“We need Uchembere Wabwino Wabambo (Safe Motherhood for Men)”:

A Qualitative Study about the Perceptions of Men in Rural Malawi about Maternal Health and Male Involvement in Maternal Health

Dyon Hoekstra

22nd of November 2011

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Abstract

For many women, especially in developing countries, it can be dangerous to be pregnant and to go into labour. About 1000 maternal deaths are occurring every day (WHO, 2011). This number of maternal deaths also means that around one million children are left motherless every year. These children are 10 times more likely to die within two years after the death of their mothers than other children (WHO, 2005). Malawi is one of the countries with the highest maternal mortality ratio in Sub-Saharan Africa and in the world. In Malawi in 2010 the MMR was estimated at 675 per 100,000 live births (National Statistics Office Malawi & ORC Macro, 2011).

Partnering with men is an important strategy for advancing reproductive health and rights (UNFPA 2005). The UNFPA (2005) further argues that there is a lack of information about the male side and that the gender literature tends to be *by* women and *on* women. Much of the data obtained from research on reproductive health is derived from studies related to women. Such data is important, but it also helps to reinforce misconception at community level which labels family planning and fertilty as a 'female's affair' (Mbizvoi & Bassett 1996). This research tries to fill this gap by focussing on the perception of men from the rural areas of Mangochi, Malawi, about maternal health and male involvement in maternal health.

The research objective mentioned above results in the following research questions of the study:

"How are men from rural Mangochi, according to themselves, involved in maternal health issues?"
&
"How can men be more involved in order to reduce maternal mortality in Mangochi?"

A triangulation of research methods is used in this study in order to answer these research questions. In collaboration with the Community-Based Safe Motherhood Project (a local NGO), 3 participants observations, 5 focus group discussions, and 12 in-depth interviews were conducted in order to gather a wide variety of perceptions and views of male community members from rural Mangochi, Malawi. A grounded theory approach is applied during the research process in which a theory is build up out of observations in the social world (Liamputtong & Ezzy, 2005). The major themes of this study are identified and developed from the empirical data and are derived inductively. The four major themes are: Perceptions of men about getting children (1), perceptions of men about pregnant women (2), perceptions of men about community influences on safe motherhood (3), and perceptions of men about male involvement in maternal health (4).

The men illustrated that the waiting period during the delivey is a time of worrying and concern about the well-being of their wives. The participants seem to be very aware of getting children being a risky event. As a consequence of the prevalent risk of dying from pregnancy-related or childbirth-related causes, are pregnant women referred to as *Mayi Wapakati* (woman in between life and death).

In order to ensure that a woman will not die in relation to her pregnancy or delivery, the participants explained that she and her husband have to make sure she remains healthy (1), that she visits the health centre voor antenatal care and delivery (2), and that she practices propor family planning. The husband is supposed to perform certain responsibilities during this period in order to reach these basic conditions of safe motherhood.

Even if both men and women are taking the responsibilities they are supposed to, other factors might still hinder a couple to obtain the basic conditions of safe motherhood. The participants indicate to be struggling with confusing values related to getting children. On the one hand customs and societal pressure towards having children enhances the belief of men that having many children is beneficial and necessary. On the other hand they know that getting children is a risky and they receive advises from health workers and radio broadcasts about the needs and benefits of limiting the number of children.

Furthermore are men in rural Mangochi trying to find their way between, on the one hand the need to take responsibility in order to protect the lives of their loved ones, and on the other hand not

being allowed to take responsibility because of gender roles and traditional customs within the community.

The participants indicated that they are partly excluded from getting children by the society and that they are willing to be more involved. Firstly because within the matrilineal society in rural Mangochi, the children belong to the mother and to the mother's family. The pregnancy likewise is explained by the participants to be belonging to the mother. Men are e.g. not allowed in the labour ward, although many participants indicated that they would like to be present and that it would even increase the understanding of men about the difficulties women are facing during delivery.

Furthermore, the participants indicated that they do not receive information regarding the pregnancy or delivery and that during the first days after the delivery they are not allowed to sleep at home because the mother and mother-in-law are then taking care of his wife and new-born. Finally, in the unfortunate event of a maternal death, the husband has no authority about what will happen to his wife and to the children who are left behind, because they belong to the mother's family.

There is a clear willingness among many of the participants to be involved in safe motherhood. However several obstacles towards male involvement are discussed by the participants. Besides the feeling of exclusion (1) are the negligent behaviour of some men (2), the image that pregnant women are dangerous to men (3), the lack of knowledge among men about safe motherhood (4), and poverty (5) factors that are a barrier towards actual male involvement.

The participants provided several option of how male involvement could be best encouraged. The solutions mentioned by the participants which would be most beneficial for increasing male involvement is the spread of *uchembere wabwino* (safe motherhood) advises. The use of male clubs within the village is often mentioned as a possible forum which can help to reach this aim. Furthermore were also drama groups, radio broadcasts, and door-to-door advisors mentioned as possible solution for increasing male involvement in maternal health.

Abbrevations

ADC	Area Development Committee
AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
BA	Bicycle Ambulance
CBO	Community-Based Organization
CBSM	Community-Based Safe Motherhood
CBSMA	Community-Based Safe Motherhood Advisor
CHAM	Christian Health Association of Malawi
COM	College of Medicine
CRH	Centre for Reproductive Health
CS	Caesarean Section
DEC	District Executive Committee
DHO	District Health Office
FP	Family Planning
GVH	Group Village Head
HC	Health Centre
HIV	Human Immunodeficiency Virus
HSA	Health Surveillance Assistant
MCH	Maternal and Child Health
MDA	Maternal Death Audits
MDG	Millennium Development Goals
MOHP	Ministry of Health and Population
NGO	Non Governmental Organisation
NND	Neonatal Death
MMR	Maternal Mortality Ratio
MoH	Ministry of Health
SB	Stillbirth
SM	Safe Motherhood
SMI	Safe Motherhood Initiative
SRH	Sexual Reproductive Health
STD/I	Sexual Transmitted Diseases/Infections
TA	Traditional Authority
TB	Tuberculosis
TBA	Traditional Birth Attendant
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
VC	Village Chief
VDC	Village Development Committee
VHC	Village Health Committee
WHO	World Health Organization

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1. Introduction

1.1 Societal relevance:

While motherhood is often a positive and fulfilling experience, for too many women it is associated with suffering, ill-health and even death (WHO, 2011). For many women, especially in developing countries, it can be dangerous to be pregnant and to go into labour. About 1000 maternal deaths are occurring per day. Approximately 358,000 women a year are dying from complications related to pregnancy or childbirth (WHO, 2010). This number of maternal deaths also means that around one million children are left motherless every year. These children are 10 times more likely to die within two years after the death of their mothers than other children (WHO, 2005).

Besides being one of the poorest countries in the world, Malawi is one of the countries with the highest maternal mortality ratio in Sub-Saharan Africa and in the world. According to the Malawi Demographic and Health Survey (National Statistics Office Malawi & ORC Macro, 2011), conducted in 2010, was the maternal mortality ratio of Malawi 675 per 100,000 live births. A significant decrease compared to the 984 per 100,000 live births estimated in 2004 by the MDHS (National Statistics Office Malawi & ORC Macro, 2005). However, Malawi is still in the top 25 world-wide with this maternal mortality ratio. Perinatal conditions are number five on the list of causes of death in Malawi, so it is clear that maternal health is a major problem in Malawi.

1.2 Scientific relevance:

Quantitative knowledge about the levels and determinants of maternal mortality and how these levels change in time is important, but for most developing countries these numbers are only estimates. Furthermore if a decline in the maternal mortality ratio is observed, it is still very hard to tell if this can be accounted to projects and policies that try to reduce maternal mortality in that specific area. (Berer & Sundari Ravindran, 1999)

The ideas or perceptions on maternal health of the people involved themselves are however not that often subject of study. Therefore, several researchers argued for more qualitative research focused on understanding the local knowledge, experiences and perceptions of women themselves (Mathole *et al*, 2004; Rosato *et al*, 2006). Moreover, according to Nigenda *et al* (2003), interventions or programs need to take into account the role of women's opinions and preferences in order to make sure that these interventions or programs will be sustainable. All the expectations, experiences and perceptions of all the people involved on the causes of maternal deaths, on maternal health care, and on how to deal with complications, are necessary improvements for interventions and programs who try to reduce maternal mortality. It is a method of reducing the gap between the professional health workers view and the patients view (Mathole *et al*, 2004).

Besides that most research about maternal health is mainly quantitative and focused on the determinants of maternal deaths there is a female bias in the gender literature. There is a lack of information about the male side and the gender literature tends to be *by* women and *on* women (UNFPA, 1999). Literature that supposedly discusses maternal health in general is still mainly focused on women and the voice of men in maternal health is only heard in a very limited amount in published research (further elaborated in chapter two).

The involvement of men in maternal health and in reproductive health is an important part of the points of action that are given by the United Nations in order to reach the targets of Millenium Development Goal 5. Providing more knowledge to men on how to support women, but also informing them about the consequences of domestic violence on women (especially pregnant women) are examples of how to implement this point of action. (United Nations, 2008a) Especially the United Nations Populations Fund (UNFPA) tries to reach a growing acknowledgement of the importance of men in maternal health interventions and research all over the world. According to a report of the UNFPA (2005) is partnering with men an important strategy for improving reproductive health and rights.

Furthermore in Malawi, involving men in sexual and reproductive health is part of the main aims of the Malawi Sexual Reproductive Health (SRH) policy and of the Community-Based Safe Motherhood (CBSM) project in Mangochi, Malawi, a project with whom is collaborated for this research (Ministry of Health Malawi 2006; CBSM project, 2007). The CBSM project found in their field studies that involving husbands in maternal health in rural areas was perceived by community members as beneficial to both man and woman (Sibande & Hutter, 2011).

Following the ideas and guidelines from the UNFPA, the Malawian SRH policy and the CBSM project in Mangochi, Malawi (UNFPA, 2005; Ministry of Health Malawi, 2006; CBSM project, 2007) about the lack of including men in maternal health research, this study tries to fill this gap. This study will explore the perceptions of men from the rural areas of Mangochi district, Malawi, about maternal health and about male involvement in maternal health issues. Studies about the perceptions of men in Mangochi district related to the field of maternal health have not been published yet or are not known. Nevertheless from implemented interventions and studies conducted in other countries (see chapter two) this research expects that also in the rural areas of Mangochi district the involvement of men in maternal health interventions can contribute to an improved maternal health situation. However, the *need for* male involvement and *the way how* to involve men should be explored by listening to the ideas and perceptions of men themselves.

1.3 Structure of the dissertation:

In chapter two the theoretical background and the research objectives will be discussed. After reflecting on maternal health and maternal mortality in Sub-Saharan Africa and in Malawi in specific, international policies regarding safe motherhood will indicate what is believed the focus of safe

motherhood research and interventions should be. Understanding the local knowledge, experiences and perceptions, and how collaborating with all local stakeholders (including the community members themselves) is mentioned as one of the important features in addressing maternal health issues. The perceptions of community members, and in specific of men, are in this context discussed. Perceptions of community members are included in maternal health research especially regarding the problem statement, health-seeking behaviour and community factors. Besides exploring the perceptions of men regarding safe motherhood, several studies and reports also reflect on how involving men in maternal health issues can improve maternal health. Finally, before discussing the research objectives and research questions chapter two will shortly reflect on the work of the CBSM project in Mangochi district. This study is conducted in collaboration with the CBSM project and their expertise and work in the field helps to shape and understand the context better within this study.

Chapter three will discuss the methodological pillars of this study. A triangulation of qualitative research methods is used in order to get an insight in the perceptions of men regarding maternal health and male involvement in maternal health. Participant observations, focus group discussions and in-depth interviews are conducted within five different villages in Mangochi district. Grounded theory is used to guide the proposal writing, data collection and data analysis and several feedback meetings with both government officials and community members were conducted to validate the preliminary research findings.

In chapter four the research findings are given. The four sections, which equally are the four major themes derived from the qualitative data analysis, are:

- The perceptions of men about getting children
- The perceptions of men about pregnant women
- The perceptions of men about community influences on safe motherhood
- The perceptions of men about male involvement in maternal health

In the fifth chapter, the results will be interpreted and placed in a broader understanding related to other studies and theoretical insights. The discussion will be guided by an inductively derived conceptual model. Furthermore the research questions will be answered in this chapter.

Final conclusions on the results and the research process, and implications of the research findings for other safe motherhood research and interventions will finally be discussed in chapter six.

2. Background Literature

In this chapter will firstly be reflected upon studies regarding maternal health and maternal mortality in Sub-Saharan Africa and in Malawi in specific (paragraph 2.1). The major direct and indirect causes for maternal deaths in different Sub Saharan countries will sketch an image of what the major physical problems are related to child bearing. Secondly, in paragraph 2.2 it will be explained what international policies prescribe regarding safe motherhood in general. Special attention is given to the advises regarding safe motherhood policies and programs from the United Nations Millennium Development Goals (MDGs) World Health Organisation (WHO), the United Nation Population Fund (UNFPA) and the Safe Motherhood Initiative (SMI). It will further discuss how understanding the local knowledge, experiences and perceptions, and how collaborating with all local stakeholders (including the community members themselves) is essential for addressing major health issues. This statement is followed up in paragraph 2.3 by a review on literature in which female community members are (or are plead to should be) included in research or interventions regarding safe motherhood. Especially studies which address women's perceptions regarding the problem statement, health-seeking behaviour and community factors in maternal health issues will be used in this review. In paragraph 2.4 literature focusing on the role of men and on male involvement within maternal health is discussed. On the one hand several studies reflect on what the perceptions of men are regarding the major problems in maternal health, and on the other hand several studies and reports explain how involving men in maternal health issues can improve maternal health. Paragraph 2.5 will shortly reflect on the work of the CBSM project in Mangochi district and their special focus on involving community members (including men). This study is conducted in collaboration with the CBSM project and their expertise and work in the field helps to shape and understand the context better within this study. Finally, in paragraph 2.6 the research objectives and research questions will be given and shortly discussed.

2.1 Maternal health and maternal mortality in Sub-Saharan Africa

2.1.1 Maternal mortality numbers

In 2008 about 1000 women died every day because of pregnancy-related or delivery-related causes. The estimates of the WHO indicated that 358,000 maternal deaths occurred in 2008 (WHO, 2010) a decrease in comparison with the 2004 estimates where it was estimated that 529,000 maternal deaths occurred (WHO, 2005). Moreover, it is estimated by the United Nations (United Nations, 2008a) that ten million women over a whole generation die from getting a child. In sub-Saharan Africa the maternal mortality ratio is estimated at 640 per 100,000 live births, which makes it the region with the highest ratio in the world (WHO, 2010).

Maternal mortality is often used as an indicator for the gap between the developed and the developing countries. 99 percent of all maternal deaths are occurring in developing countries. The risk of a woman dying a maternal death is much higher in developing countries. For example, in Malawi a woman's risk of dying from complications during pregnancy, delivery or post-natal over the course of her life is 1 in 36, compared to 1 in 17,800 in Ireland (WHO, 2010). These are maternal death levels of regions, for maternal death levels between specific countries the disparity is even larger. The death of all those mothers means furthermore that about 1 million children are left motherless and are more vulnerable to die in childhood each year (WHO, 2008a).

According to the Malawi Demographic and Health Survey (National Statistics Office Malawi & ORC Macro, 2011), conducted in 2010, was the maternal mortality ratio of Malawi 675 per 100,000 live births. A significant decrease compared to the 984 per 100,000 live births estimated in 2004 by the MDHS. However, Malawi is still in the top 25 world-wide with this maternal mortality ratio.

A research of Boerma (1987) shows a discussion on maternal mortality levels in Sub-Saharan Africa. It shows that estimates for national levels of maternal mortality vary between 250 and 900 per 100.000 live births in Sub-Saharan Africa (1980-1985). This variation is due to the proportion of maternal deaths among females aged 15 to 49 which is calculated by general mortality levels and fertility levels in a country. If fertility declines, maternal causes become relatively less important as a cause of death for women of reproductive ages. The results of Boerma (1987) shows that Malawi was already in the period of 1980-1985 one of the countries with the highest maternal mortality levels within Sub-Saharan Africa.

Maternal health refers however to more than solely complications which result in a maternal death. Much suffering of women during pregnancy, delivery and post-natal occurs without resulting in a maternal death. For every mother that dies 20 more women face complications and suffering related to getting children (Lindahl, 2011). Maternal morbidity faced by women is e.g. aneamia, fistula, infertility, uterine prolapse and maternal depression. Besides pain and suffering, these complications can cause sincere negative social consequences, such as being excluded from the family or community and being stigmatised (Lindahl, 2011).

2.2.2 Direct and indirect causes of maternal mortality

Research on the determinants of maternal mortality is available quiet dominantly in the literature concerning maternal health and maternal mortality. Knowledge about why women die is essential in order to find out what interventions are most applicable for a certain area in order to reduce the number of deaths. This type of research can be focused on either the direct causes or on the indirect causes of maternal deaths.

Overall, the major direct causes, which account for 80 percent of all maternal deaths, are severe bleeding (1), infections (2), high blood pressure (3), obstructed labour (4), and unsafe abortion (5) (WHO, 2010).

More specifically, several studies focused on discovering the causes of maternal mortality in Sub-Saharan Africa. Thonneau *et al* (2003) have done a prospective study in twelve maternity units of hospitals located in Benin, Ivory Coast and Senegal to discover the leading direct causes of maternal deaths. More than 10,000 deliveries were reviewed and 86 maternal deaths were reported. Most deaths were caused through hypertensive disorders and through post-partum heamorrhage (bleedings). A study of Mbaruku & Bergström (1995) in a regional hospital in Kigoma, Tanzania, where the maternal mortality ratio was set on 933 per 100,000, the leading causes of maternal deaths were uterine rupture, sepsis and heamorrhage. Likewise, a research from Fawcus *et al* (1996) shows that in Zimbabwe, both for urban and rural areas, the leading causes are sepsis and heamorrhage.

A study of the WHO (Khan *et al*, 2006) on the causes of maternal mortality corresponds with the results from Thonneau *et al* (2003), Mbaruku & Bergström (1995) and Fawcus *et al* (1996). They investigated 34 datasets which included 35,197 maternal deaths in total all over the world and 4508 deaths specifically in Sub-Saharan Africa. In Sub-Saharan Africa they found that most maternal deaths were due to haemorrhage (33.9 percent). Sepsis contributed to 9.7 percent and hypertensive disorders contributed to 9.1 percent of all maternal deaths in Africa.

For the southern half of Malawi a quiet similar image is presented in the research of Ratsma (2005) on maternal deaths. This research showed that from the 197 maternal deaths in southern Malawi, sepsis was the leading cause with 31.5 percent. Other important direct causes of maternal deaths in southern Malawi were; ruptured uterus, heamorrhage and complications with abortion.

In the study of Kahn *et al* (2006) also 107 maternal deaths were registered with indirect causes. Examples of indirect causes are unavailable, inaccessible, unaffordable or poor quality health care facilities (Harnmeijer, 2007), extreme poverty, or as in the case of Sub-Saharan Africa the HIV/AIDS epidemic or Malaria (Berer & Sundari Ravindran, 1999). For southern Malawi aneamia (26.2%), HIV/AIDS (25.2%) and meningitis (21.5%) are the leading indirect causes of maternal deaths (Ratsma, 2005). The exact impact of HIV/AIDS on the number of maternal deaths might be bigger however, because a HIV related immunodeficiency can trigger sepsis but still be reported as sepsis. Furthermore, because in some cases stigmatisation in association with HIV/AIDS leads to restraint in registering a death as caused by AIDS (McCoy *et al*, 2004).

2.2 International policies on safe motherhood

2.2.3 Cairo's International Conference on Population and Development

Among health experts a strong consensus exists about what kind of interventions within health systems would be effective in order to reduce the number of maternal deaths. Freedman et al (2005, p.1) states that these interventions are: 'well known and well accepted. They are generally simple and low-tech. And they are even cost-effective'. However major parts of the world's population do still lack an available, an accessible and a good quality health system for their problems. Result is the loss of human lives which mostly can be prevented. That's why at the 1994 International Conference on Population and Development in Cairo a 20-year Programme of Action was created. The world (meaning 179 countries who adopted the program) agreed at this conference that population and development are interlinked with each other and that population is not about numbers but about people. The 20-year action program was more focused on individual needs and rights, rather than on demographic targets (Demeny, 2003). This means that since the ICPD internationally there has been more acknowledgement of that 'every person counts'.

Among the goals that were included from the ICPD 20-year action plan were the following goals:

- Advancing gender equality (e.g. stop domestic violence against women)
- Basic rights for couples and individuals (e.g. decisions on the number and the spacing of their children should be free)
- Provide universal education
- Reducing infant, child and maternal mortality
- Ensuring universal access to reproductive health (including to family planning, contraceptives, antenatal care and good quality maternity care).

Major breakthrough from the ICPD Cairo meeting was the acknowledgement that empowering women is not only a goal, but also a method to reduce poverty, to improve health (including maternal health) and to stabilise population growth. (UNFPA, 2009a)

2.2.4 Millenium Development Goal 5

The ICDP put maternal health and women's empowerment on the agenda. Following the ICDP and looking at the scale and impact of the maternal mortality problem it might not be surprising that in September 2000 'improving maternal health' was stated as one of the eight United Nations Millenium Development Goals (MDG). The MDGs are eight international development goals, with measurable targets and clear deadlines, which 192 United Nations and some international organisations have agreed upon to achieve these goals by the year of 2015 (UNFPA, 2003).

MDG 5 is focused on improving maternal health globally. The target was set on a decrease of the maternal mortality ratio by three quarters from 1990 to 2015. This would mean a annual decline of the maternal mortality ratio by 5.5 percent. Additionally it aimed at achieving universal access to reproductive health by 2015. The second part of the target, universal access to reproductive health, can be monitored by four indicators: The contraceptive prevalence rate (1), the adolescent birth rate (2), antenatal care coverage (3) and the unmet need for family planning (4) (UNFPA, 2003).

The eight MDGs also show a link between poor health (including maternal health) and other social, economical and environmental conditions. Other MDGs, such as the ones on hunger and poverty, education, gender empowerment and environmental sustainability can have a great effect on the health and survival of women. E.g. clean water directly reduces infection of pregnant women. However, also indirectly other MDGs can have a significant impact on health. E.g. the empowerment of women might lead to women being more able to make decision themselves regarding emergency care during pregnancy or post-natal (Freedman, *et al*, 2005).

The United Nations MDG initiative assumes that achieving a reduction in maternal mortality depends strongly on the availability, accessibility and quality of maternal health care services. Efforts should therefore be focused on improving the health care systems. The United Nations mentioned in their report on how to achieve the MDGs, several actions that have to be made in order to achieve the final MDG goals. For MDG 5 they indicated the importance of provision of sufficient funding in order to strengthen health systems; particularly for maternal care, child care and other reproductive health services. Furthermore they argued that the distribution of medicine, equipment and contraceptives should be properly functioning. (United Nations, 2008c)

A second important point of action is the provision of skilled health workers during pregnancy, delivery and during the post-natal period. It is believed that this would support the quality of antenatal care, to have timely emergency obstetric services and to provide good help with contraception use.

Thirdly the MDGs acknowledged the need to provide adequate communication, facilities and transportation systems, so that the more remote rural areas are also reached and that people from these areas also have access to maternal health facilities. Alongside proper access also the affordability should be improved for poor families. Free services or health insurance should protect poor families from unaffordable maternity care.

Finally, the MDGs urged to increase the efforts in order to prevent child marriages, efforts in order to let young women time their first birth later, and efforts in order to inform adolescents about contraceptive use. Adolescent pregnancy is stated as one of the contributors to high maternal mortality ratios (UNFPA, 2005). Early motherhood not only increases the risk of dying during the delivery, it also has negative influences on the well-being of surviving mothers and children. A young mother more often misses education and therefore misses certain socio-economic opportunities. A child born from a young mother also has more risk of dying in infancy or childhood. That is why the United Nations MDG report 2008 (2008b, p. 27) states: ‘Reducing adolescent fertility contributes directly and

indirectly to achieving the maternal health and other goals.' They further indicated that health counseling for both women and men in adolescent times should contribute to reaching this point of action.

MDG 5 is the area which shows the least progress among all MDGs (when using the decrease in maternal mortality ratios as an indicator). However the proportion of women who attended at least one service with skilled health personnel during pregnancy, and the proportion of deliveries that has been attended by a skilled health worker (meaning a doctor, a nurse or a midwife) has increased significantly between 1990 and 2009 (see figure 2.1 & 2.2). Nevertheless, it can also be concluded from figure 2.1 and 2.2 that the progress in Sub-Saharan Africa is falling behind the average progress. The United Nations states that assistance by appropriately trained health workers must be present if aiming for a significant decrease of maternal deaths (United Nations, 2008b). The WHO and UNICEF however recommend a minimum of four antenatal care visits, in order to call motherhood 'safe' (UNICEF, 2009).

Figure 2.1: Proportion of women that attended at least one service with skilled health personal during pregnancy: Progress between 1990 and 2009, by region.

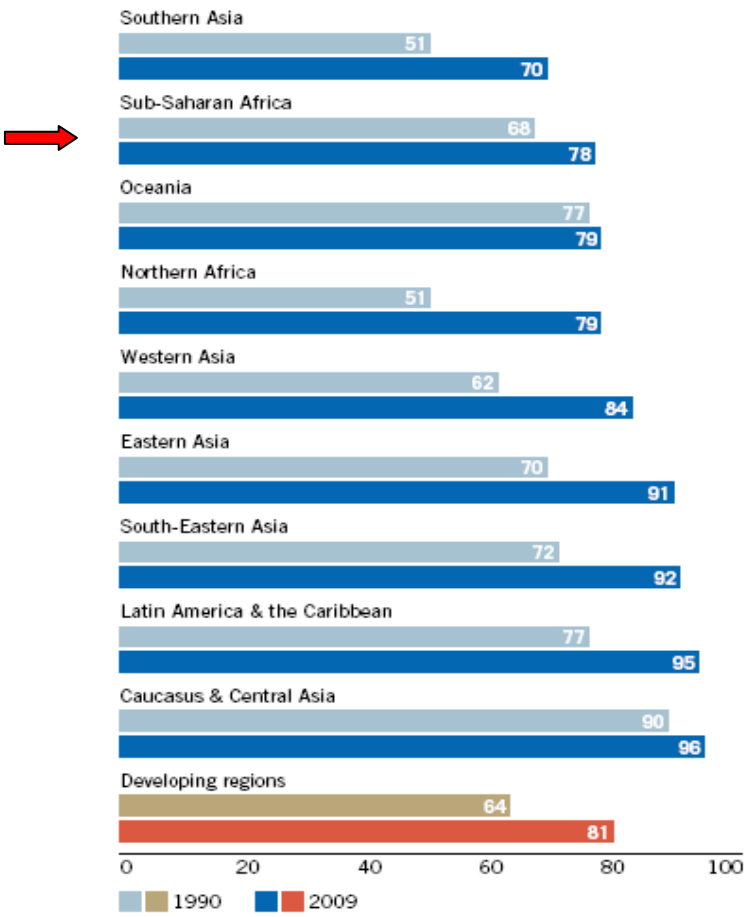
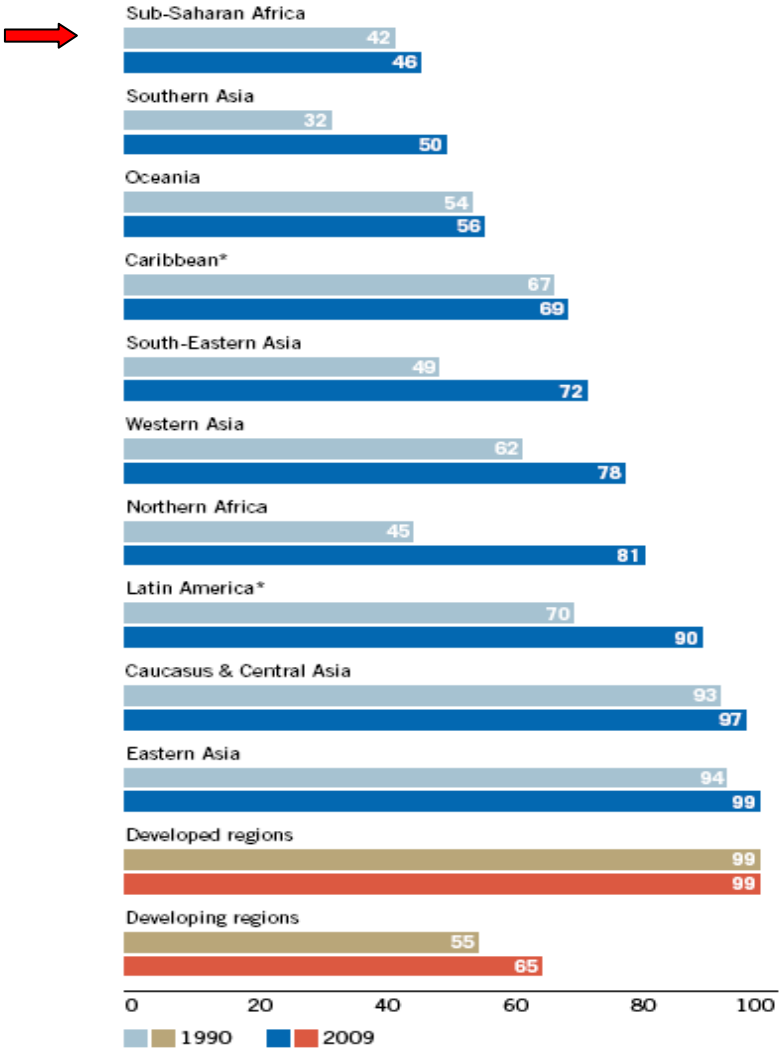


Figure 2.2: Proportion of deliveries that have been attended by a skilled birth attendant: Progress between 1990 and 2015, by region.



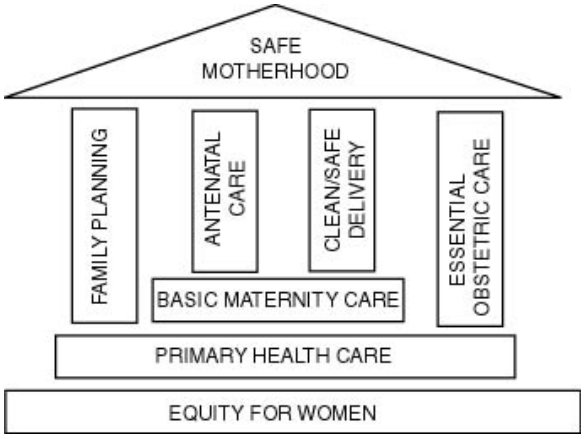
Source: Millenium Development Goals Report 2011 (United Nations, 2011)

Both targets of MDG 5 are focused on measurable facts of improved maternal health. The advantage is that it is for everybody clear if maternal health is improved or not. However, the guidelines on how to reach these targets are less clear. The United Nations mentioned some points of attention, but direct guidelines are not produced in the millennium development goals. Furthermore, it does not pay attention to local variations and does not help to understand the complex local context on the ground. The MDGs do not help to clarify which obstacles individuals have to face in achieving safe motherhood. As will be discussed in paragraph 2.3 and 2.4 the perceptions of community members themselves can explain how local beliefs and customs influence the practice of safe motherhood. Additionally, paragraph 2.5 will show how the ideas of community members can contribute to cultural relevant solutions and improvements.

2.2.5 The World Health Organization, United Nations Population Fund

International organizations like the WHO, UNFPA, and SMI are more precise in how to realize the MDGs. The focus of these organizations is mainly on a couple of basic principles on what is important for safe motherhood. A good overview about which aims should be included in programs and policies in order to improve the maternal health situation is illustrated by figure 2.3:

Figure 2.3: The four pillars of Safe Motherhood



Source: Mother-Baby Package, Implementing safe motherhood in countries (WHO, 1996)

The basic principles of safe motherhood illustrated in figure 2.3 are not really new and have been used by international organisations for years. The four pillars of safe motherhood are:

- **Family Planning**; to ensure that individuals and couples have the information and services to plan the timing, number and spacing of pregnancies.
- **Antenatal Care**; to prevent complications where possible and ensure that complications of pregnancy are detected early and treated appropriately.
- **Clean/Safe Delivery**; to ensure that all birth attendants have the knowledge, skills and equipment to perform a clean and safe delivery and provide postpartum care to mother and baby.
- **Essential Obstetric Care**; to ensure that essential care for high-risk pregnancies and complications is made available to all women who need it.

The WHO has a special section, the department of Making Pregnancy Safer (MPS) which produces, implements and uses guidelines all over the world to make making pregnancy safer (WHO, 2008b). The MPS department estimates that in order to get universal coverage of maternity care an estimate of 700.000 midwives are needed, whereof only 50 percent has been covered so far (WHO, 2008c). Besides the lack of midwives 47.000 doctors with obstetric skills are missing. They plea for increasing funds for the recruitment and training of additional health workers with midwifery skills (WHO, 2008d). Furthermore, a problem concerning the availability of good quality maternity care is the lack of satisfying equipment, supplies and medicines (WHO, 2008d).

The UNFPA focuses more on the rights of every person and on women's empowerment. Promoting gender equality, protecting human rights and using culturally sensitive approaches are main principles of the UNFPA. The UNFPA further states that fund raising is not helpful without a high-level political will to improve maternal health and to reduce maternal mortality.

In countries or regions where professional care is unavailable, an important first step is infrastructural change and health care strengthening. Especially in rural areas the presence of skilled health workers during pregnancy and childbirth is lacking and did not really improve in recent years. There is a lack of skilled health personnel to assist at birth, but also the skills of the trained birth attendants are often inadequate or of poor quality (UNFPA, 2009d).

The UNFPA mentions brain drain as one of the factors for not having sufficient skilled birth attendants, especially countries with the highest maternal mortality ratios seem to be affected by brain drain. This phenomenon is two sided: Firstly, skilled birth attendants migrate to better paying jobs in the developed world. Secondly, the number of HIV-related deaths among skilled birth attendants contributes to the lack of skilled practitioners. As many as 40 percent of the deaths among government employees in Africa is the result of HIV/AIDS. In Malawi, HIV-related death is the leading cause of death among health professionals (particularly among nurses and midwives). (UNFPA, 2009d)

2.2.6 Community involvement in maternal health research and interventions

The WHO, UNFPA and the World Bank launched the Safe Motherhood Initiative (SMI) to help raise awareness about the impact of maternal mortality and maternal morbidity (PATH, 2009). From the global experience of the SMI some important lessons are learned in how to prevent maternal death and morbidity. Several lessons learned from the SMI experiences:

- Strong political commitment at the national and/or local level can help facilitate the implementation of safe motherhood interventions and ensure their integration into the health care system.
- Involving national leaders, local leaders and other key parties (including donors and both public and private health sectors) in the planning and implementation of safe motherhood activities helps facilitate the delivery of maternal health services and ensure sustainability.
- Effective communication between health care providers at both the community level and the district (first-referral) level is essential for management of obstetric emergencies and for ensuring continuity of care.
- Community education about obstetric complications and when and where to seek medical care is important to ensure early recognition of complications and prompt care-taking behavior.
- Involving community members (particularly women and their families, health care providers, and local leaders) in efforts to improve maternal health helps ensure program success (Starrs, 2006).

Involving national and local leaders, promoting communication between health care providers and community members, enabling community education on maternal health issues and involving community members in the implementation of maternal health interventions are aims of the SMI that clearly focus on the involvement of all stakeholders. The experts in the lives of people are the people themselves (Tsey *et al,* 2004). Using the knowledge of community members in order to get a full insight in the problem and working together with them in developing interventions which are addressing these problems, is mentioned by several researchers as a must-do in order to enable research and interventions to be culturally sensitive and relevant (Pokorny *et al*, 2004; Zlotnick *et al,* 2004; Pinto *et al,* 2008).

Thaddeus and Maine (1994) based their three-delay model on the experiences of community members in different study settings in developing countries. Thaddeus and Maine argue that that the main reason for maternal deaths in developing countries is because women do not receive adequate care. Not receiving care can be related to three different delays: A delay in the decision-making to seek care when complications occur (1), a delay in reaching obstetric medical care once decided to seek care (2), and a delay in receiving adequate and appropriate care once the health centre is reached (3). Many factors influencing these delays are related to factors at community level such as the status of women within the community, local beliefs and practices surrounding the pregnancy and childbirth, failure to recognise complications, poor organisation of transport, poor local rural infrastructure and poverty. In their study, Thaddeus and Maine illustrated their three-delay model with experiences of community members themselves.

Mbizvoi and Bassett (1996) state that programs which try to improve reproductive or maternal health should take a holistic perspective; meaning that an intervention should not focus only on one part of the problem but on all the determinants. They continue by arguing that an intervention which increases contraceptive knowledge can reach its targets (increasing awareness), but still when cultural, political, socio-economical or gender factors remain untouched the use of contraception methods will remain low (Mbizvoi & Bassett 1996). The inclusion of all the expectations, experiences and perceptions on the causes of maternal deaths, on maternal health care and on how to deal with complications, of people who are in one way or another involved, is an essential requirement for interventions and programs who try to reduce maternal mortality. It is a way of reducing the gap between the professional health workers view and the patients view (Mathole *et al*, 2004).

2.3 Perceptions of women about maternal health and maternal mortality

As discussed in paragraph 2.1 and 2.2 most research related to maternal health is mainly quantitative and focused on the determinants of maternal deaths. However, as stated in paragraph 2.2.6, there is a growing recognition that the voice of community members should be included more in research in order to better understand the complex context of maternal health and maternal mortality. Although not much research is published on the perceptions or opinions of the people who are actually

facing maternal health risks, some researchers did try to grasp what people in Sub-Saharan Africa themselves think about maternal health.

Research of Nigenda *et al* (2003) was able to assess the ideas and experiences of women regarding the care they received in antenatal care clinics. 164 women participated in 24 focus group discussions in 4 different development countries. Three major topics were found to be important for women receiving antenatal care. First of all the behaviour of health workers; the idea was present in all countries that male doctors can be potentially intrusive in the intimacy of women. Secondly, the technology involved in care was perceived as important to women. E.g. the use of ultrasound technologies, which are not widely available in the countries where the study was conducted: Women did not mention the lack of such technologies. However when sensibly used, the utilization of such technologies is not only helpful to diagnose the health status of women, its presence also creates the sense among patients that they are treated according to the highest standards of quality. Finally, the role of information provided to women was a matter of common discussion. Women in all four countries who insisted on receiving information from health personnel and higher educated women seemed to be more capable to understand information received from doctors regarding pregnancy, delivery, or post.natal. According to Nigenda *et al* (2003), interventions or programs need to take into account the role of women's opinions and preferences in order to make sure that it will be sustainable.

A research of Rosato *et al* (2006) conducted in Malawi concludes the same as Nigenda *et al* (2003). Rosato *et al* (2006) investigated on what participatory women's groups identified as the major maternal health problems. Rosato *et al* (2006) argue that participation of women in finding solutions to the huge risks of pregnancy in Africa is possibly the most important part of intervention building. Participatory women's groups can trigger the collective capacity in communities to solve problems and make women's voices heard by decision makers.

According to Mathole *et al* (2004) understanding the local knowledge, experiences and perceptions of women, should be the first step in risk management in pregnancy related issues. They showed by doing focus group discussions and in-depth interviews in a rural district in Zimbabwe the perceptions of women which led to visiting or not visiting the antenatal care clinic. Young women preferred to visit the clinic so to be reassured that the baby was growing well and was in the proper position. Difference however is seen with older women who mentioned that they visit the clinic only seldom. Some older women were hestitant towards a delivery at home because they had several successful deliveries at home in the past, which results in the belief that the current pregnancy is expected to happen in a similar positive way. But some older women also mentioned to be ashamed of being pregnant again, or to be pregnant at an age above 40.

Another factor which prevented women to visit the health centre were local beliefs related to delivery at home. Some women believed that in the first period of pregnancy they were most vulnerable to witchcraft. They used traditional healers for general care and did not need antenatal

professional care then. The feat of being bewitched also resulted in the pregnancy often remaining a secret within the family; otherwise other people had the chance to bewitch the vulnerable pregnancy.

Furthermore several women had a fear for undergoing a caesarian section, so instead they hoped the traditional healer would help them resolve the problem. And finally, the uncaring attitude and irresponsible behaviour of nurses, and a lack of food and drugs at the clinic, was mentioned by the women in the study of Mathole *et al* (2004) as a reason for not going to the antenatal care clinic.

2.4 Men and maternal health

2.4.1 Female bias in literature

Literature that supposedly discusses maternal health in general is still mainly focused on women. Like Filippe *et al* (2006) with their research about maternal health in developing countries and about points of action towards improving maternal health. It draws attention on the economic and social vulnerability of pregnant women and states the needs of pregnant women for health care. Among the actions that should be taken in order to improve maternal health is women's empowerment, proper women's nutrition, access for all women to health centres and economic relieves for pregnant women. The role of the family or the role of the husband in point of action is never mentioned.

Campbell *et al* (2006), discusses strategies for reducing maternal mortality and gives an insight in interventions that have been effective in reducing maternal deaths. For a wide variety of target population groups the most threatening cause of a maternal death has been outlined and appropriate strategies are linked to it. The target populations for the different strategies are divided into groups. E.g. such as: non pregnant women of reproductive age ill, non pregnant women of reproductive age not wanting a child, pregnant women not wanting a child, intrapartum women, postpartum women with complication, and so on. A good overview is then given on what kind of treatment or intervention is needed for each specific group, such as preventing unsafe induced abortion or preventing aneamia. They further elaborated on how a possible intervention can best be distributed towards the target population. Men are not addressed as target population nor as part of certain interventions, nor as a way to improve the distribution of applicable interventions.

These examples (among others) imply that there is a female bias in the literature regarding maternal health and gender. Additionally, the UNFPA argues that there is a lack of information about the male side and the gender literature tends to be *by* women and *on* women (United Nations, 1996). Much of the data obtained from research on reproductive health is derived from studies related to women. Such data is important, but it also helps to reinforce misconception at community level which labels family planning and fertilty as a 'female's affair' and e.g. Sexually Transmitted Diseases (STDs) as a 'female's disease'. (Mbizvoi & Bassett 1996)

2.4.2 The need of male involvement in maternal health

The involvement of men in maternal health and in reproductive health is an important part of the points of action that are given by the United Nations in order to reach the targets of Millenium Development Goal 5. Providing more knowledge to men on how to support women, but also informing them about the consequences of domestic violence for women (especially pregnant women) are examples of how to implement this point of action. (United Nations, 2008c)

The UNFPA pleas that women have a right on good maternal health, but protecting that right often depends on the support of the partner. Partnering with men is an important strategy for advancing reproductive health and rights (UNFPA 2005). Sternberg and Hubley (2004) argued in their study on male involvement in reproductive health that the empowerment of male partners is essential when aiming at empowering women. Westoff and Bankole (1995) found out that the influence of husbands occasionally opposes the will of women regarding the timing and spacing of getting children.

Additionally, a study conducted in South Africa (Kunene *et al*, 2004) tried to find the influence of involving men in maternal care. In South Africa many women abstain from sex before and after delivery, and during this abstinenance period men are supposed to have other sexual partners. Involving men in maternal care helped to shape opportunities for partners to discuss reproductive health and HIV risks in setting mediated by a health care worker. This project showed that involving men in maternal care is feasible and acceptable. One-third of the couples in this intervention attended counselling, which was very uncommon for men beforehand. Furthermore, women indicated that they were more likely to be supported by their partners when they experienced problems during their pregnancies.

Summed up by Pachauri (1997, p.*): “since gender inequalities favour men in patriarchal societies and sexual and reproductive health decisions are made by them, there is a growing realisation that unless men are reached, programme efforts will have limited impact”. Because of this gender inequality, the role of men is believed to be an important factor in maternal health, and increasing the knowledge of men about maternal health and maternal mortality can contribute to a reduced number of maternal deaths.

Several researchers tried to conceptualise male involvement or male participation. Four main conceptualisations of male involvement, discussed in a study from Pachauri (2001), are (cited in Barua *et al*, 2004):

- Male involvement in decisions related to family planning
- Support of men towards the reproductive health of their wives
- Male responsibility in reducing risky sexual behaviour
- Men’s reproductive and sexual health needs

The care and support of an informed husband is also believed to improve pregnancy and childbirth outcomes and can mean the difference between life and death when complications occur and when the pregnant women needs immediate medical care. Bhalerao *et al* (1984) even found in their study conducted in Mumbai, India, that when husbands joined to the antenatal care clinics, the perinatal and neonatal mortality reduced and women were more likely to visit multiple times the antenatal care clinic. A study from Olayemi *et al* (2009) further showed that women in rural areas in Nigeria were less likely to be supported by their husband with domestic works or with going for antenatal care than women from urban areas. They also indicated that the education level, of both husband and wife, and the tribal ethnicity influenced male involvement significantly.

Additionally, supportive fathers can play an important role in the love, care and nurturance of their children. Cultural traditions and customs which assume that women are primarily responsible for children's well-being and care may discourage men from getting involved during pregnancy and childbirth. So a need is pressing for effective policies in favour of a father's supportive involvement (UNFPA, 2005).

On a global scale a growing acknowledgement of the importance of inclusion of men in maternal health interventions is emerging, e.g. by the WHO or UNFPA as mentioned above. However, introducing male involvement in multiple large scale national policies on health problems is still not reached (Walston, 2005). Targeting the general male population does not often occur yet in most health services. If programs address men, then it the focus is mainly on a certain group of men who are perceived to be at high risk, such as migrant workers (Walston, 2005). The environment needs to be changed in which reproductive health care is offered, according to the Policy Project Cambodia. It should address the cultural beliefs and customs more and should be focused more on gender equity. Waltson (2005) further argues that many health workers are men who could, if they are properly trained and equipped, be an important factor in encouraging men to use reproductive health care.

2.4.3 The case of Cambodia

The Policy Project in Cambodia (in collaboration with USAID) provides a good example of how male involvement in maternal health can actually be implemented. It provides good examples about how male involvement can be included in national policies, but it also provides examples on how this is translated into specific programs. Gender roles in Cambodia, like in many parts of the world, contribute to the idea that getting children is only an affair for women. Including men in maternal health issues is therefore an important aspect of reducing the problems in maternal health (Walston, 2005).

In different national policies of Cambodia on reproductive health, the idea of male involvement is slowly introduced. From different angles a link between men and maternal health can be found in national polices:

- The National Population Policy includes the objective: '*To support couples and individuals to decide freely and responsibly on the number and spacing of their children'*. Additionally specific strategies in order to put this policy in practise indicate: *'Promote male responsibility and partnership in RH at the household and community levels'* (Ministry of Planning Cambodia, 2003).

- The Policy on Women, the Girl Child, and STI/HIV/AIDS states: '*The Ministry recognises that this is a gender-based pandemic and that the spread of HIV/AIDS among women and girls can be slowed only if concrete changes are brought about in the sexual behaviour of men. The ministry places prevention, care, support and protection of women and the girl child plus the need to change the behaviour of men on the agenda for policy-makers and service-providers through the Policy.'* (Ministry of Women's and Veterans' Affairs Cambodia, 2003).

- The Safe Motherhood Policy includes the objective: *'Increase the awareness of families, men and women about the importance of safe motherhood* (Ministry of Health Cambodia, 1997).

Clearly, these examples show how the idea of male involvement is implemented in the national policies of Cambodia. However, these are just guidelines for what should happen and need to be implemented by going one step further. Some organisation or programs in Cambodia show that they implement the guidelines in more specific programs, such as the Reproductive Health Association of Cambodia program (RHAC). Women can visit this program for advice on STIs and can be tested for STIs. The program encourages women to return to the clinic with their partner so that both men and women can receive treatment and counselling. 80 percent of the women who visited the RHAC for a consultation, returned to the clinic together with the husband for counselling and eventual treatment. RHAC also promotes male-friendly services by separating the waiting areas, by using male service providers, and by providing separate examination rooms (Walston, 2005).

A second example of how in Cambodia policies are implemented in the field is Couples in the Know initiative. The project aims to improve the negotiation skills and the understanding of sexual health among men and women, in order to improve the safety of sexual encounters. The project selected couples on basis of positive 'couple behaviour', and these couples were leading the discussions with other couples. The discussions were on dual condom use, domestic violence, HIV transmission and the perceived roles of men and women. The project found in an earlier stage that if only women were educated on such topics, the knowledge level increased of those women, but the ability to negotiate safer sex with their partners did not increase. However, when men also joined the education on the safe motherhood topics, the women felt more at ease towards negotiating these topics with their partners. The use of condoms within those marriages had significantly increased (CARE Cambodia, 2004).

Thirdly, the Cambodia Health Education Media Services (CHEMS) are also trying to promote male involvement on reproductive health topics. They broadcast a radio phone-in show and a soap opera which are both aiming at young Cambodian men and women. The shows deal with several topics like menstruation, the first sexual experience, STIs, contraception, male responsibility. They broadcast on two of the most popular radio stations in Cambodia. Calling or writing to a radio show has been shown to be effective in obtaining information from young people about sensitive topics (Walston, 2005).

Finally, the Royal Government of Cambodia has developed projects that try to increase male involvement. The projects have tried to involve village leaders in reaching men through informal meeting and at special events. According to a report of Hou (2004) thousands of men were reached by this method and their participation in reproductive health had increased.

2.4.4 Including perceptions of men in research on maternal health

In a few studies related to maternal health and male involvement in (maternal) health the researchers paid attention to the voice of men themselves. These studies mainly focused on what the causes of a maternal death are or what the risks are which might lead to complications during pregnancy, delivery and post-natal (Becker & Robinson, 1998; Beegle *et al*, 2001; Bhalerao *et al*, 1984).

In a study conducted by Mathole *et al* (2004) a small part focused on what the partners of the women thought about pregnancy. Men explained that the fear of being bewitched was of great importance for not going into public with the pregnancy. A pregnant woman was according to some interviewed men unhealthy and therefore more vulnerable to witches.

Also in a research in Nigeria of Lawoyin *et al* (2007), in which men were asked for their perceptions on maternal deaths, some men blamed spiritual powers for occurring maternal deaths. In some cases it was indicated that the husband was the cause of these spiritual powers and some men said it could have been prevented if a traditional doctor was present at delivery.

Furthermore, in the study of Lawoyin *et al* (2007) Nigerian men pointed out that a woman bled to death because her husband was not around and money was not available. The husband was not prepared for complications during the pregnancy. The lack of funding for health services or transport was one of the main reasons for women dying a maternal death according to the men in this research. Other major causes, in which improvements were necessary according to these Nigerian men, were the poor quality of the health care services, the culture in which women were seen as ‘baby factories’, unsafe abortions and a low standard of living of women.

The willingness of husbands to be more involved seems to be bigger than expected. A research from Carter (2002) in Guatemala showed that most men wanted to be involved, but they were to shy or to embarrassed to do so or that they did not have the knowledge level to do so. Other studies also concluded that the lack of information and knowledge about maternal health is an obstacle towards

male involvement (Apte, 2000; Lakhani, 2000) However, Carter (2002) states that still little is known regarding the barriers and perceptions of men towards maternal health and towards male involvement in maternal health, and more research is necessary.

Effective research towards reducing maternal mortality in African nations should “take notice of all the people involved, and include an active participation of both men and women” (Lawoyin, 2007, p.).

This research about the perceptions of men from rural Mangochi examines which community, household and individual factors are influencing the way in which safe motherhood is perceived and practiced. Not only the women should be reached, because in many cases they are constraint by the rights a women has within the family and society. Men often control access to reproductive health information and services, finances, transportation and other resources. As heads of state and government ministers, as leaders of religious and faith-based institutions, as judges, as village heads, or as husbands and fathers, men often have a lot of power over many aspects of the lives of women. However in the past, men were mainly presented as an obstacle and not as part of the solution in maternal health issues (Ntabona, 2002).

The voice of male community members from rural Mangochi will be guiding this research. It contributes to a better understanding on the male perspective on maternal health, but it also contributes to an improvement in the collaboration with the community members, because the men are encouraged to think about possible solutions or improvements concerning maternal health.

2.5 The Community-Based Safe Motherhood (CBSM) project

This research is conducted in collaboration with the CBSM project. The main target of the project is to empower community members, to strengthen community initiatives and to improve the access to quality maternal health care (CBSM, 2007).

In 1995 the Department of Community Health, which is part of the College of Medicine of the University of Malawi, started a pilot project on community-based safe motherhood. It started in a single catchment area; the catchment area of Monkey Bay. Quickly, it was extended to six different catchment areas in the Mangochi district (on request of local village leaders themselves).

The CBSM project pays a lot attention to the collaboration with all the different stakeholders regarding safe motherhood. An important aspect of the CBSM project is the inclusion of community members. The project tries to enhance community members to participate in analysing the problems related to maternal health and to participate in finding solutions to them.

Some strategies of the CBSM project which are implemented in the project area are (CBSM, 2007):

1- Informing, educating and communicating safe motherhood and HIV/AIDS messages to community members.
2- Training and in-service training for reproductive health service providers of maternal health related care.
3- Improving the community-based referrals system to health facilities.
4- Facilitating modification of risky cultural practices/behaviors.
5- Instituting a community maternal health vital events recording system.
6- Initiating focused traditional birth attendants training and specific scope of service.
7- Initiating linkages between community structures and health structures.

An important initiative of the CBSM project is the bicycle ambulance initiative. To reach emergency obstetric care services the availability and accessibility of suitable and affordable transport is essential. Dealing with transport problems is often a neglected area in solving the accessibility problem (Hofman *et al*, 2008). Poor transport and transport costs for referral of women with obstetric emergencies contributes towards much of the delays (see Thaddeus and Maine, 1994, discussed in paragraph 2.4). Car ambulances are expensive and only present in a very limited way for the entire Mangochi district. Besides providing an ambulance to the health centres is expensive, but also fuel, maintenance and repair are costly. The car ambulances are not always available when needed for emergency obstetric care and are not always accessible for health centres without radio or telephone. Finally, the dirt roads in the Mangochi district are often difficult to drive on and travel time is increased by the lacking infrastructure (Hofman *et al*, 2008).

Where car ambulances are not the best solution to deal with the local transport problem the bicycle ambulances are considered to overcome the above mentioned obstacles. The CBSM project provides bicycle ambulances and mattresses to remote villages in Mangochi district. With this provision the community-based referral system should be improved. The delay in deciding to refer and the actual time taken to reach the health centre is supposed to be reduced by this method. If a women needs emergency obstetric care a community member, e.g. the husband, can use the village bicycle ambulance to reach the health facility on time. The bicycle ambulances does reduce the delay, also due to the fact that a car ambulance first has to drive to the village where care is needed and most bicycle ambulances are already present (Hofman *et al*, 2008). The CBSM project reported that the number of referrals to health facilities with maternal health care and the use of the bicycle ambulances for mothers with problems related to maternal health had increased after the implementation of the bicycle ambulance initiative.

However, the improvement of the number of referrals is also due to better Traditional Birth Attendants services (better training, better equipment) and to better information on safe motherhood provided to the community members (CBSM, 2007). The distribution of the bicycles is performed by the local health workers and traditional leaders in order to strengthen the collaboration between the community members and the health workers.

Some other important actions or interventions of the project are:

- Training of local leaders and initiation counsellors about maternal health, about maternal health care, and about new ideas for during the initiation counsellors ceremony.
- Providing necessary supplies and equipment all year long to Traditional Birth Attendants (TBAs).
- Conducting community-based maternal death audits (verbal autopsies).
- Organising and facilitating village meetings; the topics discussed in such meetings are birth preparedness, male involvement in reproductive health, and initiation ceremonies.

In all the initiatives of the CBSM community involvement is central. All stakeholders are included, which also means male community members. Male involvement is recently added by the CBSM project as one of the main aims of the project. Male involvement is increased by the bicycle ambulance initiative (the husband, brother or father is supposed to bike the woman to the health centre), but also by doing community verbal autopsies (where husbands are asked to reflect on the maternal death) and by organising village maternal death feedback meetings (in which information on maternal health is disseminated with all the community members). This study uses insights and experiences of the CBSM project and collaborates with the CBSM during the entire research to understand the local context.

2.6 Research objectives and questions

2.6.1 Main objective of the research

The overall objective of this study is to find out, through qualitative research, what the perceptions of men from Mangochi are about maternal health and about male involvement in maternal health. The research findings are aimed to contribute to the scientific knowledge of the Community-Based Safe Motherhood (CBSM) project in rural Mangochi, Malawi. But this research will also aim at contributing scientific knowledge more in general to other organisations or projects working in the field of family planning, maternal health, sexual and reproductive health or male involvement in health.

2.6.2. Specific objectives of the research

- To find out what the perceptions of men from rural Manogchi are about maternal health and maternal deaths.
- To explore what the perceptions are of men from rural Mangochi about the usefulness of male involvement in maternal health.
- To explore what the perceptions are of men from rural Mangochi about *how* men should be involved in maternal health.
- To describe how more involvement can contribute to an improvement in the maternal health situation in Manogchi.
- To make recommendations on how men can be more involved in maternal health within the initiatives of the CBSM Project.

2.6.3 Research questions

The research objectives mentioned above results in the following research questions which this qualitative research tries to answer:

"How are men from rural Mangochi, according to themselves, involved in maternal health issues?"

"How can men be more involved in order to reduce maternal mortality in Mangochi?''

The proposed research will mainly be an explorative study, i.e. trying to discover what the perceptions of Mangochi men are and by what or whom are these perceptions influenced. It will on the other hand partly be an descriptive study, i.e. trying to describe and indicate in what way men can be more involved in maternal health, and in what way more male involvement can help reducing maternal deaths. This structure can also be seen in the sub questions that will be answered in this research:

1- What is male involvement in maternal health in developing countries in general and Malawi in particular (literature review)?

2- What are the perceptions of men from rural Mangochi about maternal health and maternal deaths?

3- What are the perceptions of men from rural Mangochi about their involvement in maternal health?

4- How can men from rural Mangochi, according to themselves, be more involved in maternal health issues in order to reduce maternal mortality?

5- Which sources are, according to men from rural Mangochi themselves, influencing their perceptions about maternal health and about male involvement in maternal health?

3. Methodology

In this chapter the approach and the methods used will be discussed. The study is a qualitative study based on a community participation approach. In paragraph 3.1 it will be explained why a triangulation of qualitative methods (participant observation, focus group discussion, and in-depth interview) is used to explore the perception of men about maternal health and male involvement in maternal health. In paragraph 3.2 the study area will be described. The context of the study area will help to understand the research findings better. After paragraph 3.3 shortly discusses the study period, paragraph 3.4 will elaborate on the study participants and on the recruitment process of these participants. Paragraph 3.5 is about the data collection phase. This paragraph reflects on how the methods were conducted in practise and in which surrounding they took place. After the data collection paragraph 3.6 shortly mentions how the data is managed before the analysis can start. The steps taken in the data analysis is described in paragraph 3.7. Grounded theory is used in this study to assign codes to the data and to identify patterns in the data. After paragraph 3.8 explained for which audience this dissertation is created, paragraph 3.9 will discuss the ethical considerations which were important in this research. The chapter will be finalised by a reflection on the data quality and its limitations (paragraph 3.10). Several considerations need to be made before continuing to the research results and its interpretation.

3.1 Study design

3.1.1 Qualitative research

This study used qualitative methods (participant observation, focus group discussions and in-depth interviews) to gather more insights into the perceptions of men in rural Mangochi. Qualitative research is needed when a researcher wants to study meanings and interpretations in their particular research area (Liamputtong & Ezzy, 2005). Qualitative research is the best way to get information on the perceptions of men from the rural areas in Mangochi about maternal health and male involvement in maternal health. Perceptions, meanings and interpretations are more 'soft' concepts, and cannot be measured by just quantification of these concepts, it needs qualitative research. Hammersley (1992, p.45) states that qualitative data: *'documents the world from the point of view of the people studied...rather than presenting it from the perspective of the researcher'* (the emic point of view). This last statement by Hammersley exactly represents the purpose of this research.

The study is firstly an explorative study, which aimed at discovering the perceptions of men regarding maternal health, regarding male involvement in maternal health, and regarding what or whom influences these perceptions. Secondly, it is a descriptive study, which aimed at describing and indicating in what way men can be more involved in maternal health, and in what way more male involvement can help improving maternal health.

In order to get sufficient and credible qualitative data, triangulation of methods is used in this study. This means that different sources are used to obtain information, and in the course of their work different methods are used (Valentine, 2005). A combination of participant observations, focus group discussions and in-depth interviews are used. The different methods provide different insights into the topic and combining them should give a more complete story of the topic. Triangulation makes it possible to validate research findings within data which is obtained from another source and with another method. To further validate the research findings feedback meetings are held. In the feedback meetings preliminary results are presented to and discussed with the attendants.

3.1.2 Community participation approach

The research tried to enclose a community and participatory approach in which the community is not seen as the study setting, but where an active involvement of the community members and/or organisations is central. The idea of community-based research is to document the world from the point of view of the people studied (the emic point of view). The benefit of including the ideas and perceptions of community members who are affected by the problem which is studied is very well described by Tsey *et al* (2004, p.70): *'People are the experts in their own lives, who should necessarily be actively involved in decision-making planning, and then both implementing and reviewing change'*. There are many examples of studies and projects that fail because they did not consider the values and traditions of the communities itself. Not including the local values and customs makes community members hesitating or refusing towards co-operating in the research or

project (Kindon, Pain & Kesby, 2007). Communities should: *'play an active role throughout the research process to ensure that studies are culturally relevant and ensuring intervention sustainability'* (Kobetz *et al*, 2009).

Closely interlinked with a community approach is the participatory approach. Ideally, participatory approaches are about working with people rather than on people (McIntyre, 2008). Participatory research is different from conventional research which is characterized by a complete externally developed research design and which proceeds with the extraction of data from the field. The control of the research lies then mainly in the hands of the expert researcher, which tends to distance respondents from the process of knowledge production. As in other qualitative and ethnographic approaches, the knowledge and perceptions of the participant are recognised as valuable in the participatory approach Kindon & Latham (2002). However, besides this acknowledgement, the participatory approach goes one step further. This approach also recognises that the participants have the ability to take an active role in controlling or directing the research itself. In working together people can identify problems and generate and analyse data about their own lives. Pratt (2000) adds that it enhances the ability of participants to bring positive change in their own lives.

Summarised by Chambers (1997), the participatory approach generates two positive outcomes: '*The validity of a participatory research project is gauged on the quality of the data generated and by the extent to which the process itself develops the skills, knowledge and capacities of participants to use the results themselves to tackle problems that they have identified*'. On the one hand it provides the researcher with first-hand data directly from the community members, and on the other hand it promotes the knowledge and awareness of participants themselves to possible improve their own lives.

Khassay and Oakley (1999), who work with the World Health Organization on health development, give four arguments in favour of community participation in research and programs. They argue firstly that it is a basic right of communities to be involved, it builds self esteem and it encourages a sense of shared responsibility. Secondly, it mobilises community recourses (money, material, and human recourses). Thirdly, it increases the possibility that health research or programs in a developing context are appropriate and sustainable for its context. Finally, they mentioned that the participation of community members 'breaks the bonds' of dependence and promotes confidence of people in their own development.

In this study only the main idea of community participation approach is applied. The community members (in this study male community members) are included and are given the freedom to express their own perceptions and interpretations. Men themselves were asked to identify and analyse possible problems related to maternal health and male involvement, and if certain issues were identified as problematic they were asked for possible solutions.

The level of participation of the community within the research is however limited. The development of the research design, the guide for the focus group discussions and, and the guide for

the in-depth interviews took place without the participation of community members. Only after the first round of analysis community members and local leaders could influence the research findings during several feedback meetings (see paragraph 3.5.4). Preliminary results were presented in several feedback meetings and the attendants were asked to reflect themselves on the results. These meetings are aimed at contributing to the understanding and the ability of men themselves to analyse issues concerning maternal health and male involvement in maternal health. As the literature regarding the participatory approach describes, promoting the knowledge and awareness of men might help them to improve their own lives if perceived as necessary.

A participatory approach in the different phases of the research process is not applied in this study, mainly because of time and budget concerns. A complete participatory research mostly needs to be conducted over several years and includes the necessity of many human recourses (Zeelen & Linden, 2009).

3.1.3 Participant observation

For this study two participant observation periods in two different villages within the study area were planned. In total between eight and twelve days were supposed to be spent during the two observation periods in a rural village in Mangochi district.

Participant observation is a method which is about living and/or working within particular communities in order to understand how they work from the inside. The method helps to understand the ideas and ways of life of ordinary people from the inside perspective, in the contexts of their everyday experiences (Cook, 2005). The researcher in a participant observation participates in the community, by placing him- or herself into the everyday routines of community members.

Purpose in a participant observation is firstly to develop a relationship with the community members, who can show and tell the researcher what is occurring in the community (Mack *et al*, 2005). In addition, the main goal of the participant observation method is *participating* in the lives of the study participants within their own daily surrounding and *observing* patterns in behaviour and local practises in the daily context of the study participants. In order to do the observin0 the researcher needs to make sure to step out of the participating so now and then and watch the activities of the study participants from a distance (Cook, 2005). The researcher moves constantly between the two extremes of being a ‘complete participator’ and a ‘complete outside observer’ (Spradley, 1980). It is a combination between experiencing the life and context of the study participants and noting down the patterns in behaviour and opinions given of the study participants.

In the health field this method is facing a growing popularity. Firstly, because there is growing recognition that a difference exists between the perceptions and attitudes towards health of patients and of health care professionals. Secondly, because many cultural, political, historical and socio-economical factors are hard to measure in biomedical terms, but those factors do have an impact on health (Koning & Martin, 1996).

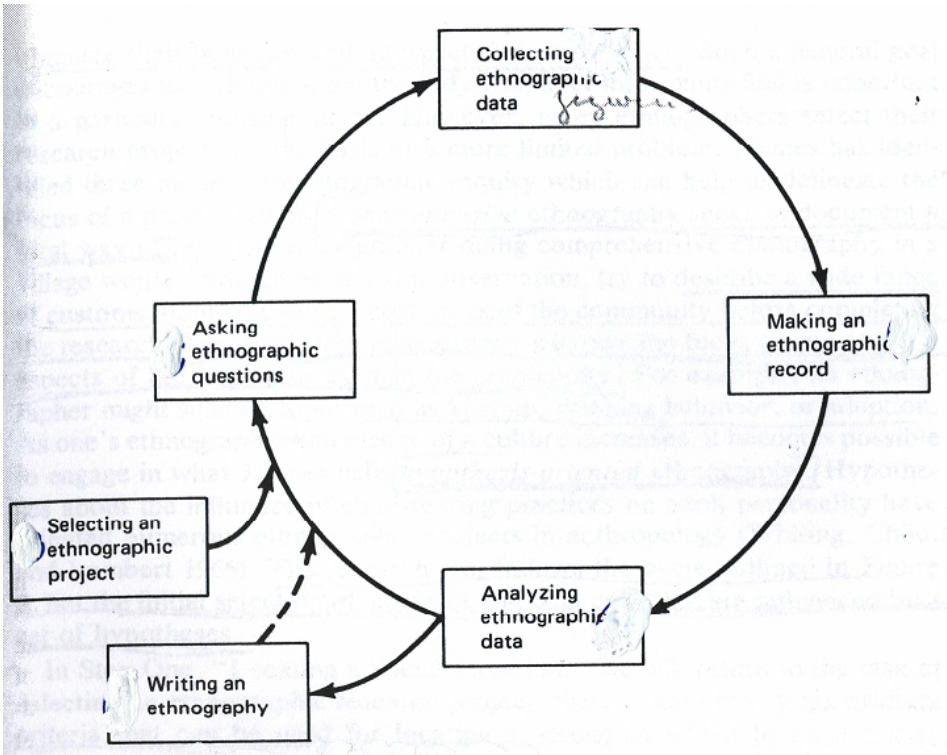
There are three main reasons for why a participant observation is beneficial to this study. First of all to experience the way of life in a rural village in Mangochi. By living within the community for several days more information was expected to be obtained about gender issues, about the interactions between community members and about the role of the community in the lives of its people. This explorative emic point of view is necessary if a researcher wants to conduct the research within an unknown culture and context. In the conducted study an understanding of the local culture, of the local context and of local beliefs is essential: This will help to make more informed and more culturally precise interpretations of reactions provided in the in-depth interviews and the focus group discussions (discussed in the next paragraphs).

Secondly, the new insights from the participant observation periods are supposed to give direction to the focus group discussions (FGD) and in-depth interviews (IDI), which are conducted after the first two participant observation periods. Certain important cultural practices or ideas discovered in the participant observation might be unknown to the researcher before the study started, however these new insight can be very important for the further research process. A good example can be found in the research of Mathole *et al* (2004) conducted in Zimbabwe. They found in their research for not going to an antenatal care clinic was the fear of becoming bewitched. The local belief is that when the pregnancy is in the beginning weeks the women is most vulnerable to witches and therefore should not be made public. This was an unknown belief to the researchers beforehand but important for understanding the context of the study topic. For this study similar new insight might emerge from the participant observation periods and the in-depth interview and focus group discussion guides can be updated with information about local beliefs after the participant observation.

Thirdly, the participant observation in this study will help building mutual trust between the research team and the community members. Both researcher and community members are given the chance to get used to each other when days pass by. When returning to the village for the FGDs and IDIs, the community members (including the village head) are familiar with the members of the research team. More trust will increase the likelihood community members being willing to participate in the focus groups and interviews, and community members feeling more comfortable during the FGD and IDI.

Conducting multiple observations must be seen as a iterative process instead as a collection of separate observations which are put together on one big pile after all the observations are conducted. Spradley (1980) describes this iterative process as the ethnographic research cycle in which the process moves from ‘asking ethnographic questions’, to ‘collecting ethnographic data’, to ‘making an ethnographic record’, to ‘analysing ethnographic data’, and then back again to asking new ethnographic questions based on the analysis (See figure 3.1). Thus, conducting participant observations moves from doing observation to analysis and back to observations again.

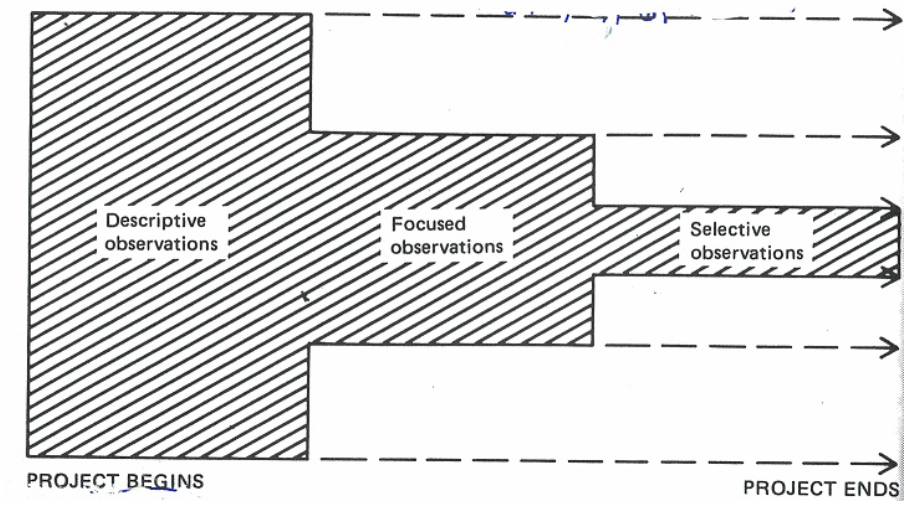
Figure 3.1: The Ethnographic Research Cycle



Source: Participant Observation (Spradley, 1980)

Within this process the focus during the participant observation narrows down towards issues which are found after the first round of analysis. Spradley (1980) prescribes that a researcher should start with making descriptive observations (in which the researcher does not have any question in mind besides "What is going on here?"). Afterwards an intensive analysis of the descriptive observations should be undertaken before continuing with focused observations. Later in the process the observer even has to narrow down more and continue with selected observations (see figure 3.2).

Figure 3.2: Changes in the scope of observations



Source: Participant Observation (Spradley, 1980)

According to Liamputtong and Ezzy (2005), a complete participant observation study (as described by Spradley, 1980) cannot be done in a short period of time, this is supposed be done over a period of multiple months or even years. For this study this is impossible, both because of time and budget constraints. Furthermore, this study will not only be an explicit participant observation study; it is aimed at getting the 'taste' of how the life of community members is in a rural village in Mangochi district. In other words; to explore the situation in the villages and to get an insight in the social norms, local language and local beliefs. This mainly corresponds with the first round of observations named by Spradley (1980) as descriptive observations.

3.1.4 Focus group discussion

The first insights in the perceptions of men from rural Mangochi, obtained from the participant observations, are necessary to further update the guide of the focus groups discussions and in-depth interviews. After the update of the guides focus group discussions are conducted.

According to Khan and Manderson (1992, p; 57) a focus group discussion (FGD) has: *'the primary aim to describe and understand perceptions, interpretations, and beliefs of a select population, to gain understanding of a particular issue from the perspective of the group's participants'.* This definition makes clear why a focus group is applicable for this research: describing and understanding the perceptions of men from rural Mangochi. Their views on maternal health and maternal mortality, and their insights on how the community copes with maternal health issues will be part of this discussion.

The role of the group plays an important role in FGDs and a focus group is not only looking for individual ideas of the participants. Cook and Crang (1995, p 56) state: *'A focus group discussion is not just a way of collecting individual statements, but rather a means to set up a negotiation of meanings through intra- and inter-personal debates'*. The interaction between the men will be important. The group members in a FGD will help each other in exploring and explaining their opinions or beliefs (Liamputtong & Ezzy, 2005). If the focus groups are going smoothly then the participants will react on each other and they will criticise or agree with the statements of other group members. The remarks of one participant can lead to new thoughts for another participant, which then again leads to new inputs in the discussion.

The FGDs are organised in such a way that a range of views and ideas of the participants about improving maternal health can be obtained. A FGD has an open character which allows participants to raise new issues themselves related to the research topic, issues the researcher may not have anticipated. Because male involvement is still a rather unexplored phenomenon (see chapter two) the focus groups are aimed at exploring new ideas and insights about male involvement. The discussion guide therefore has to be open as well. The focus group discussion guide is shown in Annex 1b. The guide is translated for the fieldwork in the local languages Chichewa and Yao (Annex 2b and

3b). The questions in the guide are only an indication on what the issues should be in the discussion. The moderator raises the stated issue, and the participants will discuss this issue *together* in the way they want to.

In addition, the FGDs might lead to new insights related to maternal health and male involvement in maternal health for the participants themselves, which is in line with the participatory approach discussed in paragraph 3.1.2.

3.1.5 In-depth interview

The third method used in this study is in-depth interviews. In-depth interviews (IDI) are a very good method to obtain subjective meanings and interpretations that people give to their own experiences (Liamputtong & Ezzy, 2005). An IDI must be seen more as a conversation than an interrogation. The method is people-oriented, meaning that the method allows the participants to construct their own accounts of their experiences by describing their *own* lives in their *own* words (Valentine, 2005).

In this study a semi-structured interview guide is developed in which the interviewer will only give some direction to the interview (see Annex ?? for the IDI guide). However it also allows to have a more open and wide-ranging discussion, more than as e.g. a questionnaire. Interviews are not representative for a whole population, but the aim is to understand the individual experiences and ideas (Liamputtong & Ezzy, 2005). Moreover, the respondent should not be seen as just a source to obtain information from, but an interview focuses on interacting and sharing information with the participants. This is argument is nicely summarised by O'Connol Davidson and Layder (1994, 121): *'The interviewee is not a research subject to be controlled and systematically investigated by a scientist, but a reasoning conscious human being to be engaged with'.*

The interview guide is adjusted with information and preliminary findings obtained during the participant observations and FGDs. The expectation is that some ideas or thoughts from the men in the FGDs or the participant observations are not anticipated, although they might be important and useful for the research and needs further exploration.

The questions stated in the in-depth interview guide are not supposed to be used as a questionnaire. The conversation in an interview is essential and new emerging questions or topics in the conversation should be discussed (if considered as relevant). Only if the conversation is going off-topic for a longer period the interviewer should react and change it back towards the topic.

3.1.6 Second participant observation round

After the first two participant observations, the focus group discussion, and the in-depth interviews, a third participant observation is conducted. The first preliminary results will help to shape the direction in the third participant observation. Information mentioned and explained by the participants in the earlier conducted methods concerning gender This approach is in the line of

thinking with the iterative process of the ethnographic cycle (Spradley, 1980), described in paragraph 3.1.3.

The purpose of the third participant observation is equal to the first two observation periods, only it is expected that the newly obtained insights will influence the focus of the observation. Where the first observations are aimed to be very general observations, the third participant observation will be more aimed at an increased focus on observing issues that were found and described in the earlier stages of the data collection phase.

3.1.7 Feedback meetings

After a preliminary analysis is made of the data collected during the participants observations, focus group discussion, and in-depth interviews, in feedback meetings preliminary results are presented to and discussed with the attendants. The aim of the feedback meetings is two-sided. Firstly, insiders (community members and other stakeholders) reflect on the interpretations made by the outsider (external) researcher about the data. The insiders will highlight misinterpretations which might have been made by the outsider. Especially regarding cultural customs and beliefs the insider might clarify and elaborate more about the context. In this way, the feedback meetings are conducted in order to validate the research findings with the study participants themselves.

Secondly, the feedback meetings are conducted in order to bring the research findings back to the community. As discussed in paragraph 3.1.2, participatory approaches are about working with people rather than on people (McIntyre, 2008). To prevent that the research only extracts data from the community members and then is taken 'home' to write a dissertation about it, the results need to be accessible to the community members themselves as well. Furthermore, the information might support the community members to reflect on their own lives and to use the information to improve maternal health in their villages. Also one feedback meeting is presented to the local policy-makers and other stakeholders in the area (e.g. from the media or NGOs).

3.2 Study place

This study is conducted in Traditional Authority (TA) Mponda and TA Chimwala in Mangochi district, Malawi. More specifically, the research is conducted in the villages Ngatala, Machenje, Stambuli, Masamba Uma and Katema. Moreover, the villages visited for the participant observation will remain confidential in order to protect the privacy of the village members who participated in the research. Nevertheless, also the villages visited during the participant observation are located in TA Mponda and TA Chimwala.

This research is conducted in collaboration with, and is part of, the Community-Based Safe Motherhood project (CBSM). The CBSM works in the study area in close collaboration with the traditional authorities, local leaders, health workers, and community members themselves. Because

this research depends on the openness, trust and participation of the community members, the research was conducted within the area where the CBSM has connections.

3.2.1 Mangochi district

Mangochi district is situated in the Southern Region of Malawi and lies on the southern and eastern tip of Lake Malawi. It is placed 320 kilometres from the capital Lilongwe and 200 kilometres from Blantyre, the major commercial and industrial city of the country, which together are the two major cities in Malawi. The district's centre is Mangochi Boma (Town) also literally situated in the centre of Mangochi district. The district government exists of both elected Members of the National Assembly (MPs) and Traditional Authorities (TAs). The district consists of nine Traditional Authorities; where TA Mponda and TA Chimwala are located in the western part of Mangochi district.

Mangochi district mainly consists of a rural population where 94 percent of the population lives in a rural village. Only the towns Mangochi Boma and Monkey-Bay are considered as urban area. The land in rural Mangochi district is for 60 percent customary land. Customary land is controlled and distributed by the traditional leaders. The main use of the customary land is self-subsistence farming and housing. The main food crops grown in the rural areas of the district are maize, cassava and ground nuts, but lately also rice is cultivated more (Mangochi District Assembly, 2009). Besides self subsistence farming a considerable amount of people live from fishery at Lake Malawi, Lake Malombe and Upper Shire River, either in small subsistence fishery or in larger scale commercial fishery.

3.2.2 Traditional Authorities

Government bodies and traditional authorities are working side-by-side at district level. At governmental district level the District Assembly (DA) and the District Executive Committee (DEC) are responsible for the policies and its implementation of all aspects of district development plans. Planning and decision-making is supposed to be participatory and the local population is supposed to be involved in the development process, from needs assessment to project implementation, monitoring and evaluation.

The DA and DEC collaborate with the traditional authorities in the district in order for the planning and policy-making of the government to be participatory. Within the district the Area Development Committees (ADC) and Village Development Committees (VDC) are responsible for ensuring that planning and decision-making reaches the community members and visa versa that community-based issues reaches the DA and DEC.

The VDC is a representative body of a village or group of villages charged with the responsibilities of facilitating planning and development at the grass-roots level (Sibande & Hutter, 2011). A VDC consists of 16 members and is led by an elected member or a Group Village Head (GVH). Furthermore the group exists of other village chiefs, ward representatives, school

representatives, four nominated women and an elected worker representative. In TA Mponda and TA Chimwala respectively 19 and 17 VDCs represent in total 410 villages.

Furthermore does Mangochi district counts 15 ADCs, of which two in TA Mponda and three in TA Chimwala. The ADC is the representative body of all VDCs under the ADC's jurisdiction. It consists of about 30 to 40 members, such as the VDC chairpersons, representatives of wards, representatives of faith-based institutions, youth and women's groups leaders, business representatives and traditional healers. The ADC supervises, supports, monitors and evaluates the implementation of all projects at the Area Level and reports to the DA about the activities (Sibande & Hutter, 2011; Mangochi District Assembly, 2009).

Working in collaboration with the village leaders and traditional authorities will help this research to be accepted within the community. Additionally, they are an important part of the cultural context in rural villages in Malawi and therefore need to be included in the study in order to understand the processes at community level. According to the UNFPA (UNFPA, 2011) including traditional leaders will support programs and research to be culturally sensitive. Furthermore does the CBSM project explain that working within these structures enhances the feedback towards the community and facilitates ownership of the initiative. VDCs and ADCs were both involved in identifying the need for the project and the needs of the community in maternal health.

3.2.3 Matrilineal society

Finally, chieftainship within the traditional authorities mostly follows the matrilineal system. The successor of the chieftainship comes from the mother's side (Mangochi District Assembly, 2009). This tradition is part of the matrilineal society which is found in most of the areas in Malawi. In matrilineal communities the men gets married into the woman's family and normally will live in the village of the woman. In a matrilineal society lineage is traced through the mother and the maternal ancestors. 'Mother-right' ensures that women have the right to be united with their own family and that women have the right to inherit land from their mothers (Phiri, 1996). Note that, within the matrilineal system both men and women can take a leadership role, only the lineage is traced through the maternal side. A matrilineal society does not imply that women are in charge within the community or within families. The brothers and maternal uncles of the wife are regarded as the heads of the family (Mwambene, 2005). In matrilineal societies the children normally belong to the mother and her family, because no bride price is paid at marriage by the family of the husband which in patriarchal societies normally entitles the rights of the husband and his family. Children are in matrilineal societies furthermore more related to the mother's brother than to the father's brother (Mtika & Doctor, 2002).

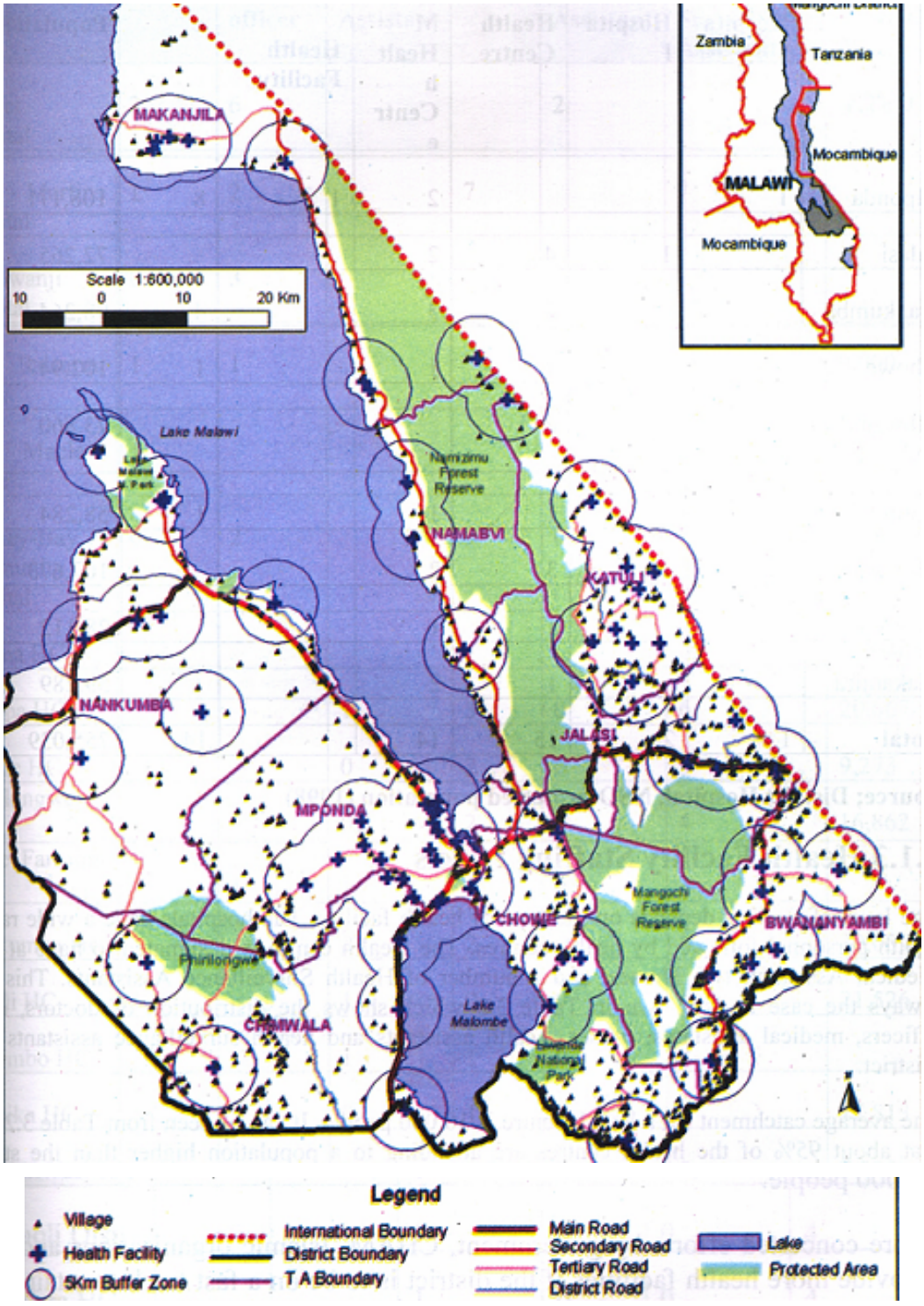
3.2.4 Health structures within the district

Besides the traditional authority and the DA the health structures in the district are an important feature for understanding the context in which this research is conducted. The District Health Office (DHO) is part of the decentralized Ministry of Health and is responsible for the health care services in the district and overviews the all the hospitals and health centres in the district. The DHO is also in charge of referral functions for the primary level health care, mainly between the hospitals. Referring patients within the district towards the rural health centres is problematic because of lacking infrastructure and a lack of ambulances.

Mangochi district has one government district hospital in the city Mangochi itself. Additionally, the district has three smaller hospital and 29 health centres. The health centres provide limited basic services such as under-five clinics, ante-natal care, delivery and post-natal care, family planning, cholera and tuberculosis prevention, and malaria treatment. The health centres are critical "in meeting the needs of Malawians who live in the rural areas" (Sibande & Hutter, 2011 p.?).

In Traditional Authority (TA) Mponda and Chimwala where this study is conducted there are seven health centres covering a population of 218,660 (National Statistics Office Malawi, 2008; Mangochi District Assembly, 2009). More than half of the rural villages in TA Mponda and TA Chimwala are at a distance of at least five kilometres from a health centre (see figure 3.3: the blue cirkerls indicating the 5km buffer zone around a health centre, the black dots indicating the rural villages). The community members in more than three quarters of the villages in TA Chimwala have to travel more than two hours to the closest health centre, where for TA Mponda one third of the villages need to travel more than two hours (Mangochi District Assembly, 2009).

Figure 3.3: Villages and distance to the health centre, Mangochi District



Source: Mangochi District Socio-Economic Profile 2009 (Mangochi District Assembly, 2009).

In the seven health centres in TA Mponda and TA Chimwala there are no doctors or clinical officers present (officially clinical officers are not equal to doctors, but they perform most of the tasks doctors do, such as: diagnosing, prescribing drugs, performing smaller operations). Occasionally a health a centre has one medical assistant, however most health centres are run by a handful of hard

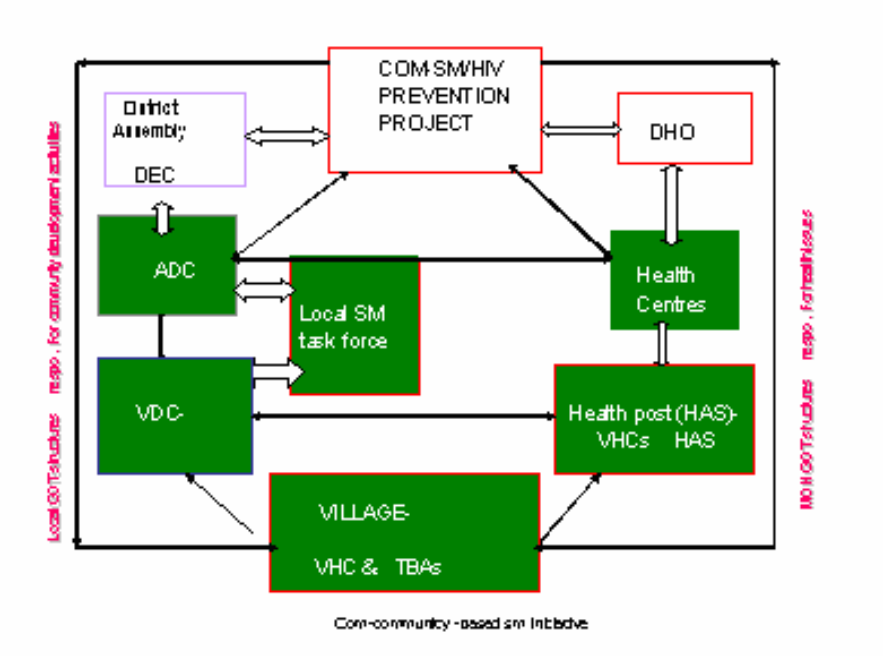
working nurses. According to data from the Mangochi District Assembly (2009), there is a huge lack of health workers in the health centres and hospitals.

The health centres supervise health services in its catchment area and work in close collaboration with Health Posts and the Village Health Committees (VHCs). The Health Posts are managed by a Health Surveillance Assistants (HSAs). They mainly offer advise, support and services related to issues such as health and hygiene (e.g. bathrooms, toilets and clean wells for safe water). The HSA furthermore reports on outbreaks of diseases such as cholera and is in charge of the under-five clinics, in which the health of children is assessed.

Finally, the VHC is a representative village body charged with responsibilities for health issues at (group) village level. The VHC, comprised of the village head, chosen women and men from the village of reproductive age, and the trained Traditional Birth Attendant, are responsible for activities at village level related to the work of the Health Posts. The VHC furthermore has to take responsibility for recording and reporting health issues and deaths, transporting patients to health facilities if necessary, collecting contributions to improve health indicators, and mobilizing villages for outreach clinics which are organised by the district hospital (Sibande & Hutter, 2011).

The CBSM project works within the framework of decentralized government institutions, traditional authorities and local health structures. This study has to work within, and has to take notice of, these stakeholders and their influence on the situation within the communities regarding maternal health. Figure 3.4 shows how the different stakeholders mentioned in the last paragraph are interlinked with each other and in which context this study is conducted:

Figure 3.4: Relevant stakeholders regarding this study



Source: Sibande & Hutter, 2011

3.3 Study period

The proposal writing and the preparation of the fieldwork was conducted from March 2009 till July 2009. The actual fieldwork in Mangochi district started in July and continued until the end of November 2009. A first preliminary analysis and organising the data was conducted shortly after the fieldwork. Finally, the analysis and the writing of the report was conducted from February 2011 till November 2011 alongside other courses of the Master studies.

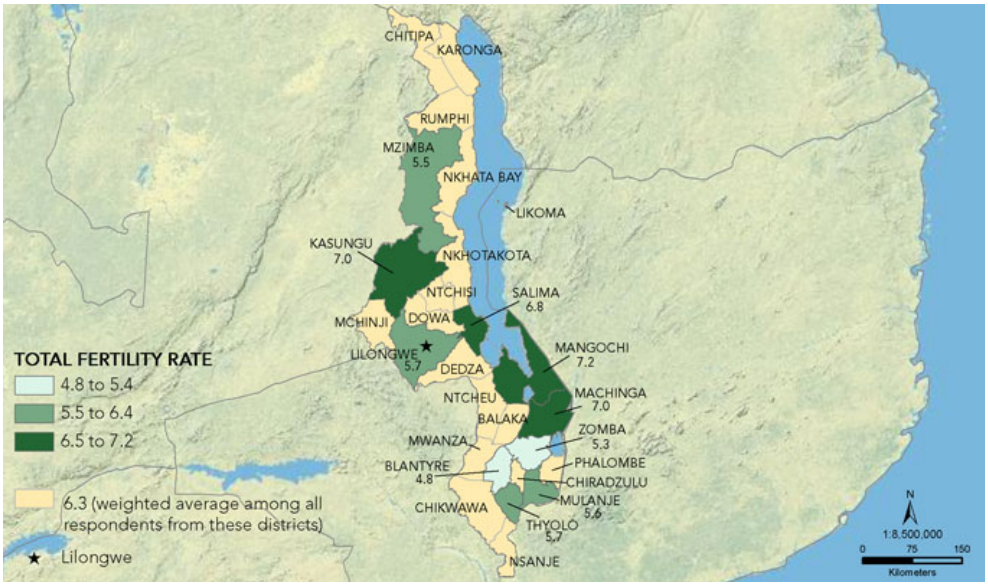
3.4 Study participants

3.4.1 Study population

The estimated population of Mangochi district in 2008 was 803,602 (National Statistics Office Malawi, 2008). For TA Mponda and TA Chimwala the population is estimated on respectively 109,399 and 109,261 (Mangochi District Assembly, 2009). The total population in Mangochi district in 1998 was 610,329, which means an annual growth rate of 3.16. The annual growth rate of Mangochi district increases although the annual growth rate nationally steadily reduces. The crude birth rate in Mangochi remained higher in comparison to national rates in the last ten years. On the other hand, the crude death rate nationally stabilised around 19.5, where the crude death rate in Mangochi district declined from 24.7 in 1998 to 17.0 in 2008 (National Statistics Office Malawi & ORC Macro, 2011).

The population in Malawi is a very young population, with over 60 percent of the population being under 20 years old. In Mangochi district, where the total fertility rate (TFR) is 7.2 compared to the national TFR of 6 (see figure 3.5), 59 percent of the population is estimated to be under 20 years old (National Statistics Office Malawi, 2008).

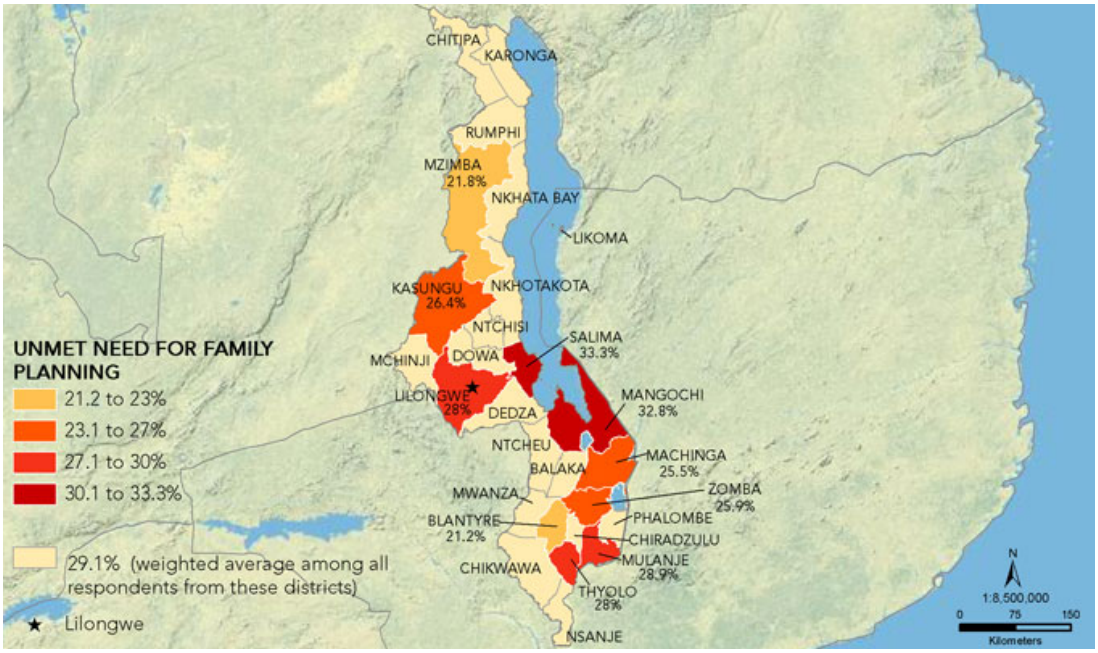
Figure 3.5: TFR in Malawi per district, 2008-2009



Source: Population Action International, 2011

Besides the high population growth, Mangochi district also shows a lack of family planning and contraceptive use. Data from the Population and Housing census (National Statistics Office Malawi, 2008) shows that Mangochi as district faces the largest unmet need of family planning and the lowest contraceptive prevalence rate (respectively figure 3.6 ad 3.7)

Figure 3.6: Unmet need for family planning in Malawi per district, 2008-2009



Source: Population Action International, 2011

Figure 3.7: Contraceptive prevalance rate Malawi, per district, 2008-2009

Source: Population Action International, 2011

The predominant ethnic group in Mangochi district is the Yao. Also in TA Mponda and TA Chimwala they are the majority. Also the main language spoken in the district is Yao, with more than 50 percent of the population understanding and speaking Yao. The official language is English, however a majority can not speak or understand English easily (Mangochi District Assembly, 2009). Furthermore people from the Chewa, Nyanja, Ngoni, Tonga, Lomwe and Tumbuka tribe are settled in the district and in the study area.

70 percent of the population in Mangochi district is Muslim, and about 28 percent of the population is Christian. In the western part of Mangochi district, where TA Mponda and TA Chimwala are located, the percentage of Christians is relatively higher and Muslims and Christians represent about 50 percent of the population each in this area (Mangochi District Assembly, 2009).

Finally, the general educational level of the population in Mangochi district is very low, only 41 percent of men and 14 percent of women are literate (Cook *et al*, 1999).

3.4.2 Recruitment of participants

The data was collected in five different villages which were randomly selected from a list of in total 29 villages with whom the Community-Based Safe Motherhood (CBSM) project has in one way or another contact with.

Participants for both the focus group discussions (FGD) and in-depth interviews (IDI) were selected in three ways:

- Firstly, gatekeepers within the communities were involved in selecting men for participating in the research. In two village was an ADC member, who lived in the particular village, asking men if they were willing to participate in both the FGDs and IDIs. In a third village the husband of a Traditional Birth Attendant was asked to search for men to participate in both FGDs and IDIs.
- Secondly, during the participant observation arrangements were made with the (group) village head for doing FGDs or IDIs after the participant observation. The (group) village head would assemble men from the village and arrange them to be present at the arranged date for the FGDs and IDIs. The (group) village head were asked to not select only family members or community members who were working together with the village chief. Furthermore the (group) village heads were asked to search for men from a different age group and if possible with a different expertise in getting children. Finally, they were asked to keep the participation voluntary, meaning that they would not demand a community member to participate against his will.
- Thirdly, during the participant observations men in the village were randomly asked if they were willing to participate. When the dates for the FGDs or IDIs was arranged with the (group) village head those men would be informed and asked if it was possible for them to participate or if they would know somebody who was suitable for participating (Biernacki & Waldorf, 1981).

During one arranged day of FGDs the arrangements were not totally clear and not enough men were present to conduct two different FGDs with men divided into two different age groups. Two young men of the host family in this village then searched in the village for men who were at home, who were of the right age, and who were willing to participate in the study. After half an hour there were enough participants for two full focus groups.

Members of the host family and the guides were excluded from the FGDs and IDIs in order to protect over representation, in order to prevent that pre-obtained knowledge would obstruct the openness of the FGD or IDI, and in order to prevent familiarities with only one of the participants in a FGD which might disturb the group interaction. Furthermore were village chiefs, ADC members, health workers, and youth development club leaders not allowed to participate in the FGDs. The presence of men who are perceived to know more about the topic would hinder other men to express their own ideas. 'Knowledge is status' sometimes within FGDs and as discussed in paragraph 3.1.4 some people do not oppose the views of 'wiser' community members.

For the participant observations contacts of the CBSM project within the community searched for a host family. The request for which characteristics of the host family were searched for was provided several days before the actual participant observation. Upon arrival in the village the family was prepared and waiting for their guest. In the third participant observation the recruitment of the host family did not work out as planned. The request was to stay with a family who are expecting a baby or who would just had a successful child birth. The gatekeepers who helped out to arrange this participant observation decided together with the health personnel that a small hut in a small rural village was not a place to receive a guest. They arranged the priest's guestroom, attached to the health centre, which was more luxurious and better suitable for guests. Also after a discussion they believed it was better that the guest would stay at the priest's place. Additionally, it was too late for arranging a new host family. It has to be concluded though, which also will be discussed in the reflection in paragraph 3.10.1, that the third observation around the health centre and its maternity ward has been very beneficial to this study as well.

3.4.3 Participants in the focus group discussions and in-depth interviews

The participants in this study comprised of men from four rural villages in TA Mponda and TA Chimwala: Machenje, Ngatala, Stambuli and Masamba Uma. The men in the five focus group discussion (FGD) were aged between 17 and 60 years old. Table 3.1 shows the name of the village (with the number of participants in brackets) and the age of the participants.

Most of the focus group discussions were conducted in Chichewa, only one was conducted in Yao. The participants were asked for their preference because the moderator could speak both Chichewa and Yao fluently. The choice for Chichewa does not imply that the majority of the discussion group was from Chewa descent or Chichewa speaking. The reasoning can be found in the fact that Chichewa is considered as the inofficial national language in Malawi (English being the

official national language) which Malawians from almost every ethnicity are able to understand and speak fluently. Yao, being the predominant language in the study area is spoken and understood by many; however Malawians from non-Yao ethnicity do not always understand and speak Yao fluently.

Additionally, the table indicates how the participants in the focus group discussions were separated by age and by experience with pregnancy and delivery. The purpose of separating men by age and by the level of experience with having children is to ensure that every participant is unrestricted by power relations within the group and feels free to express himself.

Table 3.1: Participants in the FGD

Source	Village	Age (group)	Experience with getting children
FGD1	Machenje (8)	Above 30	minimal 3 children
FGD2	Machenje (6)	Under 20	without child or expecting first child
FGD3	Ngatala (8)	25 - 40	multiple children
FGD4	Ngatala (9)	17 - 22	one child
FGD5	Stambuli (8)	20 - 25	one or two children

Although the participants were not screened and selected based on their socio-economic characteristics, attention was paid to 'status within the community' in order to prevent that the background would influence power relationships within the group. Attention was paid to socio-economic characteristics such as religion, ethnicity, welfare and position in the village. Again, this is done to ensure the openness of all the participants.

The participants in the focus group discussions were officially not questioned about their socio-economical characteristics; therefore it is difficult to make conclusions on this. Nevertheless, during the selection the gatekeepers who were partly in charge of the participant recruitment were asked to select participants with different background characteristics. Also in the recruitment of participants during the conducted participant observations themselves, attention was paid to religion and status in the community. On the other hand for the participants of the focus group discussions the education and welfare level were not assessed.

The purpose of selecting participants from different villages, different ages, different backgrounds, and with different expertise regarding getting children, is not to generalise the results towards a specific sub group. The research findings do not make it possible to make assumptions about for example men from a specific ethnicity group or about men of a certain age. The purpose is only to get a wide range of ideas and views about the topic from different men with different experiences (Liamputtong & Ezzy, 2005). E.g. Men from one village might have experienced a maternal death to be associated with one cause, where in another village the perceived cause of a maternal death might be completely different. Or men who are relatively wealthy might have a different perception of existing obstacles towards male involvement then men who are relatively poor. In this study the experiences and ideas of all men are important in order to discover the overall story of maternal health and male involvement in maternal health.

Besides the five FGDs twelve in-depth interviews (IDI) were conducted: Six in Machenje, three in Stambuli and three in Masamba Uma. The age of the interviewees varied from 25 to 72 years old, of which exactly half was under 40 years old. In some instances the participant did not exactly know his age and then the participants were asked to estimate.

For the IDIs the participants were asked to state their religion and the number of years of education they received. Furthermore the interviewees were asked which language they preferred for the interview: Chichewa or Yao. Exactly half of the IDIs were conducted in Chichewa and half in Yao. The years of education of the participants in the in-depth interviews varied from 0 to 12+ years and seven out of twelve participants indicated to be Muslim, in comparison to four being Protestant and one Catholic. The background characteristics of the interviewees are shown in table 3.2. Equally to FGDs, the variety in background characteristics of the interviewees does not allow generalisations to be made towards these demographic and socio-economic characteristics. It is only important to show the differences within the participants which enables the study to obtain a wide variety of perspectives.

Table 3.2 Participants in the IDI

Source	Village	Age	Religion	Years education	Language pref.
IDI 1	Machenje	60+	Islam	0	Yao
IDI 2	Machenje	59	Islam	7	Yao
IDI 3	Machenje	60	Islam	3	Yao
IDI 4	Machenje	35	Catholicism	2	Chichewa
IDI 5	Machenje	30	Protestantism	7	Chichewa
IDI 6	Machenje	40	Protestantism	0	Chichewa
IDI 7	Stambuli	72	Islam	6	Chichewa
IDI 8	Stambuli	29	Islam	6	Yao
IDI 9	Stambuli	25	Islam	2	Yao
IDI 10	Masamba Uma	29	Protestantism	7	Chichewa
IDI 11	Masamba Uma	25	Islam	7	Yao
IDI 12	Masamba Uma	41	Protestantism	12+	Chichewa

3.4.4 Participants in the participant observations

For the participant observation periods there is no specific study population. The main purpose was to obtain different observations in a different context. Therefore three different host families in three different villages with three different household characteristics were chosen. The first participant observation was conducted within a family that was composed of the parents and young children aged below 12 years old. The host family in the second participant observation lived without the parents. The mother lived in South Africa for employment and the father lived together with his second wife in a neighbouring village. The children of this family, aged between 28 and 15, lived all together. Two of them got a child themselves as well who lived with the family.

The third observation period took place at a local health centre. In this observation period there was no host family, but it was at the priest's place which was attached to the health centre.

During this observation period the health personnel and community health workers can be considered as the family, and much of the time was spent observing the activities in and around the maternity ward. Although the observation period was not conducted as planned with the right 'study participants', the stay at the health centre and the dialogues with the health personnel definitely enriched this study. The perceptions of the health personnel can oppose, add, or clarify the perceptions of community members, which will allow this research to get a better overview of the whole story.

Alongside the host families several community members were acting as guide during the days in the village. The guides were, among others, a GVH, a community safe motherhood advisor, a youth club leader, a member of the VHC, an HSA, and a local shop owner.

3.5 Data collection

3.5.1 Participant observation

A participant observation does not proceed to a pre-planned schedule (Spradley, 1980). It is not semi-structured like in-depth interviews and focus group discussions which will be discussed later. The researcher has to go into the participant observation with a broad view and an open mind but still needs to keep the purpose of the study and the observation in mind. Normally in a participant observation you don't make a guide like for an interview or a discussion group (Hutter *et al,* 2005).

During the participant observations field notes were taken continuously during the day. Single phrases, words and unconnected sentences were noted at the spot. This enhances the field notes to be as vivid and detailed as possible, because the mind tends to forget these details. These 'condensed accounts' (Spradley, 1980) were as quickly as possible written down as an 'expanded account', in which sentences are finished and details are included or further elaborated. More than half of the expanded accounts were written during the participant observation already, often with the light of a single candle. The other parts were filled in during the first days after the participant observation.

The aim was to literally write quotes of community members word-for-word in the field, which was not always easy during a conversation, especially when more people were involved in the conversation. In such situations, the field notes tried to describe what the different participants said as detailed as possible. The risk of describing what people said instead of quoting what they said is the loss of subtle nuances which might be present in the reaction of the participant. Furthermore Spradley (1980) describes the risk of the 'Concrete principle' when describing a conversation instead of quoting it. The risk is here that the researcher unconsciously interprets the reaction from his point of views, therefore losing subjectivity.

During the participant observations half of the time was spent with the members of the host family. The other half was spent with a few other community members, who were asked to take the responsibility of being a guide. The guides were more able to express themselves in English than most other community members and served as translators in dialogues with other community members. They showed the small village centres, the market areas, the land where community members were

growing their crops, the surrounding area of the villages, and they were in contact with the (group) village head. Furthermore, in company of the guides places were visited which were believed to be of interest for the research, such as a Traditional Birth Attendant (TBA), a maternity ward, an under-five clinic, an antenatal care clinic, a witchdoctor and a school. This was often initiated by the (group) village leader.

The observations started with broad descriptive questions in mind. The observations mainly focused on (among many other directions): the physical characteristics of the houses, villages, and surrounding, on how the family interacted with each other and with non-family members, on who are the different community members, on what the different community members are doing during the day, etc. When the observations proceeded more attention was paid to e.g. what are the differences between the daily activities of men and women, how do men and women interact with each other, how and where do people talk, where do they talk about, and how health and development have an influence on the life in the village. Finally, in dialogues or discussions questions were asked about health within the family and within the community, if applicable the focus in these dialogues or discussions was directed towards maternal health. These conversations were with the members of the host family, the guides, but also with other community members who were visited or met during the observation period.

3.5.2 Focus group discussion

Before actually starting the focus group discussions (FGD) two pre-tests were conducted in a village close to Mangochi Boma. Several examples of lessons learned from the pre-test were: not to include too many participants because this led to some participants to be underrepresented, not to include the village leader because the village leader led the discussion without a lot of participants arguing against him, and to make sure that children are asked to stay on a distance because their curiosity towards the ‘white man’ led to children trying to walk in and fighting for a place in front of the window. Furthermore, the FGD guide was slightly adjusted, mainly to ensure that the discussion would not face too much repetition.

During the focus group discussions a skilled moderator led the discussion. The moderator spoke both Chichewa and Yao, and the participants had to decide among themselves which language they preferred for the FGD. The moderator was chosen after job interviews with four applicants for this position. Because of his experience with qualitative research, his experience with the work of the CBSM project, his experience of working with larger groups of people, and his age and status (by which he gets accepted as moderator by both older and younger participants) made him the perfect candidate. The main researcher and the co-researcher were also present during the discussion groups and observed body language and the group process.

As mentioned in paragraph 3.4.3 the participants in the focus group discussions (FGD) were recruited by arranging participants during the participant observations, by key contact persons in the

villages, and occasionally by asking people to participate at the day of the FGD itself. In two villages the focus group discussions were conducted in an empty room of the local school, which made it possible to create a good focus group surrounding. Comfortable tables and chairs were arranged in a circle in a room which was private and which excluded outside noise to disturb the discussion. In the third village the focus group discussions were conducted in an empty room of the TBA's place. The room used to be a delivery room, but was not used as such anymore. The research team (moderator, co-researcher and main researcher) and the participants were sitting on the framework of a bed, a wooden bench or on the ground. It was relatively dark therefore body language was harder to observe.

During the FGDs some participants were clearly more talkative than others. In one of the FGDs the moderator turned his back in a subtle way towards one participant to ensure that he was not solely talking. Another FGD was relatively short because most participants replied shortly or not at all. Occasionally, the moderator had to ask direct questions to a participant in order to let him be part of the discussion. One participant however was completely not interested in the discussion, because he slept (eyes closed) for a longer period.

In one of the FGDs the discussion got repeatedly disturbed by female family members of one of the participants. They mentioned that the entire village was waiting for the participant because they wanted to settle the divorce between him and his wife. The participant however remained till the end of the FGD and still seemed to participate in the discussion as before being disturbed (from notes taken during the FGD)

The discussions were audio recorded with a digital audio recorder and the recording later would be transcribed word-for-word. After the FGD the research team shortly discussed the first impressions of the FGD, which was noted and used in order to improve the other FGDs.

3.5.3 In-depth interview

Equal to the FGDs also the actual in-depth interviews (IDI) have been pre-tested. The main lessons learned from the two pre-tests of the IDIs was not to conduct the interviews outside (which results in too much noise on the audio recording and too much distraction when sitting on a ants' nest) and not conducting the interview when the village chief is standing next to it (which made the reactions of the interviewee about the good efforts of the village chief clearly biased). In the pre-tests it became clear that extra clarification was needed about ensuring confidentiality. Finally, in the pre-tests it was found that participants needed to be encouraged to express their own opinions and if applicable raise their own issues on the topic. Community members are used to surveys being conducted by either researchers or government employers, through which the purpose of freely responding in the IDIs was hindered.

The interview guide (see Annex 1d) was translated in the local languages Chichewa and Yao (Annex 2d and 3d) and the interviewees could choose which language they preferred. The possibility to do the interview in the mother tongue of the participants is essential on order to ensure the

interviewee to be restricted by language barriers and therefore restrict his freedom to answer and express himself naturally. The interview guide shows first of all the leading questions of the interview, which are open-ended questions aimed at opening a topic for the interviewee to talk about. In italics the probes are given, which are helpful directions or points of extra attention for the interviewer during the conversation. The interviewer should try to get information related to these probes from the interviewee if applicable, meaning when the conversation allows the issue in the probe to be raised.

The moderator in the FGDs was also the interviewer during the IDIs for the same reasons as mentioned in the last paragraph. The main researcher and co-researcher were present during all the interviews. Two interviews in Chichewa were conducted by the co-researcher, who is a woman. No direct indications are found between the interviews conducted by a man and the interviews conducted by a woman. The openness of the participants did not seem to be hindered by the interviewer being a woman, although this comparison is not analysed in-depth.

The interviews were conducted in a classroom of the local school, in the house of one the participants (where the other interviewees from the same village waited outside for their turn), or in the house of a village chief (without the village chief being present at the interview). In one village the interviewees were not invited and asked if they were willing to participate before the research team arrived in the village. The key contact person in the village had to ask men when the research team was present. The first three men who were asked to participate agreed directly to participate. The presence of the research team, the key contact person, and the village chief might have restricted the perceived free choice of the men regarding accepting or refusing to participate. Finally, also the IDIs were audio recorded, were shortly reflected upon by the research team directly after the interview, and were transcribed word-for-word in the days after the IDIs were conducted.

The IDIs occasionally address very sensitive and personal topics. Some interviewees talked about their own experiences with a maternal death or with the death of a child. This validates the choice of conducting IDIs, in which participants are given the chance to discuss topics of a sensitive nature in ‘private’.

During one IDI problems occurred with the audio recorder. The first half of the interview was not properly recorded. The interviewee was asked if the issues in the first part of the conversation could be discussed again. Therefore, the transcript of this interview includes less open-ended questions such as: “Why do you think it is important to have children” or “Tell me about a bad experience you had during one of the pregnancies”. These types of questions were based on the remarks of the interviewee which were not properly recorded.

3.5.4 Feedback meetings

Three feedback meetings have been conducted after the first preliminary analysis was finished. One feedback meeting was attended by DEC members and two employers from the local media and took place in Mangochi Boma. The other two feedback meetings were conducted in the study area for

ADC members, VDC members, community development and health workers, and study participants. Mainly ADC and VDC members attended the feedback meetings; other community members were less represented. In the feedback meetings the first results were presented and the attendants were asked to discuss and reflect on the results.

One feedback meetings took place in a classroom, another one in the common room of a health centre and the DEC feedback meeting was conducted in a room of the civil education building. The discussions and remarks provided by the attendants will be further elaborated in the discussion chapter of this dissertation. The discussions and remarks gave valuable reflection on the research and its findings.

3.6 Data management

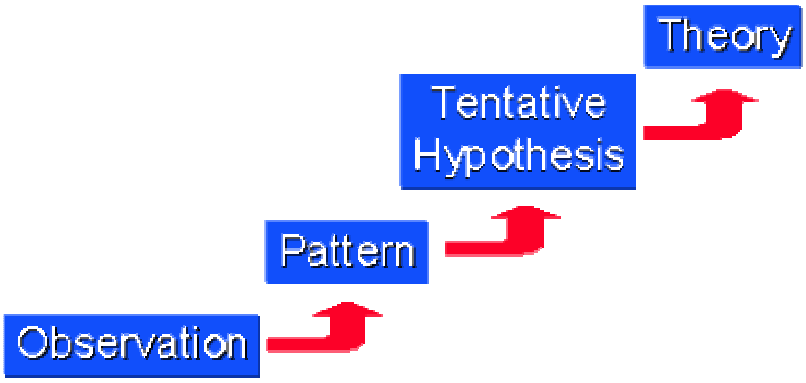
The audio recordings were transcribed and translated into English shortly after the FGDs and IDIs took place. The research assistant who moderated the FGDs and the IDIs, a second research assistant, and the main researcher were involved in the transcribing and translating. During the translating and transcribing the research team discussed and helped each other in understanding the transcript. Especially regarding words that have a double meaning or regarding local traditions, which are mentioned by the participants, the help and explanation of the research assistants were very beneficial to the research. It enabled a better understanding of cultural processes and it was a first start in the analysis process.

The written English transcripts are processed in Microsoft Word to enable simple text analysis. The qualitative data software program Atlas.Ti was used to assist in the organisation and analysis of the data. All the data, meaning all the FGDs, IDIs and field notes of the participant observation, were included in one hermeneutic unit in Atlas.Ti. Every FGD, IDI or participant observation was included as a primary doc including the notes that were taken at the spot.

3.7 Data analysis

The analysis of qualitative data can be done in a deductive or inductive way. Research with a deductive reasoning means that pre-existing theories are tested against the data. Inductive reasoning means that a theory is developed from the empirical data; whit limited reference to pre-existing theories. Most qualitative research uses a combination of both inductive and deductive analysis (Liamputtong & Ezzy, 2005); theory on forehand derived deductively and then tested/compared to an inductively derived theory. Figure 3.8 illustrates shows how inductive reasoning moves from specific observations to broader theories (or theoretical concepts) by identifying patterns in the empirical data (Trochim & Donnelly, 2007).

Figure 3.8: Induction



Source: The Research Methods Knowledge Base (Trochim & Donnelly, 2007)

For the analysis in this study the grounded theory approach is used. In grounded theory the theory is build up out of observations in the social world (Liamputtong & Ezzy, 2005). This means that the themes which will be presented in the following results chapter are identified and developed from the empirical data and derived inductively. Within this approach no real deductive pre-existing theories are used to guide the research. Although nowadays most grounded theory research makes use of pre-existing theories and is not completely inductive, it is argued that qualitative data should '*not be generated by logical argument from general laws* (which is deductive)' (Liamputting & Ezzy, 2005 p.266). The inductively derived theory is however not independently developed from other research and insights from other studies are used as background knowledge.

In grounded theory the initial step in the analysis is attaching codes to the data, secondly the codes will be grouped to form more abstract categories, and thirdly the relationships between categories are identified and linked together in order to form broader themes (Glaser & Strauss, 1968). The broader themes, or theoretical concepts, can eventually be developed into a 'formal theory' or 'inductively derived conceptual model'. Within the formal theory the links between the theoretical concepts are explained and likewise grounded in the data (Creswell, 2008). Grounded theory research does in practise not always result in a formal theory.

In the first step codes were attached to certain pieces of text in all the transcripts. A code is a label given to a specific piece of text in the transcript which represents the content and the essence of that piece of text (Saldaña, 2009). Charmaz (2006) summarises the purpose of coding as: '*generating the bones of your analyses'*.

The second step in the analysis is developing categories and sub-categories; meaning that a group of codes are brought together which collectively represent a higher-order concept (Hennink, Hutter, Bailey, 2011). After the first round of coding 47 sub-categories and 14 categories were created. After the second round of coding 32 sub-categories were created and divided into 9 categories. The link between the codes which are placed in each sub-category, and the link between the sub-categories which are placed in each category are described and explained in a descriptive record. In a descriptive

record the researcher has to defend why certain codes belong to a sub-category and why certain sub-categories are grouped together in a category. Furthermore it must be clear how a category is distinct from another category (Hennink, Hutter, Bailey, 2011). In order to validate the choices made in grouping codes and grouping sub-categories the researcher has to show that the choices made are grounded in the empirical data.

During and after the categorisation the analysis is supposed to conceptualise, which moves the analysis to a more abstract level (Hennink, Hutter, Bailey, 2011). In this phase of the study the separate categories are linked to each other in order to form so-called themes or theoretical concepts. The purpose is here to see your data as a whole. Eventually, a qualitative data analysis is attempting to tell the story about the observations, the discussions and the interviews. The overall story is explained and described in analytical records. All the relevant sentences and paragraphs mentioned in the transcripts and field notes, related to the major themes, are explained and presented together as the story about these themes. So arguments which are mentioned in the final results can be validated by referring to pieces of text from the transcripts and field notes.

This study derived four major themes out of the data, which likewise are the chapters in the following results chapter (chapter 4):

- The perceptions of men about getting children
- The perceptions of men about pregnant women
- The perceptions of men about community influences on safe motherhood
- The perceptions of men about male involvement in maternal health

It is important for a researcher to realise that, as qualitative research, coding, categorising and conceptualising is a subjective process in which the researcher labels and interprets the data (constructivist view, Charmaz, 2000). Which code belongs to which piece of text, which codes belongs to which category, and which categories belongs to which theme, is based on the researcher's judgement (Saldaña, 2009). Therefore it is important to reflect on why certain data belongs to a code, category or theme. The decisions made regarding which data to group together need to be grounded in the data in order to validate these decisions. In this way, everybody can follow and reflect the reasoning and interpretations the researcher made regarding the data.

3.8 Dissemination of the results

The research is conducted as a master thesis, which is part of the research master program 'Regional Studies: Spaces and Places, Analysis and Intervention'. A copy of the final report will be submitted to each of the following:

1. The College of Medicine Research and Ethics Committee (COMREC), Malawi
2. The College of Medicine Library, Malawi
3. The Health Sciences Research Committee (through the COMREC secretariat), Malawi
4. The University Research and Publication Committee (URPC) (though the COMREC Secretariat), Malawi
5. The Population Research Centre, University of Groningen, Netherlands
6. The Community-Based Safe Motherhood project, Mangochi, Malawi
7. Cordaid, The Hague

3.9 Ethical considerations

Because this study is conducted in close collaboration with the community members themselves is it important to reflect on the ethical issues. During the whole research process and after the results are presented, the main ethical consideration is that all the participants did not experience any harm from the research.

Firstly, the general ethical considerations for most methods applied in social research (Homan 1991) are also applicable for this research. When selecting and asking participants to involve, full information about the purpose and use of the participant's contribution are given before the discussion or interview started. Being honest, keeping participants informed about the expectations of the research, and not pressurising participants to talk is essential (Gibbs, 1997). To ensure that all the participants agreed, they were asked to sign an informed consent form after they were introduced to the topic, the use of the audio recorder and the purpose of the method. Because not everybody was able to read, the informed consent form was explained by the moderator and consent was verbally obtained. In these cases, the participants just put an X instead of their signature. The informed consent forms were in Chichewa, Yao or English available.

Because it is impossible to ask everybody in the village of the participant observation for permission, only the family members and the village head were asked for their permission. The village head needs to give permission for being present in the village and for observing within the community. It was very well explained to the village leaders what the purpose of the research and the participant observation was and that the research was conducted in collaboration with the CBSM project. There were no problems in receiving permission from the village leaders. Also the family members were more than willing to share their information.

Secondly, for the names of the participants pseudonyms were used, in order to make sure that the observations, interviews or discussion groups can not be traced back easily to the participants. The names of the villages visited during the participant observations were not pronounced in the field notes or in this report, also in order to ensure that the observations or dialogues can not be traced back easily to the participants. Total anonymity can not be promised, especially not for the focus group discussions and participant observations, where other community members in general know who participated in the research.

Thirdly, it was explained to the interviewees at the beginning of the interview that if they did not feel comfortable with answering a question, that they were free to tell this and skip the question. Furthermore, during the interview when the conversation led to sensitive experiences with for example a maternal death, it was again explained to the participants that they were not obliged to respond. The personal well-being (here mental well-being) of the participant is of course more important than the research itself.

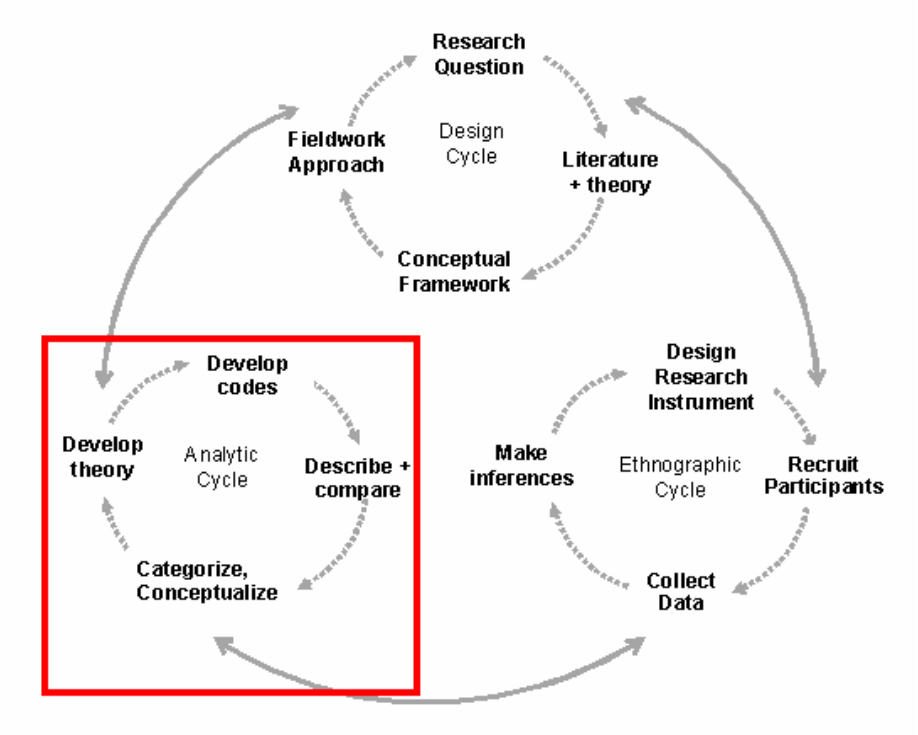
Finally, all the participants were paid a relatively small amount for their participation in the research. Some participants stopped working shortly to participate and others had to travel from outside of the village to participate, therefore they got a small contribution. During the recruitment of the participants or in the introduction of the different methods, the participants were not told about a financial contribution. This ensured that men did not only participate in order to receive money.

3.10 Reflection on research process

3.10.1 The iterative process in qualitative research

During the data collection and data analysis phases of this research several problems were faced. The main concern to reflect on in this paragraph is the iterative process of the analytical cycle as described by Hennink, Hutter, and Bailey (2011). Part of the qualitative research cycle of Hennink, Hutter and Bailey (2011) is the analytical research cycle in which the process moves from developing codes, to describing and comparing, to conceptualising, to developing theoretical concepts, and back to developing codes (see figure 3.9).

Figure 3.9: Analytical Research Cycle within the Qualitative Research Cycle of Hennink, Hutter and Bailey (2011)



Source: Qualitative Research Methods (Hennink, Hutter and Bailey, 2011)

In this iterative process the analysis gets further refined as the research proceeds. After part of the data is collected the analysis is supposed to start. Findings from the analysis will be incorporated in the research tools and this will change the following phase in the data collection. However, in this study only slight changes were made in the focus group discussion and interview guide after each day of data collection. The focus group discussions and in-depth interview were conducted in a short time period, which left no space for conducting a preliminary analysis in order to incorporate new insights and topics. Because of budget constraints several focus group discussions or in-depth interviews had to be conducted together on one day. The process of transcribing / translating, coding, categorising, and conceptualising is too long for the short time frame the research was conducted. The lack of an updated focus group or interview guide led to the problem that certain issues in the data are not totally explored. E.g. the role of the man as a father is only partly explored, which could have been studied more in-depth.

The ethnographic research cycle of Spradley (1980) (discussed shortly in paragraph 3.1.3) shows similar patterns as the qualitative research cycle of Hennink, Hutter & Bailey (2011). In the ethnographic cycle the analysis of ethnographic data is supposed to lead to new questions for further ethnographic field studies. Also the ethnographic research cycle is a iterative process in which insight from preliminary analysis of earlier phases is used to update later data collection phases.

This research intended to be conducted in a similar way, both within the whole data collection phase, as within the participant observation phase. Already during the participant observations phase the field notes should have been analysed in order to refine and narrow down the focus of the observations. However, it must be concluded that this was not successfully applied. The first two observation periods (in total ten days) were conducted without a concrete preliminary analysis during or in between the observation periods. Only in the memos, which were also written every evening during the observation period, I reflected upon the relationship with the community members and upon the observation process. This included some directions for the focus of the following days. Nevertheless, the field notes from the participant observations are mainly descriptive.

The main reason for this problem occurring during the participant observations was a combination of time, experience with conducting participant observations, and preparedness constraints. Do to a lack of experience in conducting participant observations the difficulty was maybe underestimated. A general idea of how to write the field notes, what to look for and how to place yourself as research present, however the planning of the exact participant observation needed more attention. There was no time planned between the first two participant observations to analyse the field notes and to adjust the focus of the observations. During the observation periods itself everything was noted in the field diary, from getting up to going to sleep. This led to a large amount of field notes, without a direct special focus. Therefore it can be concluded that the quantity was good, but the depth was less good. There was a need of specifying a location or type of behaviour more precise (either before or during the observation period) if a good quality participant observation was supposed to be conducted. This understanding however only came afterwards, after organising and analysing the field notes.

On the other hand it must be added that the aim of the participant observation was not to complete a whole participant observation study. Main aim was (see paragraph 3.1.3) to get introduced into the communities and to understand the context of the research better. In this purpose, the research did succeed. Many features of the lives of both men and women were explored and discussed during the participant observations. Many places important in the lives of the community members regarding health and development were introduced. Many insights related to family interactions, community sense, and difficulties faced (such as poverty or lacking infrastructure), were explained, experienced and observed. Furthermore personally, the participant observations enlarged my understanding of different cultures and it increased my connection with the participants in the research.

3.10.2 Positionality

A second limitation in the data of the participant observations is related to the influence of me as an external researcher conducting the research. Positionality is of influence on this study in three different ways.

Firstly, I could not be unobtrusive in the field which might influence the behaviour of the community members. Most villages are not used to receive a guest from Europe, which resulted in me living in the village to not go unnoticed. Just as I was curious to learn from them, some community members were curious towards me. My presence led frequently to some rumour and adjusted behaviour, which makes participating in the real life of the community members almost impossible. Furthermore, the host family and guides were still adjusting to their guest after several days in the observation period. Their hospitality seemed to lead to an adjusted behaviour, meaning that they probably behaved different because I was present. This of course influences the observations, because maybe the observed behaviour is different from their actual behaviour. Nevertheless, the daily activities such as fetching water, cooking, sweeping the ground, and taking care of the youngest children, were continued when I was present. Much information regarding the actual behaviour of community members was observed during these moments.

The positionality of the CBSM project is the second important consideration. Between the community leaders and members, and the CBSM project there seems to be a mutual respect and trust. The good relationship and the familiarity of the CBSM project within the communities was on the one hand beneficial for the research, where it eases: gaining access to the communities, recruitment of participants, communication with community members, and being accepted by community members.

On the other hand however, it must be concluded that it might have influenced the selection of the villages and of the participants, and the topics that were raised by community members during the data collection phase. The villages in which the study was conducted were randomly selected out of a list of 29 villages. However, these are villages with which the CBSM project has contact with in one way or another. Many other villages in the study area were not an option because no direct contact existed between the village and the CBSM project. It might be expected that men in the villages who did not work together with the CBSM project and who were not exposed to information and initiatives of the CBSM project, might have different perceptions and experiences related to maternal health and maternal mortality. Afterwards it can be concluded, that this study would have benefited from selecting some villages who did not receive information and support regarding safe motherhood. Practical issues such as gaining access to the community and being trusted and accepted by the community will then again be more difficult.

During the data collection the research team was seen by community members as part of the CBSM project. Responses or discussions related to the benefit of the CBSM project might be biased or exaggerated because of the perception of community members that the research team was part of the CBSM project. One interviewee e.g. continued throughout the interview with praising the CBSM

project and its initiatives. Furthermore, several participants know that the CBSM project collaborates with the ADCs, VDCs and individual village leaders; therefore the participants might be less open when the discussion or conversation focused on the role of other community members. During the participant observations it became clear that criticising the village head is normal and allowed. However, it is hard to tell if deeply rooted objections towards the village leaders have been openly discussed.

Thirdly, I must be aware of how my background and perceptions might influence the whole research process, and in specific my interpretation of the data. E.g. my views about sexual behaviour, witchcraft, religion, fatherhood etc are formed and shaped in a western European society. These views influence, consciously or unconsciously, my choice for the research topic, the choice of the research methods, the focus during the data collection, and my analysis and interpretation of the collected data. Therefore it is important to be aware of these personal views and how they might differ from the views of the participants. In order to handle this subjectivity I stayed as close as possible to the data. Grounding your results in the data will support your results to be more culturally relevant and precise. My views about sexual behaviour, witchcraft, religion, or fatherhood are irrelevant for how the community members in rural Mangochi perceive these topics. Furthermore, I worked in close collaboration with the other members of the research team, who are closer connected to the participants' reality, and they helped me to place the results in the right cultural context.

3.10.3 Loss of data

A third problem that occurred during the fieldwork is the loss of field notes of the second participant observation. The notepad with the first short key words and phrases is still present; however the more detailed condensed accounts were lost because of computer trouble. The few computers at the host facility in Mangochi Boma that worked and which had my documents on the computer got infected by many viruses after somebody repaired the internet connection of the facility. Also a few documents which were copied to a memory stick were infected. The computers collapsed within one week and the created condensed accounts got lost. If the short key words and phrases from the field work would need to be elaborated again, much information would be lost because it was not written on the spot. As Spradley (1980) described, the risk of not writing according to the 'concrete principle' and the 'verbatim principle increases when the field notes are not written directly at the study location. The danger exists that the observations would have been described as my own summary of what I still remembered. The written field report will move further away from the actual point of view of the participants themselves, which leads to a loss of essential data nuances related to culture and customs.

3.10.4 Participatory feedback meetings

The aim of the feedback meetings was two sided. Firstly they had a scientific purpose, in validating the research findings with the study participant themselves. Secondly, the feedback meetings were aimed to be participatory and to bring the research result back to the community.

The feedback meetings were very useful for this research. However, the meetings themselves could have been performed better. The purpose of having 'participatory' feedback meetings was not totally successful. I mainly presented the research findings (adjusted to the audience) as I would present a paper to fellow students or to a professor. I expected that I could easily conduct the meeting in a participatory manner, but it must be concluded that this is much harder and needs much more preparation.

The meeting with the DEC members was more interactive than the meetings with the community members, probably because the DEC members are more used to work and react during meetings in which issues are presented. The attendants in the community feedback meetings seemed to be interested but they mainly listened. Just a few attendants replied when asked for a reaction. The ones who reacted were mainly the 'leaders' or spokesmen of all the attendants. Thankfully with the help of the CBSM co-ordinator and the research assistant, who both have more experience with interactive meetings, the attendants became slightly more involved in the meeting.

4. Research results

In the following chapter the research findings will be presented. The chapter is divided into four sections. The four sections represent the four major themes derived from the analytical process. The four themes derived from the data are:

1. Men's perceptions about getting children
2. Men's perceptions about pregnant women
3. Men's perceptions about the influence of the community on safe motherhood
4. Men's perceptions about male involvement in safe motherhood

In the first section the perceptions of men about getting children will be discussed. The ideas and views of the men who participated in this study will show that the perceived value of children and the social constructs within the rural communities are influencing the important role of getting children. However it will also be shown in this section how expectations towards having children are combined with major perceived risks associated with getting children. Women are supposed to be at risk of physical complications or even at risk of dying, with every child bearing they face in their lives.

The second section will give insight in how men perceive the role of women in ensuring safe motherhood. The participants discuss a clear picture they have of pregnant women and of what the ideal behaviour of a pregnant woman is supposed to be. Pregnant women have to live up to these expected standards in order to increase their chances to be healthy during the pregnancy, delivery and post-natal period. In this section it will also be explained how pregnant women or women after their delivery are perceived as 'scary' or 'dangerous' for the man.

The third research findings section will present what the role of the community is in safeguarding the lives of women during maternal times. Several factors within the rural communities in Mangochi are influencing the maternal health situation, either positively or negatively.

The last section will reflect on the role of men in the context of maternal health. The responsibilities of men, the risky behaviour of men and the possibilities and advantages of male involvement in maternal health will be discussed. The participants clearly indicate the benefit of the involvement of men in maternal health. They presented several methods to do so. Furthermore obstacles which are preventing men to be properly involved will be discussed in this section.

Every section will be shortly introduced before elaborating the research findings and grounding the findings in the data. The research findings are presented by short statements or explanations combined with quotations from the focus group discussions, from the in-depth interviews and from the field notes of the observation periods. In this way the arguments stated in this chapter are grounded within the data.

The names of the community members who are mentioned in the field notes of the observation periods are fictive names. The participants are given Malawian names that have a meaning related to their observed personal characteristics.

Furthermore are the names of the villages visited during the observation periods not mentioned when a quote from the field diary notes are used. An average village in rural Mangochi has a rather small population and therefore it would be relatively easy to assess which character in the field notes is representing whom in reality. The exact location will not be mentioned in order to protect the privacy of the participants and to enable them to speak freely. Only the name of the Traditional Authority (TA), a part of Mangochi district will be given as description of the study area.

4.1 Research results section: Men's perceptions about getting children

In the rural villages in Mangochi district children play an important role. Getting children is therefore for a young couple one of the main concerns in the beginning of their marriage. In this section it will be discussed how the men who participated in this study perceive the meaning of getting children.

Firstly, the view of the participants on the value of having children will be explained. The participants reflect on what the main reasons are for having children. The pressure of the society and of the family is in this context described as of major influence. The community and the family expect a newly married couple to have children.

Following on this discussion the role of both men and women in getting children will be discussed. The participants indicated that men and women have different responsibilities in the process of getting children. Furthermore, after the child is born, the role of the father and of the role of the mother are perceived as different from each other. The participants explained that the mother is irreplaceable.

The first part of this section indicates the important role of getting children in the rural communities in Mangochi district. However, getting children is also perceived by the participants as a dangerous event whereby either the mother or the baby eventually can die or face serious complications. In order to understand how the risk of a maternal death is perceived in its local context, paragraph 1.5 will first reflect on how death in general is perceived in the rural communities. In the paragraphs following paragraph 1.5 the risks and dangers for a woman associated with getting children and with the pressure of getting children as quick as possible will be discussed.

4.1.1 Having children

One of the first characteristics of a rural village in Mangochi which is visibly observable is the fact that young children are present throughout the village in large numbers. Seldom were adults or groups of adults observed without a child being close by. This partly is caused by the young population and the low life expectancy of the population in the rural areas of Malawi. The fertility rate is also still relatively high in the rural areas of Mangochi; many families have five children or more. Additionally, many young adults migrated to the cities in Malawi or in South Africa to find better paid work (see paragraph 4.6.2) leaving the elder and child population behind.

Getting children seems to be essential for a couple. The participants indicated several times that a task of the woman is to get married, to become pregnant and to bare children, as shown in the following quote:

Focus group discussion:

I; What roles do we have in this village that differentiates men from women? Are their roles or responsibilities that are for men or for women?
R; (…) Becoming pregnant is the role of a woman. (…).
(FGD1: Machenje – above 30 years – minimal 3 children, 12th of August)

Marriage in the rural villages is perceived to be equal to getting children. According to the following interviewees a couple that gets married is supposed to get pregnant in the first year of their marriage:

In-depth interview:

R; I knew that when somebody gets married they are supposed to have children.
(IDI5: Machenje – 30 years, 18th of August)

R; It will depend on what she (the participant's daughter) decides. If she gets married, that is the end of it all. She will get more children and not go for education anymore.
(IDI12: MasambaUma – 41 years, 24th of August)

Families show different reasons for wanting children. As explained by (Hoffman and Hoffman, 1973), in some societies children are seen as useful support to the family's material or economical need. Children can help out with daily work, are able to provide extra income, and can get groceries or other requirements. Also in this study the participants indicated that the 'use of children' is a well appreciated gain of having children. Some of the participants explained that the children are supportive labour power when it is time for the harvest:

I: Are you trying to confirm that there is nothing exciting about having children?
R; It is exciting now that they are growing up and they have started helping me work in the garden.
(IDI6: Machenje – 40 years, 18th of August)

Other interviewees mentioned that it is pleasant to have children because they can get groceries or other necessaries for the parents:

I: Is there nothing pleasant about your child that you can share?
R; It is most exciting to note that the child is growing. We can now send him to get something for you and he does really do that.
(IDI10: MasambaUma – 28 years, 24th of August)

Many participants further mentioned that children are an old-age-insurance, meaning that the children will support the parents in the future once they get old and once they are not able to take care of themselves anymore. Considering the poverty in Malawi and the lack of governmental social services, children are the only possibility for old-age-insurance, as explained by the following quote:

R; You have pains at hands cause everybody has children. You think about when become old and powerless you have nobody to take you by hand. You think of several possibilities that if you had children probably you may fall sick they certainly will help you out.
(FGD1: Machenje – above 30 years – minimal 3 children, 12th of August)

A second reason for having children, also described by (Hoffman & Hoffman, 1973), is for happiness. The participants explained that having a child simply makes them happy; being a father gives them a good and beloved feeling:

In-depth interview:
I: How does it feel to be a father to a daughter like this?
R; I am always happy because I have the fruit. I have a fruit in the form of this daughter of mine.
(IDI1: Machenje – 60+ years, 17th of August)

Focus group discussion:
R: I feel very happy in my heart. I would go to the market and bring something back to my children, when I get home they all greet me 'dad' and I feel great.
(FGD4: Ngatala – 17 till 22 years – one child, 15th of August)

Moreover, the participants indicated that the love between the husband and the wife improves as a consequence of the presence of a child. It is mentioned in both a focus group discussion in Ngatala and Machenje that children have the ability to temper problems and quarrels between the husband and the wife, and the children's love spreads to both of the parents:

R: The presence of children would improve the love of the parents.
R: If you are having children you may have differences here and there, but you are able to bare and endure for the sake of the children. Even if you are angry you think about the children and you remain with the wife. Children are like a bond between the father and the mother.
R: If there is misunderstanding between the parents the child will act as a mediator. He would play with the father and then go to the mother do something funny until the situation calms down.
(FGD4: Ngatala – 17 till 22 years – one child, 15th of August)

R; What happens is that when you have a child at home both the father and the mother naturally love the child. And this love for the child is kind of transposed to the partner, so the father loves the wife more through the child and so does the mother.
(FGD1: Machenje – above 30 years – minimal 3 children, 12th of August)

The happiness feeling is according to the participants associated with a feeling of pride; pride for being seen and named in the community as a father. Being a father means that an individual is mature and belongs to the adults in the community:

Focus group discussion:
R: I feel respected, particularly when I am called in relation to the children.
(FGD2: Machenje – under 20 years – without child or expecting first child, 12th of August)

In-depth interview:
I: How is life being a father?
R; I feel I am a parent enough looking at the children that I have and accept that I am mature enough.
(IDI3: Machenje – 60 years, 17th of August)

One of the participants further explained that this new feeling of being mature is associated with taking responsibility in taking care of the family. It is a point in time in which a man is supposed to stop being childless (responsibilities of the men further discussed in section 4):

R; Being a father goes in this way: You feel yourself; well I am grown up now. You think of taking care of your wife. You give a stop to anything childless.
(IDI9: Stambuli – 25 years, 23rd of August)

4.1.2 Societal Pressure to have children

The feeling of pride when being named and seen as a father must be understood in the context of the local community. Besides children being an added value in terms of the family's income, and besides the individual feeling of happiness associated with getting children, societal acceptance is mentioned by the participants as an important reason for the choice of a couple to have children. The participants explained that having children makes an individual accepted and respected within their own community:

I: Is it necessary having children at all?
R: You gain respect in the society (…)
R: Children bring respect to the parents.
(FGD4: Ngatala – 17 till 22 years – one child, 15th of August)

In the event that a couple remains childless after they got married it is mentioned that the other village members will make fun of, and gossip about the couple. In the focus group discussions the participants reflected on that a childless couple will not be accepted by the other community members. Either the woman or the man would be suspected to be *gojo* (impotent) and will be given names in public related to his or her childlessness:

R: (…) if you don't have children people will always refer to you as gojo (impotent).
R: If you don't have the children people will look at you as a fool.
R: Some will refer to you like someone who fell from a pawpaw tree.
(FGD4: Ngatala – 17 till 22 years – one child, 15th of August)

R: What happens is when women are walking in a group, if some have got children and others do not the journey will not be a nice one. As they keep on talking they will part ways, so when the childless woman comes home she would complain that she was being castigated on by other women as childless.
R: If a family is childless they stay very well in the house, but problems come in from outside. There is nothing more painful, the gossip irritates and both could try ways of getting a child, so they could avoid the gossiping.
I: What would the external people say?
R: People always refer to you as somebody impotent. So you are looked at as a failure in the society. Both of you remain as a suspect. That is why people choose to go out and try, this becomes dangerous when both go out on hunting for the child.
(FGD5: Stambuli – 20 till 25 years – With one or two children, 15th of August)

In a focus group discussion conducted in Stambuli, one of the participants indicated that purely the gossips and the remarks of other community members are the obstacle for being childless. In itself, he continued, there is no problem if a couple does not have children:

I: What does this (remarks discussed above) mean altogether?
R: A family can have no children and remain peaceful if people (in the village) are not talking too much.
(FGD5: Stambuli – 20 till 25 years – With one or two children, 15th of August)

4.1.2.1 Family pressure towards having children

Part of the societal pressure towards having children comes from the family of a newly married couple. The family expects the newly married couple to get children shortly after marriage. As one of the participants explained, a marriage without children will result in a deteriorating love from the family towards the son or daughter that is childless as compared to the son or daughter who does has children:

R; It affects the love of the parents. For example if a family has two daughters who are both married and one has children and the other one doesn't the parents would be inclined to be in love with the one who has children more than the other one who doesn't.
(FGD1: Machenje – above 30 years – minimal 3 children, 12th of August)

A custom associated to this expectation is described in several focus groups: The parents of the newly married couple give a log of wet firewood to the couple. When all the wood has been burned the woman is supposed to be pregnant. One of the focus group participants mentioned that this time period to become pregnant is around two years. If the woman is not pregnant by then, consequences will be taken by the couple itself or by the family, clearly stating the family's demand for children:

R; That is why our parents used to make sure there are children in the family. What they used to do was: They would give a log of wood that is not dry to a couple to be lighting fire in the house at night and to make sure that before the log has been fully burned, the wife has to become pregnant. Parents would further frighten that if no pregnancy is seen before the end of the log the marriage would be dissolved because they feared that either of the partners would be abused and get old. This one shows that the parents held that children are important.
(FGD1: Machenje – above 30 years – minimal 3 children, 12th of August)

The participants explained that if a couple remains childless then the family will try to solve the problem of being childless firstly by using traditional herbs and medicine:

R: If the family is childless, the two families come together to see of they are able to sort out the problem. They may think of looking for medicine to make sure the problem is rectified.
(FGD2: Machenje – under 20 years – without child or expecting first child, 12th of August)

However, if traditional herbs do not help for getting the woman pregnant, there are several other possibilities that might emerge. First of all, the families might arrange a divorce for the couple in order to allow them to find another partner with whom they will have children:

R: (...) The worst would be if one of the parents was married elsewhere and had children that site, then the other partner would be held responsible. If it fails, the elders may agree that the couple separates.
(FGD2: Machenje – under 20 years – without child or expecting first child, 12th of August)

R: Certainly there would be no love in the couple. Family members may require children, and if the children are not attained in the family either of the couple would be advised to divorce the other (…).
(FGD3: Ngatala – 25 till 40 years – multiple children, 15th of August)

Another possibility mentioned by the participants is that the woman will try to find an extramarital relationship in order to become pregnant (see also paragraph 2.3.1). In this way the woman makes sure that the community will not gossip anymore about her being childless:

I: How would the wife look at the childless husband?
R: No respect. Because she feels you as impotent, she complains that you are only torturing her. Against that background she will find a way of at least having a child, this means that she will have an extramarital affair for the sake of a child. That is where problems should come in, because she may catch a disease out there and infect you in the house.
(FGD5: Stambuli – 20 till 25 years – With one or two children, 15th of August)

R: Either of the two would engage in an extramarital relationship to ensure he or she would have a child.
R: A woman may indeed love the husband, but all the same have sex with somebody else for the sake of a child.
(FGD3: Ngatala – 25 till 40 years – multiple children, 15th of August)

In some cases it is explained that the family of a couple will be even further involved in order to solve the problem of remaining childless: The *fisi* (hyena) custom is used by the family of a childless couple in order to solve their problem. Although most of the men indicated that the *fisi* custom is not practised nowadays, some of them described and explained the custom as if it still exists. The custom prescribes that the families of both the husband and the wife are inviting or hiring a different man to have sex with the wife. The purpose is to 'clean' the woman from whatever is obstructing the pregnancy and to 'heat up' the woman until she is at the same heat as her husband:

R; The other thing that was done, was the hyena fisi (hyena) practise. Whereby a different man would come and have sex with the woman so that he cleans the woman. So that if there is any danger or disease in the woman then this fisi should take it with him. (…) To make sure the secrecy was upheld, the husband would be sent elsewhere. So that he unknowingly gives room behind.
I; Who was really organizing that a hyena have to be hired in the house?
R; The two families were behind the organization. So upon agreeing both families would contribute towards the payment of the hyena.
(…)
R; Then the woman's side would start to complain that the husband is hotter than the wife. So to heat the wife up so she matches the husband a fisi (hyena) was also hired.
(FGD1: Machenje – above 30 years – minimal 3 children, 12th of August)

4.1.3 Women as a 'baby factory'

As often described in literature (Hoffman & Hoffman, 1973; Fawcett, 1976), some societies expect women to not only have one child but to have a large number of children. This can result into a serious pressure for woman to 'produce' multiple children and hinders free choice of women about when and how often to get children. Alongside pressure to have multiple children, in matrilineal societies such as the Yao tribe in, the children belong to the mother's side of the family (Mwambene, 2005).

In the in-depth interviews and in the focus group discussions the participants indicated that getting children and pregnancy mainly belongs to the woman and is a women's business. The participants in the following quotes mentioned that the pregnancy is the woman's and not the man's:

<u>Focus group discussion:</u>
R: It is the woman that becomes pregnant and it is them that deliver the baby. That is why we say that men do not give birth, and do not have power on the pregnancy.
(FGD4: Ngatala – 17 till 22 years – one child, 15th of August)

R: It is because men do not give birth, so they don't know how painful it is.
I: What do you mean when you say men do not give birth, is it true?
R: We only hear about things when they are finished, when your wife has got a baby.
(FGD4: Ngatala – 17 till 22 years – one child, 15th of August)

In-depth interview:

R; (…) But it is not permissible for a man to be found in the labour ward as far as our culture is concerned. It is absolutely a mother's business.

(IDI2: Machenje – 59 years, 17th of August)

The important role for the man in this scenario is indicated by a participant as 'Making the woman pregnant':

R; Having sex. The man is always on top of the woman, there is nothing that comes, not even gender equality that can change this reality. Becoming pregnant is the role of a woman. Making the woman pregnant is the role of the man.

(FGD1: Machenje – above 30 years – minimal 3 children, 12th of August)

4.1.4 Parenthood

The participants were asked to reflect on daily life when having young children. Parenthood for a man and for a woman seems to mean something different. In the data a small insight in how parenthood is perceived can be obtained. Several other factors that can be described as being part of 'parenthood' are however not obtained in this study. Main reason for it not being possible to conduct a complete analysis of the different tasks of men and women in parenting, is that the focus of the study was not aimed at taking care of children, but more on taking care of mothers.

How men in this study perceive fatherhood and parenting helps to understand the influence of living as a man within a matrilineal society, as is the case in rural Mangochi.

4.1.4.1 Taking care of young children

Firstly, related to parenthood, it is observed when men and women are involved themselves with parenting during the observation periods. During the observation periods it became clear that mainly the women (mothers, grandmothers, sisters, aunts) carry the youngest children around and take care of them. In the observed villages women with a baby in the *chitenje* on their back and older girls carrying the smaller children in their arms were seen everywhere. The following quote from the observational field notes show how girls around eight years old carry the youngest children and are informed by the mothers on how to do so:

The children walk around the house a little. Baraah (9 years old) is carrying Azizi on her back like the mothers in the village do as well. Another child of around eight years old, carries an even smaller child than Azizi on the back. Sometimes she lifts the baby above her head, or she keeps him upside down, like she is playing with a doll. Hameeda or Chanda than corrects her by putting the baby upwards or by yelling something to her.

(Field notes, observation period 1, day 3, 1st of August, TA Chimwala)

Only occasionally it was observed that men took action in caring for the younger children. Men carried the younger children when the mother was not able to. For example, as is explained in the

next quote from a discussion during a village meeting. Female village members mentioned in this discussion that the husband has to take care of the children when the mother is going to the health centre for *sikelo:*

The next woman reacted that women had to go there (local health centre) because that one is closest by for them. The second woman told us that the men looked after the children when they go for sikelo. At this moment I did not ask about what men do specifically, so I assumed the village chief or Agimah might have told them in the introduction that I am working on male involvement issues. Another woman continued that every time a woman is going for sikelo, the husband is supposed to stay at home.
(Informal discussion, observation period 3, day 3, 7th of October, TA Mponda)

Another example of when the father takes care of the children is when their are multiple younger children in the family and the mother is taking care of the new-born. The following quotes from respectively an observation period and from an interview show that if a baby is just being born, the main attention of the mother is supposed to go to the baby. The husband then will carry and look after the other young children.

Participants observation:
I was offered a place to sit and one minute the uncle walked in. His English was really good and he introduced himself and he explained me that the kid in his arms was his first born, I think the kid was maybe three years old. "My wife is in the back, with the new-born", the uncle told me.
(Informal dialogue, observation period 1, day 4, 2nd of August, TA Chimwala)

In-depth interview:
I: Know you have said that you had about ten pregnancies, when she was pregnant who used to take care of the other children?
R; When the mother was pregnant, I used to take care of the NTHUMBIDWA (preceding child). This was done so she was given room to work. So when she was even busier, I would cook myself. When we are going to the garden, I would carry the NTHUMBIDWA on my back and off we go.
(IDI1: Machenje – 60+ years, 17th of August)

Furthermore, it was also observed that men intervened in case children would be in danger; such as when children are getting too close to the fire or, as described in the following quote from the observation field notes, when young children ran towards a big tree that was just being cut down.

Two children running towards the tree, were quickly cut by a young man. He grabbed them both tight by the arm and took them back to the group, where one of the boys got a slap on the back of his head from a woman, maybe the mother. The other boy was laughing and ran away towards some houses where a woman came towards him.
(Field notes, observation period 1, day 5, 3rd of August, TA Chimwala)

In one of the families that was observed, the youngest child was occasionally taken care off by his older brothers, mostly when the mother of the child or the older sister insisted them to do so. The first quote from the field notes shows that the mother of the child gives the child to the child's brother so that she can continue her work on the land. The second quote shows that the brothers watch over the same child when the mother is not in the room. They prevent him to grab an unstable table with the radio on it.

We leave the garden and walk back the same path. Salar was ordered by Mehrnaz to take Azizi, and with Azizi on the arm we are walking between the banana trees again and we cross the river again. Azizi is playing with Mehrnaz hair all the time and seems to have fun in the arms of his older brother. Back at the house we sit down, (...) Azizi sits between the legs of Mehrnaz, and is trying to escape all the time, but Mehrnaz did not let him go anywhere. Gently he puts Azizi back on the spot where he was sitting.
(Field notes, observation period 1, day 4, 2nd of August, TA Chimwala)

After half an hour or so, Masrur walks in with Azizi. She smiles to me and very carefully puts Azizi on the ground. Mehrnaz (the mother of Azizi) is not there. Azizi holds the table and walks around it, towards the radio with his hands towards the pawls of the table where the radio stands on. Masrur right away grabs him while he and Salar are screaming. The radio stands on small wooden pawls which do not look to stable, and Azizi is clearly not allowed to come close.
(Field notes, observation period 1, day 2, 31st of July, TA Chimwala)

Important to realise with this statement is that because of the language it was not possible to observe what the fathers and mothers said to their children during the observation periods. Advises given, stories told, education provided and talks held are therefore not present in the field notes although this might be an important feature of parenting. Furthermore, during the observation periods the men worked on their land and the older children occasionally joined them. At these moments the interaction between father and child was not observed, because other places around the village were visited with the guides. The analysis shown in the last paragraph regarding the interaction between father and child therefore only provides limited information.

4.1.4.2 Mother's love irreplaceable

A second aspect of parenthood obtained from the data is the different perceptions that are given concerning the importance of the mother and the father. According to the participants of the focus group discussions, the nurturing capacity of the mother is stronger than that of the father.

R; Man and woman are different. Woman have the charisma to raise babies.
(FGD1: Machenje – above 30 years – minimal 3 children, 12th of August)

Furthermore, the participants indicated that the love and care of the mother is irreplaceable and in the event a mother dies the children will be the first victims because the father or other relatives are not able to take care of the children as well as the mother would do.

I; Why do you think a man cannot raise a baby himself?
R; It is very difficult to provide for the baby. For the mother it is very easy, she breastfeeds the baby and that is enough.
I; Suppose recourses are available, what can we say?
R; The recourses cannot substitute the mother. The love a mother has for her child is irreplaceable. So there is no way we can make the man raise the baby.
R; Like in my case I cannot manage to raise a baby.
(FGD1: Machenje – above 30 years – minimal 3 children, 12th of August)

R; In taking care of the baby, relatives may take care of. But is different from the way the mother herself would take care of the baby.
(FGD2: Machenje – under 20 years – without child or expecting first child, 12th of August)

Several participants indicated the importance of women in the society related to women's nurturing capacities. Women are considered by those participants as indispensable in the society. Especially their love and nurture capabilities towards children are, according to the men, irreplaceable. The participants argued that a special connection between the mother and the child exists, which a father will never have:

R; Man and woman are different. Woman have the charisma to raise babies.
(FGD1: Machenje – above 30 years – minimal 3 children, 12th of August)

R; In taking care of the baby, relatives may take care of. But is different from the way the mother herself would take care of the baby.
(FGD2: Machenje – under 20 years – without child or expecting first child, 12th of August)

The importance and the ability of women to take care of children is further explained in the following focus group discussion quote, by arguing that children will in the event of needing nurture or care always first call for the mother:

R: Even when a marriage breaks down, children would always cling to their mother. Even when a child is wounded, it will cry out 'AMAYI' (mother). The child will never call for his father.
(FGD3: Ngatala – 25 till 40 years – multiple children, 15th of August)

4.1.5 Death is part of life

As explained in the last paragraphs, getting children is an important task of a young couple. The number of babies sleeping in the *chitenje* (traditional piece of cloth) on the back of their mother, and the presence of laughing children who run around in the rural villages of Mangochi, also shows that much happiness is associated with new life. 17.5 percent of the population in Mangochi district is under five.

However, besides birth, death is a major component of life in rural societies in Mangochi. A considerable number of community members in the reproductive age groups died because of HIV/AIDS, malaria or tuberculosis. Furthermore, the under-five mortality in rural Malawi caused by similar diseases and by malnutrition is among the highest in the world (125 deaths per 1000 live births) and is significantly higher in the rural areas as in the urban areas of Malawi. (National Statistics Office Malawi, 2008)

Many discussions and dialogues during the fieldwork in the rural villages show that death plays an undeniable important part in life. During the observations conducted for this study, but also during informal visits to the rural villages, it became clear that almost every individual had lost people closely related to him or her and that death plays an important role in the society. To clarify: A considerable number of community members in the reproductive age groups died because of HIV/AIDS, malaria or tuberculosis. Furthermore in 2009 estimates, Malawi counted 650,000 children under 15 years old (out of approximately 7,000,000 in total) who were orphaned as a result of AIDS, and 350,000 more who are orphaned by other causes (Unicef, 2011). Additionally, the under-five mortality in rural Malawi caused by similar diseases and by malnutrition is among the highest in the world (125 deaths per 1000 live births) and is significantly higher in the rural areas as in the urban areas of Malawi (National Statistics Office Malawi, 2008).

At a health centre visited during the third observation period, a clinic is conducted once a week which examines malnourished children and which provides food for the family to strengthen both the mother and the child. Every week multiple children are referred to Mangochi district hospital because these children are severely malnourished and at major risk of dying. Additionally, in the following field notes from the first observation period it is described how the books at the local TBAs place showed that more than half of the babies and children passed away shortly after they were born:

When she (the traditional birth attendant) stops talking the Health Surveillance Assistant (HSA) gives the book to me and he says: "All the births that were here (he points at the house where we sit in front) are in the book". He shows me it starts with the date, the name of the mother, from which village the mother is, how much the baby weighs at birth, and if there were any problems with the delivery. In this last row some boxes are filled in with words I do not know of course. But also sometimes a date is filled in this last row. I ask what it meant, the HSA looks at it and answers himself that this are the dates of when the particular baby died. I look more closely and see some dates are the same as the birth day, and a lot of them are just a couple of weeks later.
(Field notes, observation period 1, day 3, 1st of August, TA Chimwala)

These observations were conducted in a time in which the harvest in Malawi is considered relatively good and in which the food supplies in the country are supposed to be above average, a favourable phenomenon which is not self-evident for Malawi in the last decade.

Multiple families and individuals stated that they lost children, brothers, sisters, parents or cousins. One of the host families during the observations lost a father of 55 years old and a healthy and

lively son of 18 years old shortly after the fieldwork of this study had been finished. Father and son were guides during the observations and contributed a lot of effort, information and help to this study.

Although death is perceived as an awful event, it almost seemed there is a resignation that many people are every day at serious risk of becoming ill and die as a consequence of the illness. People seemed not that shocked when people, who are not directly related to them, passed away. A first indication was observed at Mangochi district hospital. Every day at the hospital several people passed away and were carried out of the hospital towards the mortuary. Other people who were present around the hospital, either adults or children, did not pay attention to the dead body and to the mourning family members who were guided towards the mortuary.

A second indication is related to the event of a death of a community member. When a death has occurred in the village, other families in the village sent one person per family to the funeral. Not all the family members are expected to attend every funeral. In the following dialogue from the field notes a young family member during the first observation period explained that if the whole family would attend every funeral in their community, the families would have less time to work and to provide for their own family, therefore harming the welfare and health of their own family. Only one sister of the household and her baby are in the following scenario attending the funeral, although the other family members are friends with the family who lost their mother:

When I walk outside I see the whole family is there. (...) Mehrnaz I see is wearing different clothes today than the last days. She is wearing a very clean brown skirt all the way to the ankles. On top of this she is wearing a blouse and a white chitenje where she just puts Azizi (her child) in. He is not struggling and within a few seconds he closes his eyes (...) Salar (brother of Mehrnaz) walks up and down in the backyard and now walks towards me: "Mehrnaz is going for the funeral. You know, of the woman we talked about yesterday." I ask him: "Jari's (friend of Salar) mother?". Salar: "Yes, yes. You want to go?" "Uhm, No! No that would not be good idea". I explain that I want to make sure the funeral is a funeral, and do not want to disturb as non family and Mzungu (white person).

After I went to the toilet Salar offers me a seat and he sits down next me. "Are you all going?" I ask. "No, Mehrnaz is", he reacts shortly. He is looking at the ground when we talk, I don't know if it is particular because of the topic we talk about, because he does that more often when we talk together. "But Jari is a friend of yours, are you not going?" I continue. "We will stay with you. Mehrnaz is there for the family. We can go to the health centre maybe today?" I am trying to discover if they are not going to the funeral because of me. I am saying a couple of times that if they want they should go to the funeral. I told them I have a lot to write so I can stay and write in the backyard. Every time Salar shakes his head: "We are not going, Mehrnaz is going. You know, we can not go to all funerals. Masrur has to work, Hameeda is also not going. We have to look after the garden, that is why we do not go".

(Informal dialogue, observation period 1, day 6, 4th of August, TA Chimwala)

Thirdly, the following dialogue from the third observation period shows how a community member analyses the risk of dying of another woman who just had a delivery. During the delivery the woman lost a lot of blood and was very weak. Additionally, one of the twins she just delivered from did not breathe and died at birth:

I asked how the woman who had just delivered was doing at the moment and Chifundo replied: "She is very weak. She can not get dressed herself. She will have to stay at the hospital (the health centre where I am staying), she can not go home. You must know, when she has an STI, she can die at labour, you know that ok?" I nodded and wrote down what she just said. She continued: "Now she is very weak. Every time she has a child she is weak. She is loosing a lot of blood, that can kill her. Because she is weak, she must stay at the hospital." Chifundo also told me that having twins even increases the chances of getting problems during the delivery, for both mother and child. Even more when the woman is so weak. "She will not live tomorrow, I have seen it before and know we can not do something" Chifundo said with a flat and normal voice. I had to swallow one or two times because of what Chifundo told me, Chifundo on the other hand told me the story with an occasional smile as if it 'was everyday life', an expression that probably comes very close to reality here.
(Informal dialogue, observation period 3, day 1, 5th of October – 8th of October, TA Mponda)

4.1.6 *Mayi Wapakati*

As becomes clear from the last paragraphs birth and death are major components of life in rural Mangochi. Moreover, from this study it can be concluded that birth and death are closely related to each other. Occasionally, a woman in the rural villages dies because of pregnancy-related or childbirth-related causes. A maternal death is a recognised threat by the men who participated in this study. Because the risk of a woman dying in relation to pregnancy or childbirth is so present, pregnant women are often referred to as '*mayi wapakati'*, which literally means 'mother in between'. 'In between' refers here to the state a pregnant woman is in, she is in between life and death; she can either die, or she can survive, as explained by the following participants:

Focus group discussion:

I; In your village, what can you tell us about maternal death situation?
R: The pregnant woman may fall sick, but the worst is the one that does not attend sikelo (antenatal care clinic). The worst would be death, which is why we refer to such a woman as somebody Wapakati, it is between life and death. These are two conflicting forces within a pregnant woman.
(FGD3: Ngatala – 25 till 40 years – multiple children, 15th of August)

In-depth interview:

R; When she had delivered she really changed, because she was light now. Then she looks healthier, that she has been saved. Then the man remains happy.
(IDI1: Machenje – 60+ years, 17th of August)

A maternal death is described by the participants as a major tragedy. Some participants covered the tragic of a maternal death strikingly by arguing that when a woman becomes pregnant, the goal is to bring new life, not death:

R; Yes I know that everybody is going to die, but dying in this way is very difficult. When a woman becomes pregnant, there aspiration is to get well and get a child, not death. Dying, everybody would die but not dying in relation to giving birth. That is destroying the village.
(IDI2: Machenje – 59 years, 17th of August)

R; It (maternal deaths) is happening. This is very saddening indeed. Death on its own is painful.
I: Is this kind of death the same as any other deaths?
R; Yes it's the same. It is the same but there are differences.
I: What do you mean?
R; Death is one, but death of a pregnant woman is very painful. She may die leaving a baby behind, they may both die, all are painful.
(IDI3: Machenje – 60 years, 17th of August)

The participants further explained that the husband will miss his wife when she is passed away. One of the participants even explained that a husband would feel sick and eventually will die after the death of his wife:

R: (…) certain things can change because now the father will be thinking about the children. Even though he is a well to do, he will not have peace of mind with this scenario. He will be sick himself and possibly die
(FGD4: Ngatala – 17 till 22 years – one child, 15th of August)

The term *Mayi Wapakati*, and how the participants explained the term, shows that getting children is considered as a risky event. It seems that the conviction of the participants that getting children is a risky event is derived from experiences of the participants themselves. Several participants indicated that they either lost a woman closely related to them or heard about other women who died from a maternal death:

In-depth interview:
I: This means this (maternal deaths) is real here, is it not?
R; Yes it is painful, but all the same it is happening. And it is a difficult reality.
I: How is it difficult, because we know that death is there for everybody?
R; Yes I know that everybody is going to die, but dying in this way is very difficult. When a woman becomes pregnant, there aspiration is to get well and get a child, not death. Dying, everybody would die but not dying in relation to giving birth. That is destroying the village.
(IDI2: Machenje – 59 years, 17th of August)

Focus group discussion:
R: She (woman who goes for delivery) can easily die.
I: How do we know about these ourselves?
R: Some cases we have heard and others we have seen.
R: These are things we have left at home.
R: We lost women in our families.
(FGD5: Stambuli – 20 till 25 years – With one or two children, 15th of August)

The participants in this study explained that they need to take care of their wives and treat their wives well during this risky period. If they would not do that the risk that the woman falls to the side of death will increase:

I: What is that the man is not supposed to do when the wife is pregnant?
R: The man should never beat the woman, no matter what. You never know you may be involved in some kind of accident. Because we refer to her like somebody Wapakati. It is between life and death. So if you decide to beat her, you never know where you would strike, so it is safer not to beat her for any reason. There is the possibility of either the mother or the baby dying. It would only be good to advise her that in the state you are, it is not good to talk in the way you are doing.
(FGD3: Ngatala – 25 till 40 years – multiple children, 15th of August)

The responsibilities mentioned by the participants that will help to prevent a maternal death are further discussed in section four.

4.1.7 Losing an (unborn) baby

Alongside the mother being at risk of dying because of pregnancy-related and delivery-related complications also stillbirths or neonatal deaths are considered as a possible consequence. From the following quotes it becomes clear that a miscarriage is not a rare event; some couples lose several babies during their life. In the first quote two health workers explained that not all pregnancies are indeed resulting in a child born. In the second quote a 60-year old interviewee from Machenje explained that he and his wife had lost seven babies in his past:

Participants observation:
Another topic we discussed was family planning. Mtima and Ayan told me that a few years ago it was very normal for women to get around ten or eleven pregnancies. Ayan corrected me when I said with a surprised face: "Eleven children?" "No, eleven pregnancies. Not all pregnancies are a child. Some children died, so then it would not be eleven children." Mtima and Ayan laughed together after they corrected me.
(Informal dialogue, observation period 3, day 2, 6th of October, TA Mponda)

In-depth interview:
I; How many children do you have?
R; I have eight children.
I: Are there any that have passed away?
R; Yes I have lost seven babies.
I: Are all these from the same mother?
R; Yes we have had fifteen.
(IDI3: Machenje – 60 years, 17th of August)

In the following quote from the third observation period Chifundo, a nurse at a local health centre, explained that an STI can lead to a deteriorating health of a woman, which can result in complications during labour for both the mother and the child. Chifundo described the example of a woman who had just given birth at the health centre. The woman faced physical problems and simultaneously lost a child at birth. The woman herself struggled with pains and weakness during and after every delivery she had, and furthermore she had lost three babies already in the past as a consequence of her having an STI:

Around 5:30 in the morning Chifundo came outside without wearing gloves. She sat down with me and told me the women that I saw in the ANC room gave birth already as well. She got twins and the first born looked to be healthy. However, very unfortunately the second on took a lot of time to get out, did not breath properly when finally delivered and died. The woman already had four children before, whereof three died around the time of birth. If you hear this story it is not hard to guess that delivery has to be a horrible event for this woman, associated with a lot of painful memories. According to Chifundo, the children died because she has an STI, which they mostly assume when the woman and children are always in such a bad health
(Informal dialogue, observation period 3, day 2, 6th of October, TA Mponda)

4.1.8 Risks associated with pregnancy, childbirth, and post-partum

In the last quote it is described how a woman who goes into labour can suffer without eventually dying from it. Besides women being at the risk of dying when getting a child, the participants also indicated that women are at risk of several other maternal health problems. According to the participants in this study physical problems in maternal health leads to a lot of misery for women in rural Mangochi. Mothers are suffering before, during, and after the childbirth. Many physical problems and complication can emerge during the process of getting children.

4.1.8.1 Possible complications occurring during pregnancy

The participants described several complications with which women are sometimes confronted during their pregnancy. In the following quotes from both focus group discussions and from an in-depth interview, it is described that women often face pains in the body, have a high blood pressure, and are troubled by general body weakness:

Focus group discussion:
I: When a woman is going to deliver what problem can she come across?
R: Different women complain about different pains. Some complain about an arm being painful, so others would know she is about to deliver.
R: Some would have abdominal pains.
R: Some would have backaches.
(FGD2: Machenje – under 20 years – without child or expecting first child, 12th of August)

R: High blood pressure.
R: Some women become very sick when they become pregnant, sicker at this moment
(FGD4: Ngatala – 17 till 22 years – one child, 15th of August)

In-depth interview:

R; She appeared to be very weak, she was sleeping often and claiming that her heart was beating fast.

(IDI4: Machenje – 35 years, 18th of August)

R; When she was pregnant towards her ninth month she had a lot of problems because she had painful legs. At times she was crawling not walking. And at times she was very weak. Those were the major problems she went through with these two pregnancies.

(IDI5: Machenje – 30 years, 18th of August)

4.1.8.2 Possible complications during delivery

During the delivery many complications can emerge that are different to the complications that participants mentioned in association with pregnancy. Frequently mentioned is the loss of large amounts of blood which eventually can result in the woman becoming anaemic. These complications are indicated by the following interviewee as dangerous and life threatening:

I: What was the problem?

R; She was aneamic.

I: Were there any strange eventualities during this pregnancy?

R; The strange thing that I saw was the ulwere (delivery), she became very sick, lost much blood, I was afraid she would die. Then I rushed to the hospital, at the hospital they told us that when the baby grows up and the woman recovers she should close so that she doesn't give birth anymore. This time around she is healthy and fat.

(IDI6: Machenje – 40 years, 18th of August)

Furthermore, the baby can be positioned wrongly in the uterus which can result in major problems for the woman and for the unborn child during the delivery. The participants in the following example supported and added to the remarks of each other, arguing that a baby who is not properly positioned can cause excessive bleeding and general body weakness:

I; I believe we have all heard that women go through problems during delivery and childbirth in general. What problems do they encounter during pregnancy and delivery?

R; The big problem is crossing the way (breaching). Another problem would be excessive bleeding and general body weakness. All these are problems.

R; Somebody may start with the back

I; Is starting with the back different from crossing the way?

R; The two are different. For example crossing the way in the case of the road, one lies just across the road.

I; Is one that starts with the back not in the very same position, only that it's the back that starts?

R; (Laughter). Indeed it is all the same. Only that the other one could start with the back, and cross the way would start with maybe the stomach. But they are both the same.

(FGD1: Machenje – above 30 years – minimal 3 children, 12th of August)

In some cases the participants mentioned what the overall problem was that a woman faced during her delivery, however they were not always able to explain exactly what happened and why the problem they described was a problem. The following participants respectively discussed convulsions and a ruptured uterus as a risk during delivery, without being able to explain the exact problem of the mentioned risk:

In-depth interview:

I: What was the problem?
R; The problem is at times she convulses. That is why I am saying her deliveries are problematic.
I: Why does she have the convulsions?
R; I don't know, maybe problems in her body. I don't know.
(IDI7: Stambuli – 72 years, 23rd of August)

Focus group discussion:

R: If people don't follow such instructions they would come into problems like the rupture of the uterus. This will also be associated with all kind of complications during delivery. Some of the problems we cannot tell in detail what happens, it is more technical than we think.
(FGD3: Ngatala – 25 till 40 years – multiple children, 15th of August)

4.1.8.3 Diseases increase chances of complications during pregnancy and delivery

In some cases these pains were combined with an infectious disease such as malaria or tuberculosis. Both diseases are considered by the following interviewees as a sincere threat to the health of the woman and her pregnancy:

I; When your wife was pregnant did you see any changes in her?
R; When my wife is pregnant she is always cheerful. There was a time once she suffered from tuberculosis, so we went with her to Bottom Hospital in Lilongwe. It is really dangerous for her to be sick.
(IDI1: Machenje – 60+ years, 17th of August)

R; In the first marriage all the children were born peacefully. There was no problem at all. I started experiencing problems with the second. With the second one we had problems with the second pregnancy. She had fever, we went to the hospital, we went to Katema health centre and there they further transferred us to Mangochi Hospital.
I: What happened that make you feel she had fever?
R; I did not know anything, I thought it was the Ulwere (delivery) of women. But once we got to the hospital, it is when we were told she had fever and that was very bad. She was shivering, the body temperature was very high and she had severe body pains. At the hospital they told us things had combined with malaria.
(IDI2: Machenje – 59 years, 17th of August)

Thankfully the women and their unborn babies in the last quotes survived the disease after they got treated at the hospital.

Many of the participants also recognised and mentioned the threat of HIV/AIDS in general, but especially in relation with pregnancy and childbirth. The HIV/AIDS prevalence rate in Mangochi district is 21 percent (National Statistics Office Malawi, ORC Macro, 2005). The participants explained that HIV/AIDS weakens the woman and that a woman who is weakened has an increased risk of dying at childbirth:

Focus group discussion:

R; The other problem these days we are having, because the HIV pandemic that we have, women are developing strange diseases. Some just collapse as if they become epileptic when pregnant. Some survive it, others don't.

(FGD1: Machenje – above 30 years – minimal 3 children, 12th of August)

In-depth interview:

R; There are many problems around like the disease of HIV.
I: What does HIV do in this case?
R; It would get into a woman and weaken her up.
(IDI3: Machenje – 60 years, 17th of August)

4.1.8.4 Dangers to the woman after the delivery:

After the delivery the woman is not considered to be free from danger. The participants explained that when a woman has delivered successfully without complications it can not automatically be assumed that she is safe of any complications. The first months after the delivery are also described as a dangerous period where the new mother is still at risk of dying:

I: How did the first weeks after delivery go?
R; The first problem was that she would not be able to be as active as possible, she was always sick.
I: Was there anything extraordinary that you used to do to your wife after she has just given birth?
R; I used to help her with household chores.
I: What do you mean by household chores?
R; By this I mean preparing food and cleaning home, so that she will rest and not die.
I: How would you rate the period just after giving birth, was it a good time or bad time?
R; I would describe the time as a bad time.
(IDI3: Machenje – 60 years, 17th of August)

Additionally, some of the participants explained that women sometimes would go home while being convinced that they are healthy. However, occasionally some internal complications are not treated and the woman dies shortly after her delivery. The following interviewee from Stambuli argued that there is a possibility that something remains inside the body of the woman after the delivery, which eventually can kill her:

R; The woman was pregnant and she started being sick at home. Then people decided that she should go to the TBA. Then she delivered pretty well and was discharged and went home. She did not know that there was something that remained in her. She died three weeks after delivery. Before she died she would eat and vomit. That is why I believe that if she had gone to the hospital to be examined, she would have probably survived.
(IDI8: Stambuli – 29 years, 23rd of August)

It is further indicated that at the health centre they have the possibility to remove the 'remaining things'. For many of the participants this is one of the reasons why a woman should go to the health centre for the delivery. However, the men in this study could often not explain what exactly remained inside of the woman.

R: Some women would die a couple of days after giving birth; we hear that there are things that are remaining in them. But if they deliver at the hospital, those things that remain are removed and she is cleaned.
I: What is it that they remove at the hospital?
R: We don't know what they really remove, but we hear that they first get the baby out, and then there are also things that either come out or remain. So all those things that remain are the ones that would cause the diseases if they were not removed.
(FGD2: Machenje – under 20 years – without child or expecting first child, 12th of August)

Several participants explained that *ngokota* is the 'remaining thing' that causes problems to the woman. *Ngokota* is described by these participants as a scraping pain in the stomach of the woman after birth and this is caused by the uterus who 'wanders around in the body searching for the baby':

R; The first few weeks after delivery, the woman used to suffer, from a condition of Ngokota. (…)
I: If I am to ask you about how Ngokota goes, would you explain that to me?
R; They say it is something like Namwino (uterus).
I: What is the Namwino thing?
R; This is the thing that embraces the baby inside the women. It is this thing that causes pain after the baby is born. Because it moves from one point to another, so as it moves on hunting for the baby it causes pain to the mother. And that pain is what we call Ngokota. So as it goes around it goes like scraping, hence the term Ngokota.
(IDI1: Machenje – 60+ years, 17th of August)

Another physical problem that might occur after the delivery, and which is described by community members during one of the observation periods, is that a woman might suffer from fistula. In the interviews and the focus groups nobody mentioned fistula as a problem related to the health of a woman. According to health professionals in Mangochi district this is partly due to the taboo that lies on fistula in many communities. A woman who suffers from fistula sometimes feels ashamed of her problem and therefore will not always openly talk about it. The same can be assumed for their husbands or other male family members. However, important to mention is that in both the focus group discussions and the in-depth interviews no probes directly addressed fistula. If addressed, it might have been discussed and therefore the statement that people do not easily talk about fistula cannot be concluded from this study.

Fistula often has a major impact in the lives of women. A woman who suffers from fistula faces problems associated to fistula every day. She occasionally is outcasted by the family and the community. Moreover the sexual relationship with her husband is often affected negatively; some husbands refuse to have sex with their wives when the wife suffers from fistula and ultimately it can lead to a divorce (Semu-Banda, 2011). In the past it was often not able to treat fistula at the public health centres and some women are assumed to live with fistula over her entire reproductive life course.

During one of the observation periods the Group Village Head (GVH) visited a woman who suffered from fistula already for twelve years. As described in the field notes below, she did not get more children since she suffered from fistula. The GVH tried to convince both the woman and her husband that she should be treated at the hospital. She did go to the hospital in the past, after she had delivered and started to suffer from fistula, however they were not accepted at the hospital. The husband explained that afterwards they did not believe that it would be beneficial to visit the hospital again:

"That is where the GVH wants us to go", Ndulu (guide) said to me. "What are we going to do there?" I asked. "We will visit a woman there. She has fistula, it is interesting for you to talk with her. The GVH wants to talk with her", the HSA answers me.
(...)
When I stand with Kokayi (guide) and the HSA, the HSA starts to tell me: "This is the husband of the woman who is suffering from fistula." (…) The HSA tells me that twelve years ago she already got fistula after the birth of her first child. Because she has so many problems she did not have any other children anymore. (…)
(Informal dialogue, observation period 1, day 2, 31st of July, TA Chimwala)

4.1.9 Lacking family planning

The societal pressure on a married couple to get children is mentioned to be negatively influencing how family planning and child spacing is practised. The risk of a maternal death or of complications occurring related to pregnancy and delivery is believed to increase if family planning is not practised properly.

Firstly, according to the participants, girls who are allowed to marry are sometimes too young. As argued in the following quotes, some families believe it is important that a woman gets children and therefore they let her marry when she is still under-aged:

Focus group discussion:
I: Why is maternal mortality so high in Mangochi and even higher in our area?
R: Women get married too early.
I: What do we mean getting married too early?
R: Women get married whilst under aged.
R: Women are supposed to get married at the age of 18 and above, but what is happening is that they are getting married before this age and they become pregnant whilst too young for the task.
(…)
R: Some of the children get married too early as a result of influence from the parents.
(FGD5: Stambuli – 20 till 25 years – With one or two children, 15th of August)

In-depth interview:

I: Are you not thinking about marriages?
R; Oh yes that is true. We (the village members) should stop giving little children into marriage.
(IDI2: Machenje – 59 years, 17th of August)

The participants in the discussion groups in Ngatala and Stambuli explained that a consequence of young girls getting married while under-aged is that the girl will be pregnant while her body is still young and possibly not strong enough. When her body is not strong enough the risk of complications during pregnancy or childbirth increases a lot:

R: They have got cases of young woman getting married to early. When these become pregnant it becomes a big challenge for them to deliver, and a good number of these die of childbirth. These get married to early. They would get married at eleven or twelve, this means that by the age of twelve or thirteen they become pregnant, when they actually too young for the task. If an old woman would get affected with delivery, what more with somebody who is not mature and old?
(FGD3: Ngatala – 25 till 40 years – multiple children, 15th of August)

R: And what is happening with the young ones these days they become pregnant as soon as they get married.
R: They become pregnant with an immature body, such experience problems in child birth.
(FGD5: Stambuli – 20 till 25 years – With one or two children, 15th of August)

Furthermore, this phenomenon increases the chances that the girl who gets children when still under aged, will drop out of school for good:

R: The problem that we have here is that not many girls are interested in education. What education does is delaying the girl before she gets married. What happens is when the girl see that her breast are pooping she thinks of getting married.
(FGD5: Stambuli – 20 till 25 years – With one or two children, 15th of August)

During the pregnancy girls are officially not allowed to go to school, nevertheless the government tries with special programs to convince the girls to return for education once their babies are a few months old. According to a child protector, assigned by the government to make sure that teachers do not sexually abuse children and that children are going to school everyday, girls do not often go back to school after they got their first child. He mentioned in an informal dialogue that many of the girls will not stop having children after one child, therefore there is no possibility for them to re-enter education.

It is argued by the participants of the focus group discussion that when a girl is very young once she becomes pregnant the family might be hesitating in escorting her to the health centre. They might feel ashamed when they meet the health personnel and when the nurses will ask for her age. In order to prevent the shame the family might decide to go for delivery at home or at the TBAs place, which is perceived as increasing the risk of complications and death:

R: Some parents are ashamed to bring their daughters for delivery at the hospital just because the daughters are too young for pregnancy.
(FGD3: Ngatala – 25 till 40 years – multiple children, 15th of August)

Secondly, alongside the phenomenon that women are getting married and have children when they are considered too young, the participants mentioned that in some cases women are too old once they become pregnant. It is not clearly explained what the exact physical consequence is if an older woman becomes pregnant, however death is also mentioned in this context to be an eventual outcome:

I; It appears you have two issues here; you have said the mothers are quiet young, and you have also said that women are giving their daughters too early into marriage.
R; Yes the problem is with the mothers. Some are still insisting on giving birth at a age later than 40. That is why the deaths would still continue because they go beyond in age. So we have a double problem here. That either the women are having children too early or too late. And because of this death would still continue.
(FGD1: Machenje – above 30 years – minimal 3 children, 12th of August)

R: We have two groups. Some are getting married too early, for them to give birth is always a problem. Others are getting pregnant when they are too old; they also have problems in giving birth. A pregnant woman can die.
(FGD2: Machenje – under 20 years – without child or expecting first child, 12th of August)

After a woman gave birth the question arises for many couples if they want to have more children, and if so, how long after the recent birth this should take place. The participants indicated that women are supposed to be on contraceptives in order to make sure that they will not get too many children and that she will not give birth with too short birth intervals. In several focus group discussions it is furthermore recognised that without proper child spacing the risk of experiencing complications during pregnancy or delivery increases:

R: The other thing is having too many children, like fifteen, that is an accident. It should be four or five we should learn to be on contraceptives.
R: Women should not give birth frequently, this can lead in accident.
I: What do you mean by accident?
R: She can die.
(FGD5: Stambuli – 20 till 25 years – With one or two children, 15th of August)

R: Some of the problems that we are having are that we have too many children and it is difficult to care for them. If you have two or three children you are able to take care of them and the woman has time to rest.
R: If a woman has frequent births the uterus wears out. That would be one of the causes for such deaths. But if the children are spaced, the woman is giving time to rest and replenish her body.
(FGD3: Ngatala – 25 till 40 years – multiple children, 15th of August)

4.1.10 *Ulwere*

From the last paragraphs it is clear that getting children is believed to be a dangerous event for women in rural Mangochi. The word the participants use for the delivery further indicates the perceived danger of going into labour. As shown in the following quotes the participants referred to the delivery as the '*ulwere*', which means literally 'the sickness'. When a woman is going into labour the participants compared this event to the event of the woman falling ill. The word *ulwere* is used without distinguishing between a delivery with complications and a delivery without complications. In practise this means that women have to make sure they remain strong, and the man is supposed to take care of the woman as if she is ill, in order to survive the 'illness':

I: Were there any strange eventualities during the pregnancy?
R; She had ten children and the pregnancy was the eleventh one. When the Ulwere had started I was told that she was failing to deliver, then we decided to go to the hospital. As we were going to the hospital she gave birth on the way. Both the baby and the mother died.
(IDI4: Machenje – 35 years, 18th of August)

R; The strange thing that I saw was the Ulwere, she became very sick and I was afraid she would die.
(IDI6: Machenje – 40 years, 18th of August)

R; I get involved because the time I was getting her she was quite alright, but now she is like this; then I am always concerned. If the Ulwere begins at night we are always together. I am always with her, either to the hospital or providing whatever is required of me as a man.
(IDI1: Machenje – 60+ years, 17th of August)

From this first section it is clear that getting children is besides a joyful and a necessary event, perceived as an event that is characterised by a lot of concern; concern about the health of both the mother and the child. The following interviewee from Machenje explained that as a husband the day of delivery is a time of uncertainty, uncertainty about if the delivery will have a positive or a negative outcome:

I: This means that you were outside all the times when your wife was delivering, is that right? How do you feel about this?
R; It was a painful experience. Painful because I was thinking, is God going to forgive us. So those were thoughts, then upon Gods forgiveness you would just hear that there is a baby inside. Of course I would get worried that I was outside and my wife being inside. You never know what plans God has for her. (…)
(IDI1: Machenje – 60+ years, 17th of August)

4.2 Research results section: Men's perceptions about pregnant women

In the first section of this chapter it became clear that the participants assessed getting children as a riskful event. The risk of a maternal death seems to be an ever present risk in rural Mangochi. Additionally the participants described several complications that might emerge during pregnancy, delivery and post-natal.

This section will discuss how this ever present risk shapes the perception the men in this study have towards pregnant women. When discussing the different roles and responsibilities of men and women in the community the participants described many features or characteristics of how women should behave and live. As already described in the last section are women seen as very important and especially their role as companion and mother are mentioned as irreplaceable.

Firstly this section will discuss the different responsibilities of women in general (paragraph 4.2.1). It will also explain how these responsibilities change for a woman once she becomes pregnant. The participants reflect on the ideal behaviour of a pregnant woman in comparison to a woman who is not pregnant. She is supposed to change her lifestyle drastically in order to make sure she remains healthy and she survives the risky event she is facing (paragraph 4.2.2). Improving the strength of her body and preventing the woman being exposed to bad influences such as witchcraft and having negative thoughts in mind, are supposed to serve as prevention. It is supposed to prevent that women who are perceived as *wapakati* (in between) life and death will die or suffer because of bearing children.

The image of women, as perceived by the participants, will give an insight in the gender roles in the society. In this section it will be explained that not only the expected responsibilities and the behaviour of women are supposed to change, also the perceived image men have regarding women changes once women get pregnant. On the one side women are *wapakati* life and death and they need to be protected and supported by the husband, so that she does not die. On the other hand paragraph 4.2.3 will show that a woman who is pregnant or who has just delivered is perceived as something 'scary'. Not only the mother and the new-born are in danger of dying during the period that a woman is getting a child. Some participants believe hat the husband is also at serious risk, the risk of be infected with a disease called 'c*hinyera*'. The differences and similarities of HIV/AIDS and *chinyera* will be discussed from the perspective of the participants. Several customs are also described in paragraph 4.2.3 which contribute to the image that pregnant women are 'scary'.

4.2.1 Role women in the village

Before discussing how, according to the participants, the behaviour of women should change once they become pregnant, this paragraph will reflect on what general role women have within the community. The different roles and responsibilities for men and women in the community are indicated to be very clear, although there are always exceptions. During the observation periods it was quiet notable to see the separation of the men and women in everyday life. At least in public places, e.g. at village centres, at the water pump, or at a social event like a football match, women and men were gathering together in small gender-separated groups. The following quotes from field notes taken during the first observation period describe the separation of men and women respectively at a football match and at the village centre:

We talked shortly before Salar and Masrur (male family members of host family) came towards me. The audience was leaving the field very fast, I only see Mehrnaz and Hameeda (female family members of host family) standing still with a group of women of about 30 women. Some of them carrying a baby on the back in the Chitenje.
(Field notes, observation period 1, day 3, 1st of August, TA Chimwala)

When I looked around I saw only six women standing together ten meters away, still looking at the tree that was going to be cut down. Two of them had a baby on their back, put in the chitenje. Next to one of the women a small girl, in a green dress and a red sweater on top of it which was way to big for her, was standing and holding the leg of the woman. I saw only groups of men or groups of women here, they were not mixed in one bigger group. I saw Salar and Sumeer talking to some older men who were sitting in front of a grocery shop.
(Field notes, observation period 1, day 5, 3rd of August, TA Chimwala)

In the villages it is possible to observe several groups of men, mainly gathered around a *Bawo* game (a traditional Malawian board game played with hard seeds) or around a building where they had a radio or where they could recharge their cell phones:

It was definitely more crowded than at other places in the village. I saw a group of men sitting on the left side, and a group of men standing on the right side. Another group of men were standing and sitting around a Bawo game. A lot of the men turned around when we walked by, some of them really smiled and greeted me from a distance, and shouted some remarks to the Salar, Ilam and Jari, who did not reply a lot and laughed a little. One group of younger looking men did not reacted when Salar shouted something to them. They were dancing and laughing together while listening to music coming out of one of the shops.
(Field notes, observation period 1, day 2, 31st of July, TA Chimwala)

Groups of women on the other hand were more observed at places like a water pump, at the back yard or outside the village carrying firewood or food. People walking on the small dirt roads around the villages, were almost always accompanied by others from the same sex:

Besides children we did not meet that many people on the dirt road. Several times we crossed small groups of women, mainly groups of three or four women. Every time the women carried buckets, baskets or bags, and most of the times they did this on their head.
(Field notes, observation period 3, day 3, 7th of October, TA Mponda)

Within the community a distinction exists regarding which responsibilities are in general for women and which are for men. The participants indicated that the man is the main authority in the house (further discussed in paragraph 4.1.1). The next discussion, among others, shows however that occasionally the woman might pretend to be just proposing an idea, when in fact she is demanding that the proposed idea will be executed:

R: The man has the authority.
R: All the social activities are lead by the man.
R: The woman may make suggestion but the man has to make decisions to what has to be done.
(FGD5: Stambuli – 20 till 25 years – With one or two children, 15th of August)

During pregnancy the participants further indicated that the authority within the household switches to the woman; she is deciding what is supposed to happen and what not, as mentioned in the following quote:

I: When the wife is pregnant, who decides at home?
R: It is the woman that decides. She may sounds suggestive but whatever she says has to be done. A pregnant woman is like a patient in the hospital; whatever she says has to be done.
R: When she delivers the decisions go back to the man. Because men do not necessarily listen to women normally. In ordinary times the man is in control. In the families we do discuss and agree, but the husband is the head of that.
(FGD2: Machenje – under 20 years – without child or expecting first child, 12th of August)

The participants also gave an example that women's authority becomes very strong when it concerns the circumcision of the children. Women frequently want the circumcision of their children to be done in the traditional way, which involves traditional ceremonies:

R: Oh yes, things like initiation ceremonies women are always in forefront. Men may control, but women are always ahead. For example if the woman says I want the initiation of my child with a real celebration, it will be done in that way.
(FGD3: Ngatala – 25 till 40 years – multiple children, 15th of August)

Although many women might have the authority during the time that they are pregnant, the earlier described example (paragraph 1.8.4) of the woman who suffered from fistula already for multiple years is an example of a woman who after the delivery is clearly not in charge of her own well-being. The visit with the Group Village Head (GVH) and the Health Surveillance Assistant (HSA) started with a private conversation with the husband alone for about ten minutes. His wife joined later in the discussion after her husband had agreed on her going to the hospital again. She replied shortly with a agreeing nod and left into the house again:

When I stand with Kokayi (guide) and the HSA, the HSA starts to tell me about the old man: "This is the husband of the woman who is suffering from fistula."

(…)

The GVH then started talking to the old man again. He listened a lot, did not say a lot, and I could also not observe any obvious body signals. Sometimes he nodded a little or he displaced his feet in front of him. I think the conversation took about ten minutes, when the HSA and the others suddenly turned to me a little and asked me if, when I would be picked up, could bring his wife along with me to Boma (Mangochi city). The old man seemed to agree now to let his wife go to the hospital. The HSA further explained that the man now beliefs that she has a problem and is willing to co-operate.

(...)

Only after this long discussion (with the husband) the woman came from inside of the house and she said on the ground half behind her husband. (…) She also did not say a lot, and after the HSA the GVH said something to her. Then she nodded, gave all of us a hand and moved back in the house again. 'She thanked us for the opportunity', the HSA said to me. And she will be ready to go the hospital when she is asked to.

(Informal discussion, observation period 1, day 2, 31st of July, TA Chimwala)

4.2.2 Men's expectations towards the ideal behaviour of pregnant women

The men in the in-depth interviews and focus group discussions were asked about the responsibilities of men and women. Regarding the many tasks at home and in the village the roles played in these tasks by men and women are very separate from each other. Domestic work such as cooking, washing, fetching water and gathering firewood is specifically mentioned as tasks for women, where construction and work in the garden is more targeted towards men. However, several men also indicated that the separation of tasks is old fashioned and both men and women can perform similar tasks. In the next quote a lively discussion among a group of young men (aged 20-25 years) shows that nowadays the separation is not that strict anymore and that not everybody agrees on the traditional division of male and female tasks in the village:

I: When we say there are no differences what do we mean?

R: It means that these days we would be able to find a woman constructing a house or a fence, men are also cooking as a task.

I: Are we trying to agree that there is no work that a man can do without being laughed at?

R: There are.

R: No there aren't.

R: If people see a man washing baby nappies people would laugh at him.

R: If people see a man pounding, people would laugh at him.

R: What is happening is this: that people are laughing of course, but people are doing whatever they want.

I: If people laugh at you it means they see something abnormal about the work. Where does the abnormality lie?

R: Of course there is something that the people laugh at, in principal there are roles of women and roles of men.

R: Drawing water is a task for women; washing nappies and pounding are tasks for women.

R: Going into the bush to fetch firewood is the task for women.

(FGD5: Stambuli – 20 till 25 years – With one or two children, 15th of August)

When women become pregnant they have to, according to the men in this study, change their behaviour drastically. Many new responsibilities for the woman are associated with the pregnancy, delivery and post-natal period, and will be discussed in the following paragraphs.

4.2.2.1 Dress properly when pregnant

Firstly, the participants in this study indicated that women should dress properly once they are pregnant, meaning that they wear at least one *chitenje*. A *chitenje* is the most common piece of cloth with which a woman in the rural areas of Mangochi dresses herself. More importantly, the *chitenje* has multiple functions: Mainly a *chitenje* is worn as a skirt, occasionally an entire suit is made out of the cloth, and often it is used by women to carry their baby on their back.

When a woman is pregnant she often wears multiple *chitenje* skirts. As the participants in the focus group discussions explained, the more *chitenjes* a pregnant woman is wearing the better she and her husband will be seen in the community. Multiple *chitenjes* mean that the couple is prepared for the pregnancy and that the couple has enough money to take care of the pregnancy:

I: What kind of behaviour a pregnant woman is supposed to have?
R: She should improve on mode of dressing. For example is she was wrapping her Chitenje below the belly it should go up to the chest so that the stomach should not be featured.
R: She should be using two or three of the Chitenjes so that she should be well respected. Even in the mode of sitting she should be respecting herself.
(FGD4: Ngatala – 17 till 22 years – one child, 15th of August)

R: She is also instructed on how to dress properly. She is not supposed to put on tight clothes. She should put on a well respected maternity gown. This is a dress kind of thing that really makes her feel free inside. She should use two chitenje. This is all done to make sure that the pregnant woman is very well respected
(FGD2: Machenje – under 20 years – without child or expecting first child, 12th of August)

During one of the observation periods the *sikelo* (antenatal care clinic) was attended, where all the woman wore clean *chitenjes*. The field notes during this observation period show that the women all wore at least two *chitenjes*. All the different colours and motives of the *chitenjes* make a group of woman look beautiful and eye-catching. However it also makes it possible to discover more easily if a woman wears a second or third *chitenje* under her *chitenje* dress:

A few women who did get all the check-ups and measures sat down on the concrete benches where I also sat down with Chifundo. The four women in front of us looked at me almost non-stop. All the women were wearing several chitenjes in many different colours, one woman even looked to wear three chitenjes.
(Field notes, observation period 1, day 2, 31st of July, TA Chimwala)

When a pregnant woman would not wear multiple *chitenjes* or would wear *chitenjes* that are dirty, it is believed that she will be seen as 'unhealthy or unintelligent', and her husband will be seen as 'not caring' towards his wife:

R: The one who has her body deteriorating is considered unhealthy. The one that puts on dirty clothes and doesn't wash her body is unhealthy.
(FGD5: Stambuli – 20 till 25 years – With one or two children, 15th of August)

4.2.2.2 Being healthy

Secondly, the participants in this study clearly indicated the importance of good health during the pregnancy and post-natal. If a pregnant woman is healthy or unhealthy is often judged by her appearance. When the participants were asked to mention what it means to be healthy during pregnancy and delivery, many physical characteristics are mentioned. In the focus group discussions and the in-depth interviews the participants indicated that a healthy pregnant woman is a woman who looks good and beautiful, which mostly is further explained as a woman who is 'plump' or 'reasonably fat'. After the delivery a healthy woman is supposed to look strong, as if she had never delivered a baby. Furthermore, as also shown in the following quotes, pregnant women who look thin and are often sick are perceived as unhealthy. Unhealthy women are supposed to not have strength remaining after birth, and consequently would become even thinner and will look less beautiful:

In-depth interview:

I; If we say somebody is healthy, what can this mean in relation to women that has just delivered?
R; If we say somebody is healthy, this is something we see with our own eyes. So a woman that has delivered, and is healthy, has a body that is good looking and reasonably fat. Normally when a woman is pregnant she has to be plump and beautiful. And this beauty does not go with delivery then we know this one is healthy. But if she becomes weak and thin, then we know this one is not healthy.
(FGD1: Machenje – above 30 years – minimal 3 children, 12th of August)

Focus group discussion:

R: When a healthy mother delivers her body remains intact. So much so that you would not believe that she just had a baby. Where as somebody that is not healthy would look worn out after giving birth.
R: Some healthy women would even look as they have never given birth at all.
(FGD2: Machenje – under 20 years – without child or expecting first child, 12th of August)

The participants further indicated that if a woman is unhealthy, the ultimate consequence could be death, either during the delivery or during the post-natal period:

R; When such a woman delivers, she continues to be weak and thin. She never recapitulates. And consequently dies, leaving somebody behind.
(FGD1: Machenje – above 30 years – minimal 3 children, 12th of August)

The discussion in paragraph 1.7 about a woman who suffered during every delivery she had because she was infected by an STI, likewise shows that if a woman is unhealthy during her pregnancy she faces a higher risk of complications. She got treated for the STI however her husband was not treated and therefore she had the same complications with every delivery again and her health deteriorates more after every delivery. The next quote is from the observational field notes where the head nurse Chifundo explained me the danger of being unhealthy in this case:

I asked how the woman (who had just delivered) was doing at the moment and Chifundo replied: "She is very weak. She can not get dressed herself. We will have her at the hospital (the health centre where I am staying), she can not go home. You must know, when she has an STI, she can die at labour, you know that ok?" I nodded and wrote down what she just said. She continued: "Now she is very weak. Every time after she has a child she is weak. She is loosing a lot of blood, which can kill her later. Because she is weak, she must stay at the hospital."
(Informal dialogue, observation period 3, day 2, 6th of October, TA Mponda)

Being healthy or unhealthy as a pregnant woman is directly linked by the participants in the next quotes to having sufficient and good quality food available. Pregnant woman are supposed to eat good amounts and a wide variety of food, which will eventually result in a strong body that is able to handle a pregnancy and childbirth and a body which will recover much faster after childbirth:

I; (…) How can a woman remain healthy during the whole period of pregnancy? But before we proceed to this, maybe we could start by agreeing by what it means to be healthy.
R; So when we say a person is healthy, or a pregnant woman is healthy, we mean somebody who has a very good diet and is never often sick.
R; It refers to somebody with good food and with a very strong body.
(…)
R; It is possible if one has a good economic stand and is having good food. Like meat and vegetables. But this also has to go along with the condition of the body. If somebody is eating bad food or poor quality food, for example vegetables that have baking soda applied to it, you cannot expect that one being healthy.
(FGD1: Machenje – above 30 years – minimal 3 children, 12th of August)

R: It is possible (for a woman to be healthy when getting children). Some may be affected from the first month but later on they will pick up their health again.
R: Eating habits determines the health of the woman. If she is eating very well there is nothing that she is going to change, even if she has given birth. A woman that has just given birth requires to eat, and many eat massively.
(FGD4: Ngatala – 17 till 22 years – one child, 15th of August)

Furthermore, it is explained that the baby will be healthier and stronger when the mother is healthier. According to one of the health workers at the malnutrition clinic a mother will be able to give more and better quality breast milk when she is healthy:

Agimah further explained me that if people would get a bag of maize meal, it was meant for the mother as well: "She needs to be stronger as well, and healthier. The mother gives better breast milk then."
(Informal dialogue, observation period 3, day 4, 8th of October, TA Mponda)

It is finally explained by several interviewees that it is important that a woman directly after birth drinks sufficiently. Women are supposed to drink a lot of coke, Sobo (orange lemonade) or water with iron tables in order to regain strength and replace the lost blood:

I; Does that mean that both your wives do not change whilst pregnant? Then what changes in you when your wife is pregnant? Not even the diet?
R; (LAUGHTER) The food may vary according to need and time. Like just after delivery we would give her Sobo to drink, so that it should replace the blood lost in labour. If you look at her just after delivering you would see that she looks pale, showing that she has become anaemic.
(IDI2: Machenje – 59 years, 17th of August)

4.2.2.3 Working more moderate

Thirdly, women that are pregnant or who just had a baby are expected to work less or more moderate. Many tasks they used to perform before the pregnancy are indicated to be too heavy for them. The participants indicated that in order to protect the pregnancy and the health of the women, women are supposed to work on lighter duties. In the next quotes it is argued that tasks as fetching firewood in the 'bush' or carrying many goods on the head are too heavy tasks:

In-depth interview:

I: So as long as she is eating good food everything is ok, not to think of workloads?
R: We think of amount of work that she does. Actually what we do is, when she is getting tired we stop her for doing some of the hard works.
(IDI7: Stambuli – 72 years, 23rd of August)

Focus group discussion:

R: She should be working moderately. So that her body gets strong enough, but at the same time does not get exhausted.
R: When my wife is pregnant, I allow her to do what she feels she is able to do, and I advise her that she should keep and follow the instructions that she gets from the hospital. Whenever the task is big, the husband has to come in and help out.
(FGD3: Ngatala – 25 till 40 years – multiple children, 15th of August)

When pregnant women are facing hard tasks, the participants explained that men have to step in and help out. This is not always seen as an easy task for men, and especially the first weeks after birth are not always easy. Several participants complained about the 'laziness' of women in this period, however mostly the participants also added that they understand that the women are not supposed to work, and that them taking a rest is necessary for obtaining good health:

I: How would you rate the period just after giving birth, was it a good time or bad time?
R; I would describe the time as a bad time because she would not do things as she would do as when she is ok. She is always busy.
I: Busy why; busy with what?
R; Busy in taking care of the new born.
(IDI3: Machenje – 60 years, 17th of August)

R; I think the other thing that I can mention besides being rude is that she is lazy. At most of the times she doesn't want to do anything at home, but I knew what was happening. During postnatal what I also do is make sure that I do most of the work, so that she rests.
(IDI5: Machenje – 30 years, 18th of August)

As discussed, pregnant women or women who just had a baby are supposed to take on lighter work. During the observation periods several women looked to be working very hard, although they were pregnant for maybe seven to eight months or although they carried a young baby on their back. In one situation described by the following field notes, the woman was carrying a lot of firewood on her head while being pregnant:

Nobody really talked, everybody was puffing in the heat. I further saw a highly pregnant woman walking by with a big pile of firewood on her head. A small boy walked next to her while holding her

hand. The other hand she used to hold the firewood in balance. I could see the sweat dripping of her face.
(Field notes, observation period 3, day 3, 7th of October, TA Mponda)

In another situation several women were working hard with a pickaxe in the field while their young baby is sleeping on their back in the *chitenje*. The following quote from the field notes shows that the work the mothers conduct is very physical and is performed during the warmest time of the day:

Halfway this field of high dry grass, I see nine women standing next to each other in a long row. They are cutting the grass in front of them with a big pickaxe. Behind them I see already a couple of meters of flat cut grass and bushes. Besides the two women on the left, all of them have a baby on the back in the chitenje. It is hard to see but some babies look very small and young. Also Mehrnaz is standing between them, with Azizi on the back. When we come closer I see that they are all sweating. Mehrnaz is smiling and she is telling something to the others. They are all laughing. I guess, they are all aged between 25 and 50, not really young women and not the most elderly women.
I ask if I can try it out. Mehrnaz gives me the pickaxe and I look at the woman next to me how to do it. They hit the ground straight in front of them, and when pulling the pickaxe up again they shake it, to let it come loose from the ground. The woman next to me, with a really small baby sleeping on the back, hits the ground and I see the vegetation is all cut very close to the ground. I do the same thing, making sure that I do not hit my own toes. However not much result could be seen, all the dry grass was still pointing 40 centimetres up in the air. The women around me laugh out loud, so I do my second hit much harder, making a big hole in the ground but leaving the grass still standing. I kept trying, but the result was almost invisible. Besides, it took a lot of strength, because the pickaxe is so heavy. It is hard to believe that these women do this so easily, maybe for a lot of days in a row, and with a baby on their back.
(Field notes, observation period 1, day 3, 1st of August, TA Chimwala)

During the observation period it became clear that not everybody is exactly following the same guidelines of working moderately and of only take on light tasks. According to Chifundo, nurse at a health facility, do some women believe they have to work really hard in order to take care of the family:

When I asked Chifundo about this (two women being at the antenatal care clinic for the first time after seven or eight months pregnancy) she explained me that some women come very late to the health facility for sikelo. "They do not want to go to the facility, until the last moment. They say they have to work in the garden or that they have to take care of the home."
(Informal dialogue, observation period 3, day 2, 6th of October, TA Mponda)

Working more moderately does not mean that the participants believe that pregnant woman should not perform any actions. The participants explained that some physical exercise is essential for the women in order to have a strong and healthy body which is ready for the delivery:

I; Are there any particular activities that you may probably recommend that a pregnant woman should do?
R: She (a pregnant woman) should be having physical exercise like short dashes.
R: She should carry on light duties, not hard ones.
R: Whatever she carries on her head should not be excessive.
R: She should be working calmly, not to agitate what she is carrying.
(FGD5: Stambuli – 20 till 25 years – With one or two children, 15th of August)

They received this advice from the health workers in the area. Also at Mangochi district hospital, pregnant women who are waiting for going into labour are expected to run up and down several times every evening:

Focus group discussion:
R; At the hospital they (pregnant women) are advised to be carrying out physical exercises like jogging. They should not be lazy. They should be able to carry out simple works. That makes their bodies physically fit in view of labour.
I; Are there any specific activities that are necessary in view of delivery?
R; She only has to make sure that the exercises are carried out so she is fit in preparation for labour.
(FGD1: Machenje – above 30 years – minimal 3 children, 12th of August)

A young community member of a village visited during the first observation period, explained that his wife was pregnant and is therefore sleeping a lot. He additionally argued that his wife should also occasionally walk around in order to remain healthy:

The pregnant wife of Sumeer left at the meanwhile already, so unfortunately I do not have time to talk to her. I asked the others if we she lived close by. They explained that she lived with Sumeer in a house very close, maybe four houses away I think is what they meant. 'She is very tired always and sleeps, at the hospital they say she have to have rest a lot. But uh, she is walking around as well sometimes, those people in the hospital give us that advice', Salar explains.
(Informal dialogue, observation period 1, day 4, 2nd of August, TA Chimwala)

4.2.2.4 Abstain from sexual relationships

The fourth expectation the participants mentioned regarding the behaviour of a pregnant woman is that pregnant women and women who just had a baby are supposed to be abstinent from any sexual interaction.

In the next quotes it is shown that participants of the focus group discussions believe that women have sex with other men quite regularly. They mentioned that most women are having sexual intercourse with other men:

I: Is there any other reasons (for problems that occur during delivery) apart from these two?
R: Most women mix blood. They sleep with different men, and by the time they get pregnant it is all mixed.
(FGD2: Machenje – under 20 years – without child or expecting first child, 12th of August)

R; Most of women are loose. So they sleep with more men, as such they don't even need the fisi (hyena, see paragraph 3.3.3). By the time somebody organises the hyena for them, they would already have slept with several men. They are doing it on their own.
(FGD1: Machenje – above 30 years – minimal 3 children, 12th of August)

The participants explained that women should not have sex with other partners. It is believed that having sex with other men could lead to 'mixing blood', which again could result in complications during delivery or even a maternal death:

In-depth interview:

I: What is that which would lead to either improvement or the downfall of life in your family?
R; If one chooses to abstain for the sake of a longer life and the other one doesn't, then it would be the downfall of the family. That is putting the life of the other partner at risk.
(IDI4: Machenje – 35 years, 18th of August)

Focus group discussion:

R: Women should not have multiplicity of partners. Otherwise when they get pregnant and give birth they would have problems. And these would contribute to the high maternal mortality.
(FGD2: Machenje – under 20 years – without child or expecting first child, 12th of August)

Consequences that might emerge from extramarital relationships vary from being infected with a disease such as HIV/AIDS, to eventually not having a husband to support the pregnancy and the new-born. Several participants indicated that if a woman gets pregnant in the 'bush' (with a random sexual partner) she will have difficulties because she will be on her own to take care of the pregnancy:

R: Some other women have pregnancies from the bush, so care is really limited. Such women can not manage to meet all requirements of the hospital by themselves.
(FGD3: Ngatala – 25 till 40 years – multiple children, 15th of August)

A pregnant woman or a woman who has just delivered is also supposed to be abstinent from her own husband. The reasons for abstinence are later discussed in paragraph 2.3. The next participants from a focus group discussion explained that a woman should not seduce her own husband:

R; She should make sure that she is quiet distant from the husband. (...) So what is suppose to happen is the woman should moderate herself not to seduce the man in anyway up until the abstinence period is over, whether it is six or seven months.
I; It sounds good, but can somebody clarify please?
R; What I mean is the woman should take care of herself not to look or be seductive to the husband. I am saying this because there are woman who by choice dress and behave in a manner that is seductive to their husbands. (...)
(FGD1: Machenje – above 30 years – minimal 3 children, 12th of August)

However, not all participants agreed on the prescribed abstinence. The participants who did not agree argued that it is old fashioned and dangerous to abstain, because the woman might try to find another men to have sexual intercourse with before the end of the abstinence period:

R; We are not waiting for anybody who come and advise us about when to resume sex. We resume it when we long need it. The danger of not doing it this way is that if you don't start early somebody will start for you.
(FGD1: Machenje – above 30 years – minimal 3 children, 12th of August)

4.2.2.5 Ignorance of women

Apart from extramarital relationships it is indicated by the participants that some women should prevent that they are ignorant towards improving their own survival chances during pregnancy and delivery. Women who are pregnant refuse or delay going to the health centre out of ignorance. The participants explained that pregnant women use several 'excuses' for not going to the antenatal care clinic or to the health centre for delivery. E.g. it is mentioned that some women say that they only want to go to the health centre when she gets new clothes and shoes:

I: What can we do so that we reduce the number of women dying during child birth?
R: Some are always late in starting sikelo, so they kind of nurse problems in themselves, unknowingly.
R: Women would have lame excuses for not starting going for sikelo. Some would like to have new clothes, new shoes. So this would be a very big challenge for a family that is economically already challenged.
(FGD3: Ngatala – 25 till 40 years – multiple children, 15th of August)

Women are also supposed to be sharing reasons for why they should not go to the health centre. E.g. they tell each other stories about medical instruments that are remaining after a visit to the hospital:

R: It is very difficult for us. There is nothing that we can do; we tell the women to deliver at the hospital but they don't want to.
R: They have got their own stories that they share about the dangers of going to the hospital. They have got stories of metal insertion and the like so they would only go to the hospital when they have no other option.
(FGD4: Ngatala – 17 till 22 years – one child, 15th of August)

Ignorance or stubbornness of women is further mentioned several times in association with riskful behaviour. Some participants believe that women are sometimes too stubborn, do not listen to the advices of the health workers, and keep on insisting on delivery at home, thereby putting themselves in danger:

In-depth interview:
R; To move from here to Katema is very far. So because of this many women were compelled to deliver at home. Of course what made them to deliver at home was ignorance.
(IDI7: Stambuli – 72 years, 23rd of August)

Focus group discussion:
R; Some of the women are just stubborn. They do not collaborate with the maternity staff. That is to say the maternity staff would tell them to do one thing and they won't do it. Some would even undermine the medical personnel to say I am able to give birth myself alone. Others would say: "I have my mother; she is able to help me give birth".
(FGD1: Machenje – above 30 years – minimal 3 children, 12th of August)

Especially girls or young women are supposed to be more negligent towards going to the health centre. They are considered to be more afraid of treatment and operations at the health centre than older women:

I: It has been noted that a number of maternal mortality is very high in Mangochi and even higher this site. We don't know why, maybe you can help us?
R: Most of the parents give their children into marriage too early. Unfortunately such are negligent in going to the hospital. People share fears if they go to Mangochi for example, they fear of being operated on.
(FGD2: Machenje – under 20 years – without child or expecting first child, 12th of August)

The extramarital relationships and the stubbornness are mentioned as examples of purposeful behaviour of women that have a negative impact on maternal health. In these examples the participants indicated that women should change their behaviour if they want to reduce the suffering related to getting children. However, the participants also explained that women are not always aware of the risks due to a lack of information that is provided to them. Both of the participants who are quoted below, explained that women occasionally do not have the knowledge to recognise signs of complications during the pregnancy or the post-natal period, therefore putting their own lives at risk:

Focus group discussion:
I: Why do women die after giving birth?
R: If we are to talk of the village, once the child is born that is all. There is no sufficient care for the mother. The mother may claim that she is all right without knowing that she has internal complications.
(FGD3: Ngatala – 25 till 40 years – multiple children, 15th of August)

In-depth interview:
I: So you said, had the people gone faster (then the maternal death could have been prevented). What can you say about this? What happened?
R; Then she delivered pretty well and was discharged and went home. She did not know that there was something that remained in her. She died three weeks after delivery. Before she died she would eat and start vomiting. That is why I believe that if she would have known that there is something remaining in her and if she had gone to the hospital to be examined, she would have probably survived. She did not know she would die because of it all.
(IDI8: Stambuli – 29 years, 23rd of August)

The participants furthermore explained that women sometimes do not know the advantage of particular actions and therefore do not change their own behaviour. As the following participant from a focus group discussion in Ngatala mentioned, some women do not know the advantage of visiting *sikelo:*

R: There are woman who are reluctant in going for sikelo because they don't know the advantage of that.
(FGD4: Ngatala – 17 till 22 years – one child, 15th of August)

In the following quote an interviewee from Machenje indicated that advising women regarding behavioural change will contribute to improving maternal health:

I: Maybe you would have some views or suggestions saying that if we would do this or that we would improve the lives of women in the district.
R; If we are to promote lives of these mothers, we should be frequently advising them.
I: Which advises can we be giving?
R; Advices to restrain themselves. People should have a hard working spirit, so that each one should have his or her own.
(IDI1: Machenje – 60+ years, 17th of August)

4.2.2.6 Preventing kupesya

Sixthly, apart from dressing properly, eating healthy, performing only moderate physical exercises, and abstaining from sexual intercourse, the participants explained it is important for pregnant women not to argue or to have a fight with anybody. It is important that nobody lives with *kupesya* (a grudge in the heart towards others), the woman and other community members who have a connection with the woman have to make sure they do not live with *kupesya*. The participants mentioned several reasons for why it is important for pregnant women not to live with *kupesya*. First of all, 'peace in mind' is essential for a woman to be healthy; therefore both husband and wife have to hold their temper as much as possible. It is explained in the following quotes that if either the husband or the wife does not hold his or her temper, the woman would not look healthy during her pregnancy:

R: She should have peace of mind because even though she would be eating very well, if she does not have the peace of mind she would not be healthy at all.
(FGD3: Ngatala – 25 till 40 years – multiple children, 15th of August)

On the other hand man should not have grudges against their wives. This should be seen by the look of the pregnant woman. We expect that with the first month of the pregnancy the woman becomes plump.
(FGD2: Machenje – under 20 years – without child or expecting first child, 12th of August)

Second of all, it is mentioned by a participant in a focus group discussion that if a delivery or certain complications during the pregnancy comes unexpected, and the husband is not present, the woman needs help from other community members:

R: Its good that she relates very well with others, she has to be prepared that the sickness may start in the absence of the husband or relatives, so the friends are the ones that will help her.
R: Pregnancy is the heaviest task for a woman, she is not supposed to quarrel with anybody nor carry out heavy duties.
(FGD5: Stambuli – 20 till 25 years – With one or two children, 15th of August)

And lastly it is believed that if a pregnant woman quarrels with the wrong person, then this person can bewitch the pregnancy or the pregnant woman, which can lead to complications at child birth. Some participants explained that the baby would not be delivered until the quarrel has been reconciled. The other person who is part of the quarrel would be summoned to the delivery room in order to discuss and end the quarrel. Afterwards the delivery is supposed to continue as normal again:

R: If you don't compromise it is dangerous. Because it is like you are living with a grudge in the throat. And we call that in Yao: kupesya. Women have suffered in labour; they struggle from morning to sunset without delivery until reconciliation was made with their spouses. So the issue would be tables and sorted out there and then. After reconciling then she would deliver.
(FGD2: Machenje – under 20 years – without child or expecting first child, 12th of August)

Being always polite is supposed to be a very heavy task for women who are pregnant, because it is argued that at times they pregnant women can be very rude. Men complained about this rude behaviour and the following interviewee compared it with his wife taking drugs:

I: Maybe I should ask, what changes were there when she was pregnant. These changes could be about her life, behaviour, attitudes, anything.
R; There were a lot of changes, especially on the attitude. She had completely changed. She was violent, very rude and if I was not able to persevere I would have decided otherwise. But some people told me this happens, it is normal. You know she was like she has taken some drugs, which makes her drowsy and not be able to reason at all. Like the drugs we give fish if we want to catch them easily.
(IDI5: Machenje – 30 years, 18th of August)

4.2.2.7 Go for sikelo

The seventh expectation the participants have of pregnant women is that pregnant women are supposed to visit the *sikelo* (literally meaning 'scaling', which is the name for the antenatal care clinics). Women are supposed to listen to the advices of the health workers who are working at the health centre. The following interviewee from Stambuli mentioned that going to *sikelo* is the only possible action pregnant women are supposed to perform:

I: What do you think you can do so your wife does not die of child birth.
R; Just going to the hospital. She should go for sikelo, so the doctor sees her.
I: Don't you think of helping her in any other way?
R; No, the thing I am thinking of that is really important is going to the hospital and start sikelo. Because it is there where she receives instructions pertaining to her state. When time is up, something like nine months, we go to the hospital so that she awaits.
(IDI7: Stambuli – 72 years, 23rd of August)

The participants indicated that listening to the health workers and going for *sikelo* is essential. If women would not follow up the advice of the health personnel then they would increase the chance for complications during their pregnancy or delivery:

R: It is easier if people abide by the instructions they receive at the sikelo. If people think that those advices are just like stories for children, they really would have problems at the end.
(FGD3: Ngatala – 25 till 40 years – multiple children, 15th of August)

Furthermore, as men in one of the focus group discussions discussed, if a woman does not go for *sikelo* the chance for her going to delivery at the health centre decreases as well:

R: Women that never go for sikelo are always afraid to deliver at the hospital. Because they are afraid of the hospital personnel to be harsh to them for not going for sikelo. Such insist on delivering at home.
(FGD3: Ngatala – 25 till 40 years – multiple children, 15th of August)

During one of the observation periods a *sikelo* session which almost took half of the day was attended. 20 to 30 women of different ages attended the *sikelo* session. The session was split up in different parts. During the first part the nurses did antenatal check-ups; they listened with an iron horn-shaped instrument to the baby and they felt the position and the size of the baby. After the tests they estimated the number of weeks of the pregnancy and if the position of the baby should be considered as a risk factor or not. According to one of the nurses they advise the pregnant women that they should come latest after 36 weeks of pregnancy to the health centre for antenatal check-ups, preferably earlier:

The first building I saw was the waiting room. Ayan (nurse) explained me that this was the place where women could come to wait for delivery. From 36 weeks of pregnancy onwards, women are advised by the health personnel to come to the health centre and wait there for delivery. "It can be too late if they do not come from 36 weeks. Then they get a baby at home. We tell them that they should come always to the health centre", Ayan further explained.
(Informal dialogue, observation period 3, day 1, 5th of October, TA Mponda)

Inside the *sikelo* room where the antenatal check-ups were conducted the temperature felt very high and it was very humid inside. Everybody, including the pregnant women who were waiting in line for the check-up, were sweating. The mattresses where the women had to lay down on during the check-up itself were broken and covered by spots and holes.

After the check-up inside the women's length and weight were measured outside of the room and the nurses checked the blood pressure of the women. One of the nurses present at the *sikelo* explained that pregnant women who are considered short or light, are facing more risk of getting complications, therefore the nurses 'scaled' the women and afterwards they would pay more attention to the smaller women:

Pregnant women who are shorter or smaller are at more risk for getting complications, according to Chifundo (nurse), so they pay more attention to them during the pregnancy. The women do still not say a lot, they do not talk together and they do just answer the nurses shortly.
(Informal dialogue, observation period 3, day 2, 6th of October, TA Mponda)

Some women who attended the *sikelo* were already getting close to the day of delivery, although the actual advice given by the health personnel is to already go after one or two months of pregnancy. One of the nurses explained that this is a choice of the women themselves. The nurse explained that some pregnant women rather stayed at home to work in the field or to watch over the other children:

Chifundo (nurse) however told me before, that this 'booking sikelo' was for women who came for the first time, who are mostly one to two months pregnant. When I asked Chifundo about this she explained me that some women come very late to the health facility for sikelo. "They do not want to go to the facility until the last moment. They say they have to work in the garden or that they have to take care of the home."
(Informal dialogue, observation period 3, day 2, 6th of October, TA Mponda)

The last part of the *sikelo* was the '*sikelo* talk'. All the pregnant women sat together on concrete benches and a community health worker and one of the nurses of the health centre gave them advises concerning the pregnancy. Half of the time during the '*sikelo* talk' the women sang songs related to safe motherhood and safe childhood. The nurses explained some of the sentences they sang during the *sikelo*. As the following quote from the field notes shows, they sang about the benefits of limiting the number of children, child spacing, limiting physical work, and taking responsibility for the children:

They (the nurses) sang sentences in Chichewa to me, all sentences from the sikelo talk. When I asked them to translate the sentences they translated several sentences to me: "This is the last baby I shall have", "I will take responsibility for all my children", "I will not get children one year after another, because this is bad for the body of the baby and of myself". I asked if they also said something about the husband during the sikelo. With some smiling and laughing I got the answer: "No they don't." Ayan explained me that they repeated the same songs every time again to the pregnant women. Also the women got advice about not doing heavy physical work and they were told "Now you have grown up. Now you should not behave childless".
(Informal dialogue, observation period 3, day 2, 6th of October, TA Mponda)

It are mainly the women who are supposed to go the health centre for receiving advice at the *sikelo*. Sometimes the participants indicated that the woman is supposed to remember the instructions that are provided to her for during the pregnancy:

R; The first thing that I have told her in the first three months was to go to the hospital. I told her that there she would get instructions which we would to follow the rest of the period.
(FGD1: Machenje – above 30 years – minimal 3 children, 12th of August)

Additionally, the women who visited the *sikelo* are supposed to share the information they received from the health workers to their husbands:

Focus group discussion:
R; She should be adherent to the instructions of the hospital and make sure that those instructions are shared too with the husband.
(FGD1: Machenje – above 30 years – minimal 3 children, 12th of August)

In-depth interview:
I: I also asked you about your future pregnancies with your wife. What do you think you are going to do if your woman would become pregnant again? To make sure that she makes a safe delivery in the near future.
R; What I think is that I would make sure that my wife goes to the hospital for care, and if they tell her to come back to the facility, she should tell me, and I also make sure that she goes back whenever she is called.
(IDI5: Machenje – 30 years, 18th of August)

4.2.2.8 Behaving according to customs

Finally, pregnant women are expected to behave according to certain customs. Most of the customs that are mentioned by the participants focus on hygiene and food. An old, and according to several men outdated custom, is that pregnant women are not allowed to eat papaya and eggs. This could lead to baldness for the baby.

I; Don't we have any customs, traditions or taboos that forbid pregnant woman for doing anything?
R; Women were not allowed to eat paw-paw, eggs. It was believed that if she eats eggs she would give birth to a baby without hair on the head.
(FGD1: Machenje – above 30 years – minimal 3 children, 12th of August)

Other customs, which are still being practised nowadays, prescribe in one way or another that pregnant women should keep distant from their husbands. This is further explained in the next paragraph.

4.2.3 Pregnancy and delivery dangerous for both women and men

Women during the pregnancy or post-natal period need to be treated with special care. The participants in both the focus group discussions and the in-depth interviews explained that couples need to be aware of the dangers that are associated with getting a baby, in order to protect both the life of the woman and of the man. As already discussed before, a delivery is seen as a dangerous and risky event, in which a maternal death is a possible outcome. However, in this paragraph the perceived risks the man is facing during pregnancy, delivery and post-natal will be discussed.

4.2.3.1 Customs to prevent health risks

Firstly, during the pregnancy the couple needs to behave according to certain traditions or customs in order to protect the health of the man. Mainly, a pregnant woman is not allowed to perform certain actions which can harm a man, e.g. giving food to a man which she saved in front of her lap. Basic assumption behind these customs is that the woman's loins are affected by the pregnancy or by the menses and the man should not be in contact with this area 'where it all happens':

R; The woman is not supposed to give food to the man wrapping it at her lap. Otherwise the man who eats that food would have his teeth rotten.
I; Do these prohibitions go the lifetime?
R; No, it only lasts to the period of abstinence. Then you resume cohabitation, everybody is free.
R; The man would also have persistent headache if he is often fed with food from the woman's Chilolo (wrapper).
R; Because at the woman's loins, a lot happens. Menses, pregnancy, all happen there. So if man eats that he in a way gets contact with the woman's loins.
(FGD1: Machenje – above 30 years – minimal 3 children, 12th of August)

Also the clothes of the women are expected to dry separate from the clothes of other family members, and the clothes of the woman need to be dried inside the house, so nobody else has influence on these clothes. The exact reason was not given by the participants for these customs, however also this custom is related to prevent men to be indirectly in contact with the women's loins.

Furthermore, it is believed that men can develop physical problems if a pregnant woman is stepping over his legs. Therefore it is expected of a pregnant woman, as mentioned by one of the participants in a focus group discussion, to never step over the legs of a man when he has them crossed in front of them:

R; When a man is sitting with his legs stretched straight forward, the woman is not supposed to jump over the legs of the husband. Otherwise the man would suffer from general weakness of the legs.
(FGD1: Machenje – above 30 years – minimal 3 children, 12th of August)

Another custom, related to the danger of a pregnant woman towards the men, is that men and women are not supposed to share their bathing spot during pregnancy and the post-natal period. The exact reason is also regarding this phenomenon unfortunately not further discussed:

R; In the bathroom a woman that has just delivered is not supposed to have bath exactly at the same spot wit the husband, until when she is fully recovered. Of course things are dying out this time, but a man has to have his own bathing spot, just as the woman is.
(FGD1: Machenje – above 30 years – minimal 3 children, 12th of August)

4.2.3.2 Men at risk of being infected with chinyera

Another important feature of the risk men are facing associated to getting children and pregnant women, is that according to the participants the risk of dying is not solely reserved for women. They indicated that men themselves are also at risk of dying. The source of the risk is a woman during the post-natal period. Multiple participants believe that the problem emerges when the husband and the wife resume sexual intercourse too early after the delivery, as e.g. the following interviewee from Stambuli explained:

R; She said I should protect my life. Then she also said when the wife has delivered, I should not sleep with her so that I protect my life. If you are tempted to sleep with her, you would loose your life there and then. The woman can still be alive, but the man will certainly die.
(IDI8: Stambuli – 29 years, 23rd of August)

Woman during the post-natal period are perceived to possibly carry '*chinyera*' within them (or in Chichewa language: *kanyera*). For the woman this is considered to not be a threat, but for the man it can be fatal.

I: What did she say the man can die of?
R; In the house the woman that has just delivered, if slept with, the man would die. The man would die from Chinyera.
(IDI8: Stambuli – 29 years, 23rd of August)

In order to prevent being infected with *chinyera* the main remedy is abstinence for several months. The number of months the participants mentioned for a couple to abstain varies widely. Some participants indicated that it is possible to resume sex after two months; others go as far as twelve months:

R; Deliveries differ. Some children are born with a disease we call Lwaso. So those that are giving birth with Lwaso will only wait for seven to eight months. But those with Chinyera will have to wait for around twelve months.
(IDI2: Machenje – 59 years, 17th of August)

R; They told me that women kill men. For example if a woman has just given birth, any man that decides to cohabit with her within the first month, will die. So to avoid this that is why they advised me to wait for a period of six months.
(IDI10: MasambaUma – 28 years, 24th of August)

As just explained, a man can be infected with *chinyera* if he would choose to resume sex too early after childbirth. During sex the couple mixes blood and *chinyera* is transmitted from the woman to the man. Especially when the woman reaches an orgasm, it is argued by the following interviewee from Machenje, that the man would 'suck' all the *chinyera* to himself and therefore putting his life at risk:

I: What will kill the man?
R; The disease, he is going to catch from inside.I: What disease?
R; The blood and some other remains from inside. The worst would come if the woman reaches orgasm much earlier than the man, the man is going to die because he is going to suck KANYERA from the woman.
(IDI6: Machenje – 40 years, 18th of August)

Another participant also indicated that witchcraft plays a role in a woman getting *chinyera*. In his explanation, a woman gets infected by *chinyera* as a result of a witch who as soon as the childbirth is announced puts a spell on the birth. Nowadays, the community members do not publicly show anymore that they received a baby, therefore preventing witches to put a spell on the mother:

R: During our days when the woman had just delivered we would wait for up to twelve months. So the date to resume sex, they would recognise some helps and put it at the door. So this was quiet ceremonious. As a result it had has been made public. So witches would get involved. So the type of herbs used would depend on how the baby was born. If the baby was born with Chinyera (in the woman) one type of herbs would be used, if it was born normal another type would be used. These days we are safer, because we don't announce that we are resuming sex, so the witches do net get involved.
(FGD3: Ngatala – 25 till 40 years – multiple children, 15th of August)

The following quote explains that the longer a couple abstains from sex, the less *chinyera* will be present in the woman and the less problematic the consequences would be for the man if he would get infected:

R; They say kanyera has stages of seriousness. Immediately after birth it is strong. But it reduces as the time goes by after birth. They say from four to five it is reduced.
(IDI5: Machenje – 30 years, 18th of August)

In the focus group discussion the participants stated that, besides dying, a man can be confronted with back pains, a failing erection, not being able to walk anymore and general body weakness, in the scenario that he would catch *chinyera*:

R: If a baby is born, we hear the mother has been cleaned up, a thing we did not have in the past. So the things that get cleaned are the ones who used to give problems to women in the past. So with all those things inside the woman, once you sleep with her, you get in contact with those things and then you have your back absolutely stiff. At times your erection would go away. No matter how seduced you are you would not have an erection anymore.
(FGD3: Ngatala – 25 till 40 years – multiple children, 15th of August)

Additionally, if a man would have sex too early with a woman it does not automatically mean the man becomes ill or dies. As the following participant from Ngatala explained, the disease can pile up in time and eventually strike the man when it is strong enough:

R: We are told that smoking is bad, but if you smoke for a day or two you will not notice the effects. So this young brother of mine says he started having sex forty days after delivery. He does not know what he sucked from the woman. It will come back at a later stage, like smoking does. It is only waiting for him to do it again, so that it piles. So when he starts getting thin that time, we will know that it is Chinyera, but if you go to the hospital they will tell you, you have the Virus.
(FGD3: Ngatala – 25 till 40 years – multiple children, 15th of August)

Not everybody agreed on what *chinyera* exactly is and on how the disease works. One major disputable issue among the participants in this study is about the existence of a difference between *chinyera* and HIV/AIDS. At the hospital and health centres people are told that *chinyera* is actually HIV/AIDS.

Several symptoms of *chinyera* are also mentioned as possible symptoms of HIV/AIDS, like becoming very thin and cold, suffer from general body weakness, and having thin skin around the hands. Some of the participants believe that *chinyera* is actually equal to HIV/AIDS, as is told at the hospital, others remain convinced that these are two separate diseases:

R: Because we are using knowledge from the hospital we are being healthier these days.
R: We are being treated better these days because if we go to the hospital claiming that we have Chinyera, they would tell us it is not Chinyera, but you have a virus; HIV. Then they would give you the right medication for that.
R: We have a big problem here; we believe that if you come in contact with a woman too early you contract Chinyera. But at the hospital they would tell us Chinyera does not exist. The problem also is that the symptoms are usually the same. One gets weak, thin and feels cold.
R: The hospital people are basically right. But on this particular issue they are not, because Chinyera really exist.
R: What the hospital tells us are things that have been experimented on and proven effective.
(FGD3: Ngatala – 25 till 40 years – multiple children, 15th of August)

That *chinyera* is already described in a book from 1922 (Stannus, 1922 cited in Morris, 1996) and that for the woman it is not dangerous does likewise oppose the comparison with HIV/AIDS.

When the participants were asked to explain from what they would exactly die when they have sex with a woman who just got a child, some men explained it is related to the 'remaining things' in the woman after delivery. As stated in the following quote, a man can get infected with *chinyera* when he comes in contact with the remainders of the pregnancy in the body of the woman:

R; Your life can be ruined indeed. When a woman delivers, a lot do remain in her body. So if you sit with her (have sex) you come in contact with those remains. When we are having sex we exchange blood. So if she has those things inside, you catch the contaminated blood into your body.
(IDI12: MasambaUma – 41 years, 24th of August)

Some of the participants further explained that some women suffer after childbirth or that some also would die after the delivery, because there are ‘things remaining’ in them. In paragraph 1.8.4 the ‘remaining things’ are discussed as being *ngokota*, a scraping pain because the uterus is searching for the baby after the delivery. It is believed that at the health centre they can remove the remaining things and therefore prevent a woman to face complications from the ‘remaining things’.

It is not possible to obtain from the data if the remainders in the body of the woman after a delivery, which can lead to a man catching *chinyera*, are the same remainders as the ones that are perceived as a cause for the women dying a maternal death. What can clearly be obtained from the discussion in this chapter is that some participants believe that some phenomena which are associated with the delivery and with ‘everything that happens inside the woman’ can be dangerous and should be evaded.

4.3 Research results section: Men's perceptions about the influence of the community on safe motherhood

In the last section the participants reflected on how women are expected to behave in order to improve maternal health and prevent maternal deaths. However, through interpreting the experiences in the field and listening to the responses of the participants in this study, several factors that influence maternal health at a community level were obtained. The participants indicated that the pregnant woman is not solely responsible for safeguarding her health during pregnancy, delivery and the post-natal period. The family and other community members are assessed as important stakeholders who can and should support women during the process of getting children.

In this section the importance and the influence of these community factors will be explored and discussed. Some phenomena and customs within the community influence the possibility to practise safe motherhood, either positively or negatively. Firstly in paragraph 4.3.1 and 4.3.2, the community influence during pregnancy and childbirth are discussed. Especially the role of the community in giving advice regarding the pregnancy and in supporting the woman in travelling to the health centre is discussed in this context. Additionally in paragraph 4.3.3 it will be shown that nowadays there is a struggle among community members about the importance of community influence. Different views and opinions about customs and traditions that are supposed to improve maternal health are discussed by the participants in this paragraph. In paragraph 4.3.4 and 4.3.5 the role of respectively the traditional authorities, the traditional birth attendants, the health personnel, and health advises from outside the community are discussed. The participants reflect on the advantage and disadvantage of different actors that influence maternal health. Finally, in paragraph 4.3.7, the participants explain how the community is involved during the post-natal period.

Within this section it will become clear that the family plays an important role within the lives of community members. Much of the following section will therefore also be related to the role of the family. Before reflecting on the influence of the family it is essential to clarify the position of the family within the community. Within the small rural communities in Mangochi the family is one of the major factors that influence the life of individuals. Family members from the mother's side mostly live together. In these matrilineal communities it are the men who get married into the woman's family and most often live in the village of the woman. In a matrilineal society lineage is traced through the mother and the maternal ancestors. Every single family mainly has its own house and backyard, separated by reed walls from other houses, however also directly bordering the house and backyard of other family members. In most villages it is easy to observe which houses 'belong' together and often it can be concluded that family members live together in such a bundle of houses. In the following dialogue Hameeda, the oldest of the host family during the first observation period, explained that their cousins live in the house directly next to theirs:

'Are cousins, they live in that house', Hameeda points to the house just outside the fence. When we talk about it a little bit more it seems that other family members are living next door, the two houses next to the one I stay are both of the family. And all the children I saw these days were mainly cousins from next door. The family lives together. A sister of Maama and her husband live in the closest house with their children. I saw this before with families I visited. The parents live together in one house. When the kids grow older they build one or more houses (mostly smaller) around their own house on the same property (within the fence), here the adolescent children will live. Traditionally, if a man then marries into a family, he lives with the family of the wife and they build a house next to the house of the parents, outside the fence. Here they will raise their own family. If another daughter of the family gets married, traditionally this will be repeated again..
(Informal dialogue, observation period 1, day 2, 31st of July, TA Chimwala)

The host family during the first observation period showed to have much interaction among each other and seemed to spent considerable time together in and around the house. Young children played mainly with siblings and cousins who life on the same property. Both male and female family members sit together in the backyard during the warmest time of the day, and in the evening the family members are sitting inside the house or outside around a fire, while telling each other stories or singing together. They sing songs which sometimes have a specific message in them, mainly purposed as advice for the children and youngsters. The next quote from field notes taken during the first observation period shows a situation in which the family, including the young children, are sitting together in the evening and talking openly about an event from the newspaper.

After one song unfortunately the show stopped and Masrur said something to me. I did not understand it, and I think my face was showing that I did not understand it. Salar translated 'now you tell a story'. And the others were looking at me with a look of big expectation. I asked a couple of times where it should be about, more just to buy time so I could think of a nice story. 'Does it need to be a real story or a fairy-tale?' 'About everything', Salar responded. 'We tell stories to us, from the village or from the past'. They were all quiet and they all looked at me, waiting for me to start the story.
I started to tell a story in English about something I read in the newspaper that happened in Malawi. A woman somewhere in Malawi was pregnant and everything was going on well during the pregnancy. She had no problems or pains and she went to hospital once it was time to deliver. However, when the baby came out it appeared to be a stone covered in black linnen. (…) I saw that some people, like Sumeer and Masrur, were looking at me without really understanding what I was telling. I asked Salar if he could translate it to the others. When he was talking all the others looked at him and were quiet. Ilam nodded a couple of times and said yes a couple of times.
At the end Hameeda ended with a long "Aahaah!" sound which is a very recognizable sound to me, because I heard people in this area often reacting like that when they understand or agree on something. "We know that story", Salar said. "Yeah, it is not nice" Hameeda continued. I asked if it is true that it was really a stone and most of them nodded really convinced of the story. "Yes, yes, it is magic. That sister-in-law is a witch", Hameeda said. "Really? Are you sure?" I questioned. "Yes of course, the sister said she will have a stone baby, it is her fault", Hameeda explained. I could see from her face that there was absolutely no doubt in her about the story being true. Also the others didn't show any doubt or questions while they nodded. The children were quiet and seemed to listen carefully to what was said. They continued the conversation for a while in Yao.
(Field notes, observation period 1, day 1, 30th of July, TA Chimwala)

4.3.1 Community influences during pregnancy and childbirth

As already shortly reflected upon in the first section of this chapter, the family is getting closely involved when a young couple is expecting a child. Family from both the husband and the wife seem to get involved and support the pregnancy. The reason given by the participants for family being involved shows a link with the risk of a maternal death women face in Mangochi. In the focus group discussion it is explained that if the pregnant woman is not supported and protected it is argued that she might face the risk of dying. The family of the woman obviously does not want to lose a daughter within their family, and the family of the husband also feels responsible:

I: Apart from the husband, are there other people who get involved in the pregnancy, delivery or period after?
R: Relatives of the wife, relatives of the husband. And the hospital personnel.
R: The woman's side gets involved because the one that gets pregnant is their own daughter. The man's side says we have maybe some other people's daughter pregnant so we have to take care. The hospital of course it is their duty.
(FGD2: Machenje – under 20 years – without child or expecting first child, 12th of August)

R; Apart form material assistance, it is the woman's side who gets more involved. Because they say our daughter is pregnant. We have to take care of her, if she dies we loose a daughter ourselves. The man would be free to get a woman elsewhere.
(FGD1: Machenje – above 30 years – minimal 3 children, 12th of August)

4.3.1.1 Advice from the family members about uchembere wabwino

The participants explained different ways of how the family is getting involved once the woman becomes pregnant. Important part of the family's involvement is providing advice to the husbands on how to protect the pregnancy and how to practise *uchembere wabwino* (safe motherhood).

Especially the grandparents are mentioned as primary advisor because discussing issues related to sexual behaviour and pregnancy with the parents is supposed to be too sensitive.

I: Where do these questions come from?
R: They come from our parents.
I: By parents whom do we mean?
R: The ones that have given birth to us.
R: These are our fathers and mothers.
R: Our grandparents are more proactive and influential in marital internal issues.
R: It is traditional that we do not talk much about sensitive issues with mothers or fathers but with grandparents.
R: But we can choose to break the tradition by advising our own children, the ones we have given birth to.
R: That is if we are to break the tradition. But the reality now is that the grandparents are the ones that are taking the responsibility now.
(FGD5: Stambuli – 20 till 25 years – With one or two children, 15th of August)

I: Where do all these do's and don'ts come from, where do we learn them from?
R: Our grandparents are the ones who instructed us on how to do and manage these things.
(FGD2: Machenje – under 20 years – without child or expecting first child, 12th of August)

The family members provide many different advises and explanations on pregnancy and getting children. Some participants recalled advices they had received themselves from their parents or grandparents. Other participants mentioned advices the elders in general give to their children when they are confronted with a pregnancy. An important feature of the advices a couple receives related to getting children is related to the customs concerning the prevention of being infected with *chinyera* (discussed in paragraph 2.3). The participants explained that especially the grandparents give advice about the dangers of *chinyera*, about how to prevent being infected *chinyera*, and about the role of abstinence either during pregnancy, during the first weeks or months after the delivery, or during both periods:

I; What were the grandparents saying?
R; For example, when a woman has a baby, the grandparents would come and tell you not to have sex for about six months or so. When the six months are over the same would also come with some herbs, sprinkle, maybe make tattoos, and then advise you to resume sex. So they advise you to have sex gradually so as to let the baby grow. They would give you a medicine to prevent a man for catching kanyera (disease) from the woman.
(FGD1: Machenje – above 30 years – minimal 3 children, 12th of August)

R: Elders insist that you should wait for six to eight months before you start having sex.
(FGD2: Machenje – under 20 years – without child or expecting first child, 12th of August)

Furthermore, several advises given by the parents and grandparents are equal to expectations towards the behaviour of pregnant women (see paragraph 2.2) and the expectation towards the behaviour of men during pregnancy, delivery and post-natal (see section four). Some of the participants argued that the new generation of parents should give advice on safe motherhood themselves instead of leaving this to the grandparents:

R: Our grandparents are more proactive and influential in marital internal issues.
R: But we can choose to break the tradition by advising our own children, the ones we have given birth to.
R: That is if we are to break the tradition. But the reality now is that the grandparents are the ones that are taking the responsibility now.
(FGD5: Stambuli – 20 till 25 years – With one or two children, 15th of August)

4.3.2 Travelling to the health centre

Alongside giving advice it is often mentioned by the participants that the family also takes action in order to protect the pregnant woman from harm. When the *ulwere* (delivery) starts the family will be informed and the family is often involved in escorting her to the health centre for the childbirth. Several participants quoted below, described that in the decision-making process the parents of the pregnant woman are actually the final decision-makers. They stated that when the woman is showing signs of going into labour or when she is facing complications during her pregnancy, the husband informs the parents who will then decide what the next step will be:

In-depth interview:

R; When she was pregnant it was all nice. Problems came when it was time for delivery, we asked her mother who said that the way she saw things it was good that we go to the hospital.

(IDI6: Machenje – 40 years, 18th of August)

Focus group discussion:

R: The two families sit down and agree on who is to go to the hospital, so they are both involved.

(FGD3: Ngatala – 25 till 40 years – multiple children, 15th of August)

When a woman has to go the health centre to wait for the delivery at least one female family member of the pregnant woman is supposed to join as her guardian. The participants explained that the guardian will stay the whole period in or around the maternity ward where the pregnant woman is waiting to go into labour. The guardians are supposed to prepare food, wash the *chitenjes* for the pregnant woman and support her mentally. The role of the guardian is perceived to be very important, as the following quote clarifies:

Focus group discussion:

I: How do we look at the role these people (guardians) play?

R: It is a very very big role and very important. Because the people who go to the hospital for example are important people, and they leave important tasks behind. They have to help the woman with everything she needs.

(FGD3: Ngatala – 25 till 40 years – multiple children, 15th of August)

In the observation periods both health personnel and community members mentioned that female family members are taking the responsibility of the guardian. It is not clear if the guardian is particularly from the side of the woman or of the man. The following dialogue with Ayan, a nurse at a visited health centre, shows that men are normally not taking the role as guardian. Women are according to Ayan better able to understand the pregnant woman because they have been pregnant themselves:

(at the health centre) The same women as before sat under the trees hiding for the sun. Two or three were sitting together and they were either preparing food or sleeping on a small reed mat. Ayan walked towards us and without her and Mtima talking she took over the guidance trip around the health centre. She explained me that the women sitting outside were mostly guardians, people who go with the pregnant woman to the maternity ward where she is supposed to deliver and who support her in the basic needs. I asked if only women were allowed to come as a guardian. Ayan replied: "The guardians are always women. Men do not want to do that, they sit at home and are told when the child is born. Once a man was a guardian, but people laughed at him because we are not used to it. Always woman are the guardian. We are women, we know what to do and what a pregnant women is, we been pregnant woman ourselves."

(Informal dialogue, observation period 3, day 1, 5th of October, TA Mponda)

4.3.2.1 Role of the uncle

In field studies conducted (CBSM, 2007; Sibande & Hutter, 2011) by the Community-Based Safe Motherhood project (CBSM) they found that occasionally an uncle, from both the husband's and the wife's side, has the main responsibility for the couple. They are the representatives of the family when the couple wants to get married; meaning that they are in charge of the arrangements that need to be made between the two families. Additionally, these field studies found that the uncle plays an important role in the decision-making concerning the pregnant woman. In case of an emergency concerning the pregnant woman, the uncle needs to be informed and permission needs to be obtained from him before escorting the woman to the health centre.

In this study the participants were also asked to reflect on the role of the uncle in maternal health issues. They indicated that in their communities the role of the uncle is not of significant importance in relation to maternal health issues. The uncles are seen by the participants as just a family member, with no specific authority concerning the pregnancy:

I: Don't uncles have a special role to play in these issues?
R: No they are within the family members. At times we only require an individual from the family. And that person represents the rest of the family. We don't necessarily need the whole family.
(FGD2: Machenje – under 20 years – without child or expecting first child, 12th of August)

I: Traditionally, do uncles have a prominent role in pregnancy, delivery or any other of that kind?
R: Presence of the family is not limited to an uncle alone. If my mother is there, we would not take anything to my uncle. Any member of the family can represent the rest of the family.
(FGD3: Ngatala – 25 till 40 years – multiple children, 15th of August)

The participants explained that the uncle might give advice, however the parents and grandparents are much more involved in the decision-making. Apparently, for these participants, the family's interest is not per se represented by the uncle. They explained that the uncle during pregnancy might be represented by his sisters:

I: What about uncles?
R: Uncles are not very much involved when it comes to pregnancy.
R: An uncle may advise you on a few matters.
R: An uncle can be involved if he decides to send his wife to the pregnant woman.
R: Even an uncle of the woman can come in and help.
I: Can we define the role that is played by uncles?
R: Uncles are represented by their sisters during pregnancy and make sure they help in everything.
R: A bigger role is played by grandparents who advise on signs and the entire management of the pregnancy.
(FGD5: Stambuli – 20 till 25 years – With one or two children, 15th of August)

According to the following quotes from both an in-depth interview and from a focus group discussion, the important role of an uncle was a phenomenon that was more present in the past than in present rural Mangochi:

In-depth interview:

I: Is there a role you can take to reduce maternal death?
R; If people were waiting for an uncle, I would have had a role to do away with that; fortunately that is not happening here anymore.
(IDI12: MasambaUma – 41 years, 24th of August)

Focus group discussion:

R: We don't have to relay on uncles anymore.
(FGD5: Stambuli – 20 till 25 years – With one or two children, 15th of August)

4.3.2.2 Distance to health centre

As discussed above, the family is closely involved with the pregnancy, especially when transport to the health centre is required. Travelling to the health centre is however not always a simple task. The participants clarified that, because of the distance to the health centre, some women have to deliver at home or at the delivery room of the Traditional Birth Attendant (TBA):

Focus group discussion:

I: Do we have customs or habits in particular that we feel are contributing to maternal mortality?
(...)
R; The hospitals are very far apart, so in waiting for going to the hospital we get some kind of assistance from cultural practices. If we have a clinic at Ngatala or Chiunda, there would be no reason for going to the TBA. But we don't have these clinics here, and then we are assisted by those birth attendants.
R: It is really necessary that we have hospitals close by. Because we compare the distance to the health centre and the TBA. So even if the TBA says no to us, we insist that she still helps us out.
(FGD3: Ngatala – 25 till 40 years – multiple children, 15th of August)

In-depth interview:

R; To move from here to Katema is very far. So because of this many women were compelled to deliver at home.
(IDI7: Stambuli – 72 years, 23rd of August)

It is argued that the number of maternal deaths will decrease if the distance between village and health centre is shortened. An example given by a TBA during the first observation period shows that, because the roads are sometimes in a very bad state during the rain season, a woman was not able to reach the health centre properly for delivery. Consequently, she had problems on the way to the health centre which resulted in a maternal death:

(at the TBAs place) The lists of women in the books of the TBA about who delivered at the TBAs place are becoming shorter, and at first sight it also looks less children die at birth. I ask them if it also happens if women die here, when they have a baby. HSA replies: 'Yes, but in the past. But not anymore.' The TBA seems to ask the HSA where we talked about. After he answered she started to talk again as a real teacher, with her finger raised towards us and with a little bit louder voice. At the meantime I see that Kokayi is making sure the children are further away, maybe he does not want them to hear the conversation. Ndulu and the HSA explain me that she tells the story of a woman who died a couple of months ago. It was in the rain season and she could not get to the health centre because the roads were so bad. Everything looked to be fine, but she got problems and died later on. Also the baby died. The problem they could not tell me, but she was bleeding a lot the TBA told us.
(Informal dialogue, observation period 1, day 3, 1st of August, TA Chimwala)

The health centres and the Mangochi district hospital have a very limited number of ambulances. The few ambulances present need to cover the whole district; they are required to escort all types of patients and they are used in referrals to other hospitals in the country. Furthermore, the amount of small villages that are widely spread in the area, the long distances between the villages and the health centre, and the problematic infrastructure in the rural areas are contributing to long travel times. E.g. reaching the villages for the observation periods with a proper all terrain car took between 1.5 and 4 hours from Mangochi district hospital. Because of these circumstances it is often impossible with the existing number of ambulances to escort all pregnant women to the health centres for delivery in case of an emergency.

An initiative of the CBSM project provided bicycle ambulances to several villages in Mangochi in order to reduce the travel time to the health centre. Participants from villages that received a bicycle ambulance in the recent years indicated that the bicycle ambulance decreased the travel time to the health centre and therefore helps to save the lives of women:

I: What do you think that should be changed in this village so that we reduce maternal death?
R; Things in this village do not really need to change because it is good now, we received the bicycle ambulance. We are going to use that one bringing women to the hospital. These are being used frequently, which is certainly reducing the suffering that women were having. That is how we see that things are changing here.
(IDI7: Stambuli – 72 years, 23rd of August)

4.3.2.3 Elderly family members preferring deliveries at home

Besides the long distances to the health centre also the local culture in the rural villages is indicated as an influential factor towards home deliveries. Traditionally, community members rather want the delivery to be conducted in their own village. In the following discussion the participants mentioned that especially the elderly prefer their daughters to deliver at home. The participants in the following discussion group in Stambuli continued that nowadays people are less interested in deliveries at home:

R: The elders believe delivery could be easily done at home.
R: They want children to be born at home, that is where they belong.
(...)
R: What elders do is to narrate their own history, that they were all born at home; they didn't have any hospitals, the hospitals are strange reality. So they have all the experience in pregnancy and child birth, including the diagnosis of various pains and their prescriptions.
(FGD5: Stambuli – 20 till 25 years – With one or two children, 15th of August)

Although in the last quote the participants mentioned that insisting on a home delivery is a phenomenon from the past, participants from a focus group conducted in Machenje explained that still one of the main causes for the high number of maternal deaths in the villages is that deliveries are conducted at home:

I; You have said a woman can die, now let us look at maternal death. (...) We know that everybody is going to die, but we are kept wondering about why so many dying in relation to childbirth. (...) So maybe men here can help us?
R; The first one (reason for high maternal mortality in the area) is the culture in this district of ours that we do not have the interest of mothers delivering at the hospital. That is why the number is high. For example here in Mthiramanja women who deliver at Katema (closest maternity care) would maybe only be two, whilst the rest has deliveries at home. So the problem is they only went to the hospital when there was a complication. And it was often late.
(FGD1: Machenje – above 30 years – minimal 3 children, 12th of August)

A reason mentioned for the preference of some community members to conduct a delivery at home is the custom in which the ownership of the child needs to be determined. Proving the ownership of the child is mentioned as an obstacle towards deliveries being performed at the health centre. The participants explained that the family from the husband's side might want to have (female) representatives present at the delivery. The family members would ask the baby to come out if they are the husbands' baby. They try this multiple times during the delivery. If the baby is not born within the time frame of the custom, it is assumed that the woman had sexual intercourse with another man and that the baby is not the husbands':

I; It looks like we are basically Yao here, are there customs and traditions which we can say are contributing to the high number of women dying?
R; It is as we have sad already, things are changing. In the past some would boldly say mine is not delivering at the hospital. But these days not anymore. This was being done if the husband suspected that probably the pregnancy was not his, so he wanted it to be done in the traditional way so that they proof the ownership of the baby. The actual proof was done the day of the birth of the baby.
(FGD1: Machenje – above 30 years – minimal 3 children, 12th of August)

Because the family members want to prove the ownership of the child during the delivery, often it is decided to deliver at home or at the TBAs place. However, occasionally it is also explained that nowadays this custom of proving the ownership of the baby can also be conducted at the health centre. The participants did not further elaborate on how the custom is conducted at the health centre where normally nobody besides the medical personnel is present at the delivery itself:

I; What does the husbands' side do?
R; The relatives of the husband helps ferry the mother to hospital when time for delivery comes.
R; They accompany her to prove the ownership of the baby. That is to say, they say: 'if the baby is ours let the baby be born'.
(FGD1: Machenje – above 30 years – minimal 3 children, 12th of August)

In the focus groups and in most of the interviews one of the main priorities mentioned in order to reduce the number of maternal deaths is making sure every woman delivers at the health centre. As argued for in the following quotes, the chance for a woman to survive when she is *wapakati* life and death increases a lot when she delivers at the health centre:

Focus group discussion:
I: Do we have anything else so that we really reduce maternal mortality?
R: As a matter of policy every delivery should be done at the hospital. That is where lives of women can be saved. A pregnant woman is always wapakati of life and death. And they will know the required assistance the woman may need. They also know how to deal the newly born.
(FGD2: Machenje – under 20 years – without child or expecting first child, 12th of August)

In-depth interview:
I: Are you not thinking of helping her in a different way?
R; Helping her is indeed right. But it is not more important than going to the hospital. No matter how much I help her, going to the hospital is still paramount.
(IDI2: Machenje – 59 years, 17th of August)

4.3.2.4 Delay in travelling to the health centre

Although some of the family members might not be in favour of a delivery at the health centre, it can not always be concluded that the woman will eventually really not deliver at the health centre. However, this hesitation in going to the health centre for delivery is explained by several participants to cause much delay before actually going to the health centre:

I: Do we have customs or traditions that contribute to high maternal mortality that we have?
R: There are some traditional practices that delay people from going to the hospital; such include the thinking of waiting at home.
I: I suppose they say it in clear terms on what they should be waited for?
R: Yes, they say we wait for the delivery at home.
(FGD5: Stambuli – 20 till 25 years – With one or two children, 15th of August)

In a study of (Sibande & Hutter) community members in rural Mangochi described three different delays when going to the health centre in case of a delivery or an emergency during the pregnancy. The explored delays in this study were not completely equal to the health delay model of Thaddeus and Maine (1994).

Delaying the journey to the health centre is an important risk to women who are *wapakati* life and death. The next quotes from both interviewees and from participants of the focus groups show examples of women who most likely died because they did not go to the health centre in time. At least the participants indicated that their chances of surviving would have been much higher if they would have gone to the health centre earlier:

In-depth interview:

R; She had ten children and the pregnancy was the eleventh one. When the Ulwere had started I was told that she was failing to deliver, and then we decided to go to the hospital. As we were going to the hospital she gave birth on the way. Both the baby and the mother died.
I: Was it not possible to prevent this death?
R; I think it was possible to prevent the death.
I: What could have been done to prevent it?
R; If we had gone to the hospital earlier enough she would have survived.
(IDI4: Machenje – 35 years, 18th of August)

R; In enquiring we heard that there was a baby that was born dead and the mother died also. That was about four years ago.
I: In as far as people were saying could the death not be prevented?
R; What the people said was that probably she died because they went to the hospital late. Had it been that they went to the TBA earlier enough, maybe the TBA had seen the problem that was there and sent her to the hospital in time.
(IDI7: Stambuli – 72 years, 23rd of August)

Focus group discussion:

R: People get prepared differently, others would get prepared in very good time, and some would not until it is too late. So the late ones usually go to the hospital very late. The majority of these would either die on their way or just upon arrival at the hospital. No matter how much of an expert the doctor can be, if you arrive late at the hospital there is not much that can be done. But if you go in good time, something good would always comes out.
(FGD3: Ngatala – 25 till 40 years – multiple children, 15th of August)

In the field studies of (Sibande & Hutter) the different traditional means of transport to the health centre in rural Mangochi are described. These traditional means of transport were described by the participants in the study of Sibande & Hutter as very uncomfortable, especially when realising that they are mainly used in case of an emergency when the woman is already suffering. The traditional transport means vary from a ‘basket’ where the woman is placed in and which is carried by several men who had to walk to the health centre, to a ‘carrier’ where the woman lies on and which looks similar to the carriers by which death people are carried away at the hospitals. In some occasions the woman needed to walk herself or she had to sit on the back of an old bike. The preparation of these traditional transport means is discussed by Sibande & Hutter to be contributing to long delays and moreover, the journey to the health centre by foot can take up to ten hours, which is extra challenging in the warm season.

As already shown in earlier quotes, some pregnant women delivered during the journey to the health centre because they left too late or because the travel time to the health centre was too long. In some instances this led to the death of the woman, directly next to the road. Most of the participants therefore not only plead for that every delivery should be conducted at the health centre, but they also indicated that a health centre closer by would be an important improvement:

I: Now let us have a look at maternal death in this village. What can you say about deaths of women in this village in relation to child bearing?
R; Maternal death in this village in the recent four years has not been a problem.
I: Can you look at the village in the span of time longer than those four years?
R; In the past there were a lot of woman dying in relation to child birth. It has been very much of a good fortune for us that we have a health facility close by. But before this development came to us, it was very pathetic, women die. Some were dying on their way because of long distances that were encountered.
(IDI7: Stambuli – 72 years, 23rd of August)

I: Do you have anything else to share with us?
R; If the government looked at areas like ours here, we desperately need hospitals close by. This would help people leave freely. Some maternal deaths are due to distances to health centre. People walk long distances before accessing medical help. The TBA may advice the person to go to the health centre.
(IDI12: MasambaUma – 41 years, 24th of August)

4.3.3 Struggle within communities concerning customs and traditions

The last paragraphs give an indication of how parents and grandparents influence how men shape their perceptions related to safe motherhood. Some participants however indicated that the power of the grandparents and the parents is decreasing and that the husband and wife are more in control themselves:

R: These days there are no customs and the husbands are in control. The husbands would choose to disagree, even with parents, as long as the wife is saved.
(FGD3: Ngatala – 25 till 40 years – multiple children, 15th of August)

4.3.3.1 Old customs

Some men explained that this shift to the couple being in charge themselves is a consequence of the unclear and incorrect advises the elder family members gave them:

Focus group discussion:
R: Whenever there is pregnancy our parents act being very wise, so they tell us a lot of things. Things like recommendations on what to eat and not to eat, I think these are just elusions.
R: Whatever they tell us, they do not have explanations, as such we can do away with them.
(FGD4: Ngatala – 17 till 22 years – one child, 15th of August)

In-depth interview:

I: You are thinking of stopping now (getting more children); don't you see stumbling blocks to your opinion?
R; I see no problem. We discussed and agreed.
I: What about your parents-in-law?
R; They cannot say anything about this. I am sorting my problems at my house just as they sort theirs at their own home.
(IDI12: MasambaUma – 41 years, 24th of August)

The participants experienced first-hand that some of the customs which have been prescribed by the parents or grandparents were not based on reality. One example related to the custom that pregnant women should not eat particular ingredients, e.g. eggs; otherwise the child will be born bold. As the following participant in a focus group discussion indicated, nowadays they found out that when the pregnant woman eats eggs the child can still be born with hair, concluding that the advice of the elderly family members was not right:

R: It is very funny. There were all those restriction, but you may come across a woman who calls for eggs whilst pregnant, if you provide for her you see that there is nothing that happens and a baby will be born with a lot of hair and it shows that the elders were deceiving us.
(FGD5: Stambuli – 20 till 25 years – With one or two children, 15th of August)

Another example is given in relation to abstinence during pregnancy and post-natal (abstinence is further discussed in paragraph 4.5.2). Some young participants explained that because of the availability of condoms it is not necessary anymore to abstain:

R; That time I was learning to live such kind of life so I took everything as golden truth. Now I realise that some of the advices were not realistic. For example I was advised to wait for seven months. It was not easy. But this time around we have the health personnel who provide condoms. Using the condoms one can have sex with any woman and live without any effects.
(IDI10: MasambaUma – 28 years, 24th of August)

Some other traditional practises the elders give as advice, such as the advice to deliver at home, are according to the participants even supposed to be dangerous for the women:

I: Do we have customs or traditions that contribute to high maternal mortality that we have?
R: There are some traditional practices that delay people from going to the hospital, such include the thinking of waiting at home.
I: I suppose they say it in clear terms on what they should be waited for?
R: Yes, they say we wait for the delivery at home.
R: The elders believe delivery could be easily done at home.
R: They want children to be born at home, which is where they belong.
(FGD5: Stambuli – 20 till 25 years – With one or two children, 15th of August)

I; What do you think should be changed in our area here so we reduce the number of women dying from childbirth?
R; We should do away with customs that are outdated ad put the lives of pregnant mothers at risk.
(FGD1: Machenje – above 30 years – minimal 3 children, 12th of August)

They argued that the customs are in contrast with the advices they receive from e.g. the hospital and community health workers:

R: We should stop some of these cultural practices that contribute to some of the maternal deaths. If we insist on these then the scenario is not going to change. Some of the cultural practices do not agree with medical recommendations.
(FGD3: Ngatala – 25 till 40 years – multiple children, 15th of August)

One of the participants in a focus group discussion in Ngatala explained that by decreasing the power of the family during pregnancy and childbirth (which is traditionally the case), the husband would get more involved and will be more in charge of the decisions of his own family:

R: These days there are no customs and the husband are in control. The husbands would choose to disagree, even with parents, as long as the wife is saved.
(FGD3: Ngatala – 25 till 40 years – multiple children, 15th of August)

In several focus groups and interviews the participants argued that times are changing and that the young generation knows better how to safe the lives of future mothers as compared to the older generation:

I: What they say if they see this women giving birth they would divorce her, what do you say about this?
R; Such kind of men, they just need to be told repeatedly. Because you know some of us men are just born without the reasoning capacity. Some were born sometime back, they are quiet old, but there thinking capacity is quiet small. So we should not be saying that all the aged men are intelligent and wise, this time wisdom is in the young men. Because if young people is been told something they are able to listen and understand. They are able to listen and to understand and think properly, but these old people they just think because they are old they know everything. It would still be important if such type of men would be informed properly and repeatedly.
(IDI5: Machenje – 30 years, 18th of August)

4.3.3.2 Using traditional herbs or not

A second example that indicates the different opinions the participants have about the importance of traditional customs is related to the use of traditional herbs or medicine during pregnancy and childbirth. On the one hand some of the participants in this study indicated that they fetched herbs whenever it was necessary and that in some situations the parents would come and provide traditional herbs in order to heal the woman who had just delivered (see paragraph 3.7.1).

On the other hand some participants claimed that traditional herbs actually can be a cause of complications that occur during the pregnancy or after the delivery. The following quote describes how some women treat the wounds after birth in a traditional way and how this will lead to the wound not be completely healed:

R; It all depends on the lack of hygiene in the house. I am saying this because traditionally there is a lot that people do soon after childbirth. These make the period after birth much longer. For example; women are advised to be applying either ash on to the cut naval or soil. Some are advised to apply roasted, grounded seeds of pumpkins. All these are not healthy ways of managing the wound, because they are different on what they are if they have delivery at the hospital.
I; What are they advised at the hospital?
R; At the hospital they only tie a thread. But once women go home they remove the thread, and apply their own.
I; What is it that they do apply then?
R; Others apply fluids from pawpaw leaves. Others still use food remainders which are roasted to ashes to apply on the same.
I; But why would these elongate the period after birth?
R; These only make the top of the wound dry up, not necessarily healing inside.
(FGD1: Machenje – above 30 years – minimal 3 children, 12th of August)

Furthermore it is explained in quotes provided below that the use of traditional herbs or medicine can ultimately lead to a maternal death. The exact relationship between the use of traditional herbs and dying is not explained or understood by the participants; however one participant suggested that the use of traditional medicine will delay the process of going to the health centre. This delay, as discussed earlier (paragraph 3.2.4), is a major risk towards the health of a pregnant woman:

In-depth interview:
R; (…) Our parents used to rely on medication of their own. Such medicines are the ones that also increased the number of maternal deaths.
(IDI10: MasambaUma – 28 years, 24th of August)

Focus group discussion:
R: There is strong saying; that something remains and women are given herbs. We don't know how effective these herbs are but we know that women die whilst taking these herbs. So most of the women lose their lives during the time which is lost using herbs.
(FGD3: Ngatala – 25 till 40 years – multiple children, 15th of August)

Important to realise in this discussion is that there are many different local herbs and the names for the herbs can vary from one village to another. Therefore, it is difficult to compare if the participants who are in favour of using herbs and the ones who are against using herbs are actually talking about similar herbs.

4.3.3.3 The fisi, chokolo, and phululsa customs.

A third example of the division between supporters and opponents of cultural customs shows the change in the rural villages regarding the use of customs. Customs such as the *fisi* (hyena), *chokolo* (wife inheritance) and the *phululsa* (ash) are heavily discussed in the interviews and focus groups. During the *fisi* practise, a man is hired to have sex with a married woman in order to solve the problem of the childless couple. The *fisi* custom is arranged by the family members without the husband's knowledge. Moreover, the moderator in the focus group discussions asked how the participants would know for sure that the *fisi* custom is not practised nowadays; where normally the custom is arranged secretly without the husband's involvement. Some of the participants in the focus group discussions laughed about the question and did not really elaborate more.

Another reason given by the participants for not practising the *fisi* custom nowadays HIV/AIDS, where the custom normally is supposed to be practised without protection. Either the woman or the *fisi* himself can be infected with HIV/AIDS and therefore both family members and potential hyenas are not interested in practising the custom anymore.

I; I look at the issue being very complicated. What is it that makes you confident that your wife has not slept with a hyena? Because even those days husbands were neither consulted nor informed.
R; These days life is changing. People have heard about HIV/AIDS and so the families think of protecting their own children, because they never know what the hyena will bring into the house. So this practise has died a natural death.
R; Even the volunteers themselves are scared about their own lives, so they would hardly pick up the task themselves because of the pandemic.
R; I don't think we can find some man this time that would be ready to carry on such a job.
(FGD1: Machenje – above 30 years – minimal 3 children, 12th of August)

Furthermore some of the men argued that women will not wait for a *fisi* to be arranged for them. Women are considered to already have extramarital relationships arranged by themselves when they have too wait for a child or for resuming sex (see paragraph 2.2.4):

R; Most of women are loose. So they sleep with more men, as such they don't even need the hyena. By the time somebody organises the hyena for them, they would already have slept with several men. They are doing it on their own.
R; We are not waiting for anybody who come and advise us about when to resume sex. We resume it when we long need it. The danger of not doing it this way is that if you don't start early somebody will start for you.
(…)
(FGD1: Machenje – above 30 years – minimal 3 children, 12th of August)

The *chokolo* practise means that after the death of the husband the brother of the husband would inherit the wife and start a new family with her. With the *phululsa* practise a man is hired to have sex with the wife of man who just passed away. This is done because the ash of the husband has to be removed from the house and from the woman in order that she will be safe from 'remaining things' (discussion about remaining things found in paragraph 2.3.2). The participants explained in the following quote the *chokolo* and the *phululsa* custom:

R; Yes we have to remove customs like the custom of the phululsa (ash).
I; What do you mean by the custom phululsa?
R; This is a right when a husband dies, we remove the ash from the premises of the home. And to make sure that the woman is safe, she is made to sleep with a man. And that process is what we call custom of the ash. The man kinds of cleans the woman of the ashes that were used during the funeral ceremony. This is different from chokolo (wife inheritance), because they only have sex once and the man goes away. Where in chokolo the man stays on.
R; We don't have chokolo here, we have never had a case whereby anybody inherited a wife. All we have are the fisi and the phululsa. So it is these that have to be removed.
R; What happens is, when for example a man dies, the woman has to be given 'water'. Now to meet this demand the woman has to be helped to sleep with somebody. But if it is a woman that died, the man always will find his way out.
(FGD1: Machenje – above 30 years – minimal 3 children, 12th of August)

None of the participants in this study indicated to be in favour of the above mentioned customs. However, they do mention that these practices put the lives of women at risk and should be removed from the society (see last quote). In that way the participants are assuming that these practises are still being performed in their communities:

R; Yes customs like the fisi, chokolo. If we are to remove such kind of customs we are sure to improve lives of women and reduce maternal deaths.
(FGD1: Machenje – above 30 years – minimal 3 children, 12th of August)

4.3.3.4 Old customs should be promoted

As discussed in the last paragraphs there seems to be a widening gap between the old and the young generation on issues like abstinence, delivery at the health centre, and traditional customs. In the focus group discussions almost nobody opposed the remarks about the redundancy of traditional customs. Some participants in the discussion groups however put a nuance to the remarks of others about the redundancy of traditional customs, claiming that not all traditional customs have a negative influence:

R; It is not all the customs that we have to do away with. I am saying this because there are some customs which kind of scatter the community whilst others do build the community. So it is not that all have to be done away with.
(FGD1: Machenje – above 30 years – minimal 3 children, 12th of August)

Some interviewees perceived the use of customs even as beneficial for protecting the lives of new mothers. They argued that not following the customs is actually risky and can result in pregnant women dying:

R; We should share the customs so that we protect our lives. Otherwise we would put our lives on ends.
(IDI1: Machenje – 60+ years, 17th of August)

R; (…) if I were to do things just my own way (without customs) I wouldn't reach the age I am now 40 years. People are following the new ways of doing things and are dying.
(IDI6: Machenje – 40 years, 18th of August)

In the last quotes the interviewees did not clarify which customs they reflected on. Therefore it is difficult to compare these views with the views of the participants who argue that certain customs have to be removed. It can not be obtained from the data if they are talking about similar customs.

The next quote shows that another interviewee believes that the advices received from elder family members are important and beneficial to him concerning the practise of safe motherhood:

I; Where did you hear about those expectations?
R; I heard about those expectations the time I was living with my grandparents. They said if your friend is sick, work for her. If things go wrong advice her. That are some of the things that my grandparents told me. This was long before I got married. Now once married, I will always remember what they told me.
I; Finally what do you think of these expectations yourself?
R; I see justice in this.
(IDI1: Machenje – 60+ years, 17th of August)

Several interviewees furthermore advocated for more advice from the parents towards the children. They argued that the new generation of parents should give advice on safe motherhood to their children themselves instead of leaving this to the grandparents. The following interviewee argued that parents need to enforce traditional customs onto their children in order to improve maternal health or to prevent a maternal death:

I: Do you have any final words to say, for the lives of people to improve is this or that?
R; As man we should be people that are careful so that we protect our women. We should know that life today is different than what it had been in the past. People are not following the customs that used to safeguard their lives. Customs that safeguarded lives of people should be promoted even in this age. Parents should enforce these customs on their children when they get married.
I: Are you trying to say that parents need to change on something?
R; Yes, parents should sit down with their children and provide them with the customs that safeguards life.
I: Which customs do you think should be emphasised on?
R; Parents should emphasise on taking care of life of oneself and that of the partner. They should say when there is a pregnancy in the house this is what is supposed to be done, when the woman delivers this is what is supposed to be done, so that death can be avoided.
(IDI8: Stambuli – 29 years, 23rd of August)

4.3.4 Traditional structures spreading *uchembere wabwino* messages

Although there is a widespread difference of opinions about the benefit or danger of traditional practises and advises given by elderly family members, the traditional authority and structures in the community are still seen as powerful and responsible fora for spreading the correct messages on safe motherhood to the community. The traditional structures which are considered to have the responsibility in the spread of correct information are according to the participants the Group Village Head (GVH), the village chief and the Traditional Birth Attendant (TBA). Village chiefs and GVHs are supposed to use their position to impose by-laws onto the community. These by-laws are supposed to summon villagers to handle maternal health issues in a certain positive way. An example of a by-law already applied in several villages is a by-law by which the community members are summoned to go to the health centre for every delivery. A family has to pay a goat in case a family does not obey to the by-law:

I: What can traditional leaders do to improve on involvement of men?
R: Chief should make by-laws that are safeguarding safe motherhood. They should say that anyone who does not do that is given a particular fine.
R: The Chiefs themselves should summon their people on safe motherhood, they should tell their villagers about the importance of delivering at the hospital.
R; (...) We need strong laws.
(FGD4: Ngatala – 17 till 22 years – one child, 15th of August)

R; These days it is very difficult to deliver at home because the chiefs have put laws to say no deliveries at home. And there is penalty attached to it, that with every delivery at home they are to pay a goat. So people are protecting their goats and every delivery is at the hospitals these days.
I; Now just for interest sake, are the people going to the hospital because they are convinced of the necessity of delivering at the hospital or just to protect their goats?
R; (Laughter) No they are convinced and satisfied, besides the penalty that is there. People know that it is safer at the hospital.
(FGD1: Machenje – above 30 years – minimal 3 children, 12th of August)

Furthermore, the participants indicated that traditional leaders are supposed to take an advisory role; they have to advise community members on how to practise safe motherhood:

R: Chiefs should really address maternal and infant mortality in their villages and call on people to do something about it, they should explain the dangers of such situation and insure that the people take their role.
R: This is possible. This time around there are no deliveries at the TBA's place because the chief said it so, so whatever the chief said the people will always abide.
R: Chiefs need to take a proactive role, people are not going to the TBA's place. Not because they are convinced that they should not go there but they are afraid of the word of the chief. All the same it is yielding a positive result because people are going to the hospital.
(FGD4: Ngatala – 17 till 22 years – one child, 15th of August)

Some traditional leaders already take the advisory role, and share there knowledge in development meetings with other village chiefs and community members. During one of the observations a village development committee (VDC) meeting was attended. During the VDC meeting, in which all the village chiefs of the group village gather together to discuss the development of their villages, the GVH explained the new insights she obtained from training on maternal health issues. In the next quote from the field notes it is described that the GVH explains to the other participants of the VDC meeting that the dances during initiation ceremonies should not be sexually loaded.

The rest of the meeting (VDC meeting) it was mostly the GVH who was talking. Two minutes maybe the man on the side, who was writing all the time, talked. According to the HSA he explained where they will talk about today, but he does not tells me what this will be then. The GVH was then talking about the training she attended in Mangochi (where I was as well), which was about the initiation ceremonies. She tells that the dancing, which they in some situations during the initiation ceremonies teach the children, should not be sexual.
(Field notes, observation period 1, day 1, 1st of August, TA Chimwala)

The GVH attended a training for several days that was organised by the Mangochi district hospital and the CBSM project related to maternal health issues. The insights she obtained from the training she shared with the village chiefs and she requested them to share these insights further with their own village members. During this training one of the topics discussed were the (perceived) outdated and inappropriate advises and dances provided to the children during initiation ceremonies. Especially in more traditional initiation ceremonies, as a part from the field notes during this training shown below describes, the children are taught how to dance seductive for the other gender and how to have sex after the initiation ceremonies are finished:

I remember that during the meeting they discussed the dances and the songs which they have for during the initiation ceremonies, both for girls and boys.
<u>From the notes of this training in Mangochi:</u> (...) One man, who is doing the ceremonies with masks on for older boys, was singing alone. Everybody was really enthusiastic to see the dances of each other, but with this man everybody was even more enthusiastic. It is supposed to be a really good song. The people talk about why this song is good, and what kind of things are not good in the songs. The secretary explains me that nowadays it is getting better, but in the past it was very different. The dances were erotically loaded, with kissing and sex movements translated into it. With a lot of swinging and bouncing of the hips and the butt for the girls, and some 'performing the sexual act' movements for the boys (the ceremonies are for children aged between 8 and 15). Also they sing about having sex with people from the other camp, people from the other sex. An example from a song is that they sing, both in the girl and the boys camp, that after the ceremonies they should run to the other camp and find somebody and practise everything what you have learned. This means boys and girls having sex sometimes at an age below twelve. The people discuss in the group that it is better not to sing these kind of songs and that the dances should be a little bit different. According to the secretary it is definitely improving and better compared to the past.
The GVH is now telling the same disapproval of some old songs to the people who are present here at the meeting and everybody seems to pay full attention to what she says.
(Field notes, observation period 1, day 3, 1st of August, TA Chimwala)

If the village chiefs understood or agreed on the messages shared was not possible to observe. Neither was it possible to observe if the village chiefs did disseminate these insights later in their own villages. However as mentioned, participants in the focus groups and interviews did argue that if traditional leaders take their responsibility and disseminate safe motherhood advises, more people will be reached by them. Also the next quote shows the belief in the need of having village leaders in order to improve life in the village:

I: What about chiefs, can they be involved?
R: Yes the chiefs are the ones that have the people in the villages, hence there involvement.
R: In every arena of life there are leaders who are supposed to be involved in the welfare of their subjects. Such are the chiefs.
(FGD5: Stambuli – 20 till 25 years – With one or two children, 15th of August)

Important to reflect on, is that the opinion of the chief is not always intangible. The community members do not always abide to the advice of the chief, although the chief indicates that his advice would render the development of the village. During one of the observation periods a situation, not related to health issues however, shows that the villagers occasionally do not abide to the advice of the chief. As the following field notes describe, the community members used a method of fishing which involves the making of two small dams in the only small stream that was close to the village. The chief did not allow them because it might change the flow of the stream and therefore threaten the sustainability of the stream itself. Considering the small stream and the dry areas such as the rural areas of Mangochi this is a reasonable concern. However, the villagers continued their idea, blocked the stream with two dams, got all the water out the area between the two dams, and caught a lot of fish for every family in the village:

Salar sits down next to me. I realize that all the men who are here are working on this dam except for Salar and me. When I ask if he should not help he tells me that Masrur is already helping out. Every family who wants to have fish needs to help out, so Masrur is doing that for them. However Hoomun is helping out as well, it does make a bit sense to me so I stop asking more about it. Salar tells me that when the water is all out, they can easily get the fish. It is hard to imagine that many fish would be in this small part between the dams, it is maybe three metres long. Salar however tells me that they will get a lot of fish from this part.

Then he tells me that the village chief is really not agreeing with this way of fishing. He thinks it is very harmful to the river, and in the future they will have less water and fish.(…) When I ask why they do it then, although the village chief is against it Salar tells me that they bargained about it for months already. The village chief said otherwise they would not have fish in the future anymore, the men said they did not want to wait and wanted to have fish at this moment because they do not have enough food anymore. "They want to do it, so the village chief cannot do something for it. He tried, but they do it anyway." Salar points out the man who is leading this operation, and tells me that he was always going to the village chief to convince him to allow this way of fishing.

Salar also makes clear that he agrees with the village chief. "It is not good for the river. They should do it", he says. I am surprised to hear that, because his family is helping out as well. When I ask him Salar says: "They are doing it, so we are doing it. Everybody will have fish, and if you not help you will not get fish. And we want fish. Give money for it is more expensive. They ask a lot of money for the fish." He then smiles to me and says: "Masrur likes to eat fish", we laugh and Salar translates it to Masrur and the others who immediately start laughing as well.
(Informal dialogue, observation period 1, day 6, 4th of August, TA Chimwala)

4.3.4.1 Role of the Traditional Birth Attendants (TBAs)

Another part of the traditional structures in the village, who are involved in pregnancy, delivery and post-natal are the TBAs. As mentioned in paragraph 3.2.2, a consequence of the distance to the health centre is that people tend to go for delivery to the TBA's place, therefore jeopardising the health of the woman. The TBAs are part of the traditional structures in the village that are involved in maternal health. Traditionally TBAs were responsible for every delivery in the village itself.

Nowadays, the discussion among the participants in this study shows that the belief that women should deliver at the health centres is increasing. However, several participants indicated that deliveries are still conducted at the TBA's place and occasionally women die when they deliver with the help of a TBA. They explained that the TBA's under-equipment or the wrong decisions the TBAs sometimes make during the delivery can result in a maternal death:

I: Why do we have mothers dying in this village of ours?
R: Some deliver at the TBA's place, which is under equipped.
(FGD3: Ngatala – 25 till 40 years – multiple children, 15th of August)

R: Some of the concoctions made by the TBA's are too bitter for a pregnant woman.
R: Some of the TBA's insist on managing cases they can not. This contributes also to some of the deaths.
(FGD3: Ngatala – 25 till 40 years – multiple children, 15th of August)

The Community-Based Safe Motherhood project (CBSM) tries to involve the TBAs into a referral system. This referral system needs to enable that women are sent on time to the health centre for *sikelo* and for delivery. Furthermore, the CBSM project organises training for the TBAs so that they are able to keep their advisory role in the community. TBAs are the first contacts for a woman who is pregnant, and the TBA is supposed to instruct the woman and her family throughout the pregnancy and delivery.

Many of the participants also argued that the role of the TBA should be more modest. They argued that the TBA needs to take an advisory role. The TBAs still holds an important position in the society when they have the advisory role and in some villages the importance of the TBA as an advisor is already recognised:

Focus group discussion:
R: They should always follow instructions that they get from the TBA. The TBA would advise them on how to sleep and on how to take care of themselves. They are supposed to be sleeping sideward.
(FGD2: Machenje – under 20 years – without child or expecting first child, 12th of August)

In-depth interview:
R; The first experience is about the distance to the hospital. However we have TBA's who were sent to us, the TBA assists us with Sikelo. So when the days are nearing, the TBA will always advise the mother to go to the hospital and wait for delivery.
(IDI12: MasambaUma – 41 years, 24th of August)

4.3.5 Position of the health centres

When villagers are convinced of the risks of a delivery at home or when they are forced through by-laws to stop delivering at home, and, if they overcome culture- and resource-related obstacles, then the quality of the health centre becomes important regarding convincing people to deliver at the health centre. The willingness of community members to go to the health centre does not only depend on influencing factors from within the community, it partly also depends on the perceived quality and advantages of the health centres. According to a group village leader, it is essential to provide good maternal care at the health centre alongside implementing by-laws that are forbidding home deliveries. If the possibilities for a good delivery at the health centre are not good enough then the risk of hidden TBAs performing home deliveries increases, which consequently will increase the risk of a maternal death.

Therefore it is important to reflect on the context of the health centres and its personnel, on the villagers' perception on gains and disadvantages at the health centre (in particularly regarding the maternity ward), and on the experiences villagers have with health centre visits.

4.3.5.1 Lacking human and material recourses at the health centres

Firstly, it is essential to describe the health system in Mangochi district shortly. Mangochi district has one government district hospital in the city Mangochi itself. Additionally, the district has three smaller hospital and 29 health centres. The health centres provide limited basic services such as under-five clinics, ante-natal care, delivery and post-natal care, family planning, cholera and tuberculosis prevention, and malaria treatment. In Traditional Authority (TA) Mponda and Chimwala where this study has been conducted there are seven health centres covering a population of 215,844 (National Statistics Office Malawi, 2008). Almost half of the rural villages in TA Mponda and TA Chimwala are at a distance of more than five kilometres from a health centre. Five kilometres in a rural area where almost no motorised transport is available in the villages, where no ambulances are available at the health centres, and where most people have to walk to the health centre on small dirt roads, is a long and problematic distance when medical emergencies arise.

Furthermore it is important to reflect on the human recourses of the health centre. In the seven health centres in TA Mponda and TA Chimwala there are no doctors or clinical officers present (officially clinical officers are not equal to doctors, but they perform most of the tasks doctors do, such as: diagnosing, prescribing drugs, performing smaller operations). Occasionally a health centres has one medical assistant, however most health centres are run by a handful of hard working nurses. According to data from the Mangochi District Assembly (2009), there is a huge lack of health workers in the health centres and hospitals. They showed the gap of health workers for the entire Mangochi district, thus including the district hospital:

Among others, 5 out of 13 doctor positions, 14 out of 67 clinical officer positions , 37 out of 67 medical officer positions, 28 out of 70 senior nurse positions, and 73 out of 88 midwife/enrolled nurses positions are not filled. This shows the major lack of human recourses.

During the observation periods the viewpoint of the health personnel could be obtained from up close. In dialogues with nurses and Health Surveillance Assistants (HSA) they explained many difficulties concerning their work. First of all they indicated that they make long shifts of about twelve hours, both by day and by night, for about five days a week. E.g. as explained by a nurse working at a health centre in TA Chimwala:

The guys talked a little bit more to them and then a nurse walked towards me. I met her already the day before in Mangochi. (…) She recognized me and told me I was most welcome. She was free now after a shift of 12 hours and was very tired. Tomorrow she had to work 12 hours again she explained me.
(Informal dialogue, observation period 1, day 1, 30th of July, TA Chimwala)

At the health centres visited during the observation periods, the nurses worked more than half of their hours in the maternity ward. Most deliveries were performed by night, where five deliveries per night for two nurses is not an exception. As the following field notes describe, the nurses are supposed to do the cleaning of the wards and the medical instruments themselves, and additionally several nurses had a child and a household besides their work:

When we walked to the next room I saw three beds with better mattresses. This was the delivery room. One nurse inside greeted me, she was cleaning the floor with a mop. She herself was wearing plastic covers and a mouth cap, and the coloured water in her bucket smelled very strong like chloride. I asked how often they have deliveries on average. The first time I did not understand Ayan's answer totally, but the second time she told me that in the morning they had two deliveries, and in the night two as well. I could not follow Ayan's explanation totally but she did tell that most deliveries occur at night at the health centre and thus that some of the nurses have night shifts. After the deliveries the nurses always clean the mattresses and the floor.
(Informal dialogue, observation period 3, day 1, 5th of October, TA Mponda)

On the other hand there were not always patients present who required full time attention. At the waiting room and the postnatal ward women were mainly supported by their guardians and only in case of daily check-ups or when complications occur the nurses would get involved. Often the health workers on call sat outside for one or two hours without any patients that required treatment or support.

The health workers in the observation periods showed the limited medical materials they possessed and often explained they lacked many medical materials. Patients are diagnosed at the health centres based on their symptoms; they do not have the recourses to perform blood tests for the diagnosis of e.g. malaria. The stock of sterile gloves, plastic aprons, mattresses, cleaning material for getting the instruments sterile again, and bandages were often mentioned by the health centre personnel as not sufficient enough.

Furthermore, as explained in the following quotes by health workers, the basic medical needs in the rural areas such as malaria treatment tablets, blood bags, and fluids necessary to treat diarrhoea are not always available at the health centre:

I asked the nurse if they treat people at this moment, or if people stay here of they are really ill. She explained that mostly they only give medicine or do check-ups and advice and never keep people in the health centre. I did not see any hospital beds or a small ward yet so that made sense. Also with malaria the people are diagnosed, without doing a blood test, and if they have the medicine they will give them the medicine and they have to take it at home. "But sometimes we do not have the medicine; we have to send them to another health centre".
(Informal dialogue, observation period 1, day 1, 30th of July, TA Chimwala)

Mtima joined us again and I asked him about new materials and recourses for the health centre. He told me that they do not buy that themselves but that CHAM or Mangochi hospital provides them with the recourses. I asked about the broken mattresses of the maternity ward, but these are not often replaced because they are not of major importance. Also medicine they do not always have enough, sometimes they are not provided with enough medicine or it runs out before another provision arrives.
(Informal dialogue, observation period 3, day 1, 5th of October, TA Mponda)

Thus, when a patient walks for a few hours to the health centre in order to get treatment it is not unlikely that he or she has to travel onwards to another health centre to get the treatment. This is often impossible because of the distance to the other health centre. A nurse explains in the next dialogue that sometimes they can not help a patient when higher quality medical care is necessary as a consequence of the lack of an ambulance:

I know they do not have ambulances or cars here so I guess it is really difficult for somebody who feels that ill to walk or bike to another health centre at least one and a half hour away on a good bike. I asked what if somebody had a big accident or burning wounds (I saw quiet often people, especially children, coming to Mangochi District Hospital because they fell into the fire which they put on every evening). "We do not have ambulances here; we can not bring them to Mangochi. We call Mangochi, but not always they come to get the patient. We really need an ambulance here, so we can bring the people ourselves. But the government does not give us one. In Phirrilongwe they have one, but we do not have one." She explained again that most of the times when big medical help is needed there is not much they can do. They need to send emergencies to the district hospital in Mangochi or towards the national Hospital in Zomba.
(Informal dialogue, observation period 1, day 1, 30th of July, TA Chimwala)

If a patient has enough money it is possible to travel by *mathola,* privately owned pick-up cars that travel between the bigger cities and villages in the area once or twice a day as transport. They wait till the whole car is fully loaded with people and goods before they start driving, which can take a long time. During the observation periods several trips in a *mathola* showed the challenges for travelling by *mathola*. People sometimes had to sit on the roof, need to hold each others' hands not to fall off, and occasionally sit on fuel or other inflammable goods. The *matholas* stop in any village on the route where people want to get off or on and where goods have to be on or off loaded. The cars are often in a bad state and often the car breaks down several times during the journey. Occasionally it stops driving totally, whereby all the passengers are stranded in the middle of nowhere. For a patient, e.g. a

woman who is required to rush to the health centre for delivery, a *mathola* is too uncomfortable, too dangerous, and too unreliable. In a dialogue with a community member during the third observation period it was explained that in case of an emergency the *mathola* is (if available at all) the only option for a patient:

They then (when recourses are not available at the health centre) have to sent most of the people to Mangochi hospital. I asked how people go to Mangochi hospital. Mtima laughed and said: "Like you, with mathola. They can go by mathola because we do not have an ambulance for that. If we had an extra ambulance we would, but now we can't."
(Informal dialogue, observation period 3, day 1, 5th of October, TA Mponda)

4.3.5.2 Factors influencing unwillingness towards visiting the health centre for delivery

Patients in the rural areas seem not to have high demands for their health facilities. However, the unattractiveness of the health centre might have an influence on the willingness of people to choose for delivery at the health centre instead of a delivery at home. The waiting room, delivery room and post-natal room are grey empty rooms without privacy. In the rooms are only beds and mosquito nets. As the following field notes show inside of the rooms it can be very warm, especially when there are many patients, and most of the women prefer staying outside their rooms with the guardians:

The next room was a little bit bigger than the others. Ten beds spread around the room, all with mosquito nets and a mattress in a not very good state. This was the waiting room. Nobody was there, but remembering that they told me before that there are several women waiting at the health centre I asked Ayan where they were. The pregnant women were outside because inside it is too warm for them. "Their guardians are outside as well, so they can talk together instead of being inside." Besides the beds and the mosquito nets, there was nothing in this room. I could understand that the pregnant women rather wanted to be outside, because I was sweating just because I was standing in the rooms and the room looked a bit sober. The delivery room was still a normal temperature, but the antenatal clinic and the waiting room were very warm.
(Field notes, observation period 3, day 1, 5th of October, TA Mponda)

In the focus groups the participants explained that the guardians did not have a good place to stay. The guardians have to sleep outside or on the ground in the waiting room and only a reed roof protecting them when they are cooking and when they are washing clothes:

R; Yes we should be involved, like provision of the guardian shelter. This would help reduce maternal death, because some of the pregnant women would say I don't want to go to the hospital because I don't want my sister to to cook in the sun or to sleep outside.
(FGD1: Machenje – above 30 years – minimal 3 children, 12th of August)

A second reason why some people do not want to go for delivery at the health centre is, according to the participants, because some people are afraid of the health centres and the hospitals:

I: It appears that it is very important that children should be born at home, why is it this important?
(...)
R: A lot are afraid of many things at the hospital, such as electricity.
(FGD5: Stambuli – 20 till 25 years – With one or two children, 15th of August)

The participants explained that especially elderly family members do not know what exactly occurs at the health centres because they never had health centres close by in their lives:

R: What elders do is to narrate their own history, that they were all born at home; they didn't have any hospitals, the hospitals are strange reality. So they have all the experience in pregnancy and child birth, including the diagnosis of various pains and their prescriptions.
(FGD5: Stambuli – 20 till 25 years – With one or two children, 15th of August)

An interviewee from Machenje explained that some community members are afraid of undergoing an operation at the hospital and others are afraid of dying at the health centre. They heard experiences of other or experienced themselves that women are occasionally dying at the health centres. In some occasions the deaths might have occurred for unclear reasons, which makes the health centres suspicious:

I: What can you do so that your wife does not die in relation to giving birth?
R; In simply speculating that she may not die, its better than to send her to the hospital.
I: Why do you say speculating?
R; With the experience that I have had, that a woman would be attending the clinics to go for a delivery at the hospital and die there, what else can I say.
I: Yes I understand it would be difficult indeed even to trust a hospital in such situation. Is there anything strange that you can do to avert maternal mortality?
R; There is nothing strange that I can do. We try to escape to the hospital at times to no avail. It is dangerous at the hospital, women die there.
(IDI3: Machenje – 60 years, 17th of August)

The relationship between patient and the staff at the health centre is indicated as possibly being problematic. A common complaint from the participants is that the maternity staff are negligent towards their patients:

I; Is there any other reason you think make a woman die once pregnant?
R; Some of the hospitals are overcrowded. Others do have negligent staff. All these contribute to the death of mothers. Such negligent staff would probably come to attend a woman in labour two hours later.
(FGD1: Machenje – above 30 years – minimal 3 children, 12th of August)

Furthermore it is mentioned that the maternity staff can be unfriendly towards the patients. They are considered to be rude, complaining and occasionally use abusive language:

R: Some are afraid of the anger of the maternity staff.
R: Some of the maternity staff are rude to their clients.
(FGD5: Stambuli – 20 till 25 years – With one or two children, 15th of August)

In some examples (showed below) given by the participants it is explained that the maternity staff did not pay attention or forgot the woman in the delivery room, therefore arriving too late to support her in the delivery. Possible consequence of the negligence is a maternal death:

Focus group discussion:
R: Others do go to the hospital at a good time, but the hospital personnel are sometimes too slow to react to patients. Others may take their time chatting in the ward. In such circumstances it is not noticed whether one goes to the hospital at a good time or not.
(FGD3: Ngatala – 25 till 40 years – multiple children, 15th of August)

Participant observation:
(at a village meeting) Another woman, I think the oldest of all, added a long response without one of us saying anything in between. She told a story about the health personnel. During one delivery the nurses left the woman alone on the bed during the delivery itself. " They let her be", as Agimah (the HSA and guide in this village) ended his translation. She also mentioned that sometimes the health personnel sometimes had the wrong data about the women, not knowing if it was her first child or the fifth.
(Informal discussion, observation period 3, day 3, 7th of October, TA Mponda)

Some participants in the focus groups explained to the others that the behaviour of the health workers is not rude in these cases. According to a participant from Stambuli others misinterpret the health workers when they are asked personal questions related to the pregnancy:

R: They are not rude, they only ask those why they go there late, and that is being mistaken as rudeness.
(FGD5: Stambuli – 20 till 25 years – With one or two children, 15th of August)

The pregnant women do not want to talk about their mistakes during the pregnancy because they believe that it is their own business. Some of the nurses show a critical attitude in combination with giving advice. The sometimes maybe critical attitude of the nurses and the misinterpretation by patients result in a disturbed relationship. In the following quote from a focus group discussion in Machenje it is argued that some families choose to not deliver at the health centre because of this perceived rudeness.

R; The lack of collaboration with the maternity staff. Others never go for sikelo because they do not want to talk with the nurses. Negligence of maternity staff members they give as a reason. Advice is not for them (the pregnant women). They should collaborate more.
(FGD1: Machenje – above 30 years – minimal 3 children, 12th of August)

Although the circumstances at the TBA's place looks to be less favourable and attractive than at the health centre, it does provide women the privacy and trustful support they wish for. Perceived problems at the health centre such as lack of medicine, rude or negligent staff, and unknown circumstances that might kill the woman, only strengthens their desire towards a delivery in their own village.

Additionally, in the non-governmental CHAM (Christian Health Association Malawi) health centres the patients have to pay a limited amount of money for basic services, including maternal health care. CHAM health centres are only partly funded by the government and therefore they see the need to ask for a financial contribution from the patients. During a village meeting some community members explained that the costs for basic services at the CHAM health centres are relatively low, however for the poorest in the rural areas it is impossible to afford this. Furthermore they argued that because patients have to pay more when they stay for a longer period, many patients decide to go to the health centre as late as possible:

(at a village meeting) I then asked them about what they think should be improved. A lot of women reacted on this question, and it looked they were supporting each others' remarks. The woman in the chitenje dress answered again first. She said the main problem was money. They have to pay for transport to the health centre and they have to pay for the CHAM hospital. Another woman of around 40 years old told us that they wanted a government hospital.
(...) *The older woman continued when looking at the women around her. Agimah translated to me that she is telling the other women, that they should not go so late to the hospital for delivery. To us she told, that women often go as late as possible for delivery to the health centre, because the longer they had to stay the more they had to pay. The HSA and the women talked a bit more which I could not follow because I was writing the last notes down.*
(Informal discussion, observation period 3, day 3, 7th of October, TA Mponda)

A community member argued during an informal dialogue that some patients decide to travel to the district hospital much further away in order to get free treatment. Transport is apparently cheaper than treatment at the CHAM health centre:

We talked about many things like football, the new roads around Mangochi and the payments the patients have to do at the CHAM hospital. Peter and Mtima had a very short reaction about if it was fair or not to ask for money. Peter said it was too high for many people and that the poor had to go all the way to Mangochi to get help. Mtima said it is a very small amount, and for the very poor they have special arrangements.
(Informal dialogue, observation period 3, day 2, 6th of October, TA Mponda)

As discussed earlier, delaying for going to the health centre is mentioned as dangerous and occasionally women die when they have to give birth on the way to the health centre. According to a health worker at a CHAM health centre, people have to save money in case an emergency occurs or for a health centre visit in the future:

Mtima explained me further. "Many people in the village do not save money. They need to save money for going to the hospital (the health centre) if they have a problem, but they do not do that. If then something happens to the child they can not bring it to the hospital. They do not think." It was clear that Mtima supported the paying health centre and he did not think the amount that is asked by them in the CHAM health centre is too much.
(Informal dialogue, observation period 3, day 2, 6th of October, TA Mponda)

4.3.5.3 Spread of uchembere wabwino ideas from the health services

As in paragraph 3.2 explained, a lot of participants indicated the importance of going to the health centre when expecting a child, either for delivery or for *sikelo* (antenatal care clinic). However, the role of the health centre is not supposed to stop at the level of just providing safe deliveries to the local community. Safe motherhood messages shared at the health centres are mentioned as an important source of information on family planning and maternal health. The participants mentioned the importance of listening to the advices of the health centres when confronted with pregnancy and/or delivery, e.g. listening to the advises provided at the *sikelo* clinics:

I: What can we do so that mothers never die from having children?
R: From the first month of the pregnancy she should be a friend to the hospital. Whatever she comes across she should always go the hospital.
(FGD3: Ngatala – 25 till 40 years – multiple children, 15th of August)

R: Women should always attend SIKELO, the medical personnel care know for what is necessary for every individual pregnancy.
(FGD4: Ngatala – 17 till 22 years – one child, 15th of August)

Although most of the participants indicated they did not attend the *sikelo*, they did mention the health personnel as the source for their perceptions regarding taking care of the pregnancy and delivery. Advises received from the health personnel which the participants were able to recall were related to the behavioural expectations towards pregnant women (discussed in section two) and to the prescribed involvement of men (which will be discussed in section four).

Not using the ideas and messages health workers provide is perceived by several participants to be a risk for women during pregnancy. As the following quote from a focus group shows, women would get problems when they are not listening to the advices of the health personnel:

R: It is easier if people abide by the instructions they receive at the sikelo. If people think that those advises are just like stories for children, they really would have problems at the end.
(FGD3: Ngatala – 25 till 40 years – multiple children, 15th of August)

In paragraph 2.3 the struggle between the old and the young generation regarding customs showed that several participants did not belief that the traditional customs have a positive impact on safe motherhood. Some of the advices provided by the health personnel are mentioned to be enhancing the opposition traditional customs. The period of abstinence (see paragraph 4.5.2), a period of several months prescribed by the elderly family members in order to safeguard the health of both the husband and the wife, is according to the advices of the health centre not helpful and essential anymore. As some participants explained, the health personnel argues that because of the use of condoms the risk of being infected with either HIV or *chinyera* is diminished and abstinence is not necessary anymore:

R; That time I was learning to live such kind of life so I took everything as golden truth. Now I realise that some of the advises were not realistic. For example I was advised to wait for seven months. It was not easy. But this time around we have the health personnel who provide condoms. Using the condoms one can have sex with any woman and live without any effects.
(IDI10: MasambaUma – 28 years, 24th of August)

Furthermore, if the husband would abstain from sex with his wife, the vagina is believed to become 'dried up' and 'too tight'. According to a participant from a focus group discussion in Ngatala, the health personnel advised him to keep the vagina of wife smooth until the delivery. In order to do so the couple is advised to remain having sex instead of abstaining for several months:

R: It is true these days the hospital is advising us to continue having sex at home to as far as soon before delivery. My wife said that she was advised that in order not to have problems in giving birth the path should rather be soft by having sex to the very end of the whole pregnancy period. If you abstain too early and too long the path will be hard and dry. So we were having sex to the very end with no problems of any sort. We are going by the wisdom of the hospital: "You go and keep on sleeping with your wife up until the time she is going to deliver."
(FGD3: Ngatala – 25 till 40 years – multiple children, 15th of August)

Also other advises of the health centre are not always in accordance with the traditional practises in the villages. However, the participants from a focus group discussion conducted in Machenje, who started the discussion about conflicting advises, seemed to agree on the advices that were provided by the health centre. One of them explained that the women themselves do not always listen and obey to the messages of the health centre. As shown in the next quote, women do not treat the wounds after birth as advised by the health personnel, therefore putting health at risk:

I; How is life the first few weeks after delivery? What can we say about the health and everything of this time?
R; It all depends on the lack of hygiene in the house. I am saying this because traditionally there is a lot that people do soon after childbirth. These make the period after birth much longer. For example; women are advised to be applying either ash on to the cut naval or soil. Some are advised to apply roasted, grounded seeds of pumpkins. All these are not healthy ways of managing the wound, because they are different on what they are if they have delivery at the hospital.
I; What are they advised at the hospital?
R; At the hospital they only tie a thread. But once women go home they remove the thread, and apply their own.
(FGD1: Machenje – above 30 years – minimal 3 children, 12th of August)

4.3.5.4: Health Surveillance Assistants

Besides the nurses and employees at the health centre, also other health workers are disseminating ideas and thoughts about safe motherhood; e.g. the Health Surveillance Assistants (HSAs). HSAs are members of the government health system who work and life within the villages themselves and not at the health centre. The HSAs mainly focus on the prevention of infectious diseases and are sharing information about several infectious diseases. They mainly focus on the infectious diseases malaria, tuberculosis, diarrhoea and cholera.

Community members know that the HSAs received training from the government regarding health issues and that they have important information regarding these health issues. Therefore some of the participants argued that it would be beneficial if the HSAs also would provide information about safe motherhood instead of only information about general health care and sanitation:

I; Is there anything the health personnel can do?
R; The HSA's should also take the uchembere wabwino messages on board. That is to say when they go around the villages talking about sanitation, they should also talk about uchembere wabwino.
(FGD1: Machenje – above 30 years – minimal 3 children, 12th of August)

The participants in one focus group discussion indicated that the HSAs sometimes did tell them about how to keep a pregnancy and childbirth safe. They further explained that the involvement of the HSAs could be very beneficial in spreading messages about safe motherhood:

I: What about traditional leaders and maybe other village members?
R: If we all follow what the HSAs are telling us, we would certainly improve the number of men that are involved in maternal mortality issues.
(FGD2: Machenje – under 20 years – without child or expecting first child, 12th of August)

Especially for people who are more difficult to reach HSAs are considered to be essential in spreading *uchembere wabwino* messages. E.g. as mentioned in the following quotes, when the village is very remote or when people are not open for advice:

In-depth interview

R; What can happen is; we need the hospital closeby. If the hospital is near, people access different advises. Those advises reach men with much ease. But as it is for people to go to Ulongwe, nothing can reach here. Maybe through HSA's on uchembere wabwino. Everybody should know about uchembere wabwino. The government should make sure everybody knows the goodness of uchembere wabwino.

(IDI12: MasambaUma – 41 years, 24th of August)

Focus group discussion:

I: Do you think it is necessary to involve the hospital personnel to help us out?
R: Maybe if we involve the HSA's. That can certainly bring in change in the men that are being stubborn.

(FGD2: Machenje – under 20 years – without child or expecting first child, 12th of August)

Furthermore, the HSAs in the villages organise and co-ordinate the under-five clinics in the rural villages. During such under-five-clinics the children are weighted, measured and checked for their health and nutrition status. Moreover, during these clinics the HSAs also give advises about raising children and about family planning. The under-five-clinic visited during one of the observation periods showed much resemblance with the antenatal care clinic attended earlier in one of the observation periods (antenatal care clinic is discussed in paragraph 2.2.7). Part of the field notes written during the under-five clinic are shown below and it describes how the mothers gathered together and sat down on concrete benches after the weighting of their children. The mothers sang together short songs in which they discussed how to deal with parenthood. Many of the women who attended the under-five clinic knew the songs by heart. The content of the songs also addressed child spacing and limiting the number of children within families. During this clinic also younger girls of around twelve years old, who did not have a child yet, attendant and sang along:

The woman, who talked earlier already, stepped forward and had a speech of maybe ten minutes. After every couple of sentences the women shortly clapped in the special rhythm. Some were looking outside through the windows, some were talking with each other and one woman looked to be sleeping with her head against the wall. Other women were nodding along with the speech, and sometimes you heard an agreeing mumble from somewhere. The HSA translated to me that she told several things of what to do when you are pregnant. She told the women that they should deliver the baby at the hospital, that they should not do really hard work and that they should eat well. Also she told that the baby should eat very well, that the baby should eat porridge enough and something else which I did not understand. The children had to wear good clothes and they should save money for when the child is getting malaria or is getting sick. She ended by telling that when the child is sick, they should bring the child to the hospital and not to a witchdoctor.

Some babies start crying and or try to escape from the lap of the mothers. Some of them give breastfeeding as soon as the baby starts struggling, others do not really react and just listen while holding the baby tight. After the woman finished talking Ndulu (safe motherhood advisor) stood in front and started talking. He seemed to be comfortable in front of the women and also earlier, when he was helping out with the weighting outside it looked like he knew what he was doing. The HSA shortly translated to me again what Ndulu was telling about. He is telling about that the women should not have many children in a small time period and that they should wait with getting children again after giving birth. Further Ndulu told about not having too many children because then it is easier to sent them to school and to feed them. Ndulu explained me earlier that he goes door by door to tell people about child spacing and he was telling this here as well. I asked the HSA if they always speak like this to the women at the under five clinic. 'Always, yes. We have under five clinic every month, and we say this and that to them. Because it is really important that they learn that.'

(Informal dialogue, observation period 1, day 1, 3rd of August, TA Chimwala)

4.3.5.5: Educational posters and paintings

Finally, the health centres tries to disseminate *uchembere wabwino* messages by the use of paintings and posters on the walls of the health centres. These paintings and posters often show situations in a random village combined with a short advice related to the illustrated situation and to a certain health issue. At a health centre within the study area several posters were decorating the wall. One poster showed an issue related to HIV/AIDS and stigmas, another one about how to prevent tuberculosis, and one poster described the distances of the health centres to the hospital.

Similar looking posters, on different topics, were displayed at the walls of schools and other public building in the villages. Also at the under-five clinics and antenatal care clinics posters initiated by UNICEF, the WHO, or the Malawian Government were attached to the wall. The painting mainly showed one or two colourful and clear animations combined with a few short sentences explaining how to deal with the problem that was animated on the poster. Field notes from a visit to the antenatal care clinic explain that one of the posters animated a man caring for a pregnant woman intimately:

At the outside sikelo room I saw posters on the wall, that showed advice about caring for the pregnant woman. The man had a prominent place on one of the posters. He was holding the pregnant woman with an arm around her, and with the other hand he gently caressed the stomach of the pregnant woman. Everybody was smiling on the poster, also the men and the women in the background. I did not see the word 'sikelo' on the poster, so it was maybe not specifically focused on antenatal care.
(Field notes, observation period 3, day 2, 6th of October, TA Mponda)

Another poster at the under five clinic also animated men being involved in maternal issues, or in this case caring for the new born and the mother.

(at the under 5 clinic) I see also some men on the poster feeding the child or participating in buying the vegetables on the market. When I look into the room I only see women, not one man besides the HSA's, Kokayi, Ndulu (guides during this period) and me. Not one father is joining or bringing the child. Also when I ask the HSA where the men are he replies me: "They are never here. I have never seen. The mothers bring the children to the under five clinic."
(Field notes, observation period 1, day 5, 3rd of August, TA Chimwala)

However, this last quotes indicates that, as likewise described earlier in relation to the *sikelo,* men are not present at the under five clinic although the poster recommends men being closely involved. The impact of the posters on actual behaviour of community members should therefore be estimated with some concern.

4.3.6 *Uchembere wabwino* messages from outside spread into the community

In the last paragraphs it is explained how different people and institutions can and should disseminate *uchembere wabwino* (safe motherhood) ideas. However, several participants supported the idea that an individual from outside the village should come to the village and share ideas and information with the community members. The participants mentioned that e.g. these individuals could be personnel of the district hospital, governmental district officials, and employees of NGOs and CBOs (non-governmental organisations & community-based organisations). Especially personnel from the district hospital and representatives of the Community-Based Safe Motherhood project (CBSM) are mentioned as suitable options to perform the advisory task, moreover because they are considered to have the recourses and the mobility to do so:

R; We also here that there is an organisation of uchembere wabwino. This organization should also pick up the task to involve and encourage more men. They should work with the young people we have in the village, to disseminate the uchembere wabwino messages. Ourselves we cannot make it to move all around the area, but that organisation has the mechanism to move and disseminate such messages.
(FGD1: Machenje – above 30 years – minimal 3 children, 12th of August)

I: What can the hospital personnel do so that we improve the involvement of men?
R: Like you have come to share with us on what is supposed to be done, the hospital people can also do the same, they are free to do that.
(FGD5: Stambuli – 20 till 25 years – With one or two children, 15th of August)

4.3.6.1 Media spreading uchembere wabwino messages

Furthermore, the media and media groups are mentioned several times as a beneficial method for reaching more people in the villages. These sources also come from outside the community, and are able to bring messages on safe motherhood to the villages and its people. Although not everybody has a radio in the villages, a couple of radios per village is not uncommon and villagers come together to listen to popular radio programmes. During the observation periods mainly men seemed to listen to the radios. At the village centre groups of men sat together to listen to music or to a radio programme, combined with a lot of laughter and talking of the men themselves.

Salar talks for a while with him, and at the same time Masrur walks to the building next to us to greet another man sitting in front of his house. The group with men is still standing at the same spot, listening to the radio in front of them.
(...)
A group of five men, both young and old, are standing together in front of a house. I think the house is repair shop or maybe a shop for iron parts. I see some tools on the ground, a couple of electricity cords and inside I see a bicycle tire and some metal parts of maybe a car. One of them has the radio on, but I cannot hear the music. The guys are leaning towards the radio, probably to hear the sounds coming out of it better.
(Field notes, observation period 1, day 5, 3rd of August, TA Chimwala)

Inside the home of the host family during one of the observation periods, the young brothers of the family listened and danced to the music of the radio. As described in the following informal dialogue, they more often listened and danced to the music. The brothers further explained in the dialogue that their father bought the radio so he could listen to plays and talk show broadcasts:

They wave with something in their hand. When I see it from closer it seems to be a cassette for in a radio. 'We go to a friend; he has a lot of music. Masrur gets the radio from the small table in the corner and he starts doing something to the cables. Folding two cables together very tight, and then attaching it to a long grey cable coming from a hole in the wall. Salar explains me that they connect the radio to a battery. Than music comes through the speakers.
Sometimes he comes over himself, just to listen to the radio for a few hours. They joke about that he is always listening to talking programmes on the radio instead of music. "He thinks that is really funny, he laughs a lot with the radio", Salar says while smiling.
A real Malawian, or African beat, which almost automatically makes your hips move. Masrur dances a little; Salar sits down next to the radio. They explain me that normally they dance a lot in the evening, sometimes in the house, sometimes in the village centre. Baaba bought this radio for them because he thinks dancing is really important for the children.
(Informal dialogue, observation period 1, day 2, 31st of July, TA Chimwala)

From these and several other observations it is clear that many men listen to the radio, especially in groups. Advises from the radio can shape the perceptions and ideas men have regarding family planning and safe motherhood, as the following quote describes how an interviewee beliefs men should be involved in child spacing after he heard it on the radio:

I: After measuring yourself, what can you cay about it all?
R; I feel it is better not to give birth anymore. I would go to the hospital, because I hear that they are also able to do something on the man, so they should not be able to sleep with women frequently.
I: Is it true indeed?
R; Maybe, because that is what we hear from the radios
I: What do the radios say?
R; They say men also should be part of the uchembere wabwino. Men should be involved in child spacing.
(IDI7: Stambuli – 72 years, 23rd of August)

Another participant explained that he heard from a radio broadcast that he should treat his wife better:

I: What about the radio, didn't you get anything on the radio?
R; We hear a lot. They say that we should unite with the women if we were to develop the country. We also get some information from the hospital about how to care for the children, they also said we should not be cruel to women.
(IDI4: Machenje – 35 years, 18th of August)

If also many women listen to the radio is difficult to conclude from solely analysing the field notes of the observation periods. It might be possible that also women listen to the radio in groups; maybe this occurs at home when the husbands are listening to the radio at the village centre.

4.3.6.2 Drama groups incorporating uchembere wabwino messages

Where radios on the one hand might not be available to every community member and might not reach everybody in the village, drama groups on the other hand are available to practically every community member. Using drama groups is a very well known method of sharing ideas and advises within rural communities (Hughes & McCauley, 1998). Drama groups travel from village to village to perform a show, a dance or to play music. Drama groups are used in two different ways: Some of the drama groups perform a show in which ideas, advises or information are incorporated into the show itself. E.g. a show in which the main character has to deal with the stigma that exists around HIV/AIDS. Several participants argued for the use of drama groups in order to inform the rural communities:

R; If we are to involve drama groups, so they incorporate the messages in their plays, this will go a long way to the people. Such plays would be displayed anywhere in the villages or even at the health centres themselves any days they have the sikelo.
(FGD1: Machenje – above 30 years – minimal 3 children, 12th of August)

Other drama groups just try to gather as many people as possible around by providing entertainment. During the breaks of their shows it is possible that somebody speaks up related to a certain topic concerning health, development, politics or welfare. In this way this person is able to reach many villagers simultaneously, both man and woman, with information or advises. During one of the observation periods a music group that performed frequently in the area was hired by the CBSM project. They played traditional drums and performed a traditional dance by which they gathered a large enthusiastic audience around them. During the breaks representatives of the CBSM project presented some ideas about safe motherhood. As the following quote from the field notes describes, most people in the audience stayed and paid attention to the speech of the CBSM advisor. The talks were relatively short, around ten minutes, probably long enough to give important basic advises and not too long to prevent people leaving.

The talks of Mary and Baderinwa were relatively short, I guessed about ten minutes together. Mary and Baderinwa used the performers to spread messages about safe motherhood. Nobody was there to translate so I did not understand what they explained to the people around, but I did recognise the word 'chipatala', which means hospital. Most people, both adults and children were listening and paid attention pretty well. Some older women nodded and mumbled their agreement with what was said. (...) The talks of Mary and Baderinwa were relatively short, I guessed about ten minutes together.
(Informal dialogue, observation period 3, day 2, 6th of October, TA Mponda)

Likewise, Agimah, an HSA explained during one of the observation periods that they use drama groups every year in order to warn people about the dangers of cholera. They advise people to build toilets for during the rain season, to wash their hands frequently and to cover the food they store at home. He further explained that they reach 144 villages with these advices and the purpose is that they visit the villages before the rain season arrives:

We talked about the artists we both saw yesterday. Agimah told me that he sometimes hired the artists as well, to go with them to the villages and to play the drums and to perform. "144 villages we go to with them. They go there and perform, we do that if we want to tell the people about a health danger", Agimah explained. Surprised I asked if he really meant he was going to 144 villages with them. He answered that he did this together with other HSA's in the area. Agimah continued: "At the end of this month we go again, in October. We give education to the people about cholera." The advices they would give, according to Agimah, are that the people should was their hands all the time, cover all the food, build a toilet and that they should not pee in the bush. (...) Because of the rain season." At the end of October they planned to start these advises, because that is just before the rain season normally starts. "A lot of people get sick in the rain season, and a lot of children die with cholera, and if we tell the people early, they can build their toilets."
(Informal dialogue, observation period 3, day 3, 7th of October, TA Mponda)

4.3.7 Community involvement after birth

After birth the involvement of the community does not seem to end. Especially the family is still involved in decision-making and advice-giving regarding the new mother and her baby.

4.3.7.1 Traditional herbs

In first instance are after birth traditional herbs and medicine frequently prescribed and used in order to improve the health of the woman. The family members are mentioned to be the ones who pursue the couple to use traditional herbs. The use of the herbs and medicine is however very diverse. Some participants explained that herbs are used in order to heal or deal with the *ngokota* (shortly mentioned in paragraph 1.8.4), referring to the pain that remains inside of the woman after the delivery. The following quotes show how traditional medicine can be used to heal *ngokota*:

R; If we give traditional medicine within a week it (ngokota) may die out. By this time the namwino (uterus) kind of resigns, to say my thing is really gone.
(IDI1: Machenje – 60+ years, 17th of August)

R; The first few weeks after delivery, the woman used to suffer, from a condition ngokota. So if she was suffering from ngokota I would take the baby and take care of it. So I looked for traditional medicine and give her myself.
(IDI1: Machenje – 60+ years, 17th of August)

Other herbs are mentioned to be used in order to allow the couple to resume sex earlier than normal, without transmitting *chinyera* to the husband (*chinyera* is discussed in paragraph 2.3.2). The participants were not able to clarify what the exact medicine and herbs were, they only described where they were used for:

R; They would give you a medicine to prevent a man for catching a disease (kanyera) from the woman.
I; Can you tell the rite that was followed under the name of the medicines that was being administered?
R; We don't know the medicine and the rites would vary from one place to another.
(FGD1: Machenje – above 30 years – minimal 3 children, 12th of August)

R: You are supposed to wait for a period of about eight months (with having sex).
R: Some fail to reach this far.
R: Some would take some herbs just to make sure that they are free to resume sex as quickly as possible.
(FGD4: Ngatala – 17 till 22 years – one child, 15th of August)

4.3.7.2 Family in charge after death mother

In the case of a death of the mother during the delivery or during the post-natal period the family is mentioned to be playing an important role. As the following quotes from focus group discussions in Stambuli and Machenje describe, the family of the woman that passed away is in charge of the decisions that need to be made regarding the funeral and regarding the future of the children that the woman might have left behind. The husbands' role in these decisions depends on the willingness of the mothers' family and on the relationship between the husband and the mothers' family. It is likely that the family will take responsibility for the children and that the husband moves away in order to find a new wife:

R: As soon the mother dies children belong to the family of the deceased and they are not yours anymore. As such they have all the authority and you can not be stubborn.
(FGD5: Stambuli – 20 till 25 years – With one or two children, 15th of August)

R: (...) If my wife dies, her relatives would come and collect all the children. As such you would not even have the opportunity to raise the little baby. It is taken along the others and the maternal site takes the whole responsibility. So if it is a little baby, the woman relatives would look in who is to breastfeed, probably amongst the relatives. Supposing that the little baby is left with the man, it is possible to raise it up (...)
R: (...) if you choose to take the children yourself it will take a long process. Because they would be referring you from one person to another. To make you feel like a beggar. They do this to delay and frustrate you. If you insist, they would ask you where you paid the bride price for the woman.
(FGD1: Machenje – above 30 years – minimal 3 children, 12th of August)

4.3.7.3 Less family involvement needed

Finally, it needs to be clarified that not all participants are in favour of the involvement of the family regarding the whole period of getting children. As discussed in the last paragraphs, most of the participants explained how important the family's involvement is concerning the support of the woman in times of pregnancy and childbirth. However, occasionally a participant indicated that the husband should take responsibility more himself. The husband should not always leave the responsibility to the family:

Focus group discussion:

R: These days there are no customs and the husbands are in control. The husbands would choose to disagree, even with parents, as long as the wife is saved.

(FGD3: Ngatala – 25 till 40 years – multiple children, 15th of August)

In-depth interview:

I: What about your parents in-law?

R; They cannot say anything about this. I am sorting my problems at my house just as they sort theirs at their own home.

(IDI12: MasambaUma – 41 years, 24th of August)

Additionally, the participant occasionally explained that the involvement of the family can be even an obstacle in protecting the health of the woman. The following participant from Ngatala perceived the recommendations of the family as old-fashioned and their involvement in escorting the woman to the health centre can lead to delays that put the life of the woman at risk:

R: Whenever there is pregnancy our parents act being very wise, so they tell us a lot of things. Things like recommendations on what to eat and not to eat, I think these are just elusions.

R: Whatever they tell us, they do not have explanations, as such we can do away with them.

(FGD4: Ngatala – 17 till 22 years – one child, 15th of August)

4.4 Research results section: Men's perceptions about male involvement in safe motherhood

The men who participated in this study provided a detailed assessment on the problems and risks regarding safe motherhood. Many of these risks are discussed in close connection to the responsibilities men have towards their families and their wives. This section will explore what the participants believe is the responsibility of men during pregnancy, childbirth and the post-natal period. While doing so, also risks related to the behaviour, welfare, and knowledge of men will be assessed. After the risk factors related to women discussed in section two and the influential factors coming from the community discussed in section three, the participants discussed multiple risk factors related to men. This shows that getting children is not completely perceived as a purely women's business (opposing the findings discussed paragraph 4.1.3). Men likewise are supposed to take their responsibility in order to protect the lives of women during pregnancy, childbirth and post-partum.

To understand the cultural context of the responsibilities men are supposed to take during pregnancy, delivery and post-natal, this section will firstly reflect on the role of men in general when they are not faced with a pregnancy (paragraph 4.4.1). It will show that although there are traditional tasks prescribed specifically for either men or for women, nowadays some of these tasks can be performed by either the man or the woman.

Secondly, just as the woman has to life up to new expectations once she becomes pregnant, likewise the husband is confronted with many new responsibilities once his wife becomes pregnant (paragraph 4.4.2). He is supposed to provide all the requirements related to the pregnancy, he is supposed to stay close to his wife in the last months of the pregnancy. Furthermore a discussion about the question if a man has to escort his wife for *sikelo* and/or for delivery is given.

Following paragraph 4.4.2, paragraph will reflect on the idea of 'shared responsibility' which is presented by the participants as an important responsibility of the couple in favour of improving maternal health. According to some of the participants is shared responsibility essential for successfully practising safe motherhood (paragraph 4.4.3).

Fourthly, it will be discussed in what way the behaviour of men is influencing safe motherhood. The participants frequently indicated that the cause of a maternal death is related to the behaviour of the husband. Domestic violence can cause complications and eventually death during the pregnancy or the delivery. Furthermore, negligence of the husband to support and care for the pregnant woman can also lead to serious problems (paragraph 4.4.4). Additionally in paragraph 4.4.5 a reflection is given on how sexual and reproductive behaviour of the men is perceived as possible negative influence on safe motherhood. The participants makes clear that the sexual and reproductive behaviour of husbands can either safe or destroy the life of their wives. Extramarital relationships and not abstaining from sex in a certain period before and after the delivery are discussed as key problems towards maternal health issues in rural Mangochi. Also the lacking will and

knowledge of some men to use family planning methods is in this paragraph discussed as a risk threating safe motherhood.

Sixthly, poverty as a major obstacle towards protecting the pregnancy and the delivery is discussed (paragraph 4.4.6). Men are mainly responsible for the income and the support of the family. When a man is too poor or is not supporting his family properly, problems during the pregnancy, delivery and post-partum can emerge. Furthermore, poverty within the community makes it hard to practise safe motherhood. Many young people are working elsewhere in the country or abroad because of the lack of income and job opportunities in the rural villages. The lack of young adults in the rural communities is enhanced more because of the HIV/AIDS pandemic which killed many community members, especially among the young adult's age categories.

After the first paragraphs of section four has explained what the importance and practise of male involvement is, will paragraph 4.4.7 reflect on the feeling of exclusion among men in rural Mangochi which hinders male involvement. The participants explained how men are literally and metaphorically placed outside pregnancy-related issues. Several customs and phenomena are discussed as preventing men to be closely involved in the entire process of getting children. The separation of husband and wife the first days after delivery, the husband not being allowed in the delivery room, the ownership of the children in hands of the mother and the mother's family, and the exclusion from information about safe motherhood, together result in a perceived idea of exclusion among men in rural Mangochi.

In order to get men changing their behaviour and to let them be more involved into maternal health the participants mentioned several solutions. In paragraph 4.4.8 it will be shown how the participants believe *uchembere wabwino* (safe motherhood) messages and ideas should be successfully spread into the community in order to increase awareness about maternal health. Furthermore, it is indicated that disseminating more information on safe motherhood among men will reduce the feeling of exclusion and therefore increase male involvement in maternal health issues.

4.4.1 Male role in general

The men in the in-depth interviews and focus group discussions were asked to discuss the responsibilities of both men and women within the family and community. Traditionally, the tasks performed by men and women at home and in the village are different. Domestic work like cooking, washing, fetching water and gathering firewood are considered tasks for women:

R: Drawing water is a task for women; cooking, washing nappies and pounding are tasks for women.
R: Going into the bush to fetch firewood is the task for women.
(FGD5: Stambuli – 20 till 25 years – With one or two children, 15th of August)

On the other hand construction work such as preparing the crops, constructing a house, making bricks, cutting bamboo and preparing the crops in the garden is more targeted towards men

R: Molding brick, cutting bamboos, making hoe handles are some of the tasks for men.
(FGD5: Stambuli – 20 till 25 years – With one or two children, 15th of August)

However several men also indicated that the separation of tasks is old fashioned and both men and women can do similar tasks nowadays. In the next quote a lively discussion among a group of young men (aged 19-25 years) shows that nowadays the separation is not that strict anymore and that not everybody agrees on the traditional division of male and female tasks in the village. Some of the participants argued that men can and do perform tasks that traditionally women only performed, such as cooking, and that the other way around women can be found performing traditional male tasks, such as constructing the house. The discussion indicates that people in the village might laugh about men who are performing traditional female tasks, however nowadays people do not care about being laughed at anymore:

I: What differences do we have in the roles of men and women during the pregnancy?
R: None, there are no differences.
I: When we say there are no differences what do we mean?
R: It means that these days we would be able to find a woman constructing a house or a fence, men are also cooking as a task.
I: Are we trying to agree that there is no work that a man can do without being laughed at?
R: There are.
R: No there aren't.
R: If people see a man washing baby nappies people would laugh at him.
R: If people see a man pounding, people would laugh at him.
R: What is happening is this: that people are laughing of course, but people are doing whatever they want.
I: If people laugh at you it means they see something abnormal about the work. Where does the abnormality lie?
R: Of course there is something that the people laugh at, in principal there are roles of women and roles of men.
(FGD5: Stambuli – 20 till 25 years – With one or two children, 15th of August)

4.4.1.1 Main authority in household

It is indicated by the participants that traditionally men have the main authority in the household and this phenomenon is considered to be unchanged. Most of the participants agreed that the man is the leader of the household and that the man makes the important decisions within the household:

I: Who is the decision maker at home?
R: The man has the authority.
R: All the social activities are led by the man.
R: The woman may make suggestion but the man has to make decisions to what has to be done.
R: Whatever the man says should be the final word in the family.
R: If the wife chooses not to obey what the may says the marriage can be shaken up.
(FGD5: Stambuli – 20 till 25 years – With one or two children, 15th of August)

In paragraph 2.1 it is explained that the main authority might shift towards the woman in certain circumstances. Some participants indicated that women do have some influence on the decision-making and in some cases the woman has the full authority. In the following quote it is explained that the woman actually decides what is supposed to happen within the family once she is pregnant. It might seem that she just gives suggestions, however her suggestions need to be seen as final decisions.

I: When the wife is pregnant, who decides at home?
R: It is the woman that decides. She may sounds suggestive but whatever she says has to be done. A pregnant woman is like a patient in the hospital; whatever she says has to be done.
(FGD2: Machenje – under 20 years – without child or expecting first child, 12th of August)

The participants in the same discussion group did however continue by explaining that that after the delivery the authority goes back to the husband:

R: When she delivers the decisions goes back to the man. Because men do not necessarily listen to women normally. In ordinary times the man is in control. In the families we do discuss and agree, but the husband is the head of that.
(FGD2: Machenje – under 20 years – without child or expecting first child, 12th of August)

Where the participants indicated that the main authority in the household is mainly in the hands of the man, they also explained that this must be understood in combination with having the responsibility for the welfare of the family. An interviewee explains in the next quote that if his family is facing problems, he is the one who is responsible and who is to blame for the problems.

I: As a dream plan for your family, do you think the future of your family will improve or not?
R; I don't know what the future holds.
I: This is just a dream, a kind of plan.
R; I hope things will be ok. Because if things go back it is actually a reflection of how you are doing things yourself.
(IDI2: Machenje – 59 years, 17th of August)

If a man is not able to successfully take the responsibility and take care of his family a struggle between husband and wife can emerge concerning the main authority within the family. The participants from one of the focus groups explain in the following quote that if a man is not able to take care of his family, the woman will take over the main authority. They argue that the shift of the responsibility from one to another depends on the season, where the season influences the man having money or not available for the family's welfare:

R: The situation here is seasonal. There is a time we make money and have money, and there is time that we don't have money. During the time that we don't have money the women takes the lead and the responsibility.
R: With this in mind we are sharing and struggling for the leading roles.
(FGD3: Ngatala – 25 till 40 years – multiple children, 15th of August)

As described above, if a man is not able to take care of the family, authority struggles and relationship struggles can arise. On the other hand, if a man is wealthy and responsible enough to take care of several families he is within some communities (depending on religion and tribe) allowed to have multiple wives. In informal dialogues during the fieldwork it became clear that everybody recognises that this phenomenon happens in both rural and urban areas. The following quote, derived out of field notes from the first observation period, describes the situation of the host family during the observation period. In an informal dialogue with the children (aged between 12 and 28 years old) of the host family, it is described how their mother lives and works in South Africa for several years, and therefore the father insisted on a second wife in Malawi. The children explained that the first wife, their mother, is not happy with this situation:

(…) but our mother is in South Africa". "Are Baaba and Maama in South Africa still married?" I asked. Salar answered: "Yes, and now my father is married with the mother here. But Maama does not like. My father marry with the other woman when Maama was in South Africa. My father said he needed a wife here." Hameeda said something to Salar and then he said to me: "My mother really is angry, she does not like that my father has this wife."
(Informal dialogue, observation period 1, day 2, 31st of July, TA Chimwala)

The next quote shows that when the dialogue continued the children explained that they do not agree on their father having a second wife either. They mention that the second wife insists that the father will stay at her place; consequently the children of the husband live without their father and mother at home:

This was I think the first conversation in which we together not smiled or laughed one time. And I did not had to ask a lot of questions because Salar kept talking himself. "Some men do that, they want to have more wives. I think that is not good, my mother not as well. My mother wants my father to divorce this other wife, but my father does not want to." He kept talking about that his father is living with the new wife, that is also why the children all life together in this house, without the father. "My father comes here a lot times, but his wife wants my father to sleep at her place, not here. That is what my mother thinks is not good, she want him to stay with us". Salar is watching at Hameeda, she does not say anything, but she is definitely listening to the conversation. Mehrnaz walks in the room again during the conversation and sits down next to us, on the floor. "What do you as children think about it?". Hameeda said right away: "not good". Salar continued: "We think my father has to be with my mother in South Africa, but he does not want to go to South Africa, he wants to stay in Malawi."
(Informal dialogue, observation period 1, day 2, 31st of July, TA Chimwala)

4.4.2 Responsibilities of the man during maternal times

When a woman becomes pregnant the man is supposed to change his behaviour and follow new guidelines regarding how to take care of the family. Many new responsibilities for the man emerge when his wife becomes pregnant.

4.4.2.1 Provide necessities

First of all, the participants explained that the husband is expected to provide materials and specific food that is required during pregnancy, delivery and post-natal. They mentioned that women mainly indicate what is necessary, and the husbands are supposed to arrange these requirements:

I: What was expected of you during delivery; was it possible for you to be close?
R; Yes I was always close. I wanted that when she had just given birth I should receive her very well.
I: How were you receiving her?
R; I would buy all the necessities that she said she needed. I wanted her to be happy as that she has given birth and she is well.
(IDI4: Machenje – 35 years, 18th of August)

The men in the focus groups mentioned that the husband is supposed to be prepared with arranging the requirements for pregnancy; which means, as the following quote shows, that they have to arrange all the requirements early enough in order to prevent that a lack of materials becomes a problem when the time for delivery starts:

R: As men we have got a responsibility not to take pregnancy as a surprise. We should be prepared for every pregnancy, we don't want to be told that things have gone bad, we would rather opt for pregnancy and prepare everything that is necessary.
(FGD5: Stambuli – 20 till 25 years – With one or two children, 15th of August)

Some of the requirements a man is supposed to provide, according to the participants, is sufficient food and drinks. During the pregnancy the woman needs to eat healthy and after the delivery it is mentioned that it is important that she drinks a proper drink which helps her recover from the lost blood (paragraph 2.2.2)

Alongside the provision of sufficient food and drinks, the husband is supposed to arrange the requirements demanded by the health centres. The health centres tell the couples that the women who are coming for delivery need to bring a basin, plastic sheets, a razor, soap and a thread:

I; Is this getting prepared for the pregnancy?
R; There are several categories for getting prepared for pregnancy. When woman go for antenatal clinics they are told about requirements to come with for labour. So when they come home, they tell their husband that I have been advised to have a basin for the Chitenje (wrappers), a plastic paper, a razorblade, thread. So the man has to make sure that these things are provided for in good time. That's what it means, preparing.
(FGD1: Machenje – above 30 years – minimal 3 children, 12th of August)

The participants indicate that they also need to arrange enough spirit and paraffin. It is explained that spirit is used for cleaning the wounds and the paraffin is used for the lights in the house at night once the baby is there:

I: After the seven days (first seven days after delivery) were over was there anything else you were doing?
R; Nothing particular, life was just normal. I only made sure there was enough paraffin and enough matches.
I: Why more paraffin this time only?
R; Of course we use paraffin and lamps all days. But life changes when you have a little baby in the house. The lamp is supposed to to be lit all night long.
(IDI10: MasambaUma – 28 years, 24th of August)

One of the important requirements that the husband is supposed to arrange is sufficient *chitenjes* (wrappers). The woman needs *chitenjes* to wear during her pregnancy and to wrap the baby in once it is born. The *chitenjes* are an important indication towards the community that the woman is taken care of properly and that the couple is well prepared for the pregnancy.

In-depth interview:
R; The man should make sure that the woman is very well cared for. She should have good clothes and multiple chitenjes so that her outward appearance would be a good one. So that people can know she is married.
(IDI8: Stambuli – 29 years, 23rd of August)

Focus group discussion:
R: It is just lack of intelligence in some of the men. We see that the women is very poor, hardly with one Chitenje and yet the husband is there, all that the husband cares is about beer.
(FGD4: Ngatala – 17 till 22 years – one child, 15th of August)

If the woman does not have enough *chitenjes* to wear and if the material requirements at the hospital are not met, then one of the participants in the focus group argued that the woman might feel ashamed and might decide not to go to the hospital for the delivery:

I: Why do they say we need all these (requirements)?
R; This is not a custom, but there is a need to change: Men should be sympathetic with women especially when pregnant. We should make sure that we provide everything we can that a woman needs. If we fail to provide what the woman needs at the labour ward, there is danger that she would feel ashamed and choose not to deliver at the hospital.
(FGD1: Machenje – above 30 years – minimal 3 children, 12th of August)

The following participant of one of the interviews mentioned the importance of the husband to provide all these mentioned requirements. He explained that providing the requirements during the pregnancy means that he was involved in the pregnancy:

I: When she told you that she was pregnant, how involved were you?
R; I was involved. I had the responsibility of fending for her so that she should be very well provided for. To make sure she lives peacefully until her time for delivery comes.
(IDI11: MasambaUma – 25 years, 24th of August)

4.4.2.2 Stay close to wife

Another expectation focused on the husband that emerges when his wife becomes pregnant is that he should not travel long distances during this period. Especially when the expected date of delivery gets closer or during the delivery, the husband is supposed to stay close to his wife. Reasons mentioned by the participants for the need of the husband to stay close are: to provide sufficient support, to provide whatever is required and to show love towards your wife:

In-depth interview:
I: You also talked about the role of men during child birth, what did you say this was important?
R; OHOOW. What I said is that when this lady is pregnant around nine months, you need to be close by, because any time she can start labour, she can get sick and you need to be there to provide assistance. I should take care of this lady during this time, including my children.
(IDI5: Machenje – 30 years, 18th of August)

Focus group discussion:
R: When the wife is pregnant the man has to be closer at home, this will show that the man loves his wife.
(FGD4: Ngatala – 17 till 22 years – one child, 15th of August)

Additionally, staying close is to make sure that in case the woman needs to go for delivery she will not be delayed by the husband being somewhere else. In the following quote from one of the focus group discussions it is explained that such a delay eventually can lead to death of the mother or the baby.

R; If a man is not close there is a possible danger of delay in going to the hospital. The woman may loose a lot of blood at home, and at the time she gets to the hospital - very weak. The most expected result of this is death.
(FGD1: Machenje – above 30 years – minimal 3 children, 12th of August)

As mentioned in the last paragraphs, the husband is supposed to stay close and to help out in case his wife is going into labour. It also means that the husband is involved when the woman needs to be brought to the health centre for delivery, as shown in the following quote:

R: Whenever her time to deliver came, I always sent her to the hospital in Lilongwe, that is where she used to deliver.
(IDI1: Machenje – 60+ years, 17th of August)

Remaining close to the wife for a certain period is indicated as not always being an easy task. The next quotes from two interviewees make clear that remaining close is sometimes conflicting with other responsibilities such as providing food for the family that has to come from another region or work in another region. Because arranging transport for many rural community members is difficult, going to another region for food or for work will take several days. During these days the woman will be at home and has to take care of herself for several days.

I: Are there any stumbling blocks to attaining such aspirations (staying close to your wife)?
R; Yes there would be stumbling blocks, but not too many. I tell my wife I am going to the lake to buy fish because fish there are cheaper then here. During such a time my wife would be burdened with taking care herself and of all the children herself.
(IDI9: Stambuli – 25 years, 23rd of August)

I: Did you experience this (pregnancy) as good or bad time?
R; It is all good time. But during the pregnancy we moderate travelling. We even stop some journeys. I am a carpenter, as such I do get invitations to go to Monkey Bay, Mangochi. But once I am in this situation, I tell them I am busy until such, such a time. Whilst waiting for delivery.
(IDI12: MasambaUma – 41 years, 24th of August)

Furthermore, the following quote makes clear that a husband is supposed to know the expected day of delivery and when this day approaches the husband has to make sure his wife is actually going to the health centre. Alongside urging their wives to go to the health centre, the following quote mentions that the husbands are supposed to escort their wives themselves to the health centre for support:

I: How important is it that men should be involved in the lives of women in view of future mothers?
R: It is necessary because some of the women are negligent if they are given a particular date for Sikelo and the EDD (expected date of delivery). They negotiate it within themselves and choose to go on another day, it is the responsibility of the man that she follows what it is supposed to be done. He should escort her as a matter of support.
(FGD5: Stambuli – 20 till 25 years – With one or two children, 15th of August)

An initiative from the CBSM project (in collaboration with some of the communities in Mangochi) influences the husband being closer when the time of delivery arises. Within this initiative communities received their own bicycle ambulance in order to overcome the long distances to the health centres. The community members themselves indicated that a bicycle ambulance would help reducing the delay in travelling to the health centre, which is perceived as a major threat to safe motherhood in the villages. In the event of an emergency the husband will receive the bicycle ambulance, so that he can bike his wife to the health centre himself. This not only reduces the delay, it additionally also strengthens the involvement of husbands and increases their responsibility towards a safe delivery at the health centre. The following field note describes how a bicycle ambulance is easily accessible for all community members at the house of the Group Village Head (GVH). Two men assemble the different parts of the bicycle ambulance in a few minutes without a manual or explanation and biking with it is relatively easy:

(...) The GVH comes out with two loose wheels. Kokayi and Ndulu (two guides during the observation period) get up and get it from her. Both of them go inside as well, and come out with a two meter long iron framework of a bed. At one side a single hook is sticking out. At the other side, two circle shaped forms are found in the skeleton, most probably for the wheels. The GVH comes outside with a red thin mattress in one hand and woolen blanket in the other hand. Kokayi and Ndulu put the wheels under the iron bed, it takes them some effort, because I see them both sweating. They put the hook, which is at the front side of the iron bed, on the back of the bike. They twist a small rope around it and put it very tight together.

Ndulu is still struggling with one of the wheels, it has to plug in but even when Ndulu is hitting it a couple of times, it does not plug in completely. Kokayi puts the mattress in, which perfectly fits the iron framework. 'You should make a picture of this', Ndulu tells me. When I take a picture the GVH, Ndulu and Kokayi are standing next to it. They pose in a pride way, pride to show the bicycle ambulance and all three of them with a huge smile. Then Ndulu gets the blanket and he lays down in the bed, with blanket around him till his chin.

(...) Although it looks a bit funny when they are biking with it, I can understand that it is much better for ill people who have to go to the hospital, mostly women who have to deliver suddenly and have problems with delivering. Instead of walking for a long while, or instead of sitting on the back of an old bike. She can lay down and be warm under the blanket, the husband or partner himself can arrange and build the bicycle ambulance in a few minutes themselves and bring their wife to the health centre.

(Field notes, observation period 1, day 3, 1st of August, TA Chimwala)

As described in the paragraphs above, the man is supposed to be close to his wife when the day of delivery is getting closer in order that he can escort her to the health centre. However, the husband or any other male family member is never the guardian of the pregnant woman who is staying with her at the health centre. The guardian is staying with the pregnant woman the entire time that the pregnant woman spends at the maternity ward. She is supposed to cook, wash the *chitenjes*, arrange the administrative issues with the health centre, and provide support when necessary. During the third observation period every day was spent at the health centre and around the maternity ward; all the guardians observed in this period were female. During visits at other maternity wards also only female guardians were seen. Additionally, in a conversation with one of the nurses during the third observation period, it was explained that it is abnormal for a man to be the guardian:

Ayan replied: "The guardians are always women. Men do not want to do that, they sit at home and are told when the child is born. Once a man was a guardian, but people laughed at him because we are not used to it. Always woman are the guardian. We are women, we know what to do and what a pregnant women is, we are been pregnant woman ourselves."
(Informal dialogue, observation period 3, day 1, 5th of October, TA Mponda)

4.4.2.3 Male involvement regarding the visit of the sikelo

Another expectation discussed by the participants prescribes that a husband is not only supposed to take responsibility in arranging transport for going to the health centre when time for delivery comes, he also needs to take responsibility in his wife visiting *sikelo. (Sikelo* literally means scaling and is used by the participants to refer to the antenatal care clinic, see paragraph 2.2.7. The participants in both the interviews and focus groups mentioned that it is important that women always visit the *sikelo* once they are pregnant, in order to make sure that she is healthy and learns about the danger signs during pregnancy.

The participants argued that in one way or another, husbands are supposed to be involved into visiting the *sikelo.* In first instance several participants explained that a husband should encourage his wife to visit the *sikelo*, as the following quotes show*:*

In-depth interview:

I: Is there anything that we as men can do?
R; The role that we as men can play is encouraging the women in going to the hospital when pregnant.
(IDI11: MasambaUma – 25 years, 24th of August)

Focus group discussion:

R; Another thing that we could be doing is for example, if my wife is pregnant I have to encourage her to go and start sikelo. Because it is there where she is told about the condition of her body, and what is happening in her body and what she is supposed to be doing.
(FGD1: Machenje – above 30 years – minimal 3 children, 12th of August)

R: The man should make sure that the wife goes for sikelo when the she becomes pregnant. Whenever she returns from there the man has to enquire on how the service has been.
(FGD3: Ngatala – 25 till 40 years – multiple children, 15th of August)

Men in the interviews and focus groups go sometimes one step further by arguing that the husband has to take the responsibility to escort his wife himself to the *sikelo.* The next quote from one of the focus groups shows that several participants believe a husband should escort his wife to the *sikelo*, either by bike or by foot:

I: Do men take a role as partners to pregnant women at all?
(...)
R: Not all of us have bicycles over here, so those that have got bikes could bring their wives for sikelo. Those for us who don't have would only remind.
I: Is the bringing of the wife to sikelo limited only to those who have got bicycles?
R: We can even walk together to the sikelo place.
(FGD3: Ngatala – 25 till 40 years – multiple children, 15th of August)

Another participant in the last discussion explained why the husband is supposed to join and stay close when his wife is going for *sikelo.* He explained that the husband will in this way be aware of any problem that might be discovered and will be able to provide assistance when this is necessary, e.g. in case the pregnant woman is facing complications and has to stay at the health centre or is referred to the district hospital.

I: Why do we think that she is the one that has to go for sikelo?
R: It is good if we should go together. There was a time we went together with my wife. After she was examined, she was advised to stay at the hospital. So it is good that we do things together, because if she was alone we don't know how things would have gone.
(FGD3: Ngatala – 25 till 40 years – multiple children, 15th of August)

Encouraging women to visit the *sikelo* and escorting them to the *sikelo* are responses often provided by different participants when discussing issues related to male involvement and *sikelo*. Several participants do however argue that the husband should not only escort his wife to the *sikelo,* but also participate himself during the *sikelo.* In the following quotes both from an interview and from discussion groups, the participants explained that the gain of men attending the *sikelo* is that both the husband and wife receive the advices on how to practise safe motherhood, and both have the possibility to remember the antenatal care advises when they are needed.

Focus group discussion:
I: Is there anything that we as men can do, to make it come out clear that we are taking part of reducing maternal mortality?
R: Maybe we. should go together for sikelo with them, so we hear together whatever requirements are there
(FGD3: Ngatala – 25 till 40 years – multiple children, 15th of August)

I: How important is it that men should be involved in the health of women?
(...)
R: Men should also take heed of the advise that is given at the sikelo.
R: We should be going to the sikelo together with the women so that whatever they are advised we should get it together as first hand information.
(FGD4: Ngatala – 17 till 22 years – one child, 15th of August)

In-depth interview:
R; As of now I have got a position of model man. So we tell our friends, that if a woman is pregnant she should be taken care of. Because we know when a woman is pregnant she comes to tiredness. When there is need to sikelo you have to bring her there, be there as a man, so that you know how a woman is when she is pregnant.
(IDI7: Stambuli – 72 years, 23rd of August)

Although the last quotes indicate that the participants plea for couples attending antenatal care clinics together, during the observation periods in several villages opposing observations were found to this statement. First of all it was observed that during a *sikelo* session there were no husbands present:

At the outside sikelo room I saw posters on the wall, that showed advice about caring for the pregnant woman. The man had a prominent place on this poster. He was holding the pregnant woman with an arm around her, and with the other hand he gently caressed the stomach of the pregnant woman. Everybody was smiling on the poster, also the men and the women in the background. I did not see the word 'sikelo' on the poster, so it was maybe not specifically focused on antenatal care. However, I did not see men accompanying the woman who are present today at the sikelo. When I asked Chifundo about this she said: "We do ask them to bring the husband. But men do never come." She recalled, that only one man attended the sikelo in the last three months.
(Informal dialogue, observation period 3, day 2, 6th of October, TA Mponda)

Second of all, during a village meeting a discussion between the men on the one side and the women on the other side made clear that the men in that village did not join or escort their wives to *sikelo*. In the next field notes regarding this discussion one of the women explained that men do not want to go with their wives to the health centre and refuse to go when asked. She clearly stated this in a disapproving matter:

I next told them that I heard that men are never present at the sikelo or the delivery. I asked the women what they thought of this. One woman, the one with the baby in her arms, replied very short that men just refuse to go. The women in the chitenje dress continued that it is women's work to have babies. The woman next to her looked at her and replied more to her than to us. She said that men are just stubborn and do not want to go with them because they are not interested. I think she said it in a funny way, because the other women, and two men laughed about her reaction. Asking the men would not help she continued. The discussion of these two women sounded much longer than what Agimah (nurse and guide) translated to me. I guessed that Agimah just translated the main idea of what the women said.
(Informal discussion, observation period 3, day 3, 7th of October, TA Mponda)

Furthermore, the head nurse Ayan of a visited health centre stated during one of the observation periods that very few men had attended the *sikelo* itself at their health centre. She did however mention, as indicated in the following quote, that during the *sikelo* session sometimes a husband, who escorted his wife to the *sikelo,* tries to come close to the *sikelo* sessions and to listen to the advices that are given during a *sikelo* session.

Ayan and me talked more about my research and about male involvement in maternal health in general. She told me that three husbands were around the health centre today. "The men came with their wives who came for sikelo", Ayan told me. The men did not attend the sikelo, but Ayan asked the wives later why their husbands did not join for the sikelo itself. "The men wanted to attend sikelo. One husband tried to get close to listen to what was told." I was surprised by this, because I did not see any men close to the sikelo. I asked why they did not attend, but I did not get a really clear answer from Ayan. She just said: "Yes, it is unfortunate", and later continuing: "In earlier time we had two, or no, three men who attended. But now never anymore. I don't know what happened." (...)
(Informal dialogue, observation period 3, day 3, 7th of October, TA Mponda)

A few participants explained why not all the men attend *sikelo* together with their wives. According to a man in a village meeting, visited during the third observation period, men are sent away at the health centre by the health personnel. The health personnel of this particular health centre on the other hand stated the exact opposite, arguing that they tried to convince men to attend the *sikelo* session. The field notes of this discussion during the village meeting are shown below:

An older men, who till now just looked around very uninterested, said that the health personnel sends them away when they come to the hospital. Agimah, the HSA, now reacted to them that he would not sent them away at all. I added, that the nurses at the health centre just told me that they would also not sent men away of they would come for sikelo. The older woman, who reacted most often, seemed to be the TBA of the village. She asked me what I thought of the issue. I tried to give my opinion a little bit in a open and subtle way. I first summed up what the men said. First you told us that the health personnel tells you not to go. Secondly you say that the wives should be sent back to get the husbands and finally you say that the health personnel sends you away if you really would come. (...)
(Informal discussion, observation period 3, day 3, 7th of October, TA Mponda)

Additionally, the next field notes of the first observation period describe a reason for why men are not present during *sikelo*. The TBA in these field notes explained that she does not refer the husbands along with the pregnant woman for attending the *sikelo* session. As described in paragraph 3.4.1, TBAs are mentioned as important community members with an important function in the referral of new pregnancies towards the health centre and in the referral of both going for *sikelo* and going for delivery. The TBA explained that she only receives pregnant women and their female guardians, and therefore she only refers women to the health centre:

10 minutes later the HSA asks me if I have some final questions for the TBA. She has her eyes open and looks at me with a nice smile. I ask her if, when she tells to the pregnant woman to go to the hospital, she also tells this to the husband of the woman. Ndulu and Kokayi laugh just a little bit, and the HSA translates it to the TBA. She says something really shortly, and ending with shaking her head 'no'. She tells it to the people who come to her. That are only the pregnant woman and the guardian, never the husband.
(Informal dialogue, observation period 1, day 3, 1st of August, TA Chimwala)

4.4.2.4 Post-natal responsibilities for the man

Finally, in the post-natal period the husband still has certain responsibilities left which he did not have before the pregnancy. The man often takes over domestic tasks like cooking, washing, and fetching water in order to give the new mother time to regain strength:

I: You said that your wife is pregnant. When she got her baby, what do you think are the good things you are going to do different that will be pleasant to her?
R; I will be helping her doing some works.
I: Can you try to say I will help in this, this and this?
R; I am thinking of helping her cooking, even washing.
I: You have a number of brilliant ideas; Do you see any obstacles in attaining this?
R; No, I do not see any problem.
(IDI10: MasambaUma – 28 years, 24th of August)

Nevertheless, several participants indicated to have difficulties with these domestic tasks and occasionally the woman has to do work herself. In the next quote the interviewee for example mentions that he let his wife washing the baby diapers:

I; If you are to assess yourself, were you able to attain all the expectations?
R; Maybe I may not able to complete all the expectations successfully, but all in all I always try.
I: Can you tell us which ones you managed and which ones you failed?
R; Yes I can, like cooking I am able to, working in the garden, drawing water; I am able to do that.
I: And which ones did you fail at all?
R; (LAUGHTER) Things like washing baby napkins, that I could not do. On this one I asked "would you please do it alone?"
(IDI2: Machenje – 59 years, 17th of August)

Apparently, according to one participant in the interviews, having sex with his wife after the delivery is also a method to support the wife. He argued that his wife would demand sex in order that "her heart cools down" and if he refuses she would complain at the village chief:

I: The question is were you helping her?
R; Yes, I was having sex with her and buying everything that she needed.
I: Is having sex helping the woman?
R; Yes, because if you do not have sex with her she would sue you to the chief. She wants to have sex so that her heart could cools down and be happy at the same time. It is like applying fertiliser to the thing in her.
(IDI6: Machenje – 40 years, 18th of August)

4.4.3 Shared responsibility

As discussed in the beginning of this section, nowadays traditional male tasks in the village can be performed by women and traditional female tasks can be performed by men. In the focus group discussions the participants reflected on till which degree the traditional tasks should be shared or not. Some participants in the following discussion argued that men and women equally can perform the different tasks within the household, others are however opposing this statement by arguing that not all tasks can be shared between man and woman, such as drawing water, washing baby diapers, and gathering firewood:

4.4.3.1 Sharing responsibilities part of marriage

Sharing responsibility is defined by several participants as sharing different tasks within the household. According to the following two interviewees helping each other is of major importance once a couple gets married. The following quotes from these interviews highlight that a man is supposed to share responsibilities with his wife because 'getting married' means that the couple 'becomes one', and sharing responsibility is a way of showing love between wife and husband:

I; In your own thinking, looking at these expectations, what can you say about them?
R; (SILENCE)
I: Is it necessary that men should help their partners?
R; Yes I would be very happy if we help one another. Men should help their wives, so we create some kind of balance. We should help one another so that both the husband and the wife should be happy, no one is supposed to life like a slave. Life of the husband and that of the wife are one. As such both are supposed to stay together as a happy union. That is marriage.
(IDI2: Machenje – 59 years, 17th of August)

R; Yes it is very, very important that men should help their wives.
I: Can this be helpful?
R; It is helpful in this way: I moved away from my parents' home, got married with my wife, so my wife and myself are like one body. As such I have to love myself, I also have to love my wife. I should not love myself only, what I should eat she should also eat the same, that is love.
(IDI9: Stambuli – 25 years, 23rd of August)

In one of the focus group discussions a participant reflected on shared responsibility in relation to getting pregnant. He argued that husband and wife are living and doing things together and also becoming pregnant is a shared responsibility. The participant states that not only the woman is pregnant, also the husband becomes pregnant and therefore husband and wife have to work together:

R; As for me, there is no role of either man or woman, you live together and you do things together. Even the work in the bedroom the man does something and the woman below does another. Even in the bedroom we work together. Whether one is on top or one is below, the work we do is one. The man works just as the woman works. There is no difference. When you get married you get married to a woman without any children and you are also without any. After working together the woman become pregnant but in actual fact you are both pregnant. And if she delivers she will have a baby and you will have a baby. So there is no division to say this baby was made by either the father or the mother. The baby is made by both. That means even in the bedroom the work has been done by both.
(FGD1: Machenje – above 30 years – minimal 3 children, 12th of August)

The main reason the participants give for the necessity of sharing responsibility during pregnancy is that a pregnant woman is in 'need'. As the following quotes from the interviews describe, a woman needs more support and love from the husband once she is pregnant:

I: How important is this in a relation to pregnancy?
R; This time it is even more necessary to care for each other when one in need. We are supposed to love each other all the time but more when she is pregnant.
(IDI3: Machenje – 60 years, 17th of August)

I: Is it necessary that men should help their wives?
R; Yes it is. Because a pregnant woman cannot do everything alone. Men need to be active to help the women.
(IDI11: MasambaUma – 25 years, 24th of August)

Another participant used the term shared responsibility when he reflected on parenting. As the next quote shows, he believes that husband and wife have to work together in parenting and taking responsibility for the family:

I: Now looking at the fact of being a father, or in other words the role of being a father; How do you look at it?
R; I look at it as a shared responsibility with the wife.
I: Does this mean that as a man you are not capable?
R; No, it is like a family, we have to do things together.
(IDI12: MasambaUma – 41 years, 24th of August)

4.4.3.2 Sharing responsibility in practise

As the last paragraph about shared responsibility made clear, the meaning of shared responsibility is different from individual to individual. Almost all participants in the focus group discussions and in the interviews mentioned that, in one way or another, shared responsibility is an essential requirement for practising safe motherhood:

Firstly, some participants indicated that sharing responsibilities means helping the woman cook in the last weeks before the expected date of delivery, while others indicated that they took over all her domestic tasks and allowed her to take a complete rest before going into labour and during post-natal.

I: Would you be able to list the ones you successfully accomplished?
R; If the woman is pregnant at home you touch this, you touch that, making sure the home is up to date. Making sure that you are doing the works for her, helping her out. If she has just delivered I tell myself the wife here is weak, so let me work for her. Whenever she recuperates she takes over form me. I wash for her, I cook for her, so that she eats and gets strong.
(IDI1: Machenje – 60+ years, 17th of August)

Secondly, as the last paragraph explained, shared responsibility is perceived by some participants as the husband being supporting and loving, especially during pregnancy.

Thirdly, in paragraph 4.2.3 it is already described how some participants encourage their wives to go for *sikelo* while they stay at home, where other participants escorted their wife and indicated that they are willing to attend the *sikelo* themselves.

The changing reality of less strict separated male and female tasks might increase the opportunities for men being more involved in maternal health. Some young participants in the focus group discussions explained that nowadays life is changing and getting children should not be solely a women's business anymore. They argued, as the following quotes show, that men can and should play an important role in maternal health issues:

I: How important is it that men should be involved in the health of women?
(...)
R: At times men are ashamed to involve themselves in maternal issues because it is looked at as an issue for women only. Today young people are not ashamed anymore.
(FGD4: Ngatala – 17 till 22 years – one child, 15th of August)

I: Is it possible that men can really take part in things affecting women?
R: Men can do it.

R: These days life is different from the past. If we go into the hospital these days we find that the one helping giving birth is the man.
R: It is not strange for men to be involved in women issues.
R: Pregnancy is looked at as something for both husband and the wife; the wife says I am pregnant and the husband would say the pregnancy is mine. And the man can proudly claim the ownership of the pregnancy.
(FGD5: Stambuli – 20 till 25 years – With one or two children, 15th of August)

Although the last quotes clarify that the participants believe that husbands should share the burden of getting children, one of the interviewees also stated that it depends on the willingness of the woman if some responsibilities will be shared or not. In the next quote the interviewee describes how his wife had major difficulties with him performing domestic tasks:

R; At times it was hard for her that I work while she was resting, but I used to tell her: 'You should rest so you get your strength restored'. If I a have piece of work elsewhere, on my way back I collect firewood and bring it home. It was really hard to get her accept that I work on her behalf. But I insisted she rests.
I: Any other set-backs?
R; The major problem was herself, she would even say that I am feeling sympathy while I am here. I told her: 'It is all right, I work for a period of time'.
(IDI1: Machenje – 60+ years, 17th of August)

4.4.3.3 Sharing responsibility with other community members

Besides sharing responsibility between husband and wife, also the involvement of other community members, the community solidarity, is mentioned as an important tool for improving the circumstances of maternal health. As described in the following quote, the involvement of everybody gives the woman the feeling that she is supported and therefore her mental well-being increases:

I: So we see there are several people are getting involved. What is the impact of the involvement of all those people?
R: The major impact of the involvement of all these people is that the woman feels not isolated. She feels assisted and protected. She feels that the job she is doing she is not doing it alone.
(FGD3: Ngatala – 25 till 40 years – multiple children, 15th of August)

In some situations other community members are perceived as essential for saving the life of the pregnant woman. In case of an emergency, when the husband is not close by, others need to escort the woman to the health centre. Furthermore, when a woman needs to be escorted to the health centre at night, it is safer if other people join the couple in their journey:

R: It is necessary that other people are involved. For example if you are to use a bike ambulance alone you can not pull that alone, you need others. The worst should be when it happens at night you certainly need a group for safety.
(FGD4: Ngatala – 17 till 22 years – one child, 15th of August)

I: Is the involvement of these other people necessary at all?
R: We are all supposed to work together, that is why it is necessary that these other people be involved.
R: The other people really become helpful.
(FGD5: Stambuli – 20 till 25 years – With one or two children, 15th of August)

However, some men make clear that the support of others is deteriorating nowadays, and as a response husbands should take more responsibility themselves in protecting the lives of their wives (see paragraph 3.7.3).

R: Its unfortunate that the involvement of other people is deteriorating these days.
R: What is happening is that men themselves are taking their responsibility.
(FGD5: Stambuli – 20 till 25 years – With one or two children, 15th of August)

4.4.4 Risks towards safe motherhood related to male behaviour

The men who participated in this study reflected upon the many risks which can result in a dangerous situation for women during pregnancy, delivery, or post-natal. The last paragraphs showed that men have to take certain responsibilities during this period. Moreover, some risks mentioned by the participants in both the focus group discussions and in-depth interviews are related to the actual behaviour of the husband. This paragraph will discuss how the participants in this study believe that the behaviour of the husband can have a negative impact on maternal health, and eventually lead to a mother or a baby dying.

4.4.4.1 Domestic violence

Firstly, several participants indicated that some men in the village are cruel to their wives during pregnancy. 'Cruel' in most explanations given means physical domestic violence towards the woman and was mentioned in both the discussion groups and the interviews. As the following quotes describe, a possible consequence of a husband being cruel towards his wife is the woman, the baby, or both, dying. Especially during the pregnancy the participants indicate a man is not supposed to use violence against his wife, because a pregnant woman is *wapakati* (in between) life and death:

In-depth interview:
I: What reasons did they give for all or some of these?
R; 1, beating is being cruel. As a family you are not supposed to be cruel to each other. Worse still with regard to a pregnant woman, it may mean that you do not want her life. If you beat her up she can die for you. She may fall sick and miscarry, it all comes back to you.
(IDI12: MasambaUma – 41 years, 24th of August)

Focus group discussion:

I: What is that the man is not supposed to do when the wife is pregnant?
R: The man should never beat the woman, no matter what. You never know you may be involved in some kind of accident. Because we refer to her like somebody in between. It is between life and death. So if you decide to beat her, you never know where you would strike, so it is safer not to beat her for any reason. There is the possibility of either the mother or the baby dying. It would only be good to advise her that in the state you are, it is not good to talk in the way you are doing.
(FGD3: Ngatala – 25 till 40 years – multiple children, 15th of August)

In one of the focus groups the participants also discussed domestic violence towards a pregnant woman as a major problem. In the village of this focus group a woman recently had a miscarriage because of physical domestic violence, which might explain partly the obvious concern of the men from this village with 'beating up':

R: We should not be beating women up. We have had an accident recently where by a man was beating his pregnant wife and a woman gave birth to a dead baby.
(FGD4: Ngatala – 17 till 22 years – one child, 15th of August)

In the next quote one of the participants also referred to alcoholism and extramarital sex as a form of domestic violence, which can lead to a deteriorating health of a woman.

I: Thank you very much. What other messages do you have? What other message can you share with your fellow husbands?
R; The message is that I have already said. But my last message to them would be as I have said we need to stop violence within the families. Like I said sleeping outside their home, drinking beer and having extramarital relations, beating the wife and also whatever is termed as violence against women should be stopped. And this will help us a lot in getting safer motherhood.
(IDI5: Machenje – 30 years, 18th of August)

The following field notes from one of the observation periods describe a situation in which a nurse from the local health centre was physically 'bothered' by one of the medical assistants. The medical assistant tried to open the jeans jacket of the nurse while pretending to be joking. But he clearly used force to put her hands aside which was not appreciated by the nurse. It is maybe too harsh to speak of violence in this scenario, but the reaction of the nurse clearly showed their was some unwanted misbehaviour of the medical assistant towards her. The other men present did not seem to notice that there was anything going on, and the nurse herself also did not say anything to them. Although she was upset by the medical assistant's his action nobody seemed to perceive the situation as harassment:

We did not talk much before the nurse who guided me came back. Salar walked to Ilam some ten meters away, talking and holding hands and laughing a lot. The nurse was this time wearing new clothes; a long blue skirt, a blouse above the skirt and a jeans jacket on top of the blouse. On of the medical assistants laughed a bit and said that she changed her clothes for the Mzungu (meaning the white person). While he said something in Yao or Chichewa to her, he pulled at her jeans jacket on the font side. It looked to me that he was trying to rip her jacket open, but the nurse kept both sides tight together with her hands and did a small step backwards. He tried it again a second time and it looked like the nurse did not like it. Her face showed a frown and her eyes were focused on his hands. She pushed his hands away, but did not say anything or became angry. The two other guys were talking to each other and did not seem to notice anything. He stopped his effort, snared something at the nurse, and said something to Jari and the other medical assistant where after he laughed alone.
(Field notes, observation period 1, day 1, 30th of July, TA Chimwala)

As mentioned in this paragraph, the participants argued several times that a man is not supposed to be cruel to a pregnant woman. Especially in the focus groups the participants argued that husbands are expected to treat their wives nicely and with love when they are expecting a child or when they just gave birth to a child:

I: What happens, it appears men are not so concerned about the health of their pregnant wives?
(...)
R: The big thing is lack of love. Husbands do not love their wives.
R: Not all men are not loving their wives. There are some that are loving and kind. Men are different. Some show their love all the time, others show it in difficult times.
(FGD3: Ngatala – 25 till 40 years – multiple children, 15th of August)

R: What is suppose to happen is that just after giving birth, men suppose to show appreciation for the job well done by the wife by loving and be close to them. Men should be happy that the woman has made them proud.
(FGD5: Stambuli – 20 till 25 years – With one or two children, 15th of August)

The participants however also explained that pregnant women can be very annoying and have many complaints and demands which is not always easy to handle for the husbands:

Focus group discussions:
R: It really takes a man to be courageous and patient because the woman can say nasty words indeed.
(FGD3: Ngatala – 25 till 40 years – multiple children, 15th of August)

Participant observation:
I then ask to Hoomun if she (pregnant wife of Hoomun) is healthy. (...) When Sumeer talks to Salar, he starts serious, but after some sentences he is laughing again and also Masrur, Hoomun and Salar laugh. "He (Hoomun) says that his wife is healthy, only she complaints a lot. He says he has to do a lot things at home, he does not want to do that because it makes him tired." I laugh a little bit along and reply: "But your all the time here?" "She is resting now", Salar explains. "You do not have to be with her everytime."
(Informal dialogue, observation period 1, day 6, 4th of August, TA Chimwala)

As a consequence of a pregnant woman being annoying it is indicated that it is easy for a man to loose his temper. However, even though women are supposed to be complaining and demanding, it is mentioned by many participants that a man should not loose his temper; he should prevent himself using both verbal and physical violence towards his wife. The next quote from one of the participants in a focus group discussion explains that if a man is using verbal violence towards his wife whilst she is pregnant, she might become disappointed which also can affect the baby:

R; The man should be more kind and patient with a woman who is pregnant. He should take her or consider her who is young and irresponsible. The man should not be angry to a pregnant woman. Always talk good with her, to make sure that she does not get disappointed. Because if she gets disappointed the baby also will be disappointed.
(FGD1: Machenje – above 30 years – minimal 3 children, 12th of August)

4.4.4.2 Negligence

Another risk towards safe motherhood caused by male behaviour, which is mentioned in both the in-depth interviews and the focus group discussions, is 'negligence' towards the needs of the wife.

The following quote describes the experience of one of the participants with a maternal death in the village that could have been prevented if the husband would not have been negligent towards the complaints of his wife. The woman in this situation was pregnant and faced complications at night. The husband refused to wake up his wife's family or bring her to the hospital himself in first instance, only later in the night he woke her parents up who took her to the health centre. Unfortunately it was too late and the woman passed away because of the severe bleedings she suffered from:

I: What do you think about maternal deaths in this village of yours?
R; In this village of ours maternal death is the saddest event. There are men who are hopeless. If their wives wake them up to go to the hospital at night, they tell them: 'would you please go to the house of mother and wake her up'. The result for this is that the women suffer in pain, some die.
(...) I: Have you ever heard that a woman died giving birth in this village?
R; Yes, I have ever heard.
I: Where was that? Can you mention that?
R; Very close in this same very village.
I: How did things go there?
R; The sickness started at night, the woman woke the husband up to go and alert women so that they should escort her to the hospital. But the man said he was tired. Then the woman became stranded, saying my husband is refusing. After a long time, the man saw that his wife was really in pain and he decided to go and wake his mother. But this time the woman was not well at home. Had he reacted the first time she woken him up, this would not have happened.
I: How did it go?
R; When he was coming from waking and alerting the parents, she found that the woman was not well at all.
(...) I: In this particular death you have known about, were there things people said, if those were done the death could have been prevented?
R; People said the death could have been prevented if the husband had the conscience the time he woke up, to go and wake the parents. In other words the woman died because of the negligence of the husband.
(IDI9: Stambuli – 25 years, 23rd of August)

Another quote from the observational field notes describes a dialogue with Chifundo, a nurse who had just attended a delivery of twins. One of the twins died directly at birth, the other baby looked to be healthy. The nurse explained that the mother lost several children in the past, either at birth or in the first months following the birth, as a result of being infected with an STI. As discussed in paragraph 2.2.2 the STI made the woman ill, weak and in danger every time she has to deliver. Chifundo further explained that the woman got treated for the STI, but her husband refused to come to the health centre and to likewise get treatment for the STI., and on top of the suffering she lost already several children because of the STI:

Around 5:30 in the morning Chifundo came outside without wearing gloves. She sat down with me and told me the women that I saw in the ANC room gave birth already as well. She got twins and the first born looked to be healthy. However, very unfortunately the second one took a lot of time to get out, did not breath properly once it was finally born, and eventually died. The woman already had four children before, whereof three died around the time of birth. If you hear this story it is not hard to guess that delivery has to be a horrible event for this woman, associated with a lot of painful memories. According to Chifundo, the children died because she has an STI, which they mostly assume when the woman and children are always in such a bad health. I asked if she meant HIV/AIDS, but she said that was not the case. The woman got treated already before for the STI, but: "Her husband do not want to come to us and get treated." Of course in this way she will get it over and over again, which makes herself and the babies being so unhealthy every time.
I asked how the woman was doing at the moment and Chifundo replied: "She is very weak. She can not get dressed herself. We will have her at the hospital (the health centre where I am staying), she can not go home. (...) She continued: "Now she is very weak. Every time she has a child she is weak. She is loosing a lot of blood, that can kill her. Because she is weak, she must stay at the hospital."
(Informal dialogue, observation period 3, day 2, 6th of October, TA Mponda)

Furthermore, 'negligence' towards a pregnant woman is according to the participants associated with alcoholism. The alcohol is explained to make the man less responsible and non-caring, which means the pregnant woman has to take care of the pregnancy alone and essential requirements such as new *chitenjes* are not met:

R: It is just lack of intelligence in some of the men. We see that the women is very poor, hardly with one Chitenje and yet the husband is there, all that the husband cares is about beer.
(FGD4: Ngatala – 17 till 22 years – one child, 15th of August)

That alcoholism is perceived as a form of negligence is explained by the following interviewee. He argued that changes have to be made at individual level in order to improve maternal health. Some men choose to be negligent towards supporting their wives and rather drink beer:

I: Do you think it is possible to change lives of mothers in Mangochi?
R; Yes it is possible.
(...) I: How can life be changed and who is to change and what is it really that is to change?
R; It is necessary that the changes take place on an individual basis. Each individual should be asked and according to his or her answers the advise can be given. We are born the same. But there are choices we make that make us different. Someone would choose to be drinking beer or not to. It is a choice. Those things are things that people just learn there is no point clinging to them. It is possible to change.
(IDI10: MasambaUma – 28 years, 24th of August)

The negligent behaviour of a man towards supporting a woman who is pregnant or who has just delivered is not only caused by alcoholism. Some participants explained that it is strongly linked to the selfish attitude of men themselves:

R: There are some other lousy men who think that the pregnancy is only for the woman, they would sleep outside, he may keep doing his own things, he may just come home and greet the wife briefly, they never think about adjusting themselves because of the pregnancy.
(FGD5: Stambuli – 20 till 25 years – With one or two children, 15th of August)

Also at a village meeting during an observation period a woman complained that some men are just not willing to support the pregnant woman. She referred to this as stubbornness and explained this phenomenon in the context of husbands not joining for *sikelo*:

I next told them that I heard that men are never present at the sikelo or the delivery. I asked the women what they thought of this. One woman, the one with the baby in her arms, replied very short that men just refuse to go. The women in the chitenje dress continued that it is women's work to have babies. The woman next to her looked at her and replied more to her than to us. She said that men are just stubborn and do not want to go with them because they are not interested. I think she said it in a funny way, because the other women, and two men laughed about her reaction. Asking the men would not help she continued.
(Informal discussion, observation period 3, day 3, 7th of October, TA Mponda)

Many participants explained that negligence of the husband regarding support towards his wife is a sign that the husband does not love his wife enough. Men who are negligent are perceived as not loving and lazy:

R: That is why we have two types of men. There are some that are man in the house, and others who are man outside the house.
I: What difference is there between the two?
R: Some show their manhood with sleeping with their wives only. And not providing the necessities for the home, so the woman does it alone, by herself. And the other group is the group who really provides for the house.
R: Indeed there are men who are lazy. All night all they like is having sex with their wives. During the day they only go out and play with friends.
(FGD3: Ngatala – 25 till 40 years – multiple children, 15th of August)

4.4.4.3 Extramarital relationships

The sexual and reproductive behaviour of men is perceived as another threat of male behaviour towards the health of their wives. Especially during pregnancy, childbirth, and post-natal the sexual and reproductive behaviour of men seems to be an important cause of complications women are facing. Firstly, extramarital sex is perceived as a threat to safe motherhood. The following quote from one of the in-depth interviews shows that if the husband does not stop having extramarital relations during pregnancy, then he puts the life of his wife at risk (other names given for extramarital sex by the participants in this study are e.g.: 'going into the bush', 'entering various places', 'mixing blood', and 'sleeping outside').

I; Is there anything you can share with us about a woman that is pregnant before she delivers?
R; If you are a man in a house and you see a woman becoming pregnant, you tell yourself that this is a pregnancy. So pregnancy is dangerous. For me to go into the bush I know I would destroy the life of my partner. So that was the custom.
(IDI1: Machenje – 60+ years, 17th of August)

Especially, in the event a woman becomes pregnant the participants believe that the husband should stop having extramarital sext. Several men in the interviews and focus groups explained that when the woman is expecting a baby, the husband should stop having sex with other women:

I: What is a man supposed to do during pregnancy? Is there anything men do?
R; (…) During this time (pregnancy) the husband is advised to not have a multiplicity of sexual partners, so that the lives of both the mother and the baby will be protected.
R: The man is not supposed to sleep with any other woman when the wife is pregnant.
(FGD2: Machenje – under 20 years – without child or expecting first child, 12th of August)

The main risk of having sex with other partners mentioned by the participants is the possibility of being infected with HIV. Following consequence of being infected with HIV is that it can be transmitted to the pregnant woman, resulting in an increased chance of the woman facing complications or ultimately even die during or after childbirth, as explained by the following reaction of a man in one of the interviews:

R; We also advice them when a wife has a baby it is not safe for both of you to be entering various places. Because that is where the AIDS pandemic is spreading, you never know the one you are going out with is probably infected. So you take the disease from her and give it to the woman at home, which is very bad. We have people who are really understanding, who say: 'Oh yes, this is true'. You never know if it is your wife who is to go or yourself. So it safer to prevent.
(IDI7: Stambuli – 72 years, 23rd of August)

The second perceived danger of a man having extramarital relationships is that somebody might be performing witchcraft and will put a spell on the pregnant woman. One of the participants explains that the partners of the husband outside the marriage circle might put a spell on the wife, which consequently can result in complications during the pregnancy or the delivery.

R; If a man is not careful the pregnancy can be lost.
I: Was yours ever lost?
R; Yes I once lost one, I was careless in moving. Then, towards my second pregnancy, I realized it was dangerous.
I: Can you explain what happened?
R; My wife was pregnant. By then I was quite young so as somebody youthful I went out with other women, so one of these women played magic on my wife. My wife would go to the hospital and get no clear results, finally the pregnancy was lost. Then I realized that it is not safe to do things that way.
(IDI4: Machenje – 35 years, 18th of August)

Although several participants referred to stop having extramarital relationships only in relation to when the woman becomes pregnant, some participants in the focus group discussions challenged these statements. As shown in the following quotes, they argued that men and women should never have sex with other partners, because they can transmit diseases at any moment in the relationship, either pregnant or not:

R; We should not say that man should protect their wives when they are pregnant only. But women need to be protected all the time. I am saying this because if we have extramarital sex, even though the wife is not pregnant this time, by the time she gets pregnant she will still have problems if we infect her in anyway this time. So what we need to do is stop multiplicity of sexual partners.
(FGD1: Machenje – above 30 years – minimal 3 children, 12th of August)

I: What is the man not suppose to do during this time (pregnancy)?
R: He should not sleep with any other woman.
R: If he sleeps outside we call that mixing blood and that is very bad for the pregnancy.
R: I don't agree with what is being said here. Every man that is married is not supposed to sleep with any other woman whether pregnant or not apart from his wife. It doesn't make sense; choose your wife, leave, going somewhere else.
(FGD5: Stambuli – 20 till 25 years – With one or two children, 15th of August)

4.4.4.4 Abstinence

Alongside abstaining from having sex with other partners the participants explained that it is very important for a man to abstain from sex with his own partner. (Having sex is in the quotes in this paragraph also named: 'entering the house' and 'sitting with the wife').

The advice they received regarding abstinence is two sided. On one hand the couple is expected to abstain from sex a few months before the delivery. As becomes clear from the following quotes, the number of months that a couple is supposed to abstain varies from participant to another. Some mention that a couple has to start the abstinence period one month before the delivery, others mention that a couple should start four months before the delivery:

Focus group discussion:

R: The man should be counting the months; So that by the fifth or the sixth month they should stop having sex.

R: That is the traditional thing. It is just a belief.

(FGD3: Ngatala – 25 till 40 years – multiple children, 15th of August)

In-depth interview:

I: So you say there is nothing that changes when she is pregnant, does this mean now that you have sex probably soon before delivery?

R; We don't do it that way. There are regulations which say that by the seventh month we should stop having sex with the woman in the house.

I: So would you explain how the calculations go?

R; Right. Seven months old pregnancy, we stop having sex. (…)

(IDI7: Stambuli – 72 years, 23rd of August)

On the other hand, after the delivery it is indicated that the abstinence period is supposed to continue for a certain number of months. Equally to the length of the abstinence period before delivery, the indicated length of the abstinence period after birth varies from participant to participant. Some participants mention that the abstinence period after birth is supposed to continue for a minimum of four months, others indicate it is necessary to abstain after the delivery for a minimum of eight or nine months:

In-depth interview:

I: What do you mean waiting for the days to lapse?

R; Some say that if the baby did not complete six months of age, they should not have sex. Others go as far as nine.

I: Can you explain what really happens and how does it go?

R; A mother has a baby in the hands, for example in my case I wait until the baby has a very good body. After about six months, then I would sit with the woman.

I: Can you explain in clear terms, now you are saying sitting with the woman?

R; The woman has the baby in the hands. We do not think about the woman, we do not think about any other woman, we just see it, waiting for the baby to grow. We do not have sex with the woman. I wait for a period of six months without sex with the mother.

(IDI7: Stambuli – 72 years, 23rd of August)

I: How long is this period of waiting?
R; The first time she miscarried, I waited for six months.
I: So after a miscarriage you waited for six months; what about the second time when she had given birth?
R; It was also six months.
(IDI10: MasambaUma – 28 years, 24th of August)

Focus group discussion:
I: What can we say about what happens just after the woman has delivered?
R: You are supposed to wait for a period of about eight months (before resuming sex).
(FGD4: Ngatala – 17 till 22 years – one child, 15th of August)

The men who participated in this study did further also indicate that it is difficult to obey to these cultural rules of abstaining for a certain period and some of them do fail to do so, as discussed by the participants in the following quotes:

In-depth interview:
I: Now your wife has given birth she has a baby. How did you see this time, what can you say about this time?
R; Whilst the marriage was young, I looked at it to be a hard time.
I: What made it hard, why was it a difficult time?
R; It was a difficult time. Customs demand that if a woman gives birth, you are not supposed to do anything until such a time that you are advised to enter the house.
I: Can you say it in clear terms what you mean by all this?
R; Ok, (laughter). What I mean is this: That when a baby is born you cannot just rush to enter the house.
I: Are you trying to tell that when a baby is born the man is supposed to sleep outside the house?
R; No, no, no! You sleep right in the house but you are not to have sex with the woman. So the first years this was hard but not anymore. I am able to abstain for the whole period now.
(IDI10: MasambaUma – 28 years, 24th of August)

Focus group discussion:
I: What can we say about what happens just after the woman has delivered?
R: You are supposed to wait for a period of about eight months (before resuming sex).
R: Some fail to reach this far.
(FGD4: Ngatala – 17 till 22 years – one child, 15th of August)

R: Men hate the waiting (for re-entering the house); but the waiting is not the same as caring for somebody that is sick.
(FGD5: Stambuli – 20 till 25 years – With one or two children, 15th of August)

Several different reasons are given about why the custom in the rural villages prescribes to be abstinent for a certain amount of months. The custom is not just continued because it is a tradition to do so; the participants were able to explain some of the reasons. In paragraph 2.3 the fear for *chinyera* being transmitted to the man and eventually killing the man is discussed as one reason for the perceived need of abstinence. However, there are also other reasons mentioned in the focus group discussions and in-depth interviews in favour of the importance of abstinence:

One of the interviewees in the following quote explained that a woman who will have a new pregnancy too soon after the last childbirth, will face a higher risk to become anaemic, and eventually can die from their complications. The interviewee therefore argued that abstaining for a particular number of months will give her time to recover and to regain strength, and it will help her to take good care of her baby first.

R; The customs were insisting on abstinence for six months. Women's bodies vary from one body to another. Others before the six months is over may start 'bathing for the baby' (menses) others may take slightly longer. It is possible to sleep with such a woman and make her pregnant. There are local contraceptives which women tie around their waist. One may become pregnant whilst the charm is around her. These could certainly increase the number of women who die in relation to getting children. A woman who has a baby and becomes pregnant is not safe at all. Frequent births may make the woman anaemic, consequently increase maternal deaths.
(IDI10: MasambaUma – 28 years, 24th of August)

The participants in the focus group discussions and the interviews furthermore also explained that hygiene at birth is an important reason for abstinence. Some of the participants argue that if the husband has sex with his wife just before the delivery, the midwives will see the white spermatozoids of the man left around the baby once it is born.

I: What do you mean when you say after seven months the husband stops entering the house? Where does he sleep?
R: LAUGHTER
R: Well he sleeps in the very same house. He is not supposed to have sex with the wife. Because if you have sex with the wife, what you give to the woman will be seen around the baby around birth. But if you abstain at probably the sixth or seventh month, the baby will be born clean.
(FGD3: Ngatala – 25 till 40 years – multiple children, 15th of August)

Moreover, as one of the interviewees explained, the unborn baby is fed by the mother. Without abstinence the unborn baby will be 'fed' by the men's spermatozoids and this is considered as unhealthy.

R: (…) Once a woman is seven or eight months pregnant it means the man and the woman stops there. For you to have sex with a woman from seven to eight months pregnancy is not well.
I: What can happen if you have sex this time?
R; What happens is the doctors see.
I: What do they see?
R; For example if a woman sleeps with a man tonight and goes to deliver tomorrow, the doctors will see. The doctors will find the white. This is not healthy for the baby, because the baby is to be fed by the mother, but if you have sex with such a tired pregnant woman, the baby kind of gets fed from the man. So this is not good for the baby.
(IDI7: Stambuli – 72 years, 23rd of August)

Another reason for abstinence mentioned by the participants is that it will prevent the couple to have problems in their relationship. They argue that after the delivery the vagina is too width for the man to enjoy sexual intercourse. The possibility exists, as the following quote from one of the focus groups indicates, that in this scenario the man would get annoyed, that their sex life would be disappointing, and eventually that the couple would break up because of these problems:

R: You are not supposed to have sex when the woman has just delivered.
I: What can happen if you have sex this time?
R: If a man sees a woman giving birth and if that man is not interested enough, the marriage can end there and then. When a woman is pregnant you normally have sex with her be fitting the size of the man. But just after delivery the passage is wider, and having sex too early would not work. Hence the danger of separation. So that is why it is recommended that we should wait until when the passage is deters to the normal size.
(FGD3: Ngatala – 25 till 40 years – multiple children, 15th of August)

The last reason mentioned by the participants in one of the focus groups for abstaining for several months is that the love between the husband and the wife will increase during the abstinence period:

I: What is the impact of having children on the relationship of husband and wife?
R: Presence of children in the family will make our love grow. Love really grows, because after she has given birth we wait for eight months and resume sex later. So it is really like a new relationship altogether.
(FGD2: Machenje – under 20 years – without child or expecting first child, 12th of August)

According to several quotes mentioned earlier in this paragraph is the abstinence custom still practised in the rural areas of Mangochi. However some men in this study do not totally agree on the importance of the custom (see paragraph 3.3 for a discussion on fading traditions and customs).

R: We are advised to stop have sex by the seventh month, but I once missed a mark myself. I had sex with my wife in the morning the very same day she delivered and she had a baby and there was no problem. So when I look at these other customs I just wonder.
(FGD4: Ngatala – 17 till 22 years – one child, 15th of August)

Hygiene concerns, catching *chinyera* concerns, and problematic sexual relationship concerns which have been discussed as reasons for abstaining, seem to be flexible concerns which can be put aside when modern contraceptives are used, when deliveries are conducted at the health centre, or when advice from the health centres is followed.

To clarify, first of all the following quote from a focus group discussion suggests that because the personnel at the health centres uses gloves nowadays during deliveries, the spermatozoids found around the baby is not a problem anymore:

R: I would like to clear the mist. Why our parents said that we should stop at six or seven months. It was just a question of hygiene. At the village the midwife uses bare hands. As such she was disgusted seeing the white things around the baby. But at the hospitals they use gloves and they don't mind about anything.
(FGD3: Ngatala – 25 till 40 years – multiple children, 15th of August)

Second of all, it is mentioned that at the health centre people are advised to not abstain before the delivery in order to 'keep the path (vagina) rather soft'. As a participant of one of the focus groups in the following quote explained, the delivery will go smoother if the couple continues to have sexual intercourse until the delivery:

R: It is true these days the hospital is advising us to continue having sex at home to as far as soon before delivery. My wife said that she was advised that in order not to have problems in giving birth the path should rather be soft by having sex to the very end of the whole pregnancy period. If you abstain too early and too long the path will be hard and dry. So we were having sex to the very end with no problems of any sort. We are gong by the wisdom of the hospital. "You go and keep on sleeping with your wife up until the time she is going to deliver."
(FGD3: Ngatala – 25 till 40 years – multiple children, 15th of August)

And third of all, one of the interviewees mentions that a doctor explained him that with the use of a condom the man is not at risk of dying anymore in case of resuming sex too early after a delivery or miscarriage:

I: You have mentioned your granny, your mother in law and the hospital personnel; besides these people are there any other ways through which you got something on how to deal with pregnancy and child birth?
R; Yes, I had a friend who was a doctor. He told me that the custom to wait for six months after delivery is out-dated. These days there are diseases. This time the government has made condoms to help people. The condoms help prevent diseases. Even if you have sex with a woman who has miscarried, if you use a condom you can not die. With a condom you are assisted, you get what you want at the same time you are protected and you may not think of going out to some women outside.
(IDI10: MasambaUma – 28 years, 24th of August)

4.4.4.5 Men and family planning

Finally, family planning and the use of contraceptives are seen as an important influence on safe motherhood in the rural villages of Mangochi. After a woman has given birth the question of many couples arise if they want to have more children, and if so, how long after the last birth this should happen. The participants in the following quotes stated the importance of a limited amount of children and proper birth intervals:

R: I have said that long time ago I did not know anything. We used to have a lot of children and frequently for that matter. But these days I am trying to moderate so I am able to take care of the children that I have. And with this approach I feel it is better now than before.
(FGD3: Ngatala – 25 till 40 years – multiple children, 15th of August)

R: The other thing is having too many children, like fifteen, that is an accident. It should be four or five, we should learn to be on contraceptives.
R: Women should not give birth frequently, this can lead in accident.
I: What do you mean by accident?
R: She can die.
(FGD5: Stambuli – 20 till 25 years – With one or two children, 15th of August)

Several participants furthermore explained that child spacing is an important responsibility of the man in order to keep the family healthy and supported. As the following quote suggests, the man should take this responsibility whereas the woman is perceived as not being able to put a hold on the number of children she gets:

R: Women are fond of children. As such they don't understand the need of having fewer children.
(FGD4: Ngatala – 17 till 22 years – one child, 15th of August)

Also for the use of contraceptives the men's involvement can influence the outcome either positively or negatively. The participants argued that men should allow their wives to be on contraceptives, but some husbands are forbidding their wives to use contraceptives and therefore threatening her well-being:

In-depth interview:
I: Do you have any other thing to share with us?
R; Men should know that life is a precious gift given once per life time. If it goes, it goes for good. As such men should not force their wives to give birth to too many children. There are men who never allow their wives go for contraceptives. Women should be allowed to go for contraceptives so that children are well spaced so that we can protect lives of our women.
I: Thank you very much.
(IDI10: MasambaUma – 28 years, 24th of August)

Focus group discussion:
R: To make sure that not more mothers die we should go for contraceptives. Whenever she is pregnant she should go to the hospital very quickly.
R: We are saying this because some of the men do not accept that women are on contraceptives.
(FGD3: Ngatala – 25 till 40 years – multiple children, 15th of August)

Being on contraceptives is perceived as beneficial for improving the recovery of the woman and her general well-being after giving birth. The contraceptives therefore create the opportunity to protect mothers better and to prevent maternal health problems:

R: We should go on contraceptives ourselves.
I: Can we achieve this ourselves?
R: These days we can easily achieve that, having too many children is not fashionable.
R: It will be good if we are on contraceptives. Few children are economical and hygienic.
R: The woman that gives birth frequently deteriorates faster.
R: My wife last gave birth some six years ago. If you look at her you would think she is a young lady. But all this is happening because she is on contraceptives now.
(FGD3: Ngatala – 25 till 40 years – multiple children, 15th of August)

Additionally, some participants in both focus group discussions and in-depth interviews, stated that also men should go on contraceptives themselves. Besides the use of condoms several participants opted for other options. Although these participants could not always explain the details of how these other options work, they did indicate that it will be beneficial if men would be able to go on some kind of contraceptives as well, e.g. the 'closure of men' (a vasectomy) is mentioned by several participants in this context. However, because of lacking knowledge about other possible contraceptives, a lot of uncertainty remains:

In-depth interview:

I: Is it possible for us as men to change?
R; Yes we would. Like a man as myself, I will go to the hospital and tell them to make me stop having children.
(IDI9: Stambuli – 25 years, 23rd of August)

Focus group discussion:

I: At one point in time that some of the customs we have, have conformity with what the medical personnel requires from us. Do we have any specific customs that really need to be changed?
R: When we are actually on contraceptives we don't exactly know what happens. Is it the man that fails to reproduce; is it the woman that fails to reproduce? The problem is coming in because the contraceptives are only given to women. But if it were possible to for example that I get an injection, feel completely normal and have sex as normal without having children I would go for that.
(FGD3: Ngatala – 25 till 40 years – multiple children, 15th of August)

Although the ideas for either the man or the woman being on contraceptives and practising child spacing are obtained in multiple focus groups and interviews, some of the participants seem to disagree with family planning. In the following quote it is shown how participants think contraceptives are actually dangerous for women, and women might die as a result of using contraceptives:

R: Most women are having problems these days because of contraceptives. The time they decide to become pregnant, they either miscarry or they die with it.
(FGD3: Ngatala – 25 till 40 years – multiple children, 15th of August)

In another focus group one of the participants argued that child spacing means that men would not have sex for several years with their wives anymore. For this reason he rejected the benefit of practising child spacing completely:

R: Somebody says for me it is good to have a good number which are well spaced. If you have a space of three years in between the children that is ok with me. But I am not buying the idea of putting a margin of three because it sounds as if you are saying you should not enter your house.
(FGD4: Ngatala – 17 till 22 years – one child, 15th of August)

4.4.5 Lack of financial, material and human resources

The expected responsibilities of men during pregnancy, childbirth and post-natal, which have been discussed in the last paragraphs, are according to the participants not always easily achievable. The financial and material circumstances of a family in rural Mangochi are mentioned as an important influence on the possibility to provide sufficient support for a mother to safely and in a healthy way get children:

I: Is it possible to be healthy?
R: It is possible to be healthy; most of the recourses of being healthy are always around us.
I: Is it possible to have pregnant woman who are healthy?
R: It is possible only that it requires more material and financial recourses.
(FGD3: Ngatala – 25 till 40 years – multiple children, 15th of August)

4.4.5.1 Poverty and hunger

As explained in paragraph 4.2, a pregnancy means that many requirements are needed such as: Good quality food for both mother and child, materials necessary for a hygienic delivery, and good clothing for both mother and child. An average family in rural Mangochi lives from self-subsistence farming and sufficient funds for food and housing alone is often a challenge. A young man argued in an informal dialogue during the first observation period that some community members do not have good farming skills and therefore can cause a family to starve to death after a bad harvest:

We talk a little bit about what kind of preparations they have to do before the rain season will start in a couple of months. Apparently, almost everything has to be made ready still. "Making the garden ready", as he called it, "you just do one or two months before you think the rain will come". A couple of years ago they suddenly had the rain season very early, a lot of gardens were not prepared yet and people had a really bad harvest. "So that is why you have to prepare early. Some people in the village do not know much about farming. They are hungry if the rain comes early or late. They can die from hunger, also their children."
(Informal dialogue, observation period 1, day 3, 1st of August, TA Chimwala)

Life in the rural villages in Mangochi is often about surviving and good quality education and employment are not available or not affordable. A lack of sufficient food, funds, and of quality land to grow crops is threatening the health of community members in the rural areas, as the following quotes from two interviewees clarifies:

I: It is nice that you see life is going on well. Can we improve it from where it is now?
R; There is one big problem that I see. I see a hunger and an economic handicap ness.
I: How are these related to people's health?
R; If a person does not have money his life would be affected.
(IDI8: Stambuli – 29 years, 23rd of August)

I: You have given yourself an image of two children. So with these, your wife and yourself. How do you think life will be then?
R; I think life will be hard that time because the soil is degrading.
I: Why do you think life would be difficult this time?
R; I think land scarcity would be a problem that time. We are going to be too many of us.
(IDI11: MasambaUma – 25 years, 24th of August)

4.4.5.2 Not able to provide necessities because of poverty

The man is supposed to provide specific food and drinks, sufficient *chitenjes* to wear and to put the baby in once it is born, spirit, paraffin, a basin, plastic sheets, a razor, soap and a thread (see paragraph 4.2.1). The participants in the focus group discussions and in-depth interviews argued that meeting all these requirements can be a heavy burden for a couple who are expecting a child. Several of these participants explained that poverty is the main obstacle in caring properly for the future mother and baby and to provide everything which is requested:

I; Does poverty have an impact on the escalating number of women dying from childbirth?
R; Poverty contributes very much of poor health over here. For people to have good health, you need to have good food, and we don't have good food because we don't have the recourses.
(FGD1: Machenje – above 30 years – minimal 3 children, 12th of August)

The participants in one of the focus group discussions explained that a couple that is poor can not always meet the mentioned requirements of the health centre and does not always have sufficient food in order to make sure the mother and the child are healthy:

R; Some (men) are just negligent but others are indeed too poor to meet the requirement made by the maternity staff. For somebody who is jobless, to be able to buy a new basin, a number of new wrappers (ZITENJE, plural) and the plastic on top, it is almost impossible.
(FGD1: Machenje – above 30 years – minimal 3 children, 12th of August)

In the same focus group discussion the participants argued that a man who is too poor to arrange all the requirements might be mistaken by the community as a husband who does not care about his wife:

I; It seems fewer man get involved in issues of maternal health, why is the number so low?
R; It is just because of the badness of those particular men, they are just merciless. Some are just poor. For example if the woman says: 'at the hospital they require a basin', if the husband is too poor he cannot just provide that. If she says: 'I need this or that', if you don't have money you may look to be cruel.
(FGD1: Machenje – above 30 years – minimal 3 children, 12th of August)

Several men in the interviews admitted that they were not able to provide all the necessities that their wife needed. The following quotes show how these men explained that they were not able to provide everything that was needed because they did not have sufficient funds:

I: Going to the hospital is a very good idea, are you also thinking of providing some kind of assistance like food and drinks?
R; I wish I was able to do that, but you know poverty is the stumbling block. If you have little money, you would give the wife, but not sufficient like somebody rich should do.
(IDI8: Stambuli – 29 years, 23rd of August)

I: How can you rate yourself. Did you accomplish all that was expected of you?
R; I don't know if I was failing but I was trying. Whenever she had asked for something I make sure that I provide. I always wanted that she should be happy not that she should be complaining.
I: Is there anything that you had troubles in doing?
R; As somebody poor I really had problems with some other things, I always wished if I had money to meet some other things my wife was asking.
(IDI3: Machenje – 60 years, 17th of August)

4.4.5.3 Lack of young people

Another consequence of the poverty in rural Mangochi is that many young people move away in order to find work somewhere else. Some of the adolescents and young adults move to the larger cities in Malawi, many others (mainly men), move to South Africa where they will get paid much better for a low skilled job than for an higher skilled job in Malawi. In the following field notes from an observation period several members of the host family explained how their whole family step-by-step will move to South Africa because they can earn more money there. They explained that a teacher in Malawi does not earn a lot of money and will earn much more in South Africa with a low skilled job:

"My mother says it is better in South Africa for us, they pay more money in South Africa. You know, in Malawi we do not get a lot of work. Even a teacher does not get a lot money." Salar continues to tell about that all the children think their father should only be with their own mother.
(…) Then Masrur walks in, he just sits with us and listens to the conversation. He looks at me all the time when I am listening, maybe he wants to see my reaction. Salar tells me a long story (unfortunately I do not have this in quotes, because I could not keep up with what they said). At the end of the year Masrur and Baraah will go to South Africa as well, the plan is that every two years, two children of this house are going together to South Africa to life with their mother. The next time it would be Mehrnaz and Azizi, but because he is just a baby, they do not want to travel yet to South Africa. Masrur says in half English and half Yao that he is looking forward to go to South Africa, he will earn a lot of money he explains.
(Informal dialogue, observation period 1, day 6, 4th of August, TA Chimwala)

Another young man who works seasonal in South Africa shows, as the following field notes from the first observation period clarify, that the community members who come back from working in South Africa obtained new wealth and new goods which are hard to obtain in rural Mangochi itself. In this example the young man obtained new clothes and a new bicycle which are not seen in rural Mangochi normally:

He is wearing a sparkling new looking jeans, on top of that he wears a tight blue and white blouse of stretch material. I did not see him wearing this earlier, although I have seen him several times. I think every time I meet him he is wearing other clothes who all look so much different than the clothes of the other guys. Also his bike looks more fancy and new than all the bikes I have seen before in these villages. A silver Gary Fisher mountain bike with 14 gears. All the paint is still on their and I see no rust spots. The model looks very new as well, with the part of the frame which is at the front wheel being really fat. The crossbar of the frame runs diagonal downwards and has a special round edge around the back wheel. I know these designs and it is quiet modern, and the special rounded and fat framework is made just for decoration, for the looks. All in all it is clear he has a really fancy bike, which he definitely did not buy in Mangochi because I have been bike hunting in Mangochi myself everywhere.
I think they see me watching at the bike and Sumeer stands up and rolls it forward. With a proud smile he shows the bike from close, taps the saddle and says: "South Africa". Salar explains me that he has the bike from South Africa, he took it by bus to Malawi. Apparently Sumeer works mainly in South Africa where he sells clothes on the market. He also brings the clothes to Malawi sometimes to sell it here.
(Field notes, observation period 1, day 6, 4th of August, TA Chimwala)

The emigration of young community members, in combination with the numerous deaths in the last decade as a result of the HIV/AIDS pandemic mainly among the working-aged population (paragraph 1.5), leads to a lack of young community members within some of the rural villages. Consequently, women are facing pregnancy and raising the child alone, which is believed to have a negative impact on her own well-being (see paragraph 4.2.2 and 2.2.4). Especially young men seem to be missing in the villages, as reflected on in the following field notes:

When we leave the main road, and go between the houses, it catches my eye that around the houses I only see women and children. In many of the small side pathways there are no people at all. Sometimes around a house, around a water pump or on a small crossroad, I see women standing next to each other. I did not keep records of it, but at least three quarter of the women have a baby or small child on her back in the chitenje. In general, I mainly see only women, young children and older men. Young men are hardly present in the village.
(Field notes, observation period 1, day 4, 2nd of August, TA Chimwala)

Strong young people are necessary to work on the land, to help out with larger construction works in the village, to catch fish in small rivers, to make bricks, to cut trees and to travel as small tradesmen between the villages and the bigger cities by bike. The following quotes from field notes of observation period one, describe physically hard work that is needed in the villages. The first quote from the field notes given below shows the difficulties of both men and women who transport goods over long distances. They either walk while carrying a *chitenje* with goods inside, or they bike with a large amount of goods packed on the back of the bicycle.

Next to the road, women with a chitenje full of things they probably bought in Mangochi tried to get a ride. (…) I know that not a lot of cars or pick-up trucks pass by on this bumpy road, so for some it would mean that they have to walk all the way. On the way I also saw some acrobats on bikes. With a big bunch of firewood, with I think a cross-cut of about one meter, which was tied on the back of the bike with old bicycle tubes. With the enormous bunch of firewood they still achieved to bike on this sometimes horrible road with holes, cracks and obstacles. Their bikes are old, sometimes rusted and almost always without gears. They had to stand on the peddles barefooted to reach the top of some very steep hills, and every time when a car comes by they have to make sure to bike in the gutter next to the road which is one meter lower than the road, so that they will not be hit by a car. Besides firewood, some would bike with boxes full of groceries for the small local shops. With soap, sugar, cookies, rice etc. You could see how difficult it was to bike some parts of the road, and most of the men were covered in sweat.

(Field notes, observation period 1, day 1, 30th of July, TA Chimwala)

In the second quote of the observation field notes it is described how men in one of the villages are making bricks from mud themselves. They have to perform heavy physical work under hot circumstances, and it is explained that the quality of the bricks is very important:

When we walk back into the village we see on both sides of the roads, four men without shirts are making bricks. They made the ground wet and muddy, in this red mud they put a rectangular brick shaped frame, and they fill it up totally with mud. They really throw the mud into the frame, maybe to make it more squeezed al together. They carry the frame with the red mud to three meters to the side, where they in one hand movement, drop the mud on the other bricks which are drying at that place. One time I see the mud falling apart, but all the other times it stays perfectly in shape when the frame is removed. I think they dry it here in the sun. On both sides of the road are maybe 50 or even 100 bricks drying in the sun.

A little bit to the side is a man making a fire under a staple of bricks. The bricks are stapled one meter high, in a big cube shape. Only the lowest layers are not complete and some bricks are left out in order to leave a hole under the whole staple. Here they put all the burning material in and smoke comes out of all the small gaps between the bricks and from a small hole on the top. When I come closer the man steps one meter back and shows me with his hands that I can look from closer. He smiles, says something in Yao or Chichewa and gives a small demonstration on how he puts dry grass and firewood into the fire under the bricks. From three meters distance it is really hot so I step back a little bit. "It is really heavy work", Salar tells me. "A lot of stones are not good, they are not strong, you cannot make a house from the stones then. The men who make it are really important, they have to be good." I see them sweating, especially the men who are getting the shapes out of the mud. Salar explains that some men from the village make the bricks for everybody, so all the houses are made the same way.

(Field notes, observation period 1, day 4, 2nd of August, TA Chimwala)

In case there are not enough young community members the older generation has to perform the above mentioned tasks, or the tasks will not be performed at all. Furthermore, the grandparents occasionally have to take care of the young children in the family because the parents died. Taking care for the young children, keeping a household, working on the land to provide the children with sufficient food, and performing the above mentioned tasks is a difficult, and occasionally impossible responsibility for the grandparents, which can result in extreme poverty and starvation for both the grandparents and the children.

4.4.5.4 Poverty and family planning

Finally, the responsibility to take care of the family and its needs as discussed earlier in this section is by some of the men in the in-depth interviews linked with family planning. They argued that if a man can not take care of his family, he should not pursue in having more children. The following interviewee explained that only if he is able to cultivate more crops he should think of having more children, otherwise he would not have enough to support his family and it would be a 'disaster':

I: This is just like planning, you would have wishes maybe concerning like farming or anything like that. Now looking at your families' health, what are your aspirations?
R; I would rather grow more maize to feed my children. And on cash crops I would grow tobacco and ground nuts. If I get more maize and enough ground nuts to sell, there might be room for more children, but otherwise it is difficult.
I: How would you look at life, will it improve or not?
R; If my dreams really come true, certainly things would improve. But if it fails, then it would be disaster.
(IDI8: Stambuli – 29 years, 23rd of August)

The other way around, having too many children is explained by the following interviewee as a cause of poverty. He argued that having a huge amount of money will not be sufficient for a man to take care of his family, when he has 15 children to support:

I: What do you think men can do, or stop, so we could improve the lives of women in our village?
R; Here there are no companies, so the only thing we have is farming. If we had companies and different constructions, all these help uplift families. Uchembere Wabwino (safe motherhood) is very important, because it makes the money be used rightly. If you have fifteen children, even if you get MK 2000 a day, there is nothing this can do. (…)
(IDI12: MasambaUma – 41 years, 24th of August)

4.4.6 Men's feeling of being excluded

The participants indicated that men have the authority at home and are in general in charge of the decision-making concerning the family (paragraph 4.1.1). They also provided examples of how this phenomenon is different when it concerns the period of pregnancy, childbirth and post-natal. During the pregnancy and the delivery the woman and her family are considered to be mainly in charge. The participants indicated that men are during this period in one way or another literally and metaphorically placed outside.

4.4.6.1 Husband supposed to be distant from pregnant wife

Firstly, during pregnancy, childbirth and post-natal the husband is according to some customs supposed to stay distant from his wife. The husband is supposed to stay distant from his wife in different ways. As already discussed in 4.4.4 men have to remain abstinent for several months around childbirth for several reasons: to prevent that the man will be infected with *chinyera*, a disease existing in the body of the woman which can kill a man when 'mixing blood' (1), to limit the danger of women becoming pregnant too soon after the last birth which will prevent her regaining her strength (2), to prevent that spermatozoids can be seen around the baby during the delivery as a consequence of the couple having sex too short before the delivery (3), to make sure that the couple will not have problems regarding their sexual life just after delivery because 'the man does not fit the size of the woman anymore' (4). A pregnant woman is also not supposed to seduce her husband into intimacy during pregnancy and post-natal because, because as the participants described, abstaining from sex is already difficult enough for the man without temptation.

Furthermore, as discussed in paragraph 2.3.1, staying distant from the partner during the pregnancy is not only restricted to having sex. A few participants in the focus group discussions mentioned several customs that are prohibiting men to be in one way or another close to the woman. E.g. the pregnant woman is not supposed to step over the legs of the man once she is pregnant and the man is not supposed to accept food offered from the woman's loins. If not obeyed to these customs the man can risk suffering from, among others, general body weakness, impotence, or losing teeth.

4.4.6.2 Husband not allowed in the delivery room

The second phenomena in which men are partly excluded from being involved in maternal issues is the fact that during the childbirth men are not present in the delivery room.

Main reason given by the participants for why men are not allowed in the maternity ward is because the custom prescribes it. The interviewees quoted below explained that this being the custom in their villages was reason enough not to be inside, they did not further elaborate on the purpose of the custom:

I: So it appears you were there some of the deliveries how close were you?
R; I am never in the delivery room because the hospital people do not let us in. The same also apply when she delivers at home, the women say men are not allowed in the delivery room. It is a custom men do not attend child birth.
(IDI6: Machenje – 40 years, 18th of August)

I: About childbirth, what can you tell me about the way your wife delivers or what you know about childbirth?
R; Hmm, about childbirth hmm, I can not say much. Because I am just told she has a baby. Whatever happens there I don't know because I have never been there. So it just an excitement, because I just heard that the baby is born, then I rejoiced that I have a baby.
(IDI5: Machenje – 30 years, 18th of August)

The participants described that the family members of the mother and the birth attendants decide on who is allowed inside and who is not. The husband does not have a say in this and if he would insist on being present in the delivery room, people would perceive him as being rude:

I: So how do you feel that you are never there, when you are only told that youre baby is born?
R; About this there is not much I can do, because it is the birth attendants of my in-laws who can invite me to be there. Otherwise if I push it myself they will feel I am being rude. This is according to our culture, we are not allowed to go there. It is up to them to invite me to be with them there.
(IDI5: Machenje – 30 years, 18th of August)

TBAs and medical personnel at the maternity ward are mentioned in many explanations to be preventing the husband to be inside the delivery room.

I; Would you feel like going in with her?
R; No not inside, you only wait outside. But whatever she is told in there, she is supposed to report to her husband. We cannot get into there, because we do not have the permission to go in. (...)
R; It is the medical staff who chases us out of there, they don't permit us in. And we are used to that.
(FGD1: Machenje – above 30 years – minimal 3 children, 12th of August)

According to the medical personnel at the health centres men are not allowed in the delivery room in order to protect the privacy of the women inside. Inside, the maternity ward, the waiting room, and the delivery room are not completely separate from each other and when multiple deliveries will be conducted simultaneously the women also have to deliver in the waiting room. A nurse from a health centre in the area explained that if men would attend their wives, they would likewise see the other women going into labour. She argued that both men and women would feel uncomfortable with the situation and as a consequence they could decide next time to deliver at home, which is perceived as increasing the risk of complications:

Ayan further told me that men were not allowed in the labour ward because men would feel awkward when seeing the other couple. Also other men in the labour could then see their wife, and women would not have enough privacy. But when they would have just one delivery, the husband is allowed to be present as well. I asked how often that had happened. Ayan answered: "You know, we have always many deliveries. Men know this, so they do not come. Because they know other women are there."
(Informal dialogue, observation period 3, day 2, 6th of October, TA Mponda)

In one situation a nurse jumped in front of the gardener of the health centre who wanted to walk into the maternity ward to get a bucket. She made sure he could not enter, opened the door half so he could not look inside and later came back with the buckets. Clearly he was not allowed to see anything as shown by the following field notes:

Chifundo told me more about the night shifts, and that it is always very busy. Apparently it was not that specially crowded this night, a few deliveries at night is not an exception. A couple of minutes later I met the handymen / gardener of the health centre. He wanted to walk into the maternity ward but Chifundo right away stood up to stand in front of him, clearly preventing him to go in. She talked to him and she walked in while the man stayed outside. He laughed a little bit towards me as a small child that just got busted grabbing a candy, I smiled back to him and said hello. Chifundo came out again with two buckets, she gave it to him, they did not speak to each other and he walked away.
(Field notes, observation period 3, day 2, 6th of October, TA Mponda)

An accountant at one of the rural health centres that was visited during one of the observation periods explained that, although he was in charge of taking stock of the material requirements of the health centre (and thus the maternity wards), he never had been inside the maternity ward. This area is restricted to women only, and occasionally for male medical personnel. In the dialogue from the observational field notes that is shown below, the accountant also mentions that the women in the maternity ward would feel uncomfortable if he would have walked in:

We sat together and talked a little bit more about the differences between the Netherlands and Malawi. When we talked about the health care services in both countries I asked him if he had been in the maternity ward himself to see how the circumstances are. He answered me: "I have never been inside the maternity ward. Yes, the waiting room, but never the place where the baby is born. I have no purpose there." "What do you mean?", I asked. "Men do not go in, what can we do? Women will only feel uncomfortable if I will enter. And the nurses will not let me in, it is not for men." I replied that the nurses let me in and showed me around, that they were actually inviting me. "You are a doctor", Mtima replied, and he explained me that I was therefore allowed to enter the maternity ward. I explained Mtima that I was not a doctor at all, and I asked him if he could also tell that the nurses in order to prevent expectations of me that I can not fulfil. Mtima did not react that much on this remarks of mine and we continued peeling and eating our ground nuts.
(Informal dialogue, observation period 3, day 1, 5th of October, TA Mponda)

The following quote shows the exceptional case of a man who did attend the delivery of his wife. Afterwards, the medical personnel that attendant the birth were worried that he would not treat his wife with love anymore after observing his wife being in labour, that he would want to divorce her, and that he would make sarcastic remarks related to the delivery or to her body. He argued that he was surprised by this reaction of the medical personnel. He concluded that he accepted without problems that he could temporarily not have sex with his wife afterwards because 'he could not match her size, the man really would be small':

R: I once attended the woman giving birth. Whatever she was telling me is what I did until the baby was born. Then she took care of the baby. Then from there we went for the hospital, the medical personal asked me a lot of questions all of them I was able to answer. They asked if I was married so I said I was. After sometime they called me back to the hospital if my family was still going on in the house. They also asked my wife if I was making any remarks at all. They did this for several times and I was surprised. So I asked my wife why they were still probing. And she told me, the way the woman is when giving birth, most of the men would not stand it and decided to divorce their wives. This is when I discovered they were expecting that I would be making sarcastic remarks to my wife regarding all women. But all I learned this time was that physically you can not have sex with a woman who had just delivered. Your body cannot match hers; the man really would be small.
(FGD3: Ngatala – 25 till 40 years – multiple children, 15th of August)

Besides the customs and the medical personnel that forbid men to be present in the labour ward, it is important to mention that several participants also indicated that they were not interested in being present during the delivery. They did not see their presence as beneficial to either the woman or to themselves and they stayed outside because the custom prescribes them to do so:

R: Someone would remind the wife about the dates for sikelo and provide whatever she needs, that one loves his woman as well. We do not have to read the love of the husband by their attendance in the labour ward. It is because of customs that men should be out during delivery. The husband is represented in a different way. For example in my case, I don't feel that I am never there because usually my mother is always there.
(FGD3: Ngatala – 25 till 40 years – multiple children, 15th of August)

Several participants explained that the responsibility of the man lies in other tasks, such as providing whatever is necessary during the delivery, and their responsibility does not lie in being present at the delivery. The following interviewee supports this statement, and added that it is important that the husband lets the medical personnel do their work and that the husband would not obstruct the delivery:

I: Were you present during deliveries?
R; You mean in the labour ward?
I: Maybe anywhere.
R; No, not in the labour ward when the doctor is working. To watch and see what is happening, no not at all. We remain outside and make sure that we provide anything that becomes necessary.
I: How do you feel being outside waiting?
R; I feel no problem because I realise that it is me that made her so. As such I have to be close to see. Pregnancy is wapakati life and death. As such I cannot be somewhere happy whilst she is in agony. Whether it is fasting we do it together.
I: Thinking that you are one body as you said, that is why I was thinking that you would have something to say about the labour ward?
R; That would be right. But that is a working place for the doctors. That is why we remain outside to give room to the doctors, work. We wait till when we are told things are well. (...)
(IDI12: MasambaUma – 41 years, 24th of August)

The participants in both the focus group discussions and the in-depth interviews explained that most husbands are waiting just outside the delivery room in order something is required from them. Some of them wait until they got information about the mother and the baby being safe, others would wait until somebody would release them. In the last scenario they would go home and work, while waiting for news about the delivery:

<u>Focus group discussion:</u>
I: Do we really do all these things we are saying ourselves?
R: We do what we are talking about, I would bring my wife to the hospital and stay with her right there.
R: We go together to the hospital even without other women. We wait for them to come and release you.
(FGD5: Stambuli – 20 till 25 years – With one or two children, 15th of August)

In-depth interview:

I: How did you see the deliveries yourself?
R; She used to deliver at the hospital and it was all fine.
I: Were you ever present?
R; No I was never there.
I: Why?
R; I was working at the drimp, when I went back I was told my wife delivered and has a baby.
(IDI6: Machenje – 40 years, 18th of August)

Although the participants quoted above believe there is no benefit of men being inside the delivery room during delivery, multiple participants on the other hand, in both the focus groups and interviews, indicated that they are very willing to be present at the delivery. These participants added however, that although they want to be present in the delivery room, they accepted the situation that the culture or the medical personnel prescribes that the husband being present inside is a *kuwagula* (taboo):

I: The way you speak, did you want to get in and turned down? Or what happened?
R; No, I did not want to get in since I am a man. And it does not go that way when a woman is giving birth, men should watch how it goes. I was patient outside, waiting that whatever comes out of there I will be told.
I: Does this mean that you not did want to get into there?
R; I really wanted to be there, together with my wife.
(IDI9: Stambuli – 25 years, 23rd of August)

I: What do you mean with if otherwise was possible?
R; I only wished if men could be allowed in the labour ward, I could see how it is going with my wife
(IDI1: Machenje – 60+ years, 17th of August)

I: Do you believe the Yao culture is the one that deters men from entering the labour ward?
R; Yes it is our culture of course, but all the same it is a painful practice. I always feel like I want to be part and parcel of the team in the labour ward. But if the man is found in there, that is a kuwagula (taboo).
(IDI2: Machenje – 59 years, 17th of August)

The participants explained that they are very worried while they wait outside because the woman is *wapakati* life and death when she is pregnant. When she goes into delivery the fear is present that either the mother or the child would die. This uncertainty about the outcome seems to be stimulated by not being present at the delivery:

I: This means that you were outside all the times when your wife was delivering, is that right? How do you feel about this?
R; It was a painful experience. Painful because I was thinking, is God going to forgive us. So those were thoughts, then upon Gods forgiveness you would just hear that there is a baby inside. Of course I would get worried that I was outside, but I understood the situation that men are never get into the labour ward. I only wished if otherwise was possible.
(IDI1: Machenje – 60+ years, 17th of August)

Moreover, several interviewees not only indicated that they wanted to be inside the delivery room, they also explained that it would be beneficial for improving maternal health when husbands would be allowed to be present. According to the interviewees, experiencing childbirth will help men to feel more sympathetic towards their wives, because they will see the difficulties the wife goes through:

I: Are you trying to say that if man attends deliveries, marriages would not last?
R: Men who are not interested, their marriages would not last.
R: I think men can be more sympathetic and concerned, because they will know what the woman is going through.
(FGD3: Ngatala – 25 till 40 years – multiple children, 15th of August)

When men are attending the delivery of their wives it is believed that men would better understand what the woman is facing. Some interviewees added that men knowing better what happens at the delivery will enhance male involvement in family planning practises. It is believed that if a man experiences the difficulties his wife is going through during labour, he might reconsider having more children or the timing of the next child:

I: You also said that you would like to see that man would go into the labour room with their wives, what were the reasons?
R; What I said is that if you really see what is happening during childbirth, if you had the mind of continuing, have more children, you can stop. Or if the wife was telling you she wants to stop having more pregnancies, you would agree. You easily would be convinced with what you saw, that there is need to stop. This would help more men to learn what women go through during childbirth and make proper decisions in their families.
(IDI5: Machenje – 30 years, 18th of August)

I: So how do you really feel that you are not part of them and that you are not there during childbirth? How concerned are you? And how would you like things to be?
R; I as for one, I wish I was invited and I was with them there. This is my desire.
I: Why do you feel so?
R; Because if I could be there and see what she is going through. Because I just hear rumours of what happens, I don't have proof. If I had seen something in the way she is going through these programs, I would maybe suggest that she goes for family planning like TL (sort sterilisation).
(IDI7: Stambuli – 72 years, 23rd of August)

Additionally, the experience of a man attending childbirth can be used for advising other men in the villages about maternal health. The experience counts as first hand information and will give extra power to the advice they give to other, as explained by the following interviewee:

I: What do you think would be your thinking if you saw your wife giving birth and you are actually there?
R; This can help me a lot, because what you have seen will you be explaining to your fellow men, you explain with confidence. Because you say: 'that I am telling you I have seen, and this happened to me.' This makes more sense, otherwise how can you convince somebody with something you have not seen.
(IDI5: Machenje – 30 years, 18th of August)

4.4.6.3 Husband separate from wife after birth

Thirdly, during the first days after the delivery the husband is supposed to be even more distant from his wife than during the pregnancy. The husband is supposed to stay at another place than his wife and his baby for several days. The custom concerning these first days prescribes that the female elderly family members stay with the new mother and take care of her and the baby. When a woman has just delivered her mother and mother-in-law stay with her in the house for several days and nights. An interviewee from Masamba Uma explained that the custom prescribes that the husband stays somewhere else during these days and is only allowed to come home when the elderly women indicate the woman is recovered enough:

R; Oh! Yes, when a woman has just delivered, she is not supposed to have sex for a given period of time. The very first few days upon delivery she sleeps with elderly women in the house. When the period is over they come to you; telling you that we are through and we are going. So you enter the house and start sleeping. This marks the real start of sharing the responsibility of taking care of the baby.
(IDI12: MasambaUma – 41 years, 24th of August)

The participants were not able to explain exactly why this custom is performed and what the elderly women exactly do. From the following quote the custom seems to be in favour of allowing the woman to regain strength and to finalise the custom in which they want to prove if the child is really the husband's child:

R; It depends on the period when the wound will be healed. Usually it is not more than ten days; it will be five to ten days.
I: How do you feel about this? That you are not allowed to see your wife and your baby for five to ten days.
R; Actually what happens, during the day they give us the news outside the room. But the worst comes at night, because in that room it are only those two elderly ladies from both sides who sleep with the baby and the mother. So these two parents do not go home during this whole period.
I: Why do they say they do this?
R; I really not know. But maybe they know something about this and they never told me. But I think it might be important that they do it this way, according to our culture and believe.
(IDI5: Machenje – 30 years, 18th of August)

Several participants explained that this was a rather difficult time for them because they wanted to be close to their wife and baby. However they were not allowed to.

4.4.6.4 Children belong to mother

Fourthly, the participants reflected on a link between the feeling of exclusion and the matrilineal society (in which the mother and the mother's family have the ownership over the children. In paragraph 3.7.2 it was shortly mentioned that the participants explained that the ownership lies with the mother and the family of the mother. In the event a mother dies the children will be the first victims because the father is perceived as not able enough to take care of the children as properly as the mother would do (paragraph 1.4.2).

However, according to the participants, the main reason for men not being able to care for the children after the death of the mother lies in the tradition that children culturally belong to the mother, and therefore to the family of the mother:

R; (...) The problem here is not necessarily men failing to take care for the baby. But the issue is cultural. What we say here is the baby is not for the man, the baby is the mothers'. As such all children belong to their mother. So there is no way that the baby could be left to be raised by the father when the mother is not there. For example I have the wife, I have children. But if my wife dies, her relatives would come and collect all the children. As such you would not even have the opportunity to raise the little baby. It is taken along the others and the maternal site takes the whole responsibility. So if it is a little baby, the woman relatives would look in who is to breastfeed, probably amongst the relatives. Supposing that the little baby is left with the man, it is possible to raise it up. But it is more traditional than we think.

(...)

The problem is with the Yao custom, that children are considered to belong to the mothers' side, and if you choose to take the children yourself it will take a long process.

(...)

R; It is culturally impossible for the father to stay with the children because the children belong to their mothers.

(FGD1: Machenje – above 30 years – minimal 3 children, 12th of August)

It is explained in the focus groups, in the interviews, and in dialogues during the observation periods, that in many cases the father would move away to another place after the death of the mother in order to find a new wife. The children will not stay with the father but will remain with the family of the mother:

I; Is it possible for the children to stay with the father after the death of the mother?
R; Not much these days. Once the mother dies, the father moves away from the home in the view of getting married elsewhere. In this setting he cannot take the children with him. The children belong to the mother.

(FGD1: Machenje – above 30 years – minimal 3 children, 12th of August)

One of the participants further argued that in such situations the father would get married again with another woman and wants to bring his children along, the new wife and her family will often not appreciate or not accept the children that the father will bring with him:

R; The other problem that comes in when the father gets married to another woman it is very difficult for her to take care of the children from another woman. Maybe if she is extremely good, but in general it is very difficult.
(FGD1: Machenje – above 30 years – minimal 3 children, 12th of August)

Although several participants indicated that they are willing to take care of he children if the mother would die, only in exceptional cases it is possible for the father to take care of the children. It depends on the effort he puts in to convince the mother's family, on the relationship he has with the mother's family, and on how responsible and rich he is:

I: What is the real problem that lies here?
R: It depends on the relationship that was there between the husband and the relatives of the wife, if they were in good terms they may allow him to remain with the children. If the terms were not good they will not accept that he will be with the children, they urge that if the mother of the children was there alive and saw nothing good in him, what can happen in the absence of the wife. Then they belief its safer to take care of the children.
(FGD5: Stambuli – 20 till 25 years – With one or two children, 15th of August)

Thus, it is possible for a father to take care of the children alone, however it is argued in the focus group discussions that it is difficult to achieve. In the following quote it is mentioned that the father has to be determined and has to put in much effort in order to do so.

R; If the man is determined to raise a baby, he would do it. There is a man at Manjawira, he was left with a little baby, whom he raised alone. He started raising it just after birth, and the boy has grown with the father alone.
(FGD1: Machenje – above 30 years – minimal 3 children, 12th of August)

4.4.6.5 Men excluded from receiving information related to getting children

The final indication for the exclusion of men during pregnancy, childbirth and the post-natal period is related to the amount and quality of information that is shared with the husband regarding issues related to getting children. It is believed that men do not have enough know-how on how to make a pregnancy or childbirth safer. The participants indicated that if in some situations the husband would have had more knowledge about how to practise safe motherhood, then a lot of suffering could have been prevented. The following quotes from both interviews and focus groups describe situations in which a man does not know what is happening with his wife or with the pregnancy. In the first quote an interviewee reflected on a problematic pregnancy he experienced himself. The interviewee explained that he had no idea that his wife and her pregnancy were threatened by the fever she was suffering from. Because the couple did not know she was suffering from malaria, they did not realise the risk and they did not go to the health centre to be treated directly. This could have been fatal; thankfully in this case it was not.

I: What happened that make you feel she had fever?
R; I did not know anything, I thought it was the illness of women, so we stayed at home. Later the elderly women came and told her to go to the hospital. But once we got to the hospital, it is when we were told she had fever and that was very bad. She was shivering, the body temperature was very high and she had severe body pains. At the hospital they told us things had combined with malaria
(IDI2: Machenje – 59 years, 17th of August)

Also in the following quotes it becomes clear that men do not always know what is happening. In a focus group discussion a man explained that he does not know why he is supposed to arrange a bottle of coke for his wife after the delivery. In one of the interviews the participant indicated that he had no knowledge about why a maternal death occurred in his village, and yet another interviewee explained that he did not know the reason for why occasionally the baby would have troubles coming out during the delivery.

Focus group discussion:
I: Why is a bottle of coke an important option this time?
R: We do not know. But all we trust is at the hospital they know the right things a woman in this condition needs.
(FGD3: Ngatala – 25 till 40 years – multiple children, 15th of August)

In-depth interview:
I: How did things go that time? Can you share with us what happened?
R; I would not be able to explain. All I heard there was a baby born, and the mother passed away there and then.
I: It appears you heard quiet a number of things about this death. Among the things that you heard, where there no suggestions that if people to do something the death would be prevented?
R; That one I can not explain. If I had the details I would be able to, I do not have the details.
(IDI1: Machenje – 60+ years, 17th of August)

I: Was there anything strange that happened during both pregnancy and delivery?
R; Yes, It was really strange. The baby that was being born would get stuck in the passage.
I: It sounds difficult; did people tell you what the reason for this could be?
R; I do not know. Nobody told me anything. And I did not ask anything about this.
(IDI10: MasambaUma – 28 years, 24th of August)

Occasionally the husband would ask the female family members or the medical personnel for clarification on an issue related to the pregnancy or the childbirth. The medical personnel or the female family members who are present at the delivery in these examples tell the husband to go home or to wait outside. They do not further elaborate what exactly happens inside, only the end result is presented to the husband:

I: What was your role and what did you do when you heard about this strange thing?
R; I did not do anything, because the parents did everything. They were there, they knew what was happening and they dealt with it. I was only told when everything was done.
(IDI5: Machenje – 30 years, 18th of August)

I: Was there anything strange that happened during both pregnancy and delivery?
R; Yes, It was really strange. The baby that was being born would get stuck in the passage.
I: It sounds difficult, did people tell you what the reason for this could be?
R; I do not know. Nobody told me anything. And I did not ask anything about this.
(IDI10: MasambaUma – 28 years, 24th of August)

From the last quotes it can also be concluded that these participants did also not ask further explanation about the situation when limited information is provided to them. On the other hand, the following quote from the observational field notes describes a situation where two young men are guided through the maternity ward. They have never been in the maternity ward and seemed very curious and interested. They asked the nurse many questions about what they saw around them, and at the post-natal room they had the chance to shortly talk to some new mothers with their guardians. Although not all their questions are translated it was clear that they did not know much of what normally happened inside but that they were very interested to know more about what happened:

Salar and Jari were with me and they asked some questions in Chichewa or Yao. The nurse answered and pointed around a little, so my first guess is that they asked about the maternity ward. With my ideas in mind about men who have no idea about what is happening in the maternity ward, I was a bit surprised how much these young guys were questioning. They looked serious and interested when they asked all the questions.

(...)

The two guys with me were really calm now and just shortly greeted the one nurse who was cleaning. They were paying much attention to everything in the room by looking around a lot, looking in the closets, looking backwards when a door opens and sometimes asking something to the nurse. With a serious face, not making jokes as normally, and not explaining me things like normally. I realised that men are often not present at labour itself and are most often not allowed in the labour room at all. Some friends in Mangochi told me this, and also Mary from the CBSM project explained this to me. The two guys with me were probably, the same as me, for the first time inside a maternity ward, an area where men are normally not coming.

(Field notes, observation period 1, day 1, 30th of July, TA Chimwala)

As shortly reflected upon in paragraph 3.3 and 3.7.3 there is a struggle between the older generation and the younger generation. Some young participants indicated that especially the older community members are not open towards receiving new information concerning safe motherhood. The older generation is perceived as not capable enough to understand new advises that are given to them about safe motherhood. One of the interviewees argued that young people have the wisdom nowadays, meaning that they know nowadays better how to cope with maternal health issues:

I: Some men say they don't want to go as far as the labour room, what can you say about this thinking?
R; Come again?
I: What they say if they see this women giving birth they would divorce her, what do you say about this?
R; Such kind of men, they just need to be told repeatedly. Because you know some of us men are just born without the reasoning capacity. Some were born sometime back, they are quiet old, but there thinking capacity is quiet small. So we should not be saying that all the aged men are intelligent and wise, this time wisdom is in the young men. Because if young people is been told something they are able to listen and understand. They are able to listen and to understand and think properly, but these old people they just think because they are old they know everything. It would still be important if such type of men would be informed properly and repeatedly.

(IDI5: Machenje – 30 years, 18th of August)

Furthermore, it is explained by the participants that some youngsters copy the behaviour of the older generation. In combination with the last argument that the older generation does not always have the right information, the participants in one of the focus groups argued that the good information does not always or not completely reach the men in the villages:

I: It appears we know about the essential things and factors. How much of these do we accomplish?
R: As you can see most of us are quite youthful and most of us are married. So we look at some of the couples in the village who do not go with their wives to the sikelo and you say to yourself: 'why should I'?
(FGD4: Ngatala – 17 till 22 years – one child, 15th of August)

4.4.7 Involving men in maternal health by sharing *uchembere wabwino* ideas among men

The lack of knowledge some men are supposed to have regarding pregnancy, childbirth and the post-natal period, as discussed in the last paragraph, indicates that if men would receive more information they would be better able to understand what they can do to improve maternal health.

In first instance the participants compared the situation of lacking knowledge to the old situation of women in the community. It is believed that ideas and messages on *uchembere wabwino* (safe motherhood) which are disseminated in one way or another into the community can improve maternal health in the community, as experienced with the spread of information towards women in the community was beneficial. The participants explained that because of disseminating *uchembere wabwino* advises in the past more women are nowadays attending the antenatal care clinic:

I; Is there anything else amongst our customs that we can do to reduce maternal deaths?
R; If we are to think about the past two years the customs and traditions are being done away with. People are being exposed to a lot of uchembere wabwino messages. For example there was a time we went to Mtimma Bii health centre, there we got over 40 women in antenatal. The thing that has never been there before. This means that the message is sinking in the people.
(FGD1: Machenje – above 30 years – minimal 3 children, 12th of August)

The participants also argued for more counselling and information towards men. It is believed that this will help men to make better decisions for their families and to be more involved in maternal health. Men in some situations are not involved or not helping out because they simply do not know how to do this (paragraph 4.6.5). Therefore counsellors in the village who would talk to men would be a beneficial improvement:

I; Are these the only things that make men less involved?
R; Lack of counselling. Counselling would make change their mind set. Maybe they don't do much, because they don't know what they are supposed to do.
(FGD1: Machenje – above 30 years – minimal 3 children, 12th of August)

I: Is it possible to think of the set backs that we will encounter in involving men to reduce maternal health?
R: The first set back would lack of a forum. So we don't know what is required and what is required from us.
(FGD3: Ngatala – 25 till 40 years – multiple children, 15th of August)

Sharing ideas, thoughts, and messages on safer motherhood among community members themselves is mentioned in the following quote as support to men in order to assess maternal health issues better:

I; In the way that we have discussed we have gone together to say that men should be involved in the pregnancy of their wives. What can we do to get more involvement from the men?
R; Men should be encouraged to be involved in maternal health.
I; How can we encourage them?
R; Anywhere we meet as men. As we have shared here, we are also supposed to share with others who are not here. (...)
(FGD1: Machenje – above 30 years – minimal 3 children, 12th of August)

4.4.7.1 Possible ways for sharing uchembere wabwino messages among men

Besides traditional leaders, family members, health workers, NGO personnel, district governmental officials and TBAs who are mentioned as mediators for spreading information within the community on safe motherhood (see section 3) some participants indicated that the community members themselves have a responsibility to inform and support each other.

Firstly, men among each other are likewise mentioned as possible advisors regarding pregnancy. The following quote from an interview describes how friends of the participant advised him on abstaining from sex during the pregnancy in order to protect the unborn baby:

I: Are there other people who told you on how to deal with pregnancy or child birth?
R; Some of my friends used to share with me some of these issues.
I: What were they saying?
R; They used to say that we should not meet the woman frequently when she is pregnant because the baby is in its own special bag. So if you do it too often you can break the bag and both the baby and mother may die.
(IDI4: Machenje – 35 years, 18th of August)

Secondly, some participants plea for an advisor from within the village, who should go door-to-door with advise for couples concerning safe motherhood:

R: We should indeed have advisory groups going door to door, meeting couples, those that take heed would be assisted.
(FGD5: Stambuli – 20 till 25 years – With one or two children, 15th of August)

Ndulu, one of the guides during the first observation period explained that he is an advisor in his own and in surrounding village regarding family planning. In his door-to-door visits he tries to reach to the husbands as well with his advises. As the following field notes show is that he is not always received with open arms by the community members. He argued that occasionally the GVH or the village chiefs have to support him and summon the community members to listen to the advices, because some community members prefer to do other things:

The GVH, Ndulu and me were walking next in row, especially Ndulu and me talking about what he was doing. He was an advisor who goes door by door to families, to talk about contraceptives and about child spacing. (...) "When a family has a baby, then I go there and tell them they should wait for getting a new baby. They should not have ten children. You know, most of the families in our village are poor, they are too poor for ten children." I asked if people listen a lot to him. "Some people do not want to let me in the house. Sometimes the GVH says they should let me in and talk with me. Many people like to talk with me, they ask me questions also." And do you speak to a lot of men?', I asked. "I talk with the family. The man as well. But sometimes they are not there. You know, some men are always out for drinking. They come home late and do not care about the family. But I start with my family and friends, I tell them about not having much children. They always want to talk with me."

(Informal dialogue, observation period 1, day 2, 31st of July, TA Chimwala)

Also participants in both focus group discussions and in-depth interviews explained that it will not always be easy to reach all the male community members. They argued that some men might be hard to reach for counsellors or information because they are not interested (e.g. a man who is always drunk), want to have money for their time, or believe they can handle the situation themselves:

I: Are there any challenges of setback concerning this (sharing information)?
R: We have got challenges indeed. For example if somebody would like to visit a couple and finds a drunkard at home there is nothing good expected of him.
R: Receptivity of people is another problem, people would rather be given money than information.
(FGD4: Ngatala – 17 till 22 years – one child, 15th of August)

I: Do you think you have a role in the change process?
R; I think I would take a role of an advocate. It is good but it is difficult, because others would say let him manage its own home. Because people claim authorities over their families.
(IDI2: Machenje – 59 years, 17th of August)

Although the context in the following dialogue from the third observation period is different, it likewise shows that not every community member is in favour of counselling or advisory groups. A youth club leader argued that many of the youth in the village do not want to participate in the youth club and is not willing to listen to their ideas and thoughts. According to the young leader, do the other youngster rather have fun or earn money instead of talking about problems they as youngsters are confronted with:

When we continue walking Salar tells about the youth club all three of them are in. Salar is leading the youth club. He explains me that in the youth club, young people from both sexes come together, and talk with each other about everything. Sometimes he gives small lectures or presentations, about sexual behaviour. (...) When I ask him about how many youngsters join the club, he says very convinced: "around 25, as well boys as girls. We want to have boys and girls, because we learn from each other." I then ask him if that number represents most of the youngsters in the village. "No, no, many do not want to join. The youth club is not only from our village, but from villages around us as well. We have many young people but they do not want to join us. The guys think it is not for them and do not want to spent time with us. They think they know everything and do not care about advice about HIV and this and that. The guys want to have fun and hang out together and do nothing". I ask him if this was only for guys, and then he explained me that the girls are mostly at home, so he does not know what they are doing. Furthermore, some guys he knows, when he asks them to join, reply to him that they think it is a waste of time.
(Informal dialogue, observation period 1, day 4, 2nd of August, TA Chimwala)

From this study it can be concluded that multiple participants plead for a person, organisation or institution to take lead and to advise community members about safe motherhood, some participants also argued that the individual is the most important source for providing positive change into the lives of mothers in Malawi. Men can influence the health of their wives and of other community members, as long as they themselves practise safe motherhood:

Focus group discussion:

R: We are to be pioneers. Whatever we tell others we should start ourselves.
(FGD5: Stambuli – 20 till 25 years – With one or two children, 15th of August)

In-depth interview:

I: What about your parents-in-law?
R; They cannot say anything about this (safe motherhood). I am sorting my problems at my house just as they sort theirs at their own home.
(IDI12: MasambaUma – 41 years, 24th of August)

An individual is supposed to make the right choices him- or herself regarding maternal health, and individuals decide themselves if they influence the motherhood positively or negatively. One of the interviewees elaborated this argument with the example of the choice of an individual to smoke or not. Some choose to do so although they know it is unhealthy; others choose not to do so for the same reason. He reasoned that they could provide as much advises and safe motherhood messages to men as possible, it depends on the willingness of the individual man to use the advice in his (and his wife's) advantage:

I: Do you think it is possible to change lives of mothers in Mangochi?
R; Yes it is possible.
I: What about women's life in this village of ours?
R; Yes it is also possible to change.
I: How can life be changed and who is to change and what is it really that is to change?
R; It is necessary that the changes take place on an individual basis. Each individual should be asked and according to his or her answers the advice can be given. We are born the same. But there are choices we make that make us different. Someone would choose to be drinking beer or not to. It is a choice. Those things are things that people just learn there is no point clinging to them. It is possible to change life.
(IDI10: MasambaUma – 28 years, 24th of August)

Thirdly, several participants argued that one of the options for reaching men in specific with *uchembere wabwino* messages is the need of a 'good example'. This can either be a single individual or a group of people. The 'good example' is supposed to inform others about safe motherhood ideas and additionally he should give the good example by showing how to practise safe motherhood in a good manner. The next quote shows that the interviewee believes he can be a good example for other people and he indicates that together with the village chief he can be advising other community members:

I: Looking at yourself as a man, do you think you have a role to play in this village so that things may change for the better?
R; Yes I do.
I: What role do you think you can take?
R; The role that I can take is this: I would go to the chief and tell him that I have come. Let us address a need in this village. Men are negligent towards their pregnant wives. But there are also negligent women who never go for sikelo in this village of ours. I would ask the chief that even though I am a young man, but I am quiet mature with two children. Let us summon to people in the village and caution them on what is happening in the village.
(IDI9: Stambuli – 25 years, 23rd of August)

Although not every participant agreed on the importance of elderly in the village regarding sharing information and knowledge (see paragraph 3.3), one of the participants did explained that young people consider elder couples as the 'good example' and therefore copy their behaviour:

I: It appears we know about the essential things and factors. How much of these do we accomplish?
R: As you can see most of us are quite youthful and most of us are married. So we look at some of the couples in the village who do not go with their wives to the sikelo and you say to yourself: 'why should I'?
(FGD4: Ngatala – 17 till 22 years – one child, 15th of August)

4.4.7.2 Uchembere Wabwino Wabambo

A clear demand for more information and advice on (among other topics) safe motherhood specifically addressing men can be obtained from the following quotes. The participants argued that it would be beneficial if arrangements will be made in order to advise men. One of the interviewees named this *uchembere wabwino wabambo* (safe motherhood for men):

Focus group discussion:

I: What can the hospital do so that more men get more involved?
R: The health talks that are given at the hospital target women. It would be good also that there would be made an arrangement for men. So when men are also advised, we would take out these views to our daily lives.
(FGD3: Ngatala – 25 till 40 years – multiple children, 15th of August)

In-depth interview:

I: Is there a role men could do so that less women die?
R; Yes it is Uchembere Wabwino Wabambo (safe motherhood for men).
I: What do you mean by uchembere wabwino wabambo?
R; Men should have their own uchembere wabwino forums.
(IDI7: Stambuli – 72 years, 23rd of August)

A method for spreading safe motherhood advises to men in specific, which is mentioned by the participants, is the use of 'male clubs'. When the participants indicated, in both the focus group discussions and in-depth interviews, that male involvement is important, they were asked to explain how to realise or improve male involvement. The use of male clubs, or some sort of formal group meeting, was introduced multiple times by the participants as a good method to improve male involvement:

I: Who should be carrying around the messages and how?
R: We should form uchembere wabwino groups and these should be moving door to door.
R: Like we are gathered here, we are learning and some things we can share to whom is at home
(FGD5: Stambuli – 20 till 25 years – With one or two children, 15th of August)

I; What can we do to stop mothers from dying in relation to giving birth, so that we can keep our children to our selves.
R; We should create clubs to deal with uchembere wabwino.
(FGD1: Machenje – above 30 years – minimal 3 children, 12th of August)

The participants furthermore explained how the male clubs should be shaped in practise and what the exact purpose of such clubs would be. Within these formal groups men would gather together and discuss the do's and don'ts during pregnancy, childbirth and the post-natal period:

Focus group discussion:

I: Is there a role that the traditional leaders can take to reduce maternal mortality?
R: Traditional leaders should encourage men to format groups of maternal health. Such forums would expose men to require standards of maternal health.
(FGD3: Ngatala – 25 till 40 years – multiple children, 15th of August)

In-depth interview:

I: What is it that you can do in Mangochi district to improve women's health?
R; As I have already said what we need in this district maybe groups and clubs where they can discuss and talk about child birth. Also we need activities that target men.
(IDI5: Machenje – 30 years, 18th of August)

The participants clarify that in the meetings they will share and learn from each other. Some participants indicated that they already learned new insight from the two-hour focus group discussion they were part of. A male club would follow the same pattern of men gathering together to discuss maternal health and family planning issues:

R: From this discussion I really feel the need to share. Some of the things I did not know, I have known them through this discussion. So when men meet, we would really know a lot of things. Whether the others will attain the meetings or not, the messages will still reach in one way or another.
(FGD3: Ngatala – 25 till 40 years – multiple children, 15th of August)

I; In the way that we have discussed we have gone together to say that men should be involved in the pregnancy of their wives. What can we do to increase the number of men who are involved? And what can we do to get more involvement from the men?
R; Men should be encouraged to be involved in maternal health.
I; How can we encourage them?
R; Anywhere we meet as men. As we have shared here, we are also supposed to share with others who are not here. In this way we will see that we are only eight of us here but the number may come to 30.
(FGD1: Machenje – above 30 years – minimal 3 children, 12th of August)

The main perceived benefit from sharing information in male clubs is that slowly on the number of men in the village who will know how to handle a pregnancy or childbirth would increase. These newly informed men would consequently summon other men in their family and friends circle, ensuring the spread of safe motherhood messages within the villages.

I: What can we do so that we have more men getting more involved in issues affecting maternal health? We want to have more men who get involved, and these men should be doing more than what usually is getting done.
R: We should establish male clubs on maternal health. These men should be sharing, and at the end addressing the whole village. This group can come up with by-laws.
(FGD2: Machenje – under 20 years – without child or expecting first child, 12th of August)

Additionally, as also reflected upon in paragraph 4.7.1, not all community members will be open for the messages spread by male clubs. However, only one man who receives new information on practising safer motherhood is perceived as a positive gain of male clubs:

R: If messages are brought in public, even though majority may not embrace the information, at least one will get it.
(FGD4: Ngatala – 17 till 22 years – one child, 15th of August)

The participants of the male clubs are supposed to share the ideas and advices from the male club to other community members, especially to those who are uninterested and ignorant. The participants argued that they do not expect that everybody would be willing to receive their messages at first instance and that the entire village would be changed in a short time period. However they did argue that some of the men who are uninterested and ignorant will eventually receive the advices and will change their practises related to safe motherhood:

I; As men, do you think we can meet any stumbling blocks or setbacks in attaining this?
R; We may come across disinterested people, and these people may discourage us.
R; But if there are many of us we would be able to overcome them.
R; All the same we have to go ahead. Some will get our message and some will not, but we still make an impact.
(FGD1: Machenje – above 30 years – minimal 3 children, 12th of August)

R: We should form groups in which we can be sharing such information.
R: The formation of groups would be nice of course, we know that there are people who may despise, but all the same the message will reach the people at home.
R: The group would indeed help because there are people who are ignorant and these would be helped and changed.
(FGD5: Stambuli – 20 till 25 years – With one or two children, 15th of August)

R: The forum would make public statements at local meetings and elsewhere. Some may despise information but some may take heed.
I: What do you think can be done so that men can be involved?
R: We should establish men youth groups on safe motherhood.
R: The group would be making random visits in the villages. We know that some people would despise the grouping and some would take the message home.
(FGD4: Ngatala – 17 till 22 years – one child, 15th of August)

Not one participant mentioned that he himself would not accept messages or advises provided to him. The participants did not mention their own need for more information. It are always other men who are the ones who are not interested or open to receiving information related to safe motherhood. Important to realise is that this might be a consequence of the nature of focus group discussions, in which some participants might not be willing to oppose the opinion of the 'majority' in the discussion. The majority in the focus group discussions indicated that these messages are important and the majority portrayed the men who are not interested negatively.

Another feature of the male clubs described by the participants is that male clubs are supposed to correct the other group members, or even community members who are not participating in the male club, when the behaviour of these men is perceived as negatively influencing the health of their wives. If a man is misbehaving, the members of the male club should caution this man in order to eradicate his misbehaviour:

I: What can be done that more men get more involved in maternal issues?
R: Men should always come together and discuss maternal issues. Such groups should be composed of younger and older men so that they can share experiences. In such forums whoever misbehaves would be cautioned from within the group.
(FGD3: Ngatala – 25 till 40 years – multiple children, 15th of August)

R: We should from groups. In groups we would be able to eradicate whatever is inappropriate and do things according to the demands of the group
(FGD3: Ngatala – 25 till 40 years – multiple children, 15th of August)

One of the participants in the focus group discussion reflected on the benefit of separating men and women in an advisory group such as the proposed male club. He linked the separation of men and women with sexual behaviour, arguing that spending time in a discussion group together prevented the participants to be producing children at home. This remark was received with an amount of laughter:

R: Men should change their priorities. Development should be the priority and not sex. Men should be meeting and spent time together. Men should not very much cling on to their wives. For example how much we have spent here, about three hours. Otherwise that time would have been spent on making children. We have relaxed here, we have removed the tensions, and the time we go we are refreshed. No tensions anymore. (LAUGHTER)
(FGD3: Ngatala – 25 till 40 years – multiple children, 15th of August)

However, the second part of his remark which is quoted below, about separating men and women in groups such as the male club, was received by agreeing nods and an agreeing mumble by the other participants. He argued that the local choir exists of both men and women and supposedly they have had many extramarital sexual relationships among each other, resulting in a few extramarital pregnancies:

The men's group should not involve women. Like here it was very peaceful because women are not involved. Places like choirs you have a lot of nasty circumstances just because we both have men and women. A lot of pregnancies come out of choirs. But if you have men alone, in a joking manner, we would correct one another.
R: What he is trying to say, is that men can talk more seriously together when we are not involved with women during our meetings.
(FGD3: Ngatala – 25 till 40 years – multiple children, 15th of August)

Additionally, some obstacles for the formation of male clubs were mentioned by the participants. In the focus group discussion one of the men reflected on the idea of the male club and already thought ahead in the future.

R: The group is supposed to be mobile, so the problem will be mobility. How do we reach further than our own village?
R: We are thinking about the distances the group maybe possibly having
(FGD5: Stambuli – 20 till 25 years – With one or two children, 15th of August)

The last participant's remark about the lack of mobility of the male club, and therefore the limiting ability of the male club to spread the important messages to other villages, highlights an important sustainability problem. The populations of many villages in the rural areas of Mangochi are on average very small. The reach of a local male club would therefore also be very limited. Travelling to or from neighbouring villages is limited by a few villages, and where walking is the main mean of transport other villages are simply too far away.

Another obstacle, explained in a dialogue with Agimah, a Health Surveillance Assistant (HSA) is that a potential male club might face another sustainability problem. In the village where the HSA works, they had a male club in the past. However, after the men from the village did not receive any financial contribution anymore for attending the male club, they did not attend anymore and the male club disappeared. His advice for eventual newly formed male clubs, described in the following quote from the observational field notes, was that the supporting organisation of such clubs should not pay the participants from the start. Otherwise they would always expect a payment for attending the male club which is financially not sustainable:

Agimah responded: "We are trying to get more men to the hospital. All the HSAs do. But you saw it, it is very difficult for them to come. They do not want to come if they do not get paid." A bit surprised I asked: " They only would come if they get paid? Really?" Agimah: "In this village yes. We had a male club in the village. I was leading that. We had to pay them first, other the men would not come." When I asked more about this Agimah further told me: "We paid them first, so the men would come. But when we did not pay anymore and they said 'we will not come, we want to receive a contribution for our time. We could also work in the garden.' They meant money or food. So we do not have a male club in the village anymore."

I got my notebook and asked him if he could repeat what he had just said, because it sounded interesting. He then also added that another village has a male and female club. "The men and the women talk about HIV and about diseases." I asked if they get money for that. Agimah told me they did not pay them, they only provided them with a soda. Agimah's thought was, that because they did not pay them from the start, they also did not expect it. I asked again if in the village we just gave a visit, they did not want to help with community development if they do not get a contribution for it. Agimah answered: "No, that is the problem." Agimah seemed to be very honestly concerned when he said the last sentence. He shrugged his shoulders a little bit, he furrowed his brows, and he squeezed his lips together after he said it.

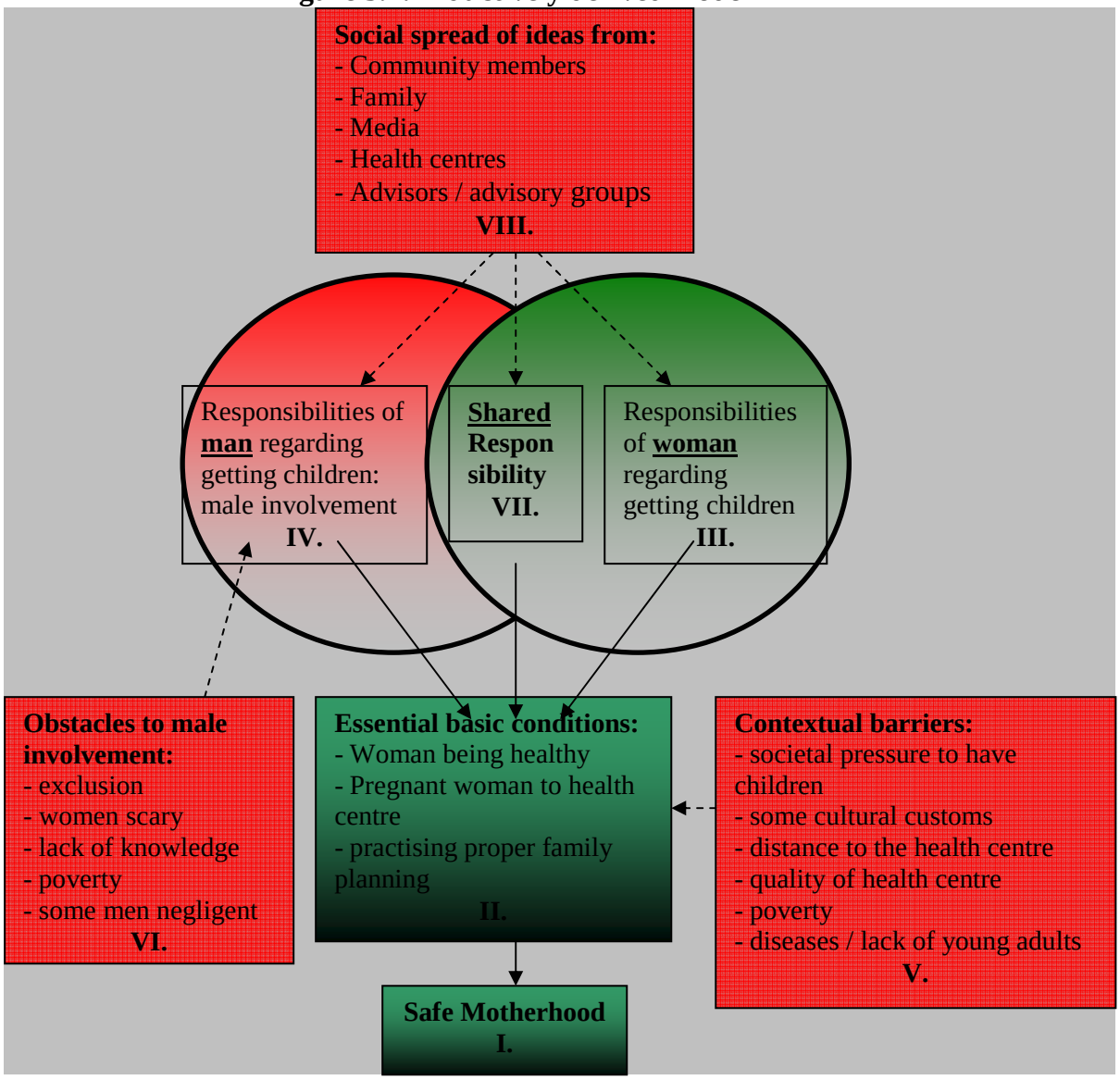
(Informal dialogue, observation period 3, day 3, 7th of October, TA Mponda)

5. Discussion

The aim of this qualitative study is to find out what the perceptions of men from rural Mangochi are regarding maternal health and male involvement in maternal health. The men were asked to reflect on the risks and problems related to getting children and they were asked to explain which factors at a community or household level are influencing these risks. A special focus of the study is on the role of men in this overall picture of risks and practising safe motherhood. Although international literature indicates that most causes of maternal deaths are preventable by known interventions which can be conducted at low cost (WHO, 2008a), the situation on the ground in the villages in Mangochi district indicates that it is a complex issue within a context of poverty, conflicting beliefs, confusing gender positions, societal expectations, and cultural customs.

In this chapter the research results from the last chapter are linked together and with international literature in order to understand how men from rural Mangochi are perceiving maternal health and male involvement in maternal health and what this means in practise. How, according to the participants, the situation on the ground is, and how different phenomena are influencing each other is illustrated in the inductively derived model (figure 5.1). This text in this chapter will be guided by the inductive model; the Roman number in brackets refers to the concepts in the model. The phenomena and concepts in the model are grounded in the data and are based on the research results. The model illustrates in which way the participants believe safe motherhood can be enhanced in the context of their rural villages in Mangochi, Malawi.

Figure 5.1: Inductively derived model



5.1 Men aware of risk (I.)

At the time of delivery itself men who participated in both the focus group discussions and interviews indicated that they waited close by to the delivery room. They illustrated this waiting period as a time of worrying and concerning about the well-being of their wives (I. in model). The participants seem to be very aware of the pregnancy being a risky event. The participants recognised that maternal mortality is a problem in their village or in neighbouring villages; the lives of women are perceived to be at risk during every delivery a woman has to face. Because the risk of dying from pregnancy-related or childbirth-related causes is so present is a pregnant woman referred to as *Mayi Wapakati* (woman in between life and death). Furthermore is the delivery itself referred to as *Ulwere (*the sickness), which means that when the time for delivery comes the woman has to be taken care for as if she is ill.

5.2 Responsibilities of husband and wife (II., III. and IV.)

In order to make sure that a woman will not die in relation to her pregnancy or delivery, the participants explained that she and her husband firstly have to make sure she remains healthy (II.). The woman herself is e.g. supposed to eat properly, to not work too hard, to dress properly, to not live with *kupesya* (hard feelings towards somebody or having a quarrel with somebody), and to not have extramarital sex (III. responsibilities of the woman). The responsibilities of the husband are e.g. providing sufficient and good quality food, taking over some heavy domestic works, being supportive and loving, not having extramarital sex, not being cruel to the woman, and arranging the requirements for during the delivery (IV.).

In addition, the participants argued that women have to go for *sikelo* (antenatal care) and for delivery to the health centre if they want to increase their chances to survive childbirth (II.). The responsibility of the husband in this context is to make sure that she is either reminded off and sent for the *sikelo* or escorted to the *sikelo* (IV.).

Thirdly, couples are supposed to practise proper family planning methods in order to prevent that women are dying during the pregnancy, delivery or post-natal period. Reducing the number of children per woman, longer birth intervals and increasing the age at first birth are mentioned as the main features of family planning which can improve maternal health. Another gain of having a well planned family is according to the participants that it is easier to take care of the family when the number of children is restricted. It will enable the parents to provide sufficient food and clothes, and it is indicated that if more funds per child are available the children's chances for going to school will increase.

Many of the ideas the participants have regarding family planning or contraceptive use seem to originate from community health workers, personnel at the health centres, and occasionally by a radio broadcast or by a drama group who perform in the villages. In order to have good family planning several participants plead for the use of contraceptives or for abstaining from sex for a certain period. The responsibility of the husband in this context is to either allow the woman to go on contraceptives, to go on contraceptives himself, to plan when to have children and how many, or to go for a vasectomy to the hospital. A vasectomy was for some men not an option, because it would lead to problems in case the woman afterwards decides that she wants to have more children. For some men it was also unclear or unknown how men could go for contraceptives or for a vasectomy.

5.3 Barriers at local level for obtaining essential basic conditions (V.)

Obtaining good health, practising good family planning methods, and going to the health centre are essentials for protecting the well-being of mothers and to practise safe motherhood. However, despite both men and women taking the responsibilities described in the last paragraph, still other factors are explained that might hinder a couple to obtain the basic conditions which are essential in safeguarding the lives of mothers.

5.3.1 Confusing values related to getting children (V.)

The men who participated in this study indicated that within the rural communities in Mangochi getting children is of major importance for a newly married couple. The family, being very involved, insists on children being born in a new marriage otherwise they would feel ashamed or even opt for a divorce. It is also possible that the family members will arrange the *fisi* (hyena) custom. Although some men say this customs is not performed anymore, others give indications that it is still occurring. The *fisi* custom is occasionally organised by the family members in order to 'clean up' the wife; another man is hired to have sex with the wife in the hope that the problem will disappear after the custom is performed. From this study it can not be concluded if the *fisi* custom is still practised nowadays because the custom is arranged in secrecy without the knowledge of the husband.

Furthermore a newly married couple is pressured to having children by the other community members. The other community members will gossip and make fun of both the husband and the wife if they remain childless for a longer period. The participants argued that in such scenarios the husband or the wife will 'search' for children somewhere else, meaning that they will have sex with other people. Like as the *fisi* custom, the main danger of this phenomenon is being infected with HIV which will destroy the family and increases the chances of a maternal death.

Men in rural Mangochi seem to be struggling with confusing values related to getting children. On the one hand the customs and the societal pressure on having children shapes the belief of men that having many children is beneficial and necessary. On the other hand they know that getting children is a risky event (pregnant woman being *wapakati* life and death) and they receive advises from health workers and radio broadcasts about the needs and benefits of limiting the number of children. One of the results of this discussion on the value of having children is that the participants in several focus group discussion indicated that within the villages there is a need that young girls are not getting married yet. They explained that some families are so eager at getting children in the family that they allow too young girls get married. Getting married in rural Mangochi is equal to getting children, and the participants indicated that too young girls are at a higher risk of dying from a maternal death.

Furthermore, young girls who get children are more likely to drop out of school and stay without education, which is believed to have a negative influence on the poverty levels in rural villages. Also a study from Magadi *et al* (2003) mentions that non-educated parents are less likely to sent their children to school, meaning that non-education is not only a consequence, but also a cause of poverty and lacking development.

5.3.2 Customs negatively influencing maternal health (V.)

Several other customs besides the *fisi* practise have a perceived negative influence on safe motherhood. The participants mentioned e.g. the *chokolo* (wife inheritance) custom and the *phululsa* (ash) customs as dangerous to the woman. These customs prescribe in one way or another that a woman has to sleep with a man other than her husband once the husband dies. A possible consequence would be to be infected with HIV which again would sincerely affect the health of the woman. Finally, some traditional customs result in the woman delivering at home or at the TBA's place. If the family wants to proof the father's ownership of the baby in the traditional way, then several female family members have to be present to do so. At the health centres this is not possible and not allowed; wherefore the family decides that the woman should not deliver at the health centre, thereby increasing the chances of a maternal death.

It must be mentioned that although the participants indicated that a few customs are threatening the health of mothers, not all the traditional customs are considered to be outdated and dangerous. Many participants mentioned explicitly that not all the customs have to be removed, and a few participants argued in favour of enhancing the traditional customs in order to promote safe motherhood.

5.3.3 Accessibility and quality of medical care (V.)

If people from a rural village in Mangochi district make sure that the pregnant woman is healthy and when are willing to go to the health centre for *sikelo* or delivery then, they still need to overcome other barriers. The distance to the health centres and the infrastructure within the district are explained by many participants as factors that hinder women in going to the health centre. Many villages are relatively far away (more than a two hour walk) from a health centre with maternity care. The participants explained that many people do not have a car or a bike available to them and in case of an emergency travelling to the health centre is done by using time-consuming transport means (Sibande & Hutter, 2011). Especially during the rain season it is difficult to move across the roads in the area which makes it even more difficult to reach a health centre in time. During the field studies some participants (in an interview and during a participant observation period) also indicated that because of the delay in travelling to the health centre, women die when giving birth literally next to the road.

The delay because of bad infrastructure and lacking transport means is a clear example of the second delay as described by Thaddeus and Maine (1994). In addition, also the third delay from the model of Thaddeus and Maine (1994) is mentioned by the men in this study as problematic. The third delay is related to receiving adequate medical care once arrived at the health centre. Several views given by the participants about the health centre and its personnel are explaining how a negative perception of the health centre can lead to home deliveries. Firstly, the health personnel is occasionally perceived as being rude and uncaring, and sometimes their lack of attention is believed to be the cause of a maternal death. Other community members are believed to be afraid of the health centre because they are not familiar with it. Some women are supposed to have fear of operations at the health centre and others are not in favour of going to the health centre because it is a place where people die.

5.4 Male involvement (IV. & VI.)

5.4.1 Husband responsible vs being excluded

As explained in the last paragraphs the husband can and should play an important part in ensuring that his wife is healthy and goes for *sikelo* and delivery to the health centre. The participants explained that the husband has certain responsibilities towards his wife once she is getting children. However, although men are (partly) responsible they are simultaneously also excluded from the process of getting children. In other words, the participants believe that the husband should be involved in order to prevent health risks, but on the other hand men are in multiple ways not allowed to be involved.

Most communities in Mangochi are living according to a matrilineal system. Within a matrilineal society the lineage within the family runs through the maternal side of the family. The man gets married into the family of the woman and most often lives with the family of the woman. This does however not mean that the woman has the authority in the family. The participants in this study indicated that once the man is getting married into the family he is the final decision-maker within his own new family. The man also has the main responsibility within the family; he is the main responsible one for making sure sufficient funds and food are available to the family.

Within the matrilineal society the children belong to the mother and the mother's family. The pregnancy also is explained by the participants to belong to the mother. During the pregnancy the authority within the family is shifted towards the mother. The husband only gets slightly involved during the pregnancy and time of delivery, and his responsibilities towards the pregnant woman are mainly restricted to providing sufficient and good quality food, taking over some heavy domestic works, being supportive and loving, not having extramarital sex and arranging the requirements for during the delivery. If the husband is not able to successfully perform these responsibilities the other community members will make fun of him or of his wife.

During the period around the delivery the responsibilities of the men are limited to escorting their wives to the health centre and staying close to the maternity ward in case new requirements have to be made. If waiting for the delivery takes longer the husband often goes home while the guardian (female family member) stays with the pregnant woman to take care of her. Men are culturally not accepted as guardian.

The men in this study explained that when their wives are in labour they were not allowed to attend. Most of the men are waiting outside of the delivery room or at home. The family members of both husband and wife, and the health personnel tell the husband that he is not allowed inside. Several participants on the one hand stated that they do not feel the need for attending the delivery. They argued that their culture prescribes men not to be present, that they do not want to be hinder the medical personnel in their work, and that the husband is represented by his mother, aunts or sisters. Multiple other participants on the other hand indicated that they actually would want to attend the delivery if they are given the chance. The benefit of the husband attending the delivery of his wife is according to the participants that:

- Attending the delivery shows love and support from the husband towards his wife, which a woman needs because going into labour is considered as a difficult and dangerous event.
- Attending the delivery enables the possibility for the father and his family to proof the father's ownership of the child. The participants argued that the possibility to perform this custom at the maternity wards will increase the number of deliveries conducted at health centre (which is perceived safer than at home or at the TBA's place).
- The experience of attending the delivery will help the husband to better understand the difficulties his wife is facing, which enhances the husband's willingness to reconsider family planning and contraceptive use (which is perceived as essential in order to improve maternal health).
- The experience of attending the delivery enables the husband to use his first-hand experiences to advice other men in his family or in his community. His arguments are considered to be much stronger because of his experience, which likewise allows him to give better advises related to safe motherhood.

As discussed earlier in the results chapter of this dissertation, there are other factors that contribute to a feeling of being excluded from pregnancy-related issues. E.g., after a successful delivery several participants indicate that the husband is still excluded. The first days the husband is supposed to sleep somewhere else when the mother and mother-in-law take care of his wife and new-born. The men in this study who discussed this custom, indicated that they would like to be present and take care of their wives, however they are not allowed to.

Additionally, men do not always receive the information they would like to receive when their wife is in labour or when she is pregnant. Even when questions are asked to the elderly family members concerning the well-being of the woman, the husband does not get all the answers.

Finally, in the unfortunate event of a maternal death, the husband has no authority about what will happen to his wife and to the children who are left behind. Because of the matrilineal society, in which children belong to the mother and to the mother's family, the children of the lost mother are taken care for by the parents of the diseased. The husband is only in exceptional cases (depending on the relationship with the family and his welfare) allowed to take care of his own children. The participants explained that they accept the custom; however some of them wished they could be more involved.

From this paragraph it becomes clear that men in rural Mangochi are trying to find their way between, on the one hand the need to take responsibility in order to protect the lives of their loved ones, and on the other hand not being allowed to take responsibility because of gender roles and traditional customs within the community.

Attending the delivery is explained by the health centre to not only cultural opposed, also practical constraints are connected to not being allowed to attend the delivery at the health centre. A health worker in a local maternity ward explained that men are not allowed to be present in order to protect the privacy of other women who likewise might are going into labour. The nurse explained that both husband and wife would feel embarrassed when the man would be present because the maternity wards are relatively small and because multiple deliveries are sometimes conducted in a similar room. In this way, the nurse explained, will a man not only see his own wife going into labour but also other women. This was assumed to be incorrect and unethical.

Important consideration in this discussion is men attending *sikelo* (antenatal care clinic). The participants stated the importance that women go for *sikelo.* The main gains of a woman attending *sikelo* are learning about the pregnancy and the danger signs, knowing what to prepare for regarding the delivery, and in case of physical complications the medical workers have the chance to detect and treat it in an early stage. A few men who participated in this study did however mention that men themselves should attend the *sikelo* in order to know more about safe motherhood. A health worker (among other health workers) explained that the health centre personnel tried to include men during the *sikelo* and to let them likewise hear the advices and warnings of the health workers. However, at the same health centre they did not see a man attending the *sikelo* for a very long time.

Earlier in this paragraph it is discussed how the participants explained that men are not receiving answers when they ask about a pregnancy-related issue and that the participants would like to receive more information related to maternal health. However, hardly any of them was willing to attend the *sikelo* himself, which shows that the willingness of men to attend the *sikelo* is not that strong among the participants. During the *sikelo* they would receive the wanted information and according to the health workers men would have been given a chance to participate. It might be possible that there is difference between the ideal behaviour of men, as stated by the participants in the field work, and the actual behaviour of men.

A discussion between a health worker and a few community members during a village meeting shows a small insight in the actual behaviour of husbands in the context of going to the *sikelo*. There seems to be a mismatch between what health workers and what patients believe. In the village meeting the men explained that they do not attend the *sikelo* because they are not allowed to attend by the health personnel, and because they have to take care of the other children at home when the mother is gone for *sikelo*. The health worker stated that they are willing to receive men at the *sikelo*. Female community members, who also attended the village meeting, reflected nevertheless that men are simply not interested and negligent towards joining the woman for *sikelo.* Important to realise is that the different insight just discussed, about ideal behaviour and actual behaviour, are derived from two different villages. The difference in the stated ideal behaviour and the explained actual behaviour might be case-sensitive, might be the result of the location effect, or might be a real existing difference between ideal and actual behaviour. However, this study did not reflect in-depth on this difference and further conclusion can not be drawn about this.

5.4.2 Obstacles to male involvement (VI.)

For many participants it can be concluded that the willingness of being involved as a man, in one way or another, exists strongly. As the list of responsibilities indicates, the men in this study were able to mention multiple ways of how men in rural Mangochi should be involved. Nevertheless, it is also explained that men need to be involved more and that some men in the communities of the participants are not involved at all.

Alongside the feeling of exclusion which is discussed in the last paragraph, other factors are explored which are seemingly influencing the actual involvement of men in maternal health. Poverty can lead to a husband not being able to perform the expected responsibilities, which consequently might lead to the husband being perceived as not caring and not involved. Some other male community members are perceived to really be not caring and negligent towards the well-being of their wives. Alcoholism and being cruel are mentioned as reasons for why men are negligent and not involved.

Furthermore, the participants explained several perceptions that together create an image that a woman who is getting a child is ‘dangerous’ for the man, which leads to men keeping distant from their wives during this period. Men can die if they resume sex too quick after the delivery. If resuming too quick, a man can be infected with a disease called *chinyera,* which can lead to physical problems and even death. In addition, other customs prescribe the husband and the wife to be distant from each other during the pregnancy, in order to prevent the man being exposed to dangerous powers. Not having a separate bathing spot, not eating food which is saved in the lap of a pregnant woman, and pregnant women not stepping over the legs of the man when he sits on the ground, can lead to physical problems for the man (such as impotence, paralysed, chronic headaches). Where earlier is discussed

how men have to stay close to their pregnant wives for when help is required, at the same time they have to stay distant in order to protect their own lives.

Finally, it is explained that a lack of information might influence men not being involved. The willingness of men to take responsibility and to be involved might exist, however the knowledge on how to do so is missing. Some community members do not know what happens at the health centre and therefore do not go to the health centre. Firstly, this means that the woman will have to deliver at home, and that information provided at the health centre regarding safe motherhood and family planning does not reach these community members. Secondly, some men in this study explained that they would like to know more about what is happening to their wife during pregnancy, delivery and the post-natal period. However, because they do not get included and do not receive information regarding their wife, they feel left out and unknowing. Not having the knowledge about what exactly the dangers and risks are and therefore not precisely knowing what to do in case complications arise, is then again mentioned as a cause of a maternal death. This process seems to be a vicious circle in which being the man excluded from information leads eventually to a more outside position for the man. This vicious circle is shown in figure 5.2 and illustrates how the process moves from being excluded, to not receiving information, to not knowing what to do, to not taking responsibility, to not being involved, to further exclusion

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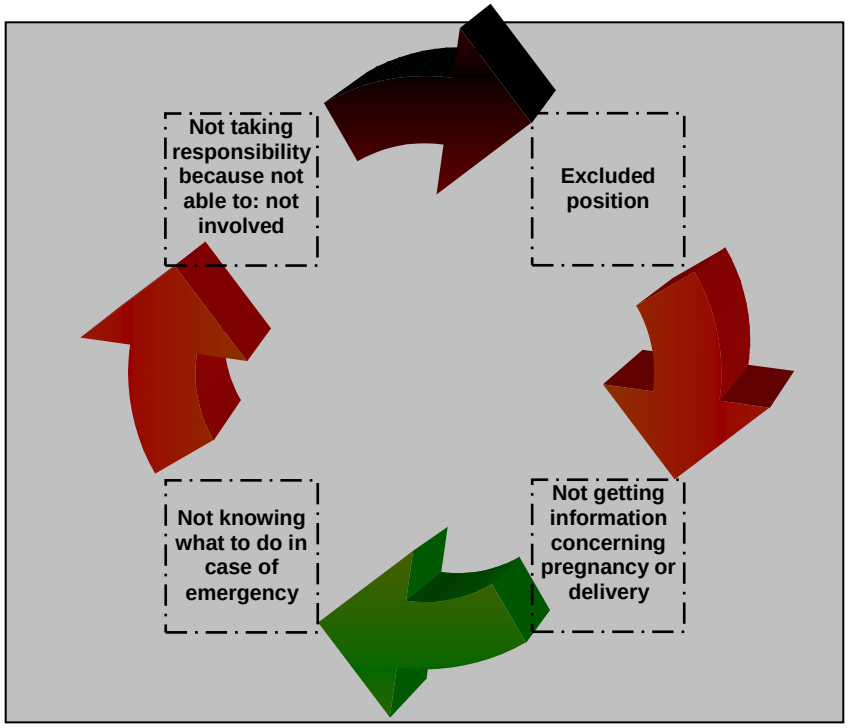
Figure 5.2: Interaction between exclusion of men and having knowledge about safe motherhood



5.4.3 Shared responsibility (VII.)

As discussed in the last paragraphs both men and women have responsibilities that are believed to safeguard the lives of future mothers. Moreover, many of the responsibilities for men which are indicated are focused on sharing responsibilities. The main idea of these responsibilities is that the woman does not have to face the pregnancy alone. Taking over heavy domestic work, taking care of the other children, arranging good quality food, arranging the necessities for the pregnancy and delivery, and being nice and loving to the woman are responsibilities aimed at supporting the woman. Also the participants, who argued that it would be beneficial if the husband attends the delivery of his wife, argued that this is a form of showing love and support to the woman, it shows that you are sharing the responsibility of getting children.

It is explained, that if a woman is facing pregnancy and delivery alone, e.g. through the husband being an alcoholic or through having a pregnancy from the 'bush' (by casual or extramarital sex), then she is expected to face many difficulties and she is perceived to be at higher risk of a maternal death. Supporting the woman is perceived as essential so that has the chance to be healthy and well prepared before she goes into labour, before the risky event of childbirth starts.

Other participants go a bit further in their sharing responsibilities ideas than others. Some of them indicate that men have to escort their wives to *sikelo* or to the delivery, and have to attend the *sikelo* themselves. Others mentioned that besides men should allow their wives to go on contraceptives, men themselves should go on contraceptives. The main idea remains that shared responsibility will increase the chances of a woman to be healthy and to survive the event of getting children.

Where the delivery is named as and compared to a 'sickness' (*ulwere)*, sharing responsibility when the woman is ill is also equal to sharing responsibility when the woman is pregnant. The participants explained that normally when the woman is ill the husband takes care of her and takes over the responsibilities in the household. Likewise as with being pregnant, when a woman is ill she might be facing serious complications or even death. If a man does not take care of his wife, the result, either when she is ill or when she is pregnant, might be death.

Shared responsibility seems to be partly opposing the idea that getting children is a women's business and that the pregnancy belongs to the mother and her family. Sharing responsibilities means that the man in one way or another has to be involved; therefore it needs some degree of inclusion. As explained by the participants, male involvement is challenged by a few obstacles that need to be overcome. Sharing responsibilities is likewise challenged by similar obstacles, but still perceived as beneficial.

5.5 Social spread of ideas and advises (VIII.)

Alongside sharing responsibility and making sure to go to the health centre for *sikelo* and delivery, the participants explained that they need good information in order to improve maternal health. A lack of knowledge among men seems to be central to maternal health problems and male involvement problems. Firstly, because of the lack of knowledge men are sometimes the cause of a maternal death. The participants explained that a man who does not know what to do in case of an emergency or in case he is not prepared for an early delivery, might be considered uncaring and cruel.

Secondly, a man who does not know what to do in case of an emergency will eventually face further exclusion from safe motherhood practices. As explained in paragraph 5.3 this vicious circle leads to a confused and unknowning husband who might not be skilled enough to provide proper support in case of an emergency. As a consequence of not all men knowing how to support their wives, men are keepen aside the trajectory of getting children which leads to receiving less information and even further exclusion.

Thirdly, the participants explored many different sources that influenced their perceptions about how to behave and how not. Family members, friends, village leaders, community health workers, NGO employees, health personnel, the media, they all shape the perceptions of men to a certain amount. Some participants even indicated that this influence from different sources shapes the perceptions of men negatively. Wrong advices from elderly family leaders are explained as a cause for some couples to still performing dangerous customs. Because in some families most of the information comes solely from the other family members, it is very important to have sufficient knowledge of ‘good’ practices towards maternal health within the families.

For future interventions that try to improve maternal health it is therefore important to focus on the spread of information to families and men as well. A few participants explained that if one or two persons within a family or a group of friends learn about safe motherhood, then they are better able to spread what they have learned and convince the other family members to practise safe motherhood. Also a study of Soldan (2004) conducted in rural Mangochi showed that social groups within the community are one of the main canals through which ideas about sexual behaviour and fertility are obtained. Social groups might be either the family, a group of friends, a religious group, a choir or a football / netball group. The participants in the research of Soldan (2004) indicated to be more comfortable to speak about sexual and reproductive health with people from their own sex and their own age. Both women and men in the study of Soldan (2004) explained that they were encouraged by people from within their social group to e.g. limit the number of children or to use contraceptives.

For men the perceived sexual or reproductive behaviour of other men seemed to be of major influence on the individual behaviour. Soldan (2004) argues that if men realise that other in their village are practising some ideas or methods of sexual and reproductive health, they might feel more compelled to do this as well. So besides talking and learning about ideas related to sexual and reproductive behaviour (social learning theories) the ideas from other group members also actually influence the individual behaviour or decision-making (social influence theories). The author concluded that social groups within rural communities in Mangochi provided a strong potential setting, in which interactions can lead to the spread of new ideas, including new ideas about sexual and reproductive health.

Family planning or safe motherhood programs can "benefit from creating bridges that link the formal channels with the the informal gossip networks in the group". Both this study and the study of Soldan (2004) show that the influence from other community members on how an individual perceives safe motherhood is of major importance. The participants in this study themselves indicated that they needed a forum in which they could discuss family planning and safe motherhood issues. This could either be an advisor moving from door-to-door, the media, or a role model who shows how to behave best. However, multiple participants argued for the use of male clubs. Within the male clubs men would be able to talk to each other and to discourage promixious behaviour of other group members. The men will bring the ideas and discussions from the male clubs home, which allows them to share and discuss the same ideas within their own family or circle of friends. Male clubs will address the urge for being more involved as a husband and it will address the knowledge gap that occasionally leads to complications. Furthermore, according to guidelines of the UNFPA (2005) and the SMI (mentioned in chapter two) will empowerment of men in sexual and reproductive health increase the chances that the men will discuss these issues with their partners, therefore likewise empowering women more.

Durig the field work and during one of the feedback meetings important comment against male clubs were mentioned. Financing of the participants and sustainability of male clubs were questioned. It might be difficult to get men to participate if they will not get paid. One of the participants mentioned by-laws from the village leader as a solution for the non-attendance of possible male clubs. Secondly, both Soldan (2004) as members of the DEC during the feedback meeting arged that if information is shared through social groups, it is really important that this will be good quality information. A network is necessary to enable the interaction and cross-checking of the different male clubs. With the participation of community health workers or with NGO employers, a network might be build which also considers training and spread of information to possible male club leaders.

5.6 Reflection on the study

The different methods used in this study all had their advantages. The information gained from the different methods both overlaps with issues found by other methods, and highlights specific issues which are solely discovered by a single method. The participant observation gave me an excellent first insight in the life of rural communities in Mangochi, Malawi. It helped to understand the context of the research and highlighted the importance to pay attention to the diversity of people within a single village. It further provided me information about e.g. the accessibility of rural villages in Mangochi, the importance of family for individuals, the role of a (group) village head in the village, the gender specific roles within the community, and the primary activities of community members.

In the focus group discussions much information was obtained related to the perceptions of men about e.g. the perceived ideal behaviour of both men and women, about the perceived risks and dangers associated with getting children, and about possible solutions or improvements in maternal health. Finally in the in-depth interviews the personal feelings of men associated with getting children, with taking care of the wife during pregnancy, delivery and post-natal, and with the loss of a wife due to a pregnancy- or childbirth-related causes, were expressed and discussed. Especially in the in-depth interviews it can be discovered that many participants are very willing to be involved in maternal health.

A major limitation of this study is that many perceptions about ideal behaviour and male involvement are focused on what men in general should do. When discussing the risk factors of maternal deaths, the participants mainly referred to other men or other community members. They argued that some men e.g. have extramarital sex, beat their wives, are alcoholics, and are not caring about their wives; therefore (among other reasons) maternal deaths are still occurring in the village. Very few participants in both the focus group discussions and the in-depth interviews reflected on their own behaviour or their own role as problematic. The few participants that did see their own negative influence, argued that they were not able to provide sufficient food and material for during the pregnancy. Further not one of the participants argued himself to behave in such a way that the health of his wife is harmed.

This observation on the one hand makes sense, especially in the focus group discussions, in which participants will not tell everything about themselves. On the other hand it raises questions about the truth of these perceptions. Are those ‘other’ men really beating their wives or sleeping with other women, and did women really die because of such reasons, or is this more a gossip or a assumption made by the community members? Secondly, it raises the question of how many men are then not caring and negligent towards their wives? In one of the discussion groups the men argued about if there are a lot of men in the community involved or not, some saying there are just a few, other stating that there are many. And are the men who are not caring and negligent the minority or exception? Are maternal deaths only occurring in families of those exceptions? Or are the participants

in this study exceptional? Do the participants have different views than most other community members, those who are maybe not willing to participate in a research?

Either way, policies and interventions have to understand that the perceptions of the participants in this study do not represent the whole population. The magnitude of the problem and the magnitude of male involvement are not measured by this study. This study focuses on the perceptions of men from different background, in order to explore as many views and opinions as there are participants. It provides a clear picture of the situation on the ground and gives important suggestions for future interventions or research. Also the Community-Based Safe Motherhood project would gain by using insights from this study. Not too one-on-one copy ideas or suggestions from the study, but as framework to better understand maternal health and male involvement in maternal health in rural areas in Mangochi district.

6. Conclusion

Men living in the rural villages in Mangochi, Malawi, can play an important role towards improving maternal health. As argued by the men who participated in this study themselves, men's role as supportive and loving husband who takes his responsibility when needed can mean the difference between life and death. However, within the local context of the rural village they have to deal with different conflicting values and expectations.

On the hand they are expected to get married and get children once arrived in adulthood. Getting married is equal to getting children which is equal to becoming an adult. On the other hand they experience the risks and dangers for a woman which is associated with getting children. Health, development and education become important issues in relation to getting children because of the spread of safe motherhood ideas and advices from community health workers, local government officials, NGOs, and safe motherhood advisors.

Furthermore did the participants reflect on the interaction between sharing responsibility and being more involved as a husband on the one side, and gender roles which seem to exclude men from the women's business of getting children on the other side. Men indicate it is a difficult balance between those different values, and every individual in the community copes differently with the different expectations. The amount and the manner of male involvement is mainly influenced by the stand individuals have within this context and its ability to perform intended behaviour. Many factors at household and community level are explained as obstacles towards actual male involvement, such as poverty, lack of knowledge on how to be involved, and alcoholism among men.

How background characteristics of an individual are influencing intentions towards male involvement and how the intentions of men are translated into actual male involvement can not be concluded from this research. Some fellow community members are described by the participants as negligent and not caring towards their wives, especially during pregnancy, delivery and post-natal. For a better understanding of how and in which manner individuals are actually performing male involvement in practise more observation and research is needed. The factors contributing to why some men are negligent and others are more in favour of being involved should be part of future research in order understand the broader picture of male involvement.

This study aimed at exploring what the perceptions are of men about maternal health and male involvement in maternal health. Men who participated in this study were asked to provide ideas and thoughts about how, if necessary, men should be (more) involved. The main idea the participants explained which would be beneficial to increase male involvement is the spread of *uchembere wabwino* (safe motherhood) advises. The use of male clubs within the village is often mentioned as a possible forum which can help to reach this aim. More research on the content and the implementation of such a male club is however necessary. A participatory approach will be beneficial in a research which tries to find out how the ideas of the participants in this study can be implemented in an intervention. Including male community members during the research process of such a participatory research, means that actual male involvement already started during the research process.

From the feedback meetings with DEC and community members several considerations regarding the implementation of male clubs are discussed. At the DEC meeting the first question was “how can this actually be implemented? Because we hear so much research which explains what the problem is”. At the DEC meeting some attendants argued that if male clubs want to be implemented a special task force is needed to do so. They continued that the thread of creating another task force is that it might conflict with or confuse other organisations and projects that work in the field. The network of existing organisations and projects should be well explored in a possible future intervention.

Finally, during the feedback meetings some attendants stated that if male clubs or another intervention is implemented, serious attention has to be given to the network between the separate male clubs in the entire area. The ADCs, VDCs and other village leaders, and an organisation such as the Community-Based Safe Motherhood project, should have an important role in this network. They need to ensure that the information which is shared and discussed in male clubs is good quality information. What the information will be needs considerable attention, as one of the attendants of a feedback meeting questioned: “who has the truth”. With the presence of a diverse population in rural Mangochi (with a variety of ethnicity, religion, and education levels), the views, perceptions and customs of whom will improve maternal health? Any intervention which tries to involve men in maternal health should therefore be based on discussion and mutual sharing of ideas in which all community members are given a voice. Including all men in maternal health and family planning is indicated by both community members and international literature to be essential in order to protect the lives of mothers. It must however not be concluded that the needed inclusion in maternal health and family planning interventions is limited to men only. The inclusion of all community members and stakeholders, at local, district and national level, is necessary to really tackle the problem and to improve the lives of mothers.

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