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DEPARTMENT OF DEVELOPMENT STUDIES

RESEARCH TOPIC

Effectiveness of male engagement in maternal health

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Dedication

This work is devoted to Prophet Emmanuel and Prophetess Ruth Makandiwa who gave me their financial support during the four years of my study at Midlands State University. Thank you so much Mhamha and Baba I would not have get this far without you, I love you so much you are my answered prayer.

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Abstract

The study examined the effectiveness of male engagement in maternal health in ward 28 of Chipinge. The area has experienced high maternal mortality rate as well as poor maternal health services. 64 respondents from the eight villages were identified four representatives from each village. The researcher used focus group discussions and structured questionnaires as the data collection tools. The findings are grounded on the structured questionnaires directed to the adult women and men, adolescent women and men and interviews to both adult and adolescent women as well as men. The study found that there is poor male engagement in maternal health and this has had negative repercussions on the state of maternal health in the area. Patriarchy has been the major cause for lack of male engagement in maternal health and it has allowed men to make uniformed decisions in terms of maternal health which has had dire effects on maternal health. However, the respondents noted that exclusion of the males in maternal health issues is due to other health facility related reasons like the behavior of the health staff. Also the campaigns that are done in the area mostly exclude men as they present maternal issues as purely feminine.

ACRONYMS

ANC.....Antenatal Care

HIV.....Human Immune Virus

MDG.....Millennium Development Goals

MMR.....Maternal Mortality Ratio

MOHCC.....Ministry of Health and Child Care

MOHCW.....Ministry of Health and Child Welfare

MWH.....Maternal Waiting Home

PNC.....Postnatal Care

S.B.A.....Skilled Birth Attendant

UN.....United Nations

UNICEF.....United Nation International Children's Education Fund

V.S.L.....Village Savings and Lending

W.A.T.C.H.....Women and their Children’s health

W.H.O.....World Health Organization

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INTRODUCTION

This research examined the involvement of men in maternal health. Maternal health is significant in terms of development because it is part of the millennium development goals (MDG), particularly goal number five which is aimed at improving maternal health. It also encourages women inclusion which is protection of vulnerable groups which is significant in development.

Globally, governments and states around the world have therefore paid much focus on reducing maternal mortality in a bid to uphold MDG number five. Maternal health has various tenets which are antenatal care, postnatal care, HIV testing and institutional delivery which is significant in promoting maternal health. According to Africa Check (2015) maternal health is measured using maternal mortality rate which is calculated through the number of live births per 100.000, live births are used instead of the number of pregnancies in a country because they are difficult to determine. Policies like the Health Transition Fund in Zimbabwe has therefore been formulated and implemented by the government as a means of mitigating maternal mortality through health staff incentives and provision of free maternity user fees. Also the third sector have been vibrant in terms of addressing maternal, newborn and child health issues around the globe, for instance the Women And Their Children Health (W.A.T.C.H.) grant under Plan International in Mutare, Chipinge and Mutasa.

However besides all these efforts and the fact that maternal mortality is highly preventable the maternal mortality rates have been on increase particularly in developing countries. This is supported by Africa Check (2014,www.africacheck.org/reports) they noted that “maternal deaths are almost entirely preventable and are therefore seen as a sentinel indicator of the quality of a country’s sector, this is illustrated by the estimate that 99 % of maternal deaths and infant

mortality occur in developing countries". Hence this research attempted to answer why all these efforts have failed and what should be done to achieve to improve maternal health in developing countries particularly in Zimbabwe.

More so, maternal health issues are at the centre of development that is in line with the human development index which place emphasis on the standards of living and life expectancy. Also in developing which are agro-based like Zimbabwe women contribute 80% of labor towards agricultural activities hence they are the basis of the economy and the country's future. Jhpiego (2015, www.jhpiego.org/content/mnch) alludes to the same ideal as they noted that "healthy women are the foundation of a strong community and healthy newborns are the future". In other words, development lies in the hands of the newborns and the women together with the country's future and economy.

The research paid attention to ward 28 in Chipinge, because it is an area dominated by the ndau clan who are mainly characterized by male chauvinism and patriarchy. This research endeavored to link the relation between maternal health and patriarchy which is key in male involvement in maternal health. Also in Zimbabwe there has been an imbalance towards gender issues whereby it only looked at women empowerment and their excluding men even though they are at the center of gender equality and development due to their influence and authority in the African set up.

Background

Over the years issues of maternal health has been predominantly seen as purely feminine issue (Kinannee and Hart 2009) and it is one of the reasons why it has been difficult to achieve the millennium development goals notably, number five which is on improvement maternal health. According to the U.N "Zimbabwe is required to reduce maternal death by two thirds from 1990 figures by end of 2015" and the target is far from being reached with the mortality rate of 960 per 100.000 though aimed at a target of 34 per 100.000. According to WHO international standards the maternal mortality rates are still high as it considers a rate below 100 as low. Also the UN Series Paper 1: Maternal Mortality in Zimbabwe denotes that "Zimbabwe is ranked among 40 countries in the world with high maternal and infant mortality ratio per 100.000 live births".

The target has been difficult to reach and exclusion or negative attitude of males has been eluded as one of the major reasons for this failure since the government together with the third sector has been coming up with solutions to improve maternal health. This is supported by (Kinanee and Hart 2009) which denote that "the poor attitude of men towards maternal health especially in Africa has attributed to the practice of male dominance often called patriarchy". In order to resolve this and improve maternal health state in the country, the idea of male involvement in maternal health was hatched under the development discourse and programming Cairo Conference in 1994 though little has been done particularly in developing countries. As well as the 1995 Beijing Conference on which Zimbabwe is a signatory, which encouraged the involvement of men in reproductive health as supported by Kinanee and Hart (2009) that " in 1995 UN 4th World Conference on women held in Beijing encouraged men to take steps towards achieving gender equality and better reproductive health".

The dominance of patriarchy in Africa has resulted in the increase of maternal mortality rates despite various interventions taken by the government and the third sector, and it is the reason why they should be involved in maternal health. The ndau culture in the ward 28 of Chipinge is a patriarchal society, for instance men are not allowed to sit at the same place with women, and women are not allowed to eat a chicken gizzard popularly known as "ngingiya" in the ndau language even if the men are absent they have to keep it for them. The idea of culture and patriarchy is centered upon decision making which is fundamental in maternal health. Ottong (1993cited in Nwokocha, 2008) describes patriarchy as a family structure or society where the man is, as of right, the head of family and regarded by the women as the lord (shewe) and master whose decision (about any and all issues including maternal health issues) is final. Nwokocha (2008) support this as he noted that patriarchy implies that women have to depend entirely on men for every decision in the family i.e. when to get pregnant, number of babies, whether or not to go for antenatal care (ANC), even when they are directly affected by the decision. Knornblun (2000) simply defines patriarchy as the dominance of men over women. Hence if they make an uninformed decision it will negatively affect maternal health on which the maternal mortality ratio constitute one of the social indicators used to measure a country's level of development (Kinanee and Hart 2009).

Much has been done in Zimbabwe to promote maternal health and achieve MDG number five target which is aimed at improving maternal health thereby reducing the maternal mortality rates by two thirds from that of 1990. According to the Zimbabwe 2012: Millennium Development Goals "supportive initiatives and programmes have been put in place to address maternal issues in Zimbabwe", these include ANC, PMTCT and PNC programmes. Also partnering with the third sector notably NGOs, for instance the Women and their Children Health (W.A.T.C.H) grant

under Plan International which was aimed at infant, child and maternal mortality reduction the MMR has remained high.

This has been attributed to by harmful cultural and religious practices in Zimbabwe which have been noted as one of the majors contributors of male exclusion in maternal health as they uphold patriarchy which is a hindrance to male involvement in maternal health. Culture entails gender roles which present maternal health issues as purely feminine as presumed by Kinanee and Hart (2009) that "tradition spell out gender roles in community, for instance boys are supposed to be hard working and to provide whilst girls should be submissive and be good wives with the burden of household chores and taking care of children". Kinanee and Hart (2009) continue to allude that culture is more of concern in developing countries where our cultural practices still dictate the nature and extent of male involvement in family health issues. Culture upholds patriarchy which is centered on decision making by men which is key in maternal health.

Men have much influence especially when it comes to decision making as noted by Nkungula (2007) "men have decision in their different roles as husbands, fathers' political, traditional and religious leaders". Hence they should be actively involved because if they make uniformed decision particularly in maternal health it can cost the life of both the mother and the unborn child. This crystal clear on the fact that, most women in Zimbabwe particularly those in the rural areas they do not go for their ANC visits though it is significant within maternal health especially when it comes to PMTCT (prevention from mother to child transition) and the male counterparts support them.

WHO summarized the reasons for maternal deaths into three, known as the three delays model and they are all linked to patriarchy, which means they clearly depict the need for male

involvement in maternal health. The three delays model identifies the three groups of factors which may stop women from accessing the levels of maternal health they need. These are on delay in decision to seek care, the delay in reaching the health care and delay in receiving adequate health care at the health facility.

Conceptual Framework

- Male engagement is the involvement of men in all aspect of family's health: maternal health, nutrition, water and sanitation, family planning, immunization and the fight against HIV/AIDS. Male engagement in maternal health is noted in terms of male support, participation and involvement in maternal health.
- Maternal health refers to the health of women during pregnancy, child birth and the postpartum period (WHO). It is measured using the following indicators;

1. Antenatal care (ANC) which is the care you receive from the health care professional during your pregnancy. The purpose of antenatal care is to monitor your health, your baby's health and support to make plans which are right for you.
2. Postnatal care (PNC), it covers the 6 week period following birth. It is the pre-eminently about the provision of a supportive environment in which a woman, her baby and the wider family can begin their new life together. It is not the management of a condition or n acute situation.
3. Maternal mortality ratio (MMR) refers to all deaths caused by any stage of pregnancy or child birth complications up to six weeks after delivery. According to Africa Check (2014,www.africacheck.org/reports) "the cause of death could be direct such as hemorrhage or indirect when pregnancy aggravates an existing condition such as kidney problem, but accidental deaths are excluded". It is usually expressed as a ratio; the number of maternal deaths per 1000 000 live births.
4. Skilled Birth Attendant (SBA) according to Mangeni et.al 2013 refers to the process of child birth at a health facility with the assistance of a skilled health personnel, in

Zimbabwe a skilled health personnel in terms of maternal health refers to an accredited health professional, such as a midwife, doctor, or nurse, who has been educated and trained to proficiency in the skills needed to manage normal (uncomplicated) pregnancies, childbirth, and the immediate postnatal period and in the identification, management, and referral of complications in women and newborns.

Statement of the problem.

Male engagement is of significance in maternal health due to men's influence in decision making as the heads of the family hence there is need for their involvement in maternal health. Hence their decisions have to be informed so that they will not compromise the maternal health of the community or nation at large. In other words there is need for change in the negative attitude of men towards maternal health which is usually attributed by culture and religion.

According to United Nations, Zimbabwe is required to reduce maternal mortality by two thirds from 1990 figures by the end of 2015, but it seems to be failing with Zimbabwe currently having a maternal mortality rate of 960 per 100.000 though aimed at a rate of 34 per 100.000. This has been accounted for by the patriarchal dominance within the Africa, hence there is need for change in the attitude of men towards men as they have the authority and influence in terms of decision making.

It also has a repercussion on development because maternal health is part of the United Nations; Millennium Development goals specifically number five. Also Jhpiego (2015, www.jhpiego.org/mnch/mnch) denotes that "healthy women are the foundation of a strong community and healthy nations are the future" hence upholding their healthy is of essential in the development of a nation. More so women are the majority as noted I. Mudeka (2012) "with

women constituting 52 % of the citizenry, they are the majority of the population…", hence protecting their health and reducing their mortality rates due to pregnancy related issues is enhancing development which is a social indicator for development. According to Africa Check (2015, ww.africacheck.org) maternal health is seen as a sentinel indicator of a country's health sector", it is also part of the human development index approach which denotes standards of living as essential in measuring the development of a nation and the health of the people particularly the majority have an effect on its development.

Theoretical Framework

This research is informed from the systems theory which explains maternal outcomes as the cumulative effect of the stages that characterize the pregnancy-postnatal process. The position of this theory is that the activity of any part affects the activity of every part and the whole in general. This implies that the impact of any stage of pregnancy in varying degrees affect every other stage and the final outcome. Maternal events are characterized by a sequence of activities that influences results following pregnancies. Onyenoru (2000) observed that a system is portrayed as an entity made up of interrelated and connected parts.

Hence rather than dealing separately with various stages of pregnancy as unrelated entities, the system approach views pregnancy as composed of interrelated and interacting stages. Systems of various orders are understood by investigating their respective parts as making a whole. This is irrespective of whether inanimate things living organisms or social phenomena are the objects of focus. By using the organismic analogy to explain the social system Bertalanffy noted that "it is necessary to study not only parts and processes in isolation but also to solve the decisive problems found in the organisation and other unifying them, from dynamic interaction of parts and making the behavior of parts different when studied in isolation or within the whole" (1968).

The implication is that analyzing each stage of the pregnancy-postnatal processes in isolation of others will only produce results related to those stages as separate subsystems. A different response is generated when their link are emphasized. The reason why literature on pregnancy outcomes is noticeably scanty is that individual scholars have been focusing on one or more aspects of the system and not all.

The closure of the limits of analysis of a subsystem from other units of analysis presents just a partial view of reality. The problem confronted by researchers as a result of such sub-systemic insulation is that knowledge is disarticulated and conclusions are extremely difficult to generate. The systems theory asserts that understanding each stage in the pregnancy – postpartum continuum and its relationship in with other stages is essential for a holistic analysis of pregnancy outcomes. For instance, the factors that affect access and use of family planning methods are examined in order to investigate their impingement on pregnancy outcomes. The decision making process underlying family planning equally has implications for the timing of pregnancy and antenatal care. This therefore denotes that, the attitude exhibited by husbands at each of these integral stages (family planning, pregnancy, antenatal care, delivery and post natal care) of pregnancy affects the psychological disposition of women which is critical to maternal outcomes. Systems theory emphasizes communication and feedback in the analysis of a whole. This is essential in maternal health particularly through processes like PMTCT and ANC which are key in male involvement in maternal health.

Objectives

The following objectives will be investigated:

1. To examine the state of maternal health in Chipinge ward 28.
2. To examine men's engagement towards maternal health in Chipinge ward 28.
3. To examine challenges and offer solutions on how best male engagement can improve maternal health in Chipinge ward 28.

Research Questions

1. What is the state of maternal health in Chipinge ward 28?
2. What is the level of men involvement in maternal health in Chipinge ward 28?
3. What are the challenges and solutions of male engagement in the improvement of maternal health in Chipinge ward 28?

Significance of the Study

This research was motivated by the desire to improve maternal health thereby reducing the high maternal mortality rate of 960/1000 in Zimbabwe as well as to achieve the MDG number four target of 34/1000 by year 2015.

The research will benefit or assist Ministry Of Health and Child Care (MOHCC) which is the implementing partner of the maternal health programmes so as to encourage male involvement in maternal issues as well as the third sector notably NGOs who are into maternal health programming in partnership with MOHCC.

The rural community as well may benefit by mobilizing itself in promoting male participation in various projects for the upliftment of their communities particularly in the

health sector as United Nations 2015 Report alludes that “children and pregnant women in the rural areas have a higher mortality rate than their urban counterparts”. This can be due to the high cultural values within the rural areas which is also one of the causes for negative attitude of men towards MNCH issues.

Limitations and Challenges

Being a female it was difficult to discuss with the males especially if it is a men’s forum hence the targeted men may refuse to participate in the study. The sampling therefore needed to involve more participants so as to capture reasonable views. However despite all these challenges the research was undertaken through the help from the community leaders and the health staffs from Mabee clinic in Chipinge ward 28.

Research Methodology

The research was carried out using qualitative research because qualitative data provides a rich detailed picture to be built about why people act in certain ways, and their feelings about these actions (Manchester Metropolitan University, 2015, archive.learnhigher.c.uk). This therefore helps to describe and reveal the underlying causes of men’s negative attitude towards maternal health.

Data Gathering Instruments

Desktop Research

Desktop research was used as one of the gathering instruments on this research because it is easy to access and helps in terms of clarification of research since maternal health is a global concern and are part of the MDGs.

Focus Group Discussions (FGD)

Focus Group Discussions were used for both adult and adolescent men with children who are two years and below, which help bring about the voice of the men which may assist in bringing about transformation which enhances a quality research and community participation.

Questionnaire

A questionnaire is a form of a structured interview. It contains designed questions that are used to retrieve the necessary information for the study from the respondents. The questionnaires were used to gather information and data. The questionnaires gave the respondents the autonomy to answer without bias. Green (2002) upholds that questionnaires are less intrusive than face-to-face surveys and respondents can complete and answer the questions at their own space and time.

The questionnaires were specifically designed to gather primary data from the selected participants with children under two years.

Sampling

Cohen and Manion (1994) defined sampling as "the process of selecting a number of individuals for a study in such a way that the individuals represent the larger group from which they were selected".. The sample will be manageable and not time consuming. It will be unbearable for the researcher to study the whole target population because the whole target population might become unmanageable and too small a sample might be unrepresentative (Cohen and Manion, 1994).The researcher will use sampling because it reduces costs; it is cheaper to collect data from a part of the whole population and is economically in advance. It also has greater speed; it gives more time in collection of data, so it is quick and has a lot of time for collection of information. It provides detailed and comprehensive information by research through a small part of the

community and it is one of the practical methods of data sampling given large numbers of people.

Target Population

The targeted population was the rural community particularly men in Chipinge ward 28 with children under the age of two. Also women particularly the elderly women who are usually the drivers of patriarchal systems in the community they also need to embrace change and contribute to the positive attitude of men towards maternal health. Ward 28 of Chipinge comprise of 8 villages with an estimated population of 4000 people according to the Plan International W.A.T.C.H Zimbabwe analysis report. The researcher used a sample of four focus group discussions which comprise of 16 older men, 16 older women, 16 adolescent fathers and 16 adolescent mothers with children who are two years and below. The selected individuals represented the entire community during the study and it was a sample of four representatives per village (two adolescent mothers and fathers, two adult mothers and fathers) and they also participated in answering the questionnaires.

Sampling Methods

The researcher used purposive sampling as a sampling method because it represents a group of different non-probability sampling techniques like random sampling. It helps focus on a particular characteristics of a population that are of interest, which best enabled the researcher to answer the research questions.

Literature Review

This section reviewed the literature on the impacts of patriarchy or negative male attitude towards maternal health. Though calculating the number of women who die as a result of pregnancy is difficult, Minister Of MOHCC Dr Prairenyatwa denotes that "960 women die out of every 100.000 and 26.55 infants die out of every 100.000 live births" (2015, www.zw.one.un.org). Just like Zimbabwe, Nigeria is said to have one of the highest level maternal mortality rate in the world, with figures ranging from 704 to 1500 per 100.000 live births (FMOH, 2014).

Kinanee and Hart (2009) pointed out that 365,064 women die due to pregnancy related cause; major causes are found in developing countries. Africa is one of the developing countries and its attribution to this rate is due to the lack of male involvement which is encouraged by culture and the older generations' particularly in-laws. They continue to note that patriarchal practices, as said earlier, are one reason for the poor maternal, newborn and child health situation in Africa. Hence traditional African culture, may have observed as not been fair to women. However Bwakali (2001) denotes that "African women are victims of injustice traditional culture not because of what the society did to them because of what the society did not to them". The African culture did not involve men in maternal health and it has resulted in the death of a lot of women and children, the traditional system has spell out roles which both men and women should play in the family as well as in the community. This is supported by the socio-biology theory by David Barash in Haralambos and Holborn which states that the reproductive capacities of both sexes determine the roles they play in society its more about gender roles. Women were given the burden of taking care of children and child bearing whilst men are more on the

provision side and this is the injustice culture did not do to women because it excluded men in maternal health and enhanced patriarchy.

According to Kinanee and Hart (2009) for the MDG number five to be achieved in Africa there is need for the achievement of gender equality with regards to sexual reproductive health. This is through the dogma that the achievement of gender equality by women with respect to sexual and reproductive health is essential in maternal health and it cannot be possible without the cooperation and participation of men. In other words there should be an integrated approach of all stakeholders with men at the leading role due to their influence as supported by UNFPA Population Report (2009) that "men whether as political leaders, judges heads of armies and other agencies of force wield enormous power over many issues relating to women, hence would need to be involved in providing solutions to maternal health".

The message being carried out by this study is that of the social and behavioural change expected of men to exhibit especially playing more responsible in reproductive health (Kinanee and Hart, 2009). This is more of concern to us in developing countries like Zimbabwe where our cultural practices still dictate the nature and extent of such male involvement and the involvement of men in maternal health arises from the numerous influences males have on almost all aspects of life, in both developing and developed countries.

The United Nations gave a 75 % reduction of maternal and child mortality in Africa and according to Kinanee and Hart (2009) "the 75 % reduction by 2015 cannot be achieved without the involvement of men and other stakeholders". They further alluded that men in different capacities such as community leaders, policy makers would have an important role in

safeguarding MNCH. Hence their influence is significant in reducing maternal mortality thereby achieving MDG number 5.

Coheh and Burge (2010) propose three basic expectations of male involvement in maternal health and sexual reproductive health which are gender equitable men, men taking ownership of the problems and becoming part of the solution. This includes supporting contraceptive use by women, helping pregnant women stay healthy, arranging skilled care delivery and avoid the three delays. This is the kind of involvement that Coheh and Burge figure appropriate for the maternal health and the systems theory support this as it calls for male involvement in every cycle.

Studies done in Tanzania by Kilewo (2001) and Chandisarewa et al (2006) revealed that male engagement is affected by social background, culture or religion, educational levels, societal roles and age disparity of partners. This also applies in a Zimbabwean situation as indicated by Chandisarewa, et. al (2006). The researcher in the same study concluded that "Prenatal and postnatal clinics in Tanzania are usually not male friendly". This meant that men were not encouraged to participate from the initial stages of maternal health which made it difficult for them to participate as the process continues (Kilewo et. al., 2001).

A study carried out by Plan International in Ethiopia indicated that participation of men from the earliest stages of ANC encouraged partner communication, partner HIV testing, condom use and other services like male circumcision (MOHCW, 2006). The programme proved to be very successful because their partners participated well in any maternal health related issues. (Kilmarx et. al 2002). Male involvement is assumed the major solution to maternal health which when facilitated, through community sensitization and friendly services to men can be of help.

Furthermore, maternal health is facilitated by knowledge levels, attitudes and beliefs as cited by Kowalczyk et al (2002).

The maternal health project in Kaemba, Zambia, successfully persuaded men to be involved in the programme (Kilewo, 2001). This was achieved by involving male community leaders who directly talked to fellow men. As it was done by Burke et al (2009) where he noted that "men preferred to receive information from other men who are peer or older". Health information from female partner is less trusted than information from a male (Burke et. al., 2009). The reports by a local reporting centre (Partner) indicated that at Kenyatta Hospital, more than half of the male partners of tested pregnant women were also tested. The report indicated a great achievement in maternal health programmes (Partner, 2001). Jackson (2002) further added that topics about circulating taboos such as sex during pregnancy, condom use to married couples during pregnancy and many others are encouraged. Traditional myths and misconceptions need to be corrected as they have a great impact on the success of the maternal health programme and are also very effective in promoting male engagement if properly corrected.

In Rwanda most women had knowledge about HIV and modes of transmission (Kilmark, 2002). However, a barrier still remains, as it is known that men dominate in sexual decision-making (Liechty, 2005). This clearly indicates that there are other factors that hinder maternal health success besides knowledge about ANC and PNC, which the investigator needs to dig much deeper to find out. From the research carried out so far men exclusion seemed to be a major barrier to promotion of maternal health in Rwanda due to their dominance in sexual decision making.

According to a study done in Nigeria by Moses et al(2009) observed that for maternal health to be successful, above optimal levels, involvement of male partners must be recognized as a necessary component. The male partner is to be involved, and educated together with his spouse, to provide necessary support whenever the need arise. Involving the partner will not only provide support and encouragement, but will also improve adherence to program ethics. In the same study it was realized that community awareness on maternal health programs is paramount as it can assist the male partner together with the family to successfully fight against stigma and discrimination for desired results as alluded by Moses et al (2009).

Chinkonde, Sundby and Martinson (2009) in Lilongwe, Malawi identified that women needed to be empowered, economically supported to access maternal health with their partners, to benefit the whole family. This therefore suggests that the male partners as they spend a fortune trying to balance work and family demands for medical care which results in unintentionally ignoring of health concerns resulting to failure to participate in the maternal health programme. For the participation of male consumers to increase, there is need to integrate maternal health fully into existing Primary Health Care activities (MOHCW, 2003). Hence the need to further educate the public especially men concerning their role and responsibilities as well as the benefits of involvement.

In the Zimbabwean context the Millennium Development Goals Progress Report depicted that Zimbabwe was supposed to reduce by two thirds below the 1990 rate of 34 per 1000 by 2015, however this is far from desired target. Despite the various efforts done by the government to reduce the maternal mortality rate, like scrapping off user fees for all pregnant women and the health transition fund which motivates the health staff through incentives, the target is difficult to reach. Just like other African countries, Zimbabwe is a patriarchal society particularly in ward 28

of Chipinge, which is characterised by male chauvinism and the decision of family planning antenatal and postnatal care that has repercussion on the newborn and maternal health is depended on the males like exclusive breast feeding and PNC visits.

Zimbabwe maternal mortality ratio is at 960 per 1000 and instead of decreasing it is at increase with a rate of 612/1000 in 2005 and 960/1000 in 2015 and this has been attributed to by various reasons that evolve around patriarchy. These reasons include decrease in contraceptive prevalence rate from 2005/06 which was 60.2 to 68.5 % in2014 also the adolescent birth rate has increased as a result of child marriage; it has increased from 96/1000 in 2009 to 114.61/1000 in 2011-2015. According to Nwokocha (2008) "patriarchy implies that women have to depend almost entirely on men for every decision in the family, for instance when to get pregnant, number of babies to have, whether or not to go for ANC..." Also supportive initiatives and programmes have been put in place to reduce maternal mortality but it is the influence of men that will bring about good and better results, for instance PMTCT (Prevention from Mother To Child Transition which was later changed to PPTCT (Prevention from Parent To Child Transmission) in order to accommodate men and prevent sending an implicit message of presenting maternal health as a purely feminine issue. Hence men need to be involved as they determine all the decisions and these are critical in maternal health particularly with the three delays which depict delay in decision making as delay number one resulting in maternal mortality.

The literature illustrates that, rural communities have higher maternal and infant mortality rates compared to their urban counter parts. This is supported United Nations (2015, www.zw.one.un.org) which portray that "rural children have a higher mortality rate than their urban counterparts; findings indicate that socio-economic status and the education levels of the

mothers lead to the lower mortality rates for children". This is noted by the verity that four preventable conditions have led to the death of the vast majority of under fives and these include AIDS, neonatal problems, pneumonia and diarrhea. These are preventable diseases that only need medical attention but the low education levels and hard economical conditions mostly in rural areas have resulted in them being contributors to child mortality. This research will largely compliment the writings of other researchers in male engagement in maternal health.

Ethical Consideration

Information sheets will be translated into shona for the benefit of those who do not understand English and informed written consent will be obtained from all the study participants. Participants will be given information sheets which outlined the purpose of research and its benefits. Explanations on pertinent issues of the research will be made by the researcher prior to signing of the consent forms. The consent form is for participation in the study. Efforts will be made to maintain confidentiality of information obtained from participants by ensuring that there will be no link between participant information and their identity. Codes will be used instead of names of participants during data collection and there will be no link between the codes used and the signed consent forms. The signed consent forms will be kept separate from the field notes and other data sources. Interviews will be conducted in a private location within the site that would be agreeable to both the researcher and the participants.

Chapter One

The state of maternal health in Chipinge ward 28

CHAPTER OVERVIEW

This chapter will look at the state of maternal health in ward 28 of Chipinge and the causes of such a state in the area. It will seek to analyze the aspects that contribute to the position of maternal health in the ward and how they have compromised.

Ward 28 in Chipinge has the worst social indicators in spite of the rich soils that does not need fertilizers it is blessed with which makes them rich in terms of agriculture which is the backbone of the Zimbabwean economy. The W.A.T.C.H baseline survey in 2012 showed that ward 28 of Chipinge has one of the highest levels of maternal mortality rates in the district with figures ranging from 67 to 68 per 1000 live births. UNFPA denotes that 345/100.000 women in Chipinge as a district die due to pregnancy related issues and this contribute to the national maternal mortality rate of 960/100.00 live births every year. Nationally, these rates are a result of pregnancy related complications while more than 52 000 die yearly due to some factors leaving over 210 million with disabilities.

The report also adds that majority of the deaths occur due to the loss of blood, obstructed labour, unsafe abortion, hypertensive disease and sepsis. This situation calls for the attention of governments at all levels in Zimbabwe and all stakeholders including our development partners within and outside the country. On a global level, the UNFPA found out that in the year 2007, one woman died from a treatable complication of pregnancy every minute of every day, within a similar time period, 190 women got pregnant without intending to. The same source reported that in the same year 365, 064 women died due to pregnancy related cause: and with very grave

consequences for the saving children and family member. Majority of these cases are found in developing countries, Zimbabwe being inclusive.

In Chipinge specifically in ward 28, maternal mortality rates have been seen to be considerably high. For instance UNDP Paper 22 in 2015 reports that in 2014 region 5 of Chipinge (where ward 28 belongs) performed very poorly in maternal health with the worst maternal mortality rates in Zimbabwe of 145 per 1000 compared with the national rates of 960 per 100.00.

The high maternal rates in the ward 28 of Chipinge are attributed to by a lot of factors which compromise the state of maternal health in the community. These factors have repercussions on maternal health from its management, antenatal care up to the period of postnatal or postpartum care as mentioned below. Home delivery has been one of the major challenges in terms of promoting maternal health and it has greatly affected the indicators of maternal health as highlighted below.

Home Delivery

Ward 28 of Chipinge is characterised by high rates of home delivery and low use of institutional services or health facility services. Home delivery refers to the process of child birth at home with the absence of a skilled health personnel known as skilled birth attendance (SBA), in Zimbabwe a skilled health personnel in terms of maternal health refers to an accredited health professional, such as a midwife, doctor, or nurse, who has been educated and trained to proficiency in the skills needed to manage normal (uncomplicated) pregnancies, childbirth, and the immediate postnatal period and in the identification, management, and referral of complications in women and newborns (Mangeni et.al 2013). Hence even if one delivers at the hospital or clinic there should be skilled personnel to assist, which is the reason why the

government of Zimbabwe has embarked on midwifery training such that at every health facility there should be at least on trained health personnel. Institutional delivery therefore refers to the process of child birth at a health centre with the assistance of skilled health personnel. Home delivery can be accidental which is usually because delay number one and delay number two. However in the community it has been noted that 90 percent of the home deliveries are intentional or voluntary as evidenced low ANC and PNC visits as well as the utilization of maternity waiting homes. Home delivery has various effects on the tenets of maternal health as shown below under the various tenets of maternal health.

1. Antenatal Care

Antenatal care is a very significant process in maternal health and one should attend at least 4 ANC visits according to the WHO standards. Regular ANC visits help to identify and treat complications as well as promote healthy behaviours. However the women in ward 28 of Chipinge have not experience all these merits of ANC due to home delivery and low use of health facility delivery, which also contribute to the high maternal mortality rates in the ward.

Maternal mortality has remained persistently high in manicaland over the last decade, where ward 28 of Chipinge belongs. These deaths have been attributed primarily to lack of professional attention during pregnancy and delivery as most of the pregnant women do not appreciate the health facility services.

2. Postnatal Care

PNC coverage is very limited in the community (ward 28) and this is mainly due to culture as noted by WHO 2013 Report on Postnatal care which depicted that “low PNC in sub-Saharan Africa is attributed to by the cultural tradition of keeping the baby indoors, especially among

women who gave birth at home". This is the scenario in the community with the majority of the women practicing home delivery hence they cannot access PNC services. It is during the PNC period that women are taught about baby care and checked if there are any complications like postpartum haemorrhage and sepsis usually around vaginal wounds or stitches that would have been made after delivery. One of the women who participated in the adolescent mothers FGD noted that "we cannot leave our homes for PNC because we have to stay in doors for six weeks according to tradition and our mother in laws will not allow us to if we try to challenge them they inform our husbands on which they will insult us saying you are not obedient to my parents".

This has therefore contributed to the high maternal mortality rates in the community through the view that during home delivery there is no professional process. Some of the women highlighted that if the baby is too big a broken glass is used to increase the baby's way, in the event of getting tired there is no room for operation so they will put 'duri' behind your back and 'mugoti' in the mouth so that you push the baby even when you are tired. All these processes have dire effects on maternal health and permanent disabilities on the women.

3. Prevention from Mother To Child Transmission (PMTCT)

HIV Testing and couple counseling is relatively low in the community due to the low use of health facility services and high home deliveries in the area. This has resulted in the death of many women and loss of newborn children who at most are HIV positive but will not be diagnosed early particularly the mothers so as practice PMTCT. Even the few pregnant women who appreciate the health facility services in ward 28 of Chipinge they usually do not want to get tested and if they do they hardly disclose their results to their spouses.

Disclosure of HIV status is of significance under PMTCT as denoted by Madiba, et al. (2013), that disclosure of HIV status to a partner is always the main gate to progress in PMTCT uptake and that is what pregnant women in Sub-Saharan Africa do not have confidence to do.

However most of the women within the community do not have the confidence, due to the fear of negative reactions they will face from their husbands and relations despite the risk that HIV has to both the mother and the unborn child. A similar case is found in Uganda through a study carried out by Bajunirwe et al (2005) in rural and urban Uganda, who found that women refused HIV testing in antenatal clinic due to fear of their husbands‟ reactions. Though King et al. (2008) depicted that the women's fears and outcomes after disclosure are totally different when he noted that "from the PMTCT programmes in Uganda, most of the women who were interviewed did not actually experience any negative outcome after disclosure rather the fear of the disclosure itself created high tension in them, which almost became a barrier to sharing a positive HIV result with partners". This implies that fear of disclosure to male partners and their absence during HIV testing maybe a barrier to PMTCT uptake which is key in maternal child and has caused dire effects within the Mabee (ward 28 of Chipinge) community.

4. Maternity waiting home

Many pregnancy complications are unpredictable and can be fatal within a short space of time. For example a serious post partum hemorrhage (bleeding within the first six after delivery) can lead to death of a woman in less than two hours and the unborn fetus may succumb much earlier. With many women living far away from health facilities where life saving care is available, MWHs provides a setting where high risk women can be accommodated during the final weeks of their pregnancy near a hospital with essential obstetric facilities. They facilitate the reduction in maternal and neonatal mortality and improved maternal and neonatal outcomes by fast

tracking women to emergency care should complications arise. They also provide an opportunity for pregnant women to receive health promotion on pregnancy including information on danger signs of pregnancy, labor and childbirth including new born care.

Poor service delivery at the health facility

Poor service delivery is defined through health staff attitude, hospital equipment and provision of drugs. It has also contributed to the high maternal mortality rates in the ward by shunning away patients and pushing away the few women who appreciates its services. This is noted through the below mentioned:

1. Rude health staff

The participants that took part in focused group discussions expressed that they were mistreated by health personnel when they go to the hospital. For example one participant said that “the nurses are rude they do not want to help us, they insult us every time we go there and they say they cannot treat two people from the same family, saying that two people from the same family cannot fall sick at once”.

Another participant added that “these health personnel, apart from not attending to two people from one family, they also refuse to treat for multiple problems. They will normally say that, one person can not suffer from two diseases e.g headache, stomach-ache”. Therefore, if one have two complaints she/he will only be allowed to be treated for one and will be told to come next time for the other problem.

2. Corrupt health workers

The majority of participants felt that the health workers in their areas were corrupt. For example, participants expressed concern over the misuse of an ambulance, drugs and charging for growth monitoring. One participant indicated that "if we call for an ambulance, we are requested to pay for it. Alternatively, we are told to buy fuel in order to transport a person to either St Peters or Chipinge General Hospital. Most of the times we do not have money, as a result deaths occur that may have been prevented if we had been given the ambulance for free. It is worrying because we actually see the ambulance doing business; it goes to Mozambique to carry packs of beer for sale while people's lives are left in jeopardy"

Others indicated that health workers sell drugs to Mozambicans at the expense of them the Zimbabwean local residents. So that a number of Zimbabweans have also started buying the medicine, "if you go to the hospital without money you will not be helped" health workers are selling mosquito nets and drugs to Mozambicans, these health workers are getting rich here for instance one health worker has stolen 16 mattresses, fortunately he was taken by police to answer charges".

One community leader at Jongwe B in Mabee village indicated that often times, the health personnel charges women who take their children for growth monitoring. They reported that they are told to pay $0.50 before weighing the children.

3. Sexual reproductive health challenges and risks

Overall the participants mentioned a number of challenges that put their reproductive health at risk. While the youth expressed scarcity of condoms and lack of knowledge on family planning as some of the challenges, the majority of women indicated lack of antenatal care, poor delivery

services and postnatal care at the health centres as challenges. This has resulted in high maternal mortality ratio in the ward due to adolescent marriages and inadequate process of ANC and PNC.

4. Lack of mid-wives

Though the health personnel in Zimbabwe are still under training, majority of the participants expressed in their health centres was a big problem: we have a hospital but only one nurse is qualified to deliver babies and if she is on off or leave or away for some workshop you will not be able to deliver hence you will be referred to St Peters hospital. Due to this will then resort to home delivery by traditional birth attendances (TBA) that are always available.

5. Insufficient items for use during delivery

Others expressed that women were left unattended if they report late to the hospital or if they have not brought the necessary items required at the hospital during delivery like candles (where there is no electricity), cotton wool, a bucket, razor blade and the baby layette. Lack of these materials was seem to be a huge hindrance so that most of the women end up delivering at home with the assistance of the TBA as they claimed that they did not afford to buy the materials.

Provision of drugs during ANC was sometimes difficult due to unavailability of the drugs hence the women preferred TBAs as they do not offer any drugs than to go for ANC and be told to come back again another day for the drugs given the long distances they have to walk to reach the health facility.

The state of maternal health in Chipinge has also been attributed to by socially constructed factors which evolve around patriarchy and culture which means with increase in knowledge

they can be deconstructed for the benefit of the community through improvement in maternal health. These aspects include:

Patriarchy

Patriarchal practices as said earlier are one reason for the poor maternal health situation in Zimbabwe. The traditional culture, many have observed had not been fair to women. As noted by Bwakali (2001) women were victims of injustice in traditional culture not because of what society did to them but did not do them. However these authors are of the region that the injustice suffered by today's women and girls are from both angles. The traditional system spelt out roles which both men and women should play in the family as well as in the community. Similarly, boys in the ward 28 of Chipinge grew up knowing that they were expected to be strong and hardworking, so as to take care of their wives. While girls on the other hand were to be concerned with domestic activities and to be submissive so as to find good husbands there were to marry. Moreover the ndau culture in the district emphasizes on submission of women and not to question their judgement in terms of decision making popularly quoted by most women that "dhodha haripikiswi" in vernacular language.

This has compromised maternal health in the sense that most of the decisions that the men make are uniformed decisions. This is mainly because maternal health issues as mentioned earlier are viewed as purely feminine to the extent that they do not want to be part of anything to do with maternal health even HIV testing though it is significant in maternal health for processes like PMTCT.

Patriarchy through culture in the ward has allowed most men to be polygamist which also have effects on maternal health. Polygamy according to the tenth edition of Oxford dictionary refers to

the practice or custom of having more than one wife or husband at the same time. In this context it is more applicable to the males who on average can have three wives or more. In such a scenario the husband will not have much attention to the health of his wives and family at large, even the provision of basic human needs like food will be limited hence the women have to look after their children and they are own selves. This has an effect on maternal health in the ward because the husband given a scenario of two wives or more he cannot attend to the maternal needs of the women. As denoted by the systems theory this will affect maternal health because the systems are interrelated and lack of support (either financially or emotionally) on one part of the cycle affect the whole system. This therefore presents patriarchy as a factor or cause towards high maternity mortality rates in ward 28 of Chipinge which calls for a change in male negative attitude in order to improve the position of maternal health in the community.

Culture and Nutrition

In relation to maternal health, a number of cultural practices abound in different countries which militate against women and their health. For instance, the nutritional taboos for pregnant women in the ward 28 of Chipinge as well as in other parts of Africa like the River Delta state in Nigeria, pregnant women are forbidden from eating eggs or snails in spite of the rich protein content which they and the foetus greatly need at such time (Nwokocha 2008). In the area there are nutritional taboos against eggs, game meat, milk and other indigenous fruit which are usually rich in vitamins. Though the area is characterized by rich soils it usually faces a lot of droughts due to low rainfalls which will result in food insecurity among households, which means that for pregnant women there is little left to eat with the available food being restricted according the cultural values and norms in the land. This therefore explains the high malnutrition rates among

children and the pregnant women which also contribute to maternal mortality since pregnant women even after delivery need a lot of food for strength, foetus growth and to avoid complications through low blood flows and other malnutrition associated diseases.

Alcohol consumption by pregnant women in the community has also in high maternal and infant mortality in the ward due to its effects on both the mother and the unborn child. A similar case is noted by Nwokocha (2008) in Nigeria on which he eluded that pregnant women are not retained by their husbands from much consumption of locally made gin which could increase proneness to pregnancy complications and cause other physical and mental health problems for the unborn child. In the area's scenario there is high consumption of locally made gin known as kachasu, 7 days or msombodia .Alcoholism will then lead to other unhealthy practices in the community though they are found in other parts of Africa, these include while wife beating practices termed under domestic. The afore mentioned practices have untold consequences on maternal health hence there is need for male involvement as they are usually labelled as perpetrators of violence and help with diet advice as well as provision to their wives.

Migration

Migration refers to the movement of a person to settle in a new area in order to find work (oxford 10th ed). Majority of the men in ward 28 of Chipinge migrate to South Africa (popularly known as majoni joni) in search of greener pastures leaving behind their wives in the hands of their parents as noted by the W.A.T.C.H 2012 baseline survey. This therefore minimize male engagement in maternal health particularly under ANC and PNC which takes note of HIV testing which can lead to processes like PMTCT if found positive. Also it gives room of manipulation by parents or in laws who are at most the drivers of culture which is sometimes harmful to

maternal health through the encouragement of the use of cow dung for cervix contraction which has been reported to contribute to about 30 percent of cervical cancer. Male migration to South Africa has also led to an increase in HIV AND STIs in the area which is deadly to them with the low use of institutional services in the area, this is usually attributed to by the fact that most of the men indulge in extra marital affairs whilst they are away even some of the women despite the fact that they will have unprotected sex when they meet again hence creating a high risk of contracting the disease. Sister Mlambo who is the sister in charge at Mabee clinic which is the clinic in the ward reports that most of the women are only dictated positive with the humane immune virus when it is too late it is mostly when they have complications as most of them do not appreciate the health facility services.

Child marriages and Teenage Pregnancies

Child marriages and teenage pregnancies are also one of the contributors to the high maternal mortality ratio in ward 28 of Chipinge. Most of the girls in the community (ward 28) get pregnant or married as early as 13 years old, the W.A.T.C.H baseline survey denotes that most of the girls get pregnant as soon as they reach puberty particularly when they start their menstruation cycle. Globally about 16 million women aged 15 to 19 years old give birth each year and they contribute to about 11% of all births worldwide (WHO, 2015). More than 50% of the teenage pregnancies take place in Sub-Saharan Africa with Rwanda constituting 0.3 percents and Zimbabwe constituting 12.2% of the teenage pregnancies. This has had an effect on maternal health as noted by WHO (2015) that “although adolescent aged 15 -19 years account for 11 percent of all births worldwide they account for 23 percent of the overall burden of the disease (disability-adjusted life years), due to pregnancy and childbirth”. This therefore means that in as much as teenage are contributing to maternal health their contribution is more than double

towards maternal mortality. This is clearly noted on the WHO: Maternal, Newborn Child and Adolescent Health Report which denotes that "about 2.5 million adolescents have unsafe abortions every year and adolescent are more seriously affected by complications than older women".

Most of the teenage experience complications during pregnancy even at post partum stage which result in either maternal mortality or permanent disabilities on them as noted by WHO (2015) that "many health problems are particularly associated with negative outcomes of pregnancy during adolescence". For example anaemia, malaria, HIV, and other sexual transmitted infections, postpartum haemorrhage and mental disorders such a depression. In ward 28 of Chipinge this has been the daily routine given a scenario that the area is malaria stricken area and the low use of health facility services hence resulting in high maternal mortality rates in the area. This is further supported by the WHO (2015) report which depicts that "up to 65 percent of women with obstetric fistula develop this as adolescents, with dire consequences of their lives, physically and socially". This means that adolescence pregnancy has lasting effects on women which is a negative contribution towards maternal health hence there is need for male involvement in order to reduce teenage pregnancies by educating them about the importance of the girl child. Also to work together with other stakeholders to mitigate child marriages and adolescence pregnancies due to their influence in decision making as noted by Nkungula (2007) that "men have decision-making powers in their different roles as husbands, fathers and political, traditional and religious leaders. The decision-making powers of men transcend all the spheres including health matters". It is therefore very essential that men, as decision-makers should play an active role in ensuring that maternal health outcomes are favorable for a healthy mother and

baby through reducing adolescence pregnancies or child marriages which are one of the drivers of adolescence pregnancies.

Adolescent pregnancies have also had negative impacts on the development of the community which is characterised by poverty and under development as it lacks the basic indicators of development using either the Human Development Index approach or the Economic growth approach. The area consists of poor infrastructure in terms of roads, schools the clinic also there are high illiteracy rates particularly among women and this can be accounted for by adolescence pregnancies which mostly results in the girls dropping out of school. This has long term complications for them as individuals, their families and communities. Studies have shown that delaying adolescent births could significantly lower population growth rates, potentially generating broad economic and social benefits in addition to improving the health of adolescents. This therefore means that male involvement in maternal health will not only enhance maternal health but development at large.

CONCLUSION

Ward 28 of Chipinge is characterized by high maternal mortality ratio and this is caused by a number of reasons mentioned above. These include teenage pregnancies, culture and nutrition and patriarchy, however there is need for male involvement and positive attitude towards maternal health in the area so as to bring about change in terms of the unpleasing state of maternal health within the community.

Chapter Two

Male engagement on issues of maternal health in ward 28 of Chipinge

CHAPTER OVERVIEW

This chapter will look at the issues that require male engagement in maternal health particularly ward 28 of Chipinge. It will analyze the attitude of men towards maternal health and how they can bring about change in terms of promoting maternal health. In essence it will look at the barriers of male involvement so as to come up with recommendations on how to achieve it and promote maternal health.

The involvement of men in maternal health in ward 28 of Chipinge is relatively low in dealing with the subject of sexual health generally and it is centered within culture which upholds patriarchy. This is of particular concern because culture determines the extent of male involvement, as noted by Kinanee and Hart (2009 "this is more of concern to us in a developing country like Nigeria where our cultural practices still dictate the nature and extent of such male involvement". The essence of that was to further call on men around the world to care for their pregnant wife, care for their baby, educate their daughters and partner in the task of parenting. The involvement of men in maternal health arises from the numerous influences males have on almost all aspects of life, both in developing and developed countries, as discussed below.

Supporting Contraceptive Use.

Lack of contraceptive use by women in ward 28 of Chipinge has resulted in a number of unwanted pregnancies amongst adolescence and married women which also had various consequences on the women as mentioned above. Most of the women have suffered from

postpartum hemorrhage or obstetric fistulas which are one of the leading causes of maternal mortality in the community. Most women have highlighted that men are not supportive with use of contraceptive use particularly condoms and if they take tablets they are told to stop taking them hence most of them take them in secret. Some of the women highlighted that they have tried to take jadalle but the men are now aware of it and they check the upper part of their right or left hand and suppose they feel it they are asked to remove it.

Patriarchy

Patriarchal practices have been alluded to as one of the reasons for poor maternal health in Chipinge as well as a barrier to male involvement in maternal health (Nkungula, 2007). The traditional culture, in the ward has spelt out roles for both men and women and the roles have deprived men from being part of maternal health. Patriarchy has also given men power in terms of decision making which has compromised maternal health due to uninformed decisions.

The ndau culture in ward 28 of Chipinge is characterised by male chauvinism and they also have a custom of men's forum known as 'dare' in vernacular language. The men's forum has impact in terms of influencing maternal health if the men are educated towards maternal health. It will greatly contribute to the positive attitude of men towards maternal health because the men's forum is culturally scarred and issues discussed in the forum are followed and abided to hence it will positively contribute towards maternal health.

Culture and Nutrition

The nutritional taboo for pregnant women in the ward 28 of Chipinge along the droughts in the area has left women with limited choice in terms of food. Nwokocha (2008) points out that, the

importance of food that like snail and eggs that is usually presented as taboos for pregnant women though it has nutritional benefits for them. Male involvement in culture and nutrition is therefore vital for maternal health given that malnutrition is one of the leading causes of maternal and newborn mortality in the ward. The male have to adequately provide for their spouses so as to protect their health through nutrition and promote maternal health. However the case has been different in the community as the men indicated that we only provide our wives with the food that we are told by either our mothers or sisters to and we were told that there are certain foods that they should not eat because they affect the baby as well as our sexual lives. For instance if a pregnant woman eat eggs they will give birth to children with bold head and if they eat birds like "zvingozha" they will have low sex drive".

Home delivery against Institutional delivery.

High rates of home delivery and low use of institutional services or health facility services, with in – laws influencing their sons to continue the historical legacy of home delivery on which they practiced themselves. Culturally the daughter in law cannot challenge a decision made by her in laws under the ndau set up. For this reason home delivery has been perpetrated and the young mothers particularly below 35 cannot challenge their in laws.

More so, culture emphasizes value and dominance on the male child which clarifies Kinanee and Hart's view that "In the first place, men have decision-making powers in their different roles as husbands, fathers and political, traditional and religious leaders". Thus given this influence male can optimistically influence the in laws behavior towards home delivery which is a barrier in the achievement of MDG 5 in the community.

Findings by USAID (2015) do not support the null hypothesis that there is no association between male involvement in maternal health care and utilization of skilled birth attendant

during delivery. All over the world there is an increasing interest in mainstreaming male participation in reproductive health, since men usually are the key decision-makers in the home and often control household finances. In reducing maternal mortality, the value of direct male involvement in maternal health care cannot be underestimated. It is unfortunate that the men in the area take uniformed decisions due to what they were taught by society. The men highlighted that "according to tradition home delivery is the best and we are even told that the spirits will be guiding that child and if any complications occur it means the woman have sinned hence she has to confess".

Antenatal Care (ANC)

ANC visits were reported to be low in the community and they have contributed to maternal mortality rate and the declining maternal health state in the area. There is need therefore for increasing attention to men's role in the uptake of maternal health care due to their influence and authority so that they can assist in promoting maternal health in the community through encouraging women to deliver at the health facility. To achieve this MOHCC came up with a resolution that, husbands should accompany their wives for their ANC visits. Though it has not been successful studies in Kenya by USAID under the DHS Working Paper (2015) have shown that" women whose husbands accompanied them to at least one ANC visit were almost twice as likely to deliver using an SBA as those who had ANC but without husband's presence". This could imply that men who accompanied their wives to ANC were educated about the importance of skilled birth attendance or institutional delivery. Kabakyenga et al. (2012) support this as he noted that "women were more likely to have better outcomes when their husbands got directly involved in maternal health care by attending ANC visits and supported their wives during pregnancy".

The case has been different in ward 28 of Chipinge; most men do not accompany their wives to the health facility even for ANC. The men indicated that the role of going to the health facility for neonatal, infant or maternal health is purely feminine.

Further, some studies have shown that, when men know the danger signs of pregnancy and delivery, they may act as life-saving agents, ensuring that their wives get appropriate attention in obstetric emergencies (Chowdhury et al. 2007; Rahman et al. 2011). They can only know these danger signs during the ANC visits on which they will be educated by the health personnel with regards to maternal health delivery. In contrary, most of the men showed that they do not have knowledge about the danger signs of pregnancy and only four men out of the thirty two adolescent and adult males managed to know at least two danger warning signs during pregnancy.

Postnatal Care (PNC)

PNC coverage has been a challenge in the community given the high rates of home deliveries with much influence from culture as noted by WHO 2013 Report on Postnatal care that cultural tradition particularly that of keeping the baby indoors has hindered PNC which is supposed to take place 72 hours after delivery. Men have not been supportive in terms of PNC due to culture in the area. Women highlighted that the men are not supportive because according to our culture we are not allowed to leave our homes six weeks after delivery and our men know that hence they encourage us to uphold culture.

Prevention from Mother To Child Transmission (PMTCT)

HIV has been a leading cause of maternal and newborn mortality but with the introduction of PMTCT mortality rates were reduced but the case has been different in the community with low use institutional delivery.

Ditekemena, et al. (2012) and Koo, et al. (2013) clearly show this when they reported that mothers that adhered to PMTCT programmes are more often accompanied by their husbands to ANC/PMTCT clinic than those who do not adhere. They also found that these couples have some level of education and found it easier to freely discuss issues related to their HIV status and family health care management. Most of the men do not go with their women for HIV testing though it is critical in PMTCT. One of the male participants noted that "by virtue of being men we are labeled as transmitters of HIV and some of us have extra marital affairs hence we are afraid of getting tested especially in the presence of our spouses because there is high possibility of being positive".

Maternity waiting home (MWH)

The effectiveness of WMH has already been demonstrated for instance in a study by Millard P. et al, women who stayed at a MWH experience better pregnancy outcomes than women admitted directly from home.

However despite the positive gains of the use of MWH above mentioned maternal mortality has been high in the community. This is due to the high rates of home delivery which deprive the use of MWH in the community despite its positive contribution to maternal health

Majority of the men indicated that "they did not want their wives to stay in MWH because it had extra costs since the women were not given food during their stay hence it added a burden on the men and it will be difficult for them to share the little food that they have between the family staying at home and the mother going to stay at the MWH for this reason they will just stay home and deliver with the help of TBAs because it is cheaper as they only go there for delivery". This calls for men's attention as they are supposed to provide for their wives during their stay at the MWH in order to manage the high risk associated with home delivery.

Barriers of Male involvement in maternal health

The involvement of men in ensuring and enhancing maternal health is actually a new idea, first hatched at a conference in Cairo in 1994, but not much has been done in practical terms in the developing world (Kinanee and Hart 2009). The idea of male involvement in maternal health have faced a lot of limitations that has led to difficulties in its implementation particularly in Sub- Saharan Africa which is highly cultural and other highly cultural communities like 28 of Chipinge. They barriers evolve around culture and traditionally constructed concept as mentioned below:

Barriers to male involvement

In an attempt to find answers to the problems with male involvement result King et al. (2008); Madiba, et al., (2013) and Medley et al. (2004) conducted in-depth interviews and focus group discussions (FGDs) with pregnant women who attended ANC with their male partners. The outcome of the interviews with the women revealed fear of their husbands‟ reaction and insecurity how to tell them about the results of HIV or any unsafe condition during pregnancy s they usually get the blame for it. Men mentioned fear as one of the barriers that prevented them from participating in ANC/PMTCT. They feared the reactions of their wives to the positive result and were also afraid of stigmatization which is also found by Turan, et al., (2013). Discussions among those couples could have alleviated the fears of both partners. Ezeanolue, et al. (2013) found that most of the women interviewed for their study, said they would be more comfortable to share their HIV positive result with their husbands if they were tested together on the same day. Some of the barriers affecting the uptake and involvement of men in PMTCT or

participation in maternal health in Sub-Saharan Africa that were identified through the literature review are as follows:

Fear of disclosure to partners

Akarro, et al. (2011) and Koo, et al. (2013) reported that fear is a big factor that stops pregnant women that tested HIV positive from revealing their status to their husbands and thus involve them in their care. They fear losing their marriages or relationships and be abandoned with their babies. Disclosure can be made easy if proper counseling is done. Medley, et al. (2004) reported that pregnant women, who cannot tell their partners, are encouraged to allow the nurses or counselors to disclose to their partners since they have the skill do it better and in a more neutral way at the same time providing correct facts about the disease and its management. A similar approach can be adopted in other countries in Sub-Saharan Africa and a change in policy should be advocated to allow for different models of disclosure according to the clients wishes.

Lack of awareness

Brusamento et al. (2012), explained that most maternal health awareness efforts have been directed almost exclusively at women, oblivious to the cultural role men play in women's decision-making. They further assert that this situation has led men to admitting that they do not have sufficient knowledge or understanding of their roles in the prevention of HIV, baby care or other maternal related health. Acceptance of any concept relies on how well this concept is understood, so if husbands have a clear understanding of maternal health they can be enabled to make an informed decision that will benefit their family. Involving men in maternal health will also lead to an increased uptake of facility delivery which was mentioned before with a probable impact on maternal and newborn mortality. Integration of HIV- and reproductive health services will lead to increased cost-effectiveness and synergies and even more so if men are routinely

involved. HIV-testing in PMTCT can be an entry point to this type of male involvement in maternal health at large.

Socio-cultural factors and stigmatization

According to Reece (2010), the perception of male gender inequality is a barrier to male involvement in maternal health Men believed that culturally maternal health is a women's activity and so a man should not be seen there. When a man accompanies his wife and he is seen by other men they may stigmatize him. Gender-based stigma has been identified as a barrier to reproductive health services for women in the literature as decision-making and the generation of funds for treatment of women is still left to men. Increased involvement of men in reproductive care may lead to better utilization of health care by women or even increased decision-making power for women regarding their own health.

Attitudes of service providers

Byamugisha et al. (2010) documented in a cross sectional survey in Uganda, the rudeness and hostility sometimes experienced by men from health providers. Men described the overly aggressive nature of physical examinations of their wives. In many instances, the men were not allowed to enter the ANC clinics with their wives even if they wanted to. Ditekemena, et al. (2012) confirms this finding, stating that the harsh treatment meted out to the men "discouraged them from returning or participating in maternal health activities".

Economic factors

According to the study done by Nkuoh et al. (2010) men complained of ANC and obstetric care bills as an obstacle hindering them from participating in ANC/PMTCT though a maternal health grant was implemented to scrap off user fees for maternal and under fives user fees at health facilities in Zimbabwe. They indicated the overbearing demands of their wives for money for

one ANC activity or the other. In addition accompanying the wife to hospital brings about waste of time which will not afford them the opportunity to go about looking for their means of livelihood. Maternal services are officially free of charge in almost all Sub-Saharan African countries even in Zimbabwe. However, in reality, unofficial, indirect and opportunity cost sum up to a significant expenditure for these services which may deter many couples from attending. Governments and also health facility management need to make sure that maternity services are delivered free of charge and that access to them is equitable.

CONCLUSION

Various issues require male involvement in the community which includes ANC, PNC, and PMTCT inter alia above mentioned. Due to men's characteristics usually given by African traditional culture W.H.O came up with the need for male involvement though they are barriers to it.

Chapter Three

Ways of enhancing male engagement in maternal health.

Chapter Overview

Though male engagement is important for the promotion of maternal health it has faced a lot of barriers in terms of its implementation and this is attributed to by a lot of reasons. These include fear of disclosure on HIV status, socio-cultural stigmatization inter alia the above mentioned. Henceforth this chapter seeks to address the ways of enhancing or promoting male engagement in maternal health.

Include men in income generating projects.

Organizations like Plan International have introduced a number of income generating projects in the area in support of women so as to capacitate them to cater for maternal expenses that may occur during or after pregnancy. For instance the organisation introduced village savings and lending (VSL) so that the women will cover their referral expenses, baby layette and food costs. However the projects have failed and this is mainly due to lack of support from the males either as fathers or husbands. This is noted by the women who depicted that "we are the one who are registered to the VSL groups but we do not have dominance over the income we get, our husbands know that we are into profit making groups and they take all the money at the end of the day, in other words we are male representatives in female groups". For this reason there is need to involve men in these groups so that they will be mutual benefits to both men and women and profits will eventually be realized in the benefit of maternal health. One of the male participants noted that "the reason why we take the money they get from the VSL it's because we give the women the starting capital hence at the end of day they cannot deny us the money they accumulate from the group". This therefore denotes there is need for male involvement in

VSL groups for its financial benefits to be realized in maternal health and promote the maternal health status in the community.

Nutritional gardens at the maternity waiting homes (MWH)

Failure to provide food have been one of the major challenges which have resulted in the under utilization of MWH despite its significance in promoting maternal health in the area. Hence there is need to provide food at the MWH so as to increase its utilization and promote maternal health in the community. The local clinic in the area known as Mabee clinic tried to come up with strategies to provide food for the pregnant women staying in the maternity waiting home, they tried to buy food for them with income generated from the health centre committee projects and the result based funding incentives that they receive. However the strategy was not sustainable because the income did not come as anticipated. Given that the area is drought stricken water has been a problem but the clinic has a borehole donated by Plan International. Therefore if men support the idea of provision of food at the MWH they can place a nutritional garden because they are sustainable given that there is a nearby water source at the health facility. Male participants indicated that they can do that for their wives because it lessens the burden of providing for their women during their stay at the MWH and the remaining family at home.

Awareness Campaigns and male involvement

A lot of awareness campaigns have been done either by NGOs or the government per se in the area so as to promote maternal health but they have not been successful and this mostly because they were only women gatherings. This was depicted by the fact that only four out of the 36 of the men that answered questions on pregnancy danger warning signs managed to know two danger warning signs. This was contrary to the women on which 32 out of the 36 that participated in attempting to respond to the questionnaires managed to know at least two

pregnancy danger warning signs. Both the men and women alluded that the lack of knowledge on pregnancy related issue by men was due to the fact they were not invited to gatherings that educated the community on maternal health. This is due to the misconception afore mentioned that maternal health was presented as purely feminine hence men were not included. However for these awareness campaigns to work they have to in cooperate and give them leading roles in terms of maternal health projects done in the community. The W.A.T.C.H 2014 Report by Plan International in Ethiopia noted that men seem to embrace advice given by other men especially in patriarchal societies hence they tend to overlook on information offered to them by women. This therefore depicts that there is need to involve men in the gatherings done in the community particularly those looking at maternal health and they should also give them leading roles so as to gain their support and of others as well.

Provision of adequate health care

After behavior change the women might therefore embrace the services offered at the health facility but there should also be the provision of adequate and comprehensive health-care for pregnant women and girls. This can be obtained through proper use of funds obtained from the health ministry and other voluntary organizations that are into maternal health since the health facility staff was reported by community members to be corrupt. Also the community should be educated about anti-corruption services so that they work hand in hand with it to avoid abuse of both health funds and properties. Also there should have access to communication with either the district nursing or medical officer or their representative because the people the participants noted that they “the health officials from the district are not even aware of the corrupt behavior by their counterparts here because they are hardly here and if they come we only here about it when they are gone we do not have time to interact with them and present their grievances”

Provision of Youth-friendly centers

Given the high number of child marriages and teenage pregnancies in the area there is need for youth friendly centers so as to educate the adolescent parents that denoted that they were not comfortable talking to the elderly women at the health facility and it is one of the reasons why they do not utilize its services. The adolescent mothers noted that they did not want to deliver at the health facility because "their ward is a small community and most of the health workers know them and they are as good as their parents and given a scenario whereby they are impregnated they tend to judge them and most of them are even rude towards saying you brought this upon yourself by rushing into sexual affairs hence they will not attend to them".

For adolescent girls and boys, there should be youth-friendly health-care centers where they could seek help when the need arises particularly on sex related issues.

Education

The education of girls and women, as well as their male counterparts, could considerably improve overall maternal health. The need to promote women and girls' education is hereby emphasized. Education is a veritable tool in promoting healthy sexual and reproductive relationships. In a study conducted by Odimegwu et al.(2005), they found that there was a high level of awareness of emergency obstetric conditions by men, particularly in relation to pregnancy signs and labor pains, which was traceable to education on the part of those men. This is in contrary to the state in ward 28 because most of the people either men or women are not educated due to the high level of school dropout rates amongst both girls and boys due to poverty, teen pregnancies and high migration rates to South Africa. Hence for the community to understand the importance and other maternal health related issues there is need to ensure that they are educated and if possible be provision of the dropout girls and boys to go back to school

though this will require assistance of the third sector notably NGOs. For the adult people there is much need for training particularly on maternal health related issues. This is noted by Odimegwu et al (2005) who noted that "data obtained from many countries (developing countries) have shown that women with at least a secondary level education end up giving birth to one-third to one-half as many children as women with no formal education. This result is possible because better educated women are able to delay marriage and exercise more control over their reproductive lives, including decisions about childbearing". These have serious implication for maternal health because it empowers women and give them control over their sexual reproductive lives particularly in terms of decision making.

Provision of privacy at the health facility.

Majority of the men reported that it was against tradition to have sex with their wives in the six months after delivery of the baby, and they would like to discuss such issues at the health facility but they cannot because there is an open infrastructure. With most of them being polygamist it has resulted in home based conflicts amongst their wives and it has become a barrier for them utilizing the health facility because if one of the wives hears that they have been to the health facility with other partner they tend to fight. Nurse Chikangaise the nurse in charge at Mabee health denote that this has led to a number of physical fights in the clinic. Another provider said: 'It is not easy for men to come, though we are trying… and they have got more than one partner so they are afraid to be seen at the clinic with this one. Somebody will see him and then go and tell the other partner that his other partner is pregnant, you see.' The facilitator asked: 'They know each other?' The provider responded: 'Yes! And the arrangement of the clinic ensures that everybody sees.' Hence there is need to create a private room or consultation space at the health

facility so as to protect women against violence and increase male involvement of men in health related issues particularly maternal health.

There is a need to find comfortable and convenient ways of involving men in reproductive health services.

Although both men and women said they are willing to have male involvement in a number of reproductive health services (antenatal care, postpartum visits and family planning consultations), nurses initially felt that not all clients were convinced about this. Having male partners present during the delivery was considered the least popular service. Nevertheless, half of the men and women interviewed said they would like to be involved. Some were not comfortable about attending with their partners, especially if the women in the group were of different age groups. One provider said: 'we one told the women, that they should come with their husbands and they laughed because they did not think that men would attend and we asked them if they liked it and they said no, even the men themselves have refused to come they say these are women issues and we are not part of them'. Another provider added: 'And another thing, most of our clients are very young and then what I've noticed is that they laugh at each other. If someone has brought their partner, others are giggling, they scrutinize him and so others do not bring their partners. Sometimes the partner is standing outside and I have to go and ask if he accompanied anyone to the clinic and then he'll be comfortable, whereas the sister in antenatal has asked who has brought her partner today and no one answered.' Therefore there is need to do much explanation to both the men and women on the benefits of male engagement in maternal health. Also to create a men friendly environment at the health facility like serving those who come with their partners first so as to avoid stigmatization by fellow members as they wait at the long queue at the health facility.

There is a need to involve hospital delivery staff and address infrastructure in labor wards

Majority of the men indicated that, want to accompany their partners to the labor ward even though they should begin at the ANC stage to PNC stage. However, the providers at the health facility discouraged men from being involved during delivery. This resulted in confusion for clients and clinic staff, one of the males said: "accompanying your wife for delivery is disappointing. The worst part of it is that the nurse sends away the men that come with their wives for delivery the nurse even said that this was not a private hospital." One of the reasons stated by hospital delivery staff for turning men away when asked by the researcher was that the wards were often crowded and not set up for couples. One said: 'But people are still not allowed because they say that it is not only one woman in the labor ward; sometimes there are two or three.' Hence there is need to set up couple friendly infrastructure and educate the health staff on the significance of male engagement in maternal health.

Stigma reduction

To increase male participation in ANC but also in HIV testing, this is a concept that is difficult to change but creating awareness and basic education will help in societal individual behavioral change, (Piot et al. 2008).

Reduction of fear of disclosure

Encourage couple HIV counseling and testing together Testing together will make the couple support each other and decrease fear of how to present the results to the partner. The counselors too can be authorized by the clients to disclose results were problems are feared.

Change in provider attitude:

Health workers should be trained on attitude modification already at pre-service training and any service provider caught being rude to clients should be warned and if not change penalized. Such events often occur when the workers are tired due to work overload and understaffing, therefore

there should be more staff on duty especially on most busy days in departments with a high turn-over of clients and where staff is dealing with sensitive issues such as HIV-testing and counseling. Duty allocation should be clear and concise so that staff responsibilities will be evident to the provider and the client.

• Integrating other reproductive health services such as STI, family planning, voluntary counseling and testing, and prevention of mother-to-child transmission with antenatal and postnatal care.

Health services need to be re-orientated to see men as clients.

Men should be encouraged to take responsibility for their sexual behavior. They should understand that in the absence of a cure, men's behavior is crucial to the prevention of the spread of HIV. This could be discussed in community, social and religious forum.

It is also expected that men, among other things, should be actively involved in being strong advocates for men's participation in maternal health and more generally, reproductive health. Men should be concerned about the preconception, prenatal and postnatal care given to women. This is important because early prenatal care for pregnant women, for instance, produces better birth outcomes compared to women who receive little or no care during their pregnancies. This applies to other forms of care already mentioned.

Conclusion

Male involvement has faced a lot of barriers in terms of maternal health and it has discouraged men to participate in maternal health issues. There is need therefore to include men in maternal health meetings and give them influencing positions as maternal health representative in the community amongst others afore mentioned.

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APPENDIX ONE

RESEARCH QUESTIONNAIRE

My name is Norah Comfort Nyanzira, an undergraduate in Development Studies student at Midlands State University carrying out a study to evaluate male engagement in maternal health which might help promote maternal health in the community.

You are therefore requested to answer the attached questionnaire. Please be assured that the information collected shall be for the purpose of this study and shall be treated with utmost confidentiality. Please answer all questions honestly and to the best of your knowledge.

Descriptive Section

a. Date ----------

b. Location/place----------

Demographic Section

1. What is your Gender? (**Please tick**)

□ Male

□ Female

2. Which of the following is your age group?

□ 13-19

□ 20+

3. Are you employed?

   □ Yes

   □ No

4. What is the highest level of formal education that you achieved?

   □ Primary School

   □ Secondary School

   □ Technical/ teachers/vocational College/ apprenticeship

   □ University

5. For how long have you been staying in Mabee (ward 28)?

   Less than 5 years

   More than 5 years

   Ten years

   More than ten years

6. Did you accompany your wife to the clinic when she was pregnant ? (Yes/NO) ☐

   Did your husband accompany you to the clinic when you were pregnant? (Yes/NO) ☐

Did you accompany you wife to the clinic for PNC (78 hours after delivery)? (YES/NO) ☐

Did your husband accompany you for PNC (78 hours after delivery)? (YES/NO) ☐

7. What are the five pregnancy danger warning signs that you know?

……

……

……

……

Have you ever attended meetings on maternal health? (YES/NO) ☐

If no why not?

……

……

……

……

If yes approximately, how many women participated in each of those trainings? ……..

If yes approximately, how many men participated in each of those trainings? ……..

8. Were the trainings relevant to the needs of the community in terms of maternal health?

☐ Yes ☐ No

9. Give at least two reasons for your answer……

……

……

……

……

10. How does your local culture embrace the issues of male engagement in maternal health?

……

……

11. In your opinion, are men in your community able to engage and dialogue on issues to do with maternal health? Yes/No

12. If your answer is yes, how? ……

……

……

……

……

Has the cultural dynamics in terms of male engagement in maternal health changed the last 5 years? Yes/NO Give a reason for your answer? .....

.....

.....

.....

Are there any hindrances at the health facility that hinder male engagement in maternal health?

……

……

13. In your opinion, how would you rank and list these positions in terms of hindering male engagement? Use a scale of 1 to 5 where 1 is the lowest and 5 is the highest.

Name of Position	Ranking
A……	……..
B……	……
C……	……
D……	……..
E……	……

APPENDIX TWO

INTERVIEW GUIDE

1. Sex? ……
2. How old are you? .....
3. How old is your last child? .....
4. For how long have you been staying in Mabee? .....
5. For the past five years, how has been the state of maternal health in your community? .....

   ……
6. In your opinion who is more involved in maternal health men or women in this community and indicate why?

   .....

   ……

   ……
7. As a woman or men, did you partake in any maternal health related meetings in your community? .....
8. After these meetings, are you now able to participate meaningfully in terms of maternal health? Yes/No.
9. If yes, specify how? .....

   ……

   …….. ……
10. Do you own any asserts in your name? Yes/ No.
11. If yes, state the type of asserts……..

    ……
12. Are you able to acquire and dispose of key asserts as and when you want? Yes/No
13. Give reasons for your answer……

    ……
14. Are you able to inherit property? Yes/No.

    ……

15. Give a reason for your answer? ……..
16. Do women own land in your community? Yes/No
17. If not why? Give reasons……..
    ……..
18. How does your culture embrace issues of maternal health and other women empowerment initiatives? Explain briefly……..
    ……
19. What do you think should be done to enhance male engagement in maternal health? Suggestions.
    ……
    ……
    ……

……