during the birth and afterwards. However, this study found a clear gap between such expectations and men's own experiences. Many fathers felt that attending childbirth pulled them out of their comfort zone and thus, out of their ability to control. The study also found that fathers found the birth room quite stressful, particularly at times of crisis. As a result, the birthing women were worrying about their partners instead of focusing on themselves. Even where the practice has become accepted, men still feel out of place in the delivery-room and may even have a negative impact on the experience of birthing for the woman.

## 8.10 Conclusions

This chapter has clearly identified married men as women's intimate partners in the process of *uchembere* (motherhood). However, it has highlighted that although men are considered partners, they are only expected to take a supportive role. Married men are allowed to acquire a minimal and selective form of maternal knowledge, enough to let them perform that supportive role. Their roles during [illegible]ustrated in a number of ways. Men are expected to perform the role of [illegible]rovider. It is the expectation of the spouse and the entire community [illegible]intain 'sex taboo' periods during pregnancy if necessary. Men are [illegible]tional gatekeepers of maternal and social ideals. Therefore, as elder[illegible]ands, their prompt decisions can facilitate the access of their spou[illegible]oductive health services. Men as heads of households and decision makers can also support and enable their wives to follow the recommended maternal health counsel. However, the majority view among men and women is that men should not be allowed access to the feminine space called *chikuta* (birthing place and birthing knowledge sphere). Their presence in such spaces are seen as an intrusion on the privacy and birthing experience of women and as potentially undermining gendered knowledge domains and power.



It is my contention that despite the insistence of health care workers, the presence of men in the labour ward is not perceived by a husband in Chilooko as being at the core of showing care or ensuring the safety of the woman during her pregnancy and labour. Male involvement in childbearing involves a great deal more.

# CHAPTER NINE: CONCLUSIONS AND RECOMMENDATIONS

## 9.1 Introduction

In this study I set out to investigate men's perceptions of their role in reproductive and maternal health. Although conventional public health literature identifies the importance of male involvement in reproductive and maternal health activities, male involvement has not been elaborated in the maternal health policy in Malawi. This study, therefore, focused on understanding the relationship between local constructions of masculinity, fatherhood and reproductive health. The attempt was to define the local and gendered male roles in pregnancy and childbirth activities and spaces. Using a qualitative research design of investigation and analysis, the study arrived at several conclusions.

### The main arguments of the thesis

Using social constructionism as a framework, men's gendered practices were investigated as social products of unceasing interactions among men and women within established social structures and cultural settings. This study has shown that in Chilooko men's gendered roles are socially constructed and enacted in almost a replica of the classical dialectical process of externalization, objectivation and internalization elaborated by Berger and Luckman (1966). Men's gendered practices in everyday life are tied to the importance of their performance of agricultural, domestic and sexual activities. The secondary socialisation obtained by boys in the *Nyau* secret society or exposure to Christian teaching and doctrines also help to shape the construction and performance of these gendered practices. The study also adds to the nuanced understanding of context-specific dominant masculine ideals of males: as bread-winner in the household, hyper-heterosexuality, fertility and being hard-working among many others. It has been shown in the study that among the Chewa in Chilooko, masculinity is both constructed and experienced as a reality or truth. Masculinity is seen as something that men do or perform. In Chilooko, men "do" masculinity through a whole spectrum of related gendered roles in sexuality, marriage, in parenthood and through communication on reproductive and maternal issues with their spouses. In resonance with other studies, the thesis also shows that the local construction of masculinity is complex and shifts from one setting to another. A married man can, for instance take on most of the hegemonic expectations, power and dividends of manhood if he, his wife and children reside with his matrikin – where the

husband also has authority as a brother or uncle of his sisters (avunculate). If he lives with his wife's matrikin, his manhood is subordinate to that of his wife's maternal uncle or brother. For an individual man the hegemony of a particular masculine ideal can change from one setting to another. For example a manly hardworking married man may not be fertile. As such his manliness might be subordinated to those of men who are capable of impregnating a woman. This study thus shows that there are subordinate ways of being a man – even if one is heterosexually "manly". A man who disrupts local culturally informed ideas about manhood – e.g. by not adhering to "traditional" ways of getting married - arguably also affects the dominant form of manliness. At the same time the study shows that elaborate measures (e.g. the intervention of kin and the payment of a fine) are sometimes put in place to reconstitute subordinate masculinities into "proper" manhood. This thesis shows that, through the formalisation of an ideal marriage in Chilooko, hegemonic ideas of what it is to be manly and to be married can be validated. In this regard the community co-construct an ideal marriage and define what being a good married man is. The various constructions of masculinity discussed, tend to illustrate that its constant self-presentation occurs throughout every social interaction in which a man is involved. This ongoing refining or re-creation is a defining feature of masculinity. This re-invention occurs in the household, at work in the garden, in meetings with other community members and in all other social settings.



In connection with reproductive and maternal health, my study has highlighted that men in Chilooko have always been involved in women's pregnancy and child bearing experiences. However, men expressed resistance to new maternal health policy requirements that call for the presence of men at childbirth. In a sense, men avoid being involved in maternal and reproductive activities that will subordinate their masculine identity. Masculine constructions, practices and role expectations among men to some extent hinder them from taking up certain roles or limit them to certain activities of maternal importance. The underlying goal of this performance is the assertion of power and dominance which has been discussed as "hegemonic masculinity".

The social constructionist framework also confirms that the ideas of Berger & Luckmann (1966), regarding the process of the production of reality, are still useful and pivotal in the study of the performance of masculinities as real experiences, and not just abstracts. We can still operationalize the construction of reality through externalization, objectivation and internalization. The construction of multiple masculinities demonstrates that in Chilooko,

men can live in multiple realities. Through initiation (*Nyau* and *Chinamwali*) certain masculine constructs are internalized while patterned practices of masculinity are externalized. Marriage enables the masculine constructs of sexuality and industriousness to be fulfilled or objectified. The thesis shows that masculinity is an important lens through which we can understand fatherhood and the paternal roles men are willing to accept, from the time they contribute to conception through to the birth and socialisation of their children in Chilooko.

The study shows that pregnancy is regarded as a liminal state, or even as a "sickness". Male involvement in pregnancy means the man should take over the physically taxing but routine household chores such as drawing water, fetching firewood and, if necessary, cooking. If they do so, they still remain manly in the eyes of the community. Societal expectations of manhood can be flexible. A man who helps his wife at home (when she is not pregnant) can be constructed as "hen pecked", yet another who does exactly the same will still be a "real" man. This equivocation in expected gender practices among men underscores the specificity of the construction and "enacting" of hegemonic masculinities in different cultural contexts. It validates the relevance of the concept of complicity which in this case encapsulates nurturing masculinities or "caring masculinities". It emphasises men's emotional closeness to their pregnant spouse, their children and a man's sharing of the pleasures and effort of caregiving with mothers. As stated earlier (see 2.6) the desire to express or demonstrate masculinity can also be an obstacle that prevents some men from taking up nurturing parental roles. Hegemonic masculinity is tied to manliness most significantly as a demonstration of hyper heterosexuality and the ability to produce a child, not as the conduct of caretaking and nurturing.

Men construct their involvement in reproductive and maternal health matters within a gendered framework influenced to a large extent by commonly-held ideas and practices of a matrilineal Chewa grouping. This is done in spite of the continued pressure exerted on the matrilineal system from westernised education, Christianity and governance. This study demonstrates that hegemonic masculinity, though variously constructed in different social contexts like Chilooko, is still a a useful analytical tool. The thesis argues that, in the absence of a thorough exploration of the ideas and practices of the men who are to be involved in this regard, the public health policy call on men in Malawi is ambiguous and ill-informed. This

study recommends that a wider study is required in Chilooko to confirm and widen the understanding of fatherhood and masculinity.

## 9.2 Local Constructions of Masculinity as A Basis for Men's Sexual and Reproductive Health Behaviour

This research shows that the processes and practices men engage in as individuals also position and construct gender differences. Ideally, a 'real' man is expected to embody various constructions and rigorously enact or practice them when and if social circumstances demand it. The construction of masculinity in the research area refers to a wide category of social life and landscapes of knowledge. The study showed that masculinities are constructed within the context of a matrilineal system that is changing due to the influence of Christian and westernised social ideals and under an education system based on a British model.

All constructions of masculinity have flaws, they lack complete control and they may be disrupted or even disrupt themselves. It therefore clearly emerges from the study that manhood or manliness cannot be seen as a distinct static and single category, it will vary with individuals. However, it has been observed in the study that there exists an 'ideal' way of being a man: a construction of masculinity also closely connected to sexuality and reproduction.



## 9.3 Male Heterosexuality, Masculinity and Matrilineal Marriage

The study has attempted to show that male heterosexuality is a framework or script: adolescents are socialised into it through, e.g. *Nyau* and are expected to enact it from then on. Constructions of masculinity emphasise dimensions of male heterosexuality such as male sexual performance and fertility. In Chilooko male sexuality is ideally to be channelled through the formation of marriages and the subsequent practices of fatherhood or parenting. Marriage is seen as the ideal even though it is not always the practice. The study also illustrates that the Chewa of Chilooko have a strong sense of their own way of life, their "traditional" ideals and their own rituals and sanctions regarding marriage. Marriage is a special type of social and legal contract governed by well-articulated principles. This research shows that the people of Chilooko still largely adhere to their "traditional" marriage procedures (even if it is sometimes combined with a "church' wedding) notwithstanding external social pressures. It has been shown in the study that male heterosexuality is

sometimes perceived as hasty and irresponsible. When young men are supposedly "sexually driven" they get involved in *Kubachikumu* (assisted theft) and *Kulowana* (matrilocal residence without the necessary sanctions). Legitimacy is however later restored.

## 9.4 Men's Constructions and Practices of Fatherhood

This thesis has also explored dimensions and involvement of males in reproduction and the maternal well-being of their spouses. An attempt was made to elucidate the involvement of married men in pregnancy. This is one predicator of their level of commitment in caring for their offspring and this research hinged on how men understood fatherhood and the ways in which it was constructed, practised and experienced in pregnancy and childbirth. Pregnancy is an important stage in the life of every woman. There are several Chichewa terms used to describe the state of being pregnant. A husband treats his wife with care and circumspection, as befits someone in a liminal state.

The quest to understand who the father is, and what fatherhood entails, brought into play local terminology used to describe men who have been able to make their spouses pregnant and take it to full term. *Bambo* and *Ndoda* were the two local terms used to designate a "father". There was not consensus on what best and most easily designated a man who has fathered a child. In fact, there was a degree of indifference towards men in the reproductive cycle of life compared with women who have a stable role and a well-known term *ntchembere* from the time they start bearing children. *Uchembere* as a term was constructed as a gender neutral term but it is much gendered in practice. Therefore, although men were recognised as *ntchembere* they are expected only to assume a supportive role.

This research echoes earlier studies in which the notion of fatherhood is quite variable and dependent on social circumstances that are not only limited to their biological connection as the progenitor. It has also shown that the concept of fatherhood is very current in reproductive discourse but for different reasons. This study found that fatherhood was perceived as a complementary social role to motherhood.

Men are expected to "take care" of their pregnant wives, in several ways. It entails steering clear of sexual taboos. The failure of married men to observe sexual taboos during their wife's pregnancy was perceived as a major contributor to maternal and infant mortality. Besides doing household chores and ensuring nutritional or food security, a married man was

also expected to oversee the overall health status of the woman. As heads of households men should provide guidance and ensure not only the financial well-being of their family members but also their healthy daily living. Men are expected to take the lead in sourcing the relevant information that can boost the health of their spouses during pregnancy or they must seek advice to pass on to her. The current study shows that it is incumbent on the father to socialise his children, especially boys, in preparation for later marriage. Based on the way he has raised his children, a father is applauded or commended by the people of his community or village. A man acquires a good reputation if he manages to inculcate restraint in his children, if they do not transgress the norms of the community, and/or if he sends them to get a formal education and supports them until they have succeeded in this.

## 9.5 Spousal Communication Habits on Reproductive and Maternal Health Matters

This study also explored the prevailing practices and ideas related to knowledge-sharing about reproductive and maternal health matters among couples. Men and women are excluded from each other's domains because these are gendered. This gendered exclusion from particular social spaces reinforces the discrepancy in reproductive health knowledge between men and women. The difference is further exacerbated by the unequal access to reproductive health and pregnancy education offered by a health professional at antenatal care sessions. Although there are three sources from which men and women can obtain reproductive and maternal health information, antenatal care sessions are the major source. But this research has established that verbal and candid spousal communication, especially on reproductive matters, has yet to become a norm. Although men confess to knowing very little about maternal health during pregnancy and birthing, they also express indifference to the few possible opportunities of obtaining such information. Among men, communication on reproductive health information only happens in situations of joking, or when there is a pressing personal need for a solution. This research shows that it is still possible for men to learn from their spouses and peers if these resources are properly exploited.



## 9.6 Men's Knowledge of Women's Reproductive and Maternal Health Risks

The research scrutinised the role of masculinities in reproductive health, especially how men may contribute to changing current poor maternal outcomes and/or how they can effectively contribute to solutions. A part of this objective was the exploration of men's perceptions of the public health clamour for the involvement of men in events surrounding pregnancy. It

was noted that the social relations in the home, as well as cultural ideologies in the community, posed challenges to the health system and public health officials in Malawi. The study found evidence to suggest resentment among a significant number of pregnant women towards the treatment they get and the quality of service they received at the public health facilities. In response, there is an increasing tendency among pregnant women to deliver at home under the care of traditional birth attendants.

However, the study indicates that as gatekeepers, men have the power to determine when a woman will be allowed to leave home or if she will have to continue to carry out certain household activities during pregnancy. Making resources available to the spouse ensures that she is able to attend reproductive health services. Men are considered indispensable in women's birth preparedness. Women expected their husbands to provide the resources and articles necessary for birth –sheets, blankets, baby paraphernalia etc. The study also established that men's financial unpreparedness, disinterest or inability to carry out household chores compromised the extent to which women could heed maternal counsel.

The majority view among men and women is that males should not enter or intrude on the gendered space of birthing, called *chikuta*. Men who did so found the experience embarrassing and disconcerting. They did not feel that it contributed in any way to the health outcome for their birthing wives – neither did the women.



## 9.7 Recommendations

1. This research cannot be extrapolated to the general population in Ntchisi but it is a good starting point for understanding the responses of Chichewa speaking men to reproductive and maternal health matters. More in-depth research in this regard is recommended.

2. This research has shown that men have a limited biomedical knowledge of reproductive and maternal health and it is a struggle to get them to access antenatal care sessions where such knowledge is disseminated. There is need for community and male-led knowledge-sharing campaigns to improve their gaps in knowledge.

3. There is a need for further and broader research on the construction of fatherhood and masculinity in Malawi so that public health policy on reproductive and maternal health can be culturally informed.

4. The research also shows that local people do not agree with or are resentful towards public health policies that seem to deliberately disregard locally held beliefs and 'traditions' in favour of 'western' ideals. It is recommended that before policies from international conventions and agreements are implemented in the local context, thorough research needs to be done to gauge their acceptability.

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**APPINDICES**

**APPENDIX A: CONSENT FORM**

I am ***Phillip Klemens Kapulula*** a student from the University of the Western Cape in South Africa. In collaboration with the Ministry of Health and Population, I am carrying out a study entitled,

**"The role of men in promoting women's reproductive and maternal health in a matrilineal marriage system in Malawi: The case of Ntchisi District".**

The aim of the study is to investigate social and cultural issues that shape or influence the perception of fatherhood among men. It will among other things attempt to investigate the knowledge of men on women's reproductive health, examine men's knowledge on maternal health risks, explore men's knowledge on the extent of good parenthood, probe men's preference on parity and family planning and enquire coping mechanisms for a denied access to family planning by married women.



The study is earmarking married men and women who are willing to inform the investigator on the issues just explained. People have the freedom to take part in the study and express their knowledge on these issues. Participation or lack of it has no relationship whatsoever to one's access to health services. The study is offering nothing in exchange for your participating in a discussion or answering questions. Information that a participant voluntarily wishes to share is welcome and will be kept confidentially to inform the research. Even for those who accept to take part have the freedom to withhold answers or completely stop the interview at any point if they so wish. In order to capture all ideas discussed, I wish to ask for permission to record but the recording will not be used for any other purposes save that of this research and after making a full transcript, the information will be destroyed. You will not be required to mention names so that everyone remains anonymous.

We/I agree to take part,

……,

**Signature/Finger print/Verbal consent given.**

## APPENDIX B: FOCUS GROUP DISCUSSION GUIDE FOR MEN.

***The role of men in promoting women's reproductive and maternal health in a matrilineal marriage system in Malawi: The case of Ntchisi District.***

### A. MEN'S KNOWLEDGE ON WOMEN'S REPRODUCTIVE HEALTH

1. What do we know of motherhood (*uchembere)*?
2. Are men supposed to know what their wives go through to bear a child?
3. What can they do to help their wives safely go through this process?
4. Should men get involved in women's reproductive affairs?
5. Do we as men have knowledge of our own reproductive health?
    a. Follow each question with a probe for clarity.

### B. MEN'S KNOWLEDGE OF WOMEN'S MATERNAL RISKS

1. Have any women in this village died during or after child bearing?
2. What could be the reasons leading to such death?
    a. Probe for : delays to seek care, availability of antenatal services, role of culture, beliefs
    b. What do husbands do to help their wives avoid these problems
3. Traditionally, what do husbands do to ensure the safety of their wives in child delivery?
4. How are husbands whose wives die due to child birth treated in this village?



### C. MENS KNOWLEDGE AND PRACTICES RELATED TO FATHERHOOD

1. Who do you consider to be a real man in this village?
2. What do you consider to be the practice of good fatherhood in this village?
    a. What is good fatherhood (*uzibambo wabwino*)
    b. What are the attributes of a good father?
    c. What is the role of good fatherhood in pregnancy and after child delivery?
    d. How does good fatherhood relate to your understanding of masculinity (*uchamuna*)?
        i. What does fathering a child entail?
        ii. What role should men take in raising children

## D. MEN'S PREFERENCE ON NUMBER OF CHILDREN

1. How do you decide how many children you want to have in a marriage?
2. Whose suggestion should carry more authority in deciding how many children to bear?
3. How do you make sure that you only have the right number of children?
4. How do you ensure the health of your wife to bear you these children?
5. What is the best length of time to wait before fathering another child?
6. Who decides on the length of the period?
7. What role do you play to make sure you have the right number of children

## APPENDIX C: KEY INFORMANT/INDIVIDUAL IN-DEPTH INTERVIEW GUIDE

***The role of men in promoting women's reproductive and maternal health in a matrilineal marriage system in Malawi: The case of Ntchisi District.***

### A. MENS KNOWLEDGE AND PRACTICES RELATED TO FATHERHOOD

1) What do you expect men to do to be considered real men?
2) What are real men expected to do when they marry?
3) How does uxoricality (Chikamwini) influence the perception and practice of masculinity (*uchamuna*)?
4) What do you understand of fatherhood (uzibambo)?
5) Should married men be involved in motherhood issues?
    a. How should they be involved?
    b. Should men discuss reproductive issues?
    c. Do men discuss with their spouses?
    d. How should real men relate with their wives?
    e. What role should men take in raising children?

### B. MEN'S KNOWLEDGE OF WOMEN'S MATERNAL RISKS

1. What problems do women experience during and after child delivery here?
2. What do you think are the causes of such problems?
3. Do you think men have any role to play in avoiding or reducing such problems?
    a. How could men help in solving these problems

### C. MEN AND WOMEN'S REPRODUCTIVE HEALTH

1. What do you know about motherhood?
2. How do you get information on motherhood?
    a. Where do men get information about their role in child bearing?
3. Are men supposed to know what their wives go through to bear a child?
4. Should men be involved in child bearing issues at all? Explain.

**D. MEN'S PREFERENCE ON NUMBER OF CHILDREN**

1. How do you make sure that you only have the right number of children?
2. How do you ensure the health of your wife to bear you these children?
3. Who should make the decision on the number of children?
4. What factors do you consider to help you decide the number children?

## APPENDIX D: ETHICAL APPROVAL BY MINISTRY OF HEALTH MALAWI

Telephone: + 265 789 400
Facsimile: + 265 789 431
e-mail doccentre@malawi.net
**All Communications should be addressed to:**
**The Secretary for Health and Population**

*In reply please quote No. MED/4/36c*
MINISTRY OF HEALTH
P.O. BOX 30377
LILONGWE 3
MALAWI

17th January, 2012

**Phillip Kapulula**
University of Western Cape, RSA

**Dear Sir/Madam,**

**RE: Protocol # 974: The role of men in promoting women's reproductive and maternal health in matrilineal marriage system in Malawi: The case of Ntchisi district**

Thank you for the above titled proposal that you submitted to the National Health Sciences Research Committee (NHSRC) for review. Please be advised that the NHSRC has **reviewed** and **approved** your application to conduct the above titled study.

- **APPROVAL NUMBER : NHSRC # 974**
  The above details should be used on all correspondence, consent forms and documents as appropriate.
- **APPROVAL DATE : 17/01/12**
- **EXPIRATION DATE** :This approval expires **on 16/01/2013**
  After this date, this project may only continue upon renewal. For purposes of renewal, a progress report on a standard form obtainable from the NHSRC secretariat should be submitted one month before the expiration date for continuing review.
- **SERIOUS ADVERSE EVENT REPORTING** :All serious problems having to do with subject safety must be reported to the National Health Sciences Research Committee within 10 working days using standard forms obtainable from the NHSRC Secretariat.
- **MODIFICATIONS**: Prior NHSRC approval using standard forms obtainable from the NHSRC Secretariat is required before implementing any changes in the Protocol (including changes in the consent documents). You may not use any other consent documents besides those approved by the NHSRC.
- **TERMINATION OF STUDY**: On termination of a study, a report has to be submitted to the NHSRC using standard forms obtainable from the NHSRC Secretariat.
- **QUESTIONS**: Please contact the NHSRC on Telephone No. (01) 724418, 0999218630 or by e-mail on moh@gmail.com
- **Other:**
  Please be reminded to send in copies of your final research results for our records as well as for the Health Research Database.

Kind regards from the NHSRC Secretariat.

.....
**FOR CHAIRMAN, NATIONAL HEALTH SCIENCES RESEARCH COMMITTEE**

**APPENDIX E: RESEARCH APPROVAL FROM NTCHISI DISTRICT COUNCIL**

# NTCHISI DISTRICT COUNCIL

*All correspondence to be addressed to:*

**The District Commissioner,**
P.O. Box 1,
Ntchisi.
*Tel:* 285 326
*Tel / Fax:* 285 286

*Our Ref: NSDC/*
*Your Ref:*
*Date:* 27th January, 2012.

Kupita kwa : Gogo Chalo Chilooko

Kope : Magulupu onse

**KAFUKUFUKU WA ZA UMOYO**

Alandireni bambo Phillip Kapulula omwe akudzachita kafukufuku wa za umoyo kudera lanu.

P. Manyungwa
M'malo mwa: **DISTRICT COMMISSIONER**



## APPENDIX F: SENATE RESEARCH COMMITTEE'S APPROVAL

UNIVERSITY of the
WESTERN CAPE

**OFFICE OF THE DEAN**
**DEPARTMENT OF RESEARCH DEVELOPMENT**

27 October 2011

**To Whom It May Concern**

I hereby certify that the Senate Research Committee of the University of the Western Cape has approved the methodology and ethics of the following research project by:
Mr PK Kapulula (Anthropology/Sociology)

| | |
|---|---|
| Research Project: | The role of men in promoting women's reproductive and maternal health in a matrilineal marriage system in Malawi: The case of Ntschisi District. |
| Registration no: | 11/9/6 |



*Ms Patricia Josias*
*Research Ethics Committee Officer*
*University of the Western Cape*

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Tel: +27 21 959-2948/9
Fax: +27 21 959 3170
Website: www.uwc.ac.za

## APPENDIX G: MAP OF MALAWI SHOWING NTCHISI AND MAP OF NTCHISI SHOWING TRADITIONAL AUTHORITY CHILOOKO.