objectives, phenomena related to them are shown (Yin, 2008 ; Creswell, 2005). In this study, the researcher opts to use the research questions model and this is because research questions are the essence of most research conducted and in this study, they acted as tools to think with in generating knowledge to fill the gaps that existed before the inquiry (Mertler and Vannatta, 2001). In general, research questions are “specific questions that researchers seek to answer” (Creswell, 2005: 117). According to Maxwell (2005:69), “research questions state what you want to learn”. The answers to the three research questions therefore, are set as follows:

Referring to research question number one: In what areas do mothers say men are involved and could get involved when the mothers are attending antenatal care, labour and postnatal care? In this study, mothers agreed that their husbands were involved in their care from antenatal to post natal. The involvement could be categorized as within and outside the health facilities. Men seemed to be involved more in activities outside the health centre than activities inside the health centre and were involved more in the

activities that required less effort or time than more effort and time. In this study, men were seen to be involved in fourteen domains and these domains include:

1. Accompanying partner to antenatal clinic
2. Attending health education and counseling sessions
3. Providing money
4. Emotional support
5. Helping in household chores
6. Ensuring birth preparedness
7. Accompanying partner to deliver
8. Infant care
9. Providing food
10. Attending childbirth
11. Accompanying partner to postnatal care
12. Decision making
13. Taking baby to under-five clinic
14. Supporting postpartum abstinence

Regarding research question number two: What roles do mothers expect or not expect men to perform in antenatal care, labour or postnatal care? It was found that numerous contradictions existed among mothers in the focus groups regarding what they expected their husbands to do or not do. Individual attitudes and behaviors among mothers towards male involvement varied enormously in the focus groups with mothers who seemed to have had some education agreeing with the current movement of male involvement. On balance, however, the evidence suggests that very few male partners of the women in the sample performed all of the roles above and that many men would not participate in antenatal, labour and postnatal care in Chinsali District.

Considering research question number three: Based on the selected areas that mothers say men could be involved, why do mothers have particular decisions regarding male involvement in antenatal care, labour and postnatal care? The answer is that mothers'

views have dual motives and these relate to past experiences and what they envisage presently and into the future. The motives were actually experienced or perceived benefits or threats of male involvement.

## **5.2 Meaning of The Study (Lessons learnt)**

There are many lessons that have been learnt in this study. It is true that mothers desire that their husbands or men generally ought to play significant roles in reproductive matters starting from antenatal through labour to the postnatal phase of mothering. The study has shown that men are involved in the care of their pregnant partners but the involvement is more during the antenatal phase than the other two phases. This according to Theuring et al (2009), is as a result of the attention that Prevention of Mother to Child Transmission PMTCT of HIV is currently receiving both from local and international organizations, and couple antenatal HIV counseling and testing services are widely recognized as one potential entry point for reaching out HIV prevention to the large population groups in low-resource settings where HIV prevalence is high.

The lack of involvement during labour is related to (i) the attitudes of men and women and (ii) the organization of health services. Men tend to stay away from screening or physical examination for various reasons and notably the embarrassment of witnessing another seeing what they privately see. In addition, the organization of health services seems not ready to provide room for husbands to attend a birth. Even if men want to be involved in maternity care in Chinsali, societal and health system norms may often mitigate against this. But what the researcher desires to attest is that men were involved invariably in the care when the fourteen domains described earlier were examined. Nonetheless, the low involvement by men is not new. Research by Mullick et al (2001) in South Africa for instance shows the influence of traditional culture, and health service delivery issues. However this was not the case in Katmandu Nepal where cultural and health system barriers were overcome and men tended to be actively involved in the care of their wives (Mullany, 2006).

Though mothers expressed varied positions regarding the roles men were involved in and what they expected husbands to do or not do, broader gender structures are implicated in the fourteen dimensions of male involvement. For example, husbands, if available, may be involved in their wives' maternal matters in ways that differ from those of involved women. If men or women systematically have greater control over some resource useful during pregnancy and birth such as money or medical advice then such differences could be expressed in the nature of involvement. It is plausible that the gendered division of labour, stereotypes about birthing and power so often found in paternalistic tribes or even in households and communities, as well as the ideologies that sustain this division, also extends to informal (traditional birthing attendance) and formal maternal health care. Therefore, these divisions are important to understanding why husbands are involved as well as not involved in any particular way in Chinsali.

While mothers described how traditional Chinsali society or particular mothers stigmatized husbands that wanted to play a supportive or helpful role during their wives' pregnancy, most of the discussion points showed that the majority mothers did not want their husbands to witness childbirth and many mothers did not want their husbands to do households – perceived as women's work.

As Chinsali becomes more modernized, supportive behaviours of men towards their wives will be more accepted in the near future. Understanding the context-specific barriers and enablers in Chinsali to and attitudes towards men being involved in antenatal, labour and postnatal care is a crucial step in designing appropriate and applicable interventions that will be welcome to both men and women. The findings presented in this paper provide important information regarding barriers and enablers expressed in the motives that, until now, have prevented men from or encouraged men to provide more positive support and involvement during their wives' pregnancies. The results also suggest that health education services could mitigate these obstacles and could enhance the positive practices of mothers and husbands by providing information to increase knowledge levels and decrease stigma, and by initiating communication over sensitive subjects especially physical examinations and birthing. The

predominantly favourable attitudes of some mothers and men, towards encouraging greater male involvement in antenatal, labour and postnatal care imply that the introduction of such health education services would be both feasible and well accepted.

The findings have revealed no domination of women by men in reproductive matters. There are no critical areas within the theory that require emancipation of women. There are no factors inherent of men that bring about and perpetuate inequality in this area. The voices of the mothers show that the crude forms of social, ideological or cultural determinism (Carr, 1987) that keep men at bay to participate especially in birthing are propelled by women themselves.

The study has shown particularly that Chinsali mothers that they have a selective preference for male involvement in maternity care. These mothers have shown contrary views held by upper-middle-class elitist women (Freedman, 2002; Tong, 2009) who espouse the assumptions within critical theory arguing that the knowledge of the upper and middle classes cannot be considered capital and are not wholly valuable. This kind of thinking by elitist women cannot be wholesomely used to increase male involvement. This great transformation which is a western form of thinking poses tremendous challenges to health care providers in Zambia to rethink their basic tenets, to deploy the emergent thinking about sex, sexuality and reproduction to respond constructively and progressively to the needs of local cultures.

### **5.2.1 Limitations of the Study**

Noting that there is no research without limitations, this study has its own limitations too. The limitations arise from the methodology that was adopted and the nature of the setting. These limitations play an important role in interpreting study findings and making suggestions for future research. The limitations are due to the exploratory nature of the research. The researcher did not have a large sample because the study

was qualitative in nature. Given this state of affairs, the findings do not have sufficient power to confer validity – to use a quantitative factor. However, noting that mothers cutting across three mothering experiences were included in the study and that the focus group discussions were detailed, whatever mothers could have reported about in in-depth interviews was captured by the focus group discussions in both rural and peri-urban settings.

The second limitation is related to the use of induction and abduction in the approach to the inquiry. According to Blaikie (2000), the use of induction and abduction do not allow the researcher to test any hypothesis and not even to use theory in guiding the inquiry. In addition, it is not possible for a researcher to explain causes and effects which are generated by qualitative data sets. However, the researcher is arguing that one does not need any hypotheses to be tested in order to establish cause and effect. One may use qualitative excerpts to show cause and effect. In the example below, ***you get transferred is the cause*** (or reason why most mothers wanted husbands to accompany them to the clinic for delivery) and ***can accompany you and be supportive*** is the outcome.

*Sometimes it happens that **you get transferred** to another distant hospital such as Kasama, Lusaka, Kabwe and so on. So the husband should be available so that he **can accompany you and be supportive** wherever you may go.*

In spite of the fact that the two strategies were used and enabled the researcher to collect qualitative data without testing any hypothesis, lack of tested hypothesis does not give greater explanatory power at all times. However, the strategies make the research credible because the findings are drawn from a large sample within the setting.

The third is about the preference for a non-probability sample. This limits the generalizability of the study findings only to the population of mothers from which the sample was drawn namely married and single mothers attending antenatal, labour and postnatal health care services at Location and Lubwa Clinics in Chinsali District.

Related to this is the tentativeness of the findings in part because of the constraints of the data, which are all from mothers' points of view.

The fourth and last limitation concerned the lack of eagerness of the participants to discuss sexual and birthing matters with a male stranger particularly because they were predominantly older mothers. This resulted in participants giving brief responses to the questions asked. Probing had to be done very delicately. Despite these limitations however, the study provides relevant information on how mothers view male involvement in maternity care and the extent to which they want men to be involved. The study has also provided missed opportunities for interventions to enhance male involvement in maternity care.

### **5.3 Conclusion**

The study has generally shown that men are involved in antenatal, labour and postnatal care. The level of involvement is rather low considering that most of the activities men are involved in are outside the health facility. Mothers do not seem to be eager to have husbands attend physical examinations and the birth of a child. These positions are feminine stereotypical roles. Mothers are eager to have men get involved only in "neutral gendered" roles like providing food, providing money, baby care, escorting wives to the health centre, among other such roles. This is in line with what has been found in other studies in South Africa and Malawi where the majority women want their husbands to get involved in pregnancy health through to the postnatal phase but not in Childbirth (Mullick et al, 2001; Kululanga et al, 2012).

We have seen that there are no measures in the health centres to enact gendered roles that embrace male involvement. Given this picture, it is no doubt that the health institutions that were studied in Chinsali have not managed to lure men to be equal partners in reproductive health. We have seen that a wide gender gap exists and that no men may be fully involved in the whole mothering experience from antenatal to postnatal care. The researcher hopes that this work provides the impetus for policy-

makers to strengthen their commitment to realising the need for male involvement in antenatal, labour and postnatal care - what is still largely considered as a woman's territory by both men and women.

#### **5.4 Research Policy Implications**

Arising from the research outcomes, the following are the policy implications and the study recommendations that:

- Cultural stereotypes that birthing is a preserve of women is without doubt, the most fundamental premise to begin understanding some cultural barriers which could be maintained or broken. There is need therefore to undertake a quantitative survey with a large number of women to solicit their positions. This is possible. In addition to research, there may be need for the Ministry responsible for male involvement in reproductive health – the Ministry of Community Development Mother and Child Health – to develop information education and communication materials like posters, pamphlets to carry messages that appeal to both men and women to be equal partners in antenatal, labour and postnatal care.
- There is need to develop advocacy programmes that could reach out to both men and women in Chinsali. Women groupings like Alangizi, Bana Fimbusa and Traditional Birth Attendants could be reached out by way of community mobilisation strategies. These may augment breaking the traditional culture of patriarchy that surrounds physical examinations and birthing. Tapping into cultural attributes as potential positive forces is an important approach to introducing new interventions in different settings.
- The Office of the Provincial Gender Focal Point Person within Chinsali should be involved in reproductive matters by changing the strategy of merely voicing out gender inequities and inequalities. The office could work towards guaranteeing

equity and equality by applying gender main streaming strategies. These, in many contexts involve the application of feminist approaches against the misunderstanding on the role of men in reproductive health and sometimes outright hostility towards the subject. In order to build positive alliances for gender mainstreaming, the Office needs to understand the institutional contexts where the promoters or stakeholders in male involvement advocacy come from, and how the cultural context shapes the ways of conceptualizing gender mainstreaming.

## REFERENCES

- Akarro, R.R.J., Deonisia M., & Sichona F.J. 2011. An evaluation of male involvement on the programme for PMTCT of HIV/AIDS: A case Study of Ilala Municipality in Dar es Salaam, Tanzania.
- Babbie, E.R. & Mouton, J. 2001. The practice of social research. Oxford University: Press Cape Town
- Barua, A.1998. Young husband's involvement in reproductive health in rural Maharashtra. Paper presented at a workshop on men as supportive partners in reproductive and sexual health, Katmandu, Nepal. Population Council. India.
- Barton, E. 2001. Design in observational research on the discourse of medicine: toward disciplined interdisciplinarity. *Journal of Business and Technical Communication*, 15, 309 – 332.
- Basavanthappa, B.T. 2007. *Nursing Research*. 2<sup>nd</sup> ed. Jaypee Brothers, Medical Publishers: New Delhi.
- Beegle, K. Frankenberg E. & Thomas D. 2001. Bargaining power within couples and use of prenatal and delivery care in Indonesia. *Studies in Family Planning*, 32(2), 130-146.
- Beveridge, F. Nott S. and Stephen K. 2000. Mainstreaming and the Engendering of Policy-Making: A Means to an End. *Journal of European Public Policy* 7 (3): 385-405.
- Blaikie, N. 2000. *Designing Social Research: The Logic of Anticipation*. Polity Press. Cambridge.
- Blanc, A.K. 2001. The effect of Power in Sexual Relationships on Sexual and Reproductive Health: An Examination of the Evidence. *Studies in Family Planning*. Vol 32. Number 3. September 2001. p200.
- Bless, C. & Higson-Smith C. 1995. *Fundamentals of Social Research Methods: An African Perspective*. 2<sup>nd</sup> ed. Juta: Cape Town
- Bloom, S.S. Wypij, D. & Das Gupta, M. 2001. Dimensions of women's autonomy and the influence on maternal health care utilization in a North Indian city. *Demography*, 38(1), 67-78.
- Boyatzis, R.E. 1998. *Transforming qualitative information: thematic analysis and code development*. Sage.

Carr, W. 1987. Critical theory and educational studies. *Journal of Philosophy of Education*, Vol. 21, No.2.

Carter, M.W. 2002a. Husbands and maternal health matters in rural Guatemala: wives' reports on their spouses' involvement in pregnancy and birth. Department of Sociology, Office of Population Research, Princeton University, Wallace Hall, Princeton, NJ 08544, USA. *Social Science & Medicine* 55 437– 450 pages.

Carter, M.W. 2002b. Because he loves me: Husbands' Involvement in Maternal Health in Guatemala. *Culture, Health and Sexuality* 4, no.3 (2002): 259-279.

Central Statistical Office (CSO) [Zambia] and Macro International Inc. 2009. Zambia Demographic and Health Survey 2007: Key Findings. CSO and Macro International Inc: Calverton, Maryland, USA.

Cohen, G.L. Sherman, D.K. Bastardi, A. McGoey, M. Hsu A. & Ross L. 2007. Bridging the partisan divide: Self-affirmation reduces ideological closed-mindedness and inflexibility in negotiation. *Journal of Personality and Social Psychology*, 93, 415–430.

Creswell, J.W. 2005. *Educational Research: Planning, Conducting, and Evaluating Quantitative Research*. 2<sup>nd</sup> ed. Merrill Prentice Hall: New York.

Drennan, M. 1998. Reproductive Health: New Perspectives on Men's Participation. *Population Reports*, Series J, No. 46.

Dudgeon, M.R. & Inhorn, M. C. 2004. Men's influences on women's reproductive health: Medical anthropological perspectives. *Social Science & Medicine*, 59(7), 1379–1395.

Dyson, T. & Moore M. 1983. On Kinship Structure, Female Autonomy, and Demographic Behaviour in India. *Population and Development Review*, 9(1), 35-60.

Erikson, F. 1986. Qualitative methods in research on teaching. In: Wittrock M.C. (ed.) *Handbook of research on teaching* (PP. 119 – 161). Macmillan: New York

Farquhar, C. Kiarie J.N. Richardson B.A. Kabura M.N. John F.N. & Nduati R.W. 2004. Antenatal Couple Counseling Increases Uptake of Interventions to Prevent HIV-1 Transmission. *Journal of Acquired Immune Deficiency Syndromes* 2004; 37(5):1620-1626.

Freedman, E. B. 2002. *No Turning Back: The History of Feminism and the Future of Women*. London: Ballantine Books.

Gadamer, H.G. 1989. *Truth and method*. 2<sup>nd</sup> ed. Sheed & Ward: London.

Glaser, B.G. 1978. Theoretical sensitivity: Advances in the methodology of grounded theory. *Sociology Press*: Mill Valley, CA.

Godlove, N.N. Meyer, D.J. Tih, P.M. & Nkusai, J. 2010. Barriers to men's participation in antenatal and prevention of mother-to-child HIV transmission care in Cameroon. *Journal of Midwifery & Women's Health* Volume 55, No. 4, July/August, 2010.

Green, M.E. Mehta, M. Puterwitz, J. Wulf, D. Akinrinola, B. & Singh, S. 2001. Involving men in reproductive health: contributions to development. Background paper to the report public choices, private decisions: sexual and reproductive health and the millennium development goals. Millennium project.

Guba, E.G. & Lincoln, Y.S. 1994. Competing paradigms in qualitative research. In Denzin N.K. & Lincoln Y.S. (eds.) *Handbook of qualitative research* (pp. 105-117). Sage: Thousand Oaks, CA.

Gubrium, J.F. & Holstein, J.A. 1997. *The New Language of Qualitative Method*. Oxford University Press: New York.

Hanson, S. Hunter, L.P. Bormann, J.R. & Sobo, E.J. 2009. Paternal fears of childbirth: A literature review. *The Journal of Perinatal Education*, 18(4), 12–20.

Haralambos, M. 1985. *Sociology: themes and perspectives*. Bell & Hyman Ltd: London.

Hindin, M.J. 2000. Women's autonomy, women's status and fertility-related behavior in Zimbabwe. *Population Research and Policy Review* 19(3), 255-282.

Horizons Program, 2001. Integrating HIV prevention and care into maternal and child health care settings: Lessons learned from Horizons studies. Population Council: Washington DC.

International Conference on Population and Development ICPD, 1996. Programme of Action, Chapter VII: Reproductive Rights and Reproductive Health 7.8. P.48. Cairo, 5-13 September 1994. United Nations Population Fund.

Joesoef, M.R. Baughman, A.L. and Utomo, B. 1988. Husband's approval of contraceptive use in Metropolitan Indonesia: programme implications". *Studies in Family Planning*, vol. 19, No. 3, pp.162-168.

Kakaire, O. Kaye, K. & Osinde, O.M. 2011. Male involvement in birth Preparedness and complication readiness for emergency obstetric referrals in rural Uganda

Kankasa, C. Mshanga, A. Baek, C. Kalibala, S. & Rutenberg, N. 2002. Report on the rapid assessment of the unsupported PMTCT pilot programme in Zambia. UNICEF: PMTCT Secretariat Zambia and Population Council.

Kerlinger, F. 1969. *Foundations of behavioural research*. Holt Rinehart & Winston: London.

King, R. Waiswa, G. Serukka, D. Homsy, J. Kitabire, F. & Kabatesi, D. 2006. Linking VCT and PMTCT: An opportunity to increase male partner involvement in PMTCT in Kampala, Uganda. 16<sup>th</sup> International AIDS Conference. Abstract no. TuPEO361. August 2006. Available from: [www.aegis.org/conferences/iac/2006/TuPEo361.pdf](http://www.aegis.org/conferences/iac/2006/TuPEo361.pdf) [Accessed November 13, 2012].

Koblinsky, M.A. 2005. Community-based postpartum care: An unmet urgent need. USAID, Catalyst Consortium.

Kombo & Tromp, L.A. 2006. Proposal and thesis writing: An introduction. Paulines Publications Africa: Nairobi

Krueger, R.A. 1994. Focus Groups: A practical guide for applied research. 2<sup>nd</sup> ed. Sage Publications, Thousand Oaks.

Kululanga, L. Sundby J. Malata A. & Chirwa E. 2012. Male involvement in maternity health care in Malawi. African Journal of Reproductive Health March 2012: 16 (1): 145.

Kumar, O.M. 1999. Fostering male involvement and partnership: a stepwise process, Reproductive health through advocacy, promotion and education 6(2): 16-19.

Lasee, A. & Becker S. 1997. Husband-wife communication about family planning and contraceptive use in Kenya. International Family Planning Perspectives, Vol.23, No.1, pp. 15-22.

Lee, R.B. 1999. Male involvement in women's reproductive health projects and programmes in the Philippines. Reproductive health matters 7(14): 106-117.

Maxwell, J. A. 2005. Qualitative research design: An interactive approach. 2<sup>nd</sup> ed. Sage Publication: Thousand Okas, CA.

Mehta, M. 2002. Communicating with men to promote family planning: lessons learned and suggestions for programming. Paper presented in the meeting of Regional Advisors in Reproductive Health. WHO/PAHO, Washington DC, USA 5 – 7 September 2001. World Health Organisation.

Mertler, C.A. & Vannatta R.A. 2001. Advanced and multivariate statistical methods: Practical application and interpretation. Pyczak Publishing: Los Angeles, CA.

MacNealy, M.S. 1999. Strategies for empirical research in writing. Addison Wesley Longman: New York.

Malhotra, A. Schuler S.R. & Boender C. 2002. Measuring Women's Empowerment as a variable in International Development. Washington, D.C., the World Bank, Gender and Social Development Group.

- McKellar, L. Pincombe, J. & Henderson, A. 2008. Enhancing fathers' educational experiences during the early postnatal period. *The Journal of Perinatal Education*, 17(4), 12–20.
- Meyer, M.K. & Prugl, E. (eds.), 1999. *Gender politics in global governance*. Lanham, MD: Rowman and Littlefield.
- Miles, M.B. & Huberman, A.M. 1994. *Qualitative data analysis: An expanded sourcebook*. 2<sup>nd</sup> ed. Sage: Thousand Oaks, CA.
- Mullany, B.C. 2006. Barriers to and Attitudes towards Promoting Husbands' Involvement in Maternal Health in Katmandu, Nepal. Johns Hopkins Bloomberg School of Public Health, Baltimore, MD 21205, USA. Available online 20 December 2005. *Social Science & Medicine* 62 (2006) 2798–2809.
- Mullick, S. Kunene, B. & Wanjiru, M. 2001. *Involving men in maternity care: Health Service Delivery Issues*.
- Mungaila, S. 2007. *Decision making and reproductive health issues: A case of expectant married mothers at Chainama antenatal clinic in Lusaka*. Master Thesis, University of Zambia.
- Nakambo, I. 2008. *Involving men in safe motherhood of men and women in Kafue District*. Master Thesis, University of Zambia.
- Nsemukila, B.G. Phiri, D.S. Diallo, H.M. Banda, S.S. Benaya, W.K. and Kitahara, N. 1998. *A study of factors associated with maternal mortality in Zambia*.
- Ntabona, AB. 2002. *Involving men in safe motherhood: the issues*. In: WHO, (2002). *Programming for Male Involvement in Reproductive Health*. Report of the Meeting of WHO Regional Advisors in Reproductive Health. WHO/PAHO, Washington DC, USA 5-7 September 2001. Geneva: WHO: 54-57. (WHO/FCH/RHR/02.3).
- Omondi-Odhiamb, 1997. *Men's Participation in Family Planning Decisions in Kenya*, *Population Studies*, Vol. 51, pp. 29-40.
- Pachauri, S. 1997. *Point of view*. In: *Toward a new partnership: encouraging the positive involvement of men as supportive partners in reproductive health*. Population Council Newsletter No.3.NOV, 1997.
- Pawson, R. & Tilley, N. 2001. *Realistic evaluation bloodlines*. *American Journal of Evaluation* 22:3, 317–324.

Pearce, J.C. 1971. *The crack in the cosmic egg: challenging constructs of mind and reality*. Washington Square Press New: York.

Peters, D.A. 1993. Improving quality requires consumer input: using focus groups. *Journal of Nursing Care Quality*, 7, 34-41.

Piotrow, P.T. Lawrence D.K. & Hindin M.J. 1992. Changing Men's Attitudes and Behaviour: the Zimbabwean Male Motivation Project. *Studies in Family Planning*, 23(6):365–373.

Phiri Christabel, 2011. Men's participation in family planning in Chilanga Ward of Kafue District, Master Thesis, University of Zambia.

Polit, D.F. & Beck, C.T. 2004. *Nursing research: principles & methods*. 7<sup>th</sup> ed. Lippincott Williams & Wilkins: Philadelphia.

Population Council, 2005. Maternal and child health. Mixed success involving men in maternal care worldwide [online] available: Population Council Website: [www.popcouncil.org/publications/popbriefs/pb11\(1\)1.html](http://www.popcouncil.org/publications/popbriefs/pb11(1)1.html). Accessed on 8/01/2013.

Pratschke, J. 2003. Realistic models? Critical realism and statistical models in the social sciences. *Philosophica*71: 13–38.

Rigge, M. 1994. Involving patients in clinical audit. *Quality in Health Care*, 3 (supply), S2-S5.

Robey, B. Thomas, E. Baro, S. Kone, S. & Kpakpo, G. 1998. Men: Key partners in reproductive health. A report on the first conference of French-speaking African countries on men's participation in reproductive health. Available from: [www.jhuccp.org/pubs/sinistp/10/10.pdf](http://www.jhuccp.org/pubs/sinistp/10/10.pdf) [Accessed March 12, 2012].

Roy, K. & de Vargas Pinto, E. 1999. Women's perceptions – providers' challenges: CEMOPLAF clients on partner participation in reproductive health services. Population Council, Latin America and the Caribbean operations Research and technical assistance in family planning and reproductive health. New York. (Unpublished).

Rutenberg, N. Kalibala, S. Mwai, C. & Rosen, J. 2002. Integrating HIV prevention and care into maternal and child health care settings; lessons learned from horizons studies, July 23-27, 2001. Maasai Mara and Nairobi, Kenya consultation report. The population report: New York.

Rutter, K. 2011. Paternity Leave: all about paternity leave, decent work, leave for working fathers in Zambia. Last modified Aug 31, 2011 03:07.

Ryan, G.W. & Bernard H.R. 2000. Data management and analysis methods. In Denzin, N.K. and Lincoln, Y.S., (eds.). Handbook of qualitative research, second edition. Sage, 769\_ 802.

Schatzman, L. & Strauss, A. 1973. Field research: Strategies for a natural sociology. Prentice-Hall: Englewood Cliffs, NJ.

Shore, R. 2011. Male involvement in family planning empowers women. Women of the world, K4Health, JHU-CCP | Comm. Specialist.

Singh, A. & Ram, F. 2005. Men's involvement during pregnancy and childbirth: evidence from Rural Ahmadnagar, India. Population Review 48 (1): 83 – 102.

Smelser, N.J. & Baltes, P.B. (eds.), 2001. International Encyclopedia of the Social and Behavioural Sciences. Oxford: Elsevier Science Ltd: 16165- 16170.

Sorrell, M. & Redmond, G.M. 1995. Interviews in Qualitative Nursing Research: Differing Approaches for Ethnographic and Phenomenological Studies. Journal of Advanced Nursing. 21, 6, 1117 – 1122.

Stewart, D.W. and Shamdasani, P.N. 1990. Focus Groups: Theory and practice. Sage Publications: Newbury Park.

Strauss, A. and Corbin, J. 1990. Basics of Qualitative Research: Grounded Theory Procedures and Techniques, Sage Publications: Newbury Park.

Thaddeus, S. & Maine, D. 1994. Too Far to Walk: Maternal Mortality in Context. Social Science and Medicine 38 (8): 1091 – 1110.

Theuring, S. Nchimbi, P. Jordan-Harder B. & Harms G. 2009. Partner involvement in perinatal care and PMTCT services in Mbeya Region, Tanzania: the providers' perspective. Journal: Aids care – psychological and socio-medical aspects of Aids/hiv – AIDS CARE, Vol. 22, no. 12, PP. 1562 – 1568, 2010.

Tong, R. 2009. Feminist Thought: A More Comprehensive Introduction (Third ed.). Boulder: Westview Press. pp. 284–285, 289.

Tshibumbu, D.D. 2006. Factors influencing male involvement in prevention of mother to child transmission PMTCT of HIV programmes in Mambwe District, Zambia. Master Thesis, University of South Africa.

Tsui, A. Wasserheit, J. & Haaga, J. 1997. Reproductive health in developing countries: expanding dimensions, building solutions.: National Academy Press: Washington, DC.

United Nations UN, 2010. Gender mainstreaming: 10 steps for integrating gender into the policy-making process. United Nations: New York.

Finnbogadottir, H.N. Crang Svalenius, E. & Persson, K. 2000. Expectant first-time fathers' experiences of pregnancy. *Midwifery* 2003; 19(2):96-105.

United States Agency for International Development USAID, 2002. Interagency gender working group. Involving men in sexual and reproductive health: An orientation guide. Washington DC.

Van Manen, M. 1990. Researching Lived Experience: Human Science for an Action Sensitive Pedagogy. SUNY Press: New York.

Von Wright, G.H. (1971). Explanation and understanding. Cornell University Press: New York.

Wegner, M.N. Landry, E., Wilkinson, D. & Tzanis, J. 1998. Men as partners in reproductive health: From issues to action. *Int. Family Plan Perspect*; 24:38–42.

Waltson N. 2005. Challenges and opportunities for male involvement in reproductive health in Cambodia. USAID: Policy Project/Cambodia.

White Ribbon Alliance for Safe Motherhood 2011. Safe Motherhood is everybody's business. Global Secretariat: Washington DC.

White C.J. 2005. Research: A practical guide. Prentice Hall Inc: Pretoria.

White V. Greene M. & Murphy E. 2003. Men and reproductive health programs: Influencing gender norms. The Synergy Project: Washington DC.

World Health Organization (WHO), 2002. Programming for male involvement in reproductive health. Report of the meeting of WHO Regional Advisors in reproductive health. WHO/PAHO, Washington DC, USA 5-7 September 2001. Geneva: WHO: 54-57. (WHO/FCH/RHR/02.3).

Williams, P. 2000. Fathers should miss birth, says Guru. *The Independent*, January 16, p. 5.

Wolcott, H.F. 1994. Transforming qualitative data: Description, analysis, and interpretation.: Sage: Thousand Oaks, CA.

Wright, G.H. 1971. Explanation and Understanding. Routledge and Kegan Paul: London.

Yin, K.R. 2008. Case Study Research: Design and Methods Volume 5 of Applied Social Research Methods. 4<sup>th</sup> ed. Sage Publications: Washington DC.

# **APPENDICES**

## **Appendix I – Informed Consent Form**

### **Topic: Women’s Social Constructions of Male Involvement in Maternity Care in Chinsali District**

Dear Participant,

My name is Michael Kani, a postgraduate student in the department of Gender Studies at the University of Zambia in the School of Humanities and Social Sciences conducting a study on the above topic.

You have been purposively selected to take part in the study by way of providing information through interviews and Focus group discussions. Your participation is purely voluntary and you reserve the right to withdraw any time without any explanations. Even when you agree to participate, you are free to refuse to answer certain questions you are not comfortable with.

#### **Purpose of the study**

The purpose of the study is to establish the views of women regarding the roles of men in maternity care among mothers attending antenatal, intra natal and postnatal care services at this facility. This is in order to provide research driven recommendations that takes into consideration women’s views in the advocacy for male involvement in maternity care.

#### **Procedures**

You will be asked questions on issues regarding the roles of your partners in antenatal care, labour and postnatal health care issues. The information provided will be kept confidential. Should you agree to participate in this study, you will be requested to sign the informant consent form below. The responses you provide will be recorded and you are assured that identification will not be possible since your name will not be recorded anywhere at all.

### **Possible benefit to participants**

Though there are no immediate benefits to you as an individual, you will have an opportunity to discuss what you see or feel to be the roles of men in antenatal care, labour and postnatal care and offer suggestions on how male involvement can be strengthened. Your participation will yield findings that will be used to augment advocacy on male involvement as well as informing relevant stakeholders that are instrumental in issues of gender and reproductive health.

### **Risks and/ or discomforts**

Although you may find some questions to be sensitive, there is no risk to you as a participant. If you are uncomfortable with some of the questions asked you are free to refuse to answer and your refusal to participate or answer any questions carries no risk at all.

### **Reasons why you may withdraw from the project**

Participation is voluntary and can be withdrawn any time without any explanation

### **Costs to you**

You will not incur any material and or financial costs for participating in this study

### **Confidentiality**

The information obtained from you is confidential and will be treated as such to the extent permitted by law. If you have understood the nature of this study please put your initials or thumb print where indicated.

If you have any concerns regarding this study, please contact UNZA Research Ethics Committee PO BOX 32379 Lusaka. For any questions, you may call Dr. Annie Phiri at cell 0976669166, Mr. Mwanza Jason at cell 0977945790.

I.....having fully understood the nature and implications of the study, agree to participate.

Participant's Signature or Thumbprint .....

Date .....

Researcher's signature .....

Date .....

## **Appendix II - FGD and In-depth Interview Guide**

Since this study was qualitative, the following guidelines were used to collect data during FGDs and One to One in-depth interviews.

- 1) Theme I: Please describe yourself (yourselves) Probe for age, number of children, number of previous pregnancies, marital status, education, income when not mentioned.
- 2) Theme II: Please describe what your views are in respect to your partner getting involved during pregnancy, delivery and post natal care (Probe for availability in the screening room, health education sessions, making decisions on future pregnancy or family planning, child spacing, support materially, emotionally).
- 3) Theme III. Please describe how much your partner participates in your putting the baby to bed (delivery). Probe for frequency of availability, enhancers and inhibitors.
- 4) Theme IV: Please describe the reasons for your views regarding your partners getting involved in what happens during pregnancy, delivery and postnatal care (Probe for availability in the screening room, health education sessions, making decisions on future pregnancy or family planning, child spacing, support materially, emotionally).
- 5) Theme V Please look at what you have just said concerning your views on this subject, Describe how your particular views in respect to male involvement during pregnancy, delivery and postnatal care could be incorporated in health care practice within Chinsali? (Probe for home strategies, community strategies, institution based strategies).

## Appendix III – Research Proposal Approval Letter



### THE UNIVERSITY OF ZAMBIA SCHOOL OF HUMANITIES AND SOCIAL SCIENCES

Telephone:: 292884 /291777  
Telegrams: UNZA LUSAKA  
Telex: UNZALU ZA 44370  
Fax: +260-1-253952

P.O. Box 32379  
Lusaka Zambia

Your Ref:

30<sup>th</sup> October 2012

Michael Kani  
Department of Gender Studies  
University of Zambia  
LUSAKA

**RE: APPROVAL OF RESEARCH PROPOSAL**

The Graduate Studies Committee of the School of Humanities and Social Sciences has approved your research entitled **Women's Social Constructions of Male Involvement in Maternity Care in Chinsali District**. Your supervisor is Mr Jason Mwanza.

You are required to contact either the Head of the Department of Gender Studies or your Supervisor in order to be guided on the way forward.

C F K Chilala (PhD)  
**ACTING ASSISTANT DEAN (POSTGRADUATE), HSS**

Cc Dean, HSS  
Director, DRGS  
Head, Department of Gender Studies  
Mr Jason Mwanza

## Appendix IV – Ethical Approval Letter



**The University of Zambia**  
**DIRECTORATE OF RESEARCH AND GRADUATE STUDIES**

HSS/ED/LAW/INESOR RESEARCH ETHICS COMMITTEE

Telephone: 290258/291777  
Fax: +260-1-290258/253952  
E-mail: drgs@unza.zm  
IRB: 00006464  
IORG: 0005376  
13<sup>th</sup> November 2012

P O Box 32379  
Lusaka, Zambia  
Your Ref:  
Our Ref:

Mr. Michael Kani  
University of Zambia  
Department of Gender Studies  
Lusaka  
**ZAMBIA**

Dear Mr. Kani

**Re: EXEMPTION FROM FULL ETHICAL CLEARANCE**

With reference to your research proposal entitled:

**“Women’s Social Constructions of Male Involvement in Maternity Care in Chinsali District”**

As your research project does not contain any ethical concerns, you are hereby given an exemption from full clearance to proceed with your research.

Please note that you must also obtain express written authority from the Permanent Secretary, Ministry of Health, before conducting your research. The address is: Permanent Secretary, Ministry of Health, Ndeke House, P O Box 30205, Lusaka: Tel:+260-1-253040/5; Fax: +260-1-253344.

Finally, please also note that you are expected to submit to the Directorate of Research and Graduate Studies Secretariat (a) a Progress Report Form (which can be obtained from the Secretariat) every six months and (b) a copy of the full report on completion of the project.

  
Dr. Augustus Kapungwe  
Chairperson  
Humanities and Social Sciences Research Ethics Committee

Cc The Director, Directorate of Research and Graduate Studies  
Assistant Director, Directorate of Research and Graduate Studies  
Assistant Registrar (Research), Directorate of Research and Graduate Studies

---

## Appendix V – Authority to Undertake Research

All Correspondence should be addressed to the  
Permanent Secretary  
Telephone: +260 211 253040/5  
Fax : +260 211 253344



REPUBLIC OF ZAMBIA  
**MINISTRY OF HEALTH**

In reply please quote:  
**MH/101/17/6**  
No.....

28<sup>th</sup> November, 2012

NDEKE HOUSE  
P. O. BOX 30205  
LUSAKA

Mr. Michael Kani  
University of Zambia  
Department of Gender Studies  
P.O. Box 32379  
Lusaka  
Zambia

Dear Mr. Kani,

**Re: Request for Authority to Conduct Study**

The Ministry of Health is in receipt of your request for authority to conduct research study titled “**Women’s Social Constructions of Male Involvement in Maternity Care in Chinsali District**”. I wish to inform you that following submission of your research proposal to my Ministry, our review of the same and in view of the ethical clearance, my Ministry has granted you authority to carry out the study on condition that:

1. The relevant Provincial and District Directors of Health where the study is being conducted are fully appraised;
2. Progress updates are provided to MoH quarterly from the date of commencement of the study;
3. The final study report is cleared by the MoH before any publication or dissemination within or outside the country;
4. After clearance for publication or dissemination by the MoH, the final study report is shared with all relevant Provincial and District Directors of Health where the study was being conducted, and all key respondents.

Yours sincerely,

A handwritten signature in black ink, appearing to read 'P. Mwaba'.

Dr. P. Mwaba  
Permanent Secretary  
**MINISTRY OF HEALTH**  
Cc: District Medical Officer