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ABSTRACT

The impact of male involvement in reproductive health and early childhood care in European countries including Norway has shown to yield great benefits for both the mother and child and the man himself. It has demonstrated significant potential in encouraging men's positive roles in building gender equality and improving men's and women's health. However, this is a new concept for most African countries including Zambia where the culture of differences in gender and gender roles is promoted. This has drastically affected the lives of children, women and including men. Involving men in reproductive and early childhood care is one of the strategies that Zambia is using to attain the MDGs 3, 4, and 5 which are; gender equality, promotion of maternal health and reduction of infant mortality.

The purpose of the study was to explore male involvement in reproductive health and early childhood care in Norway and Zambia. A qualitative study design that was explorative, descriptive and contextual was used to purposively select nurses working at the health institution, men who are fathers and the grandfather in Sogndal. The sample consisted of 12 informants; three nurses providing reproductive health services in Sogndal, 5 men from Norway including a grandfather and 4 men from Zambia who were studying in Norway. The sample size was determined by saturation. Data were collected using a semi-structured interview schedule and analysed using content analysis.

The findings of our study showed that men in Norway are very involved in reproductive health and early childhood care while the informants from Zambia also reported having participated in reproductive health and early childhood care. However, this is not typical of the Zambian men as this is done by a few men who have the information and know the benefits of gender equality. Findings of this study also showed that Norway is a high modern society which promotes gender equality while Zambia is a traditional society where there is inequality between men and women. The results of this study further showed that both Norwegian and Zambian men were proud of their participation in reproductive health and early childhood care as it made them to be responsible fathers as well as strengthened the relationship with their partner and baby. However, one of the challenges experienced by both Norwegian and Zambian men in their participation in reproductive health and early childhood care was to make adjustments to their work/school program in order to help their partners take care of the baby. This was more pronounced by the grandfather who participated despite the practice not having been common during his time.

Parental leave was cited to be one of the best aspects in promoting male involvement in reproductive health and early childhood care as it provides enough time for fathers to stay home and take care of their partner and baby. However, most of the Norwegian informants did not take their parental leave while none of the Zambian informants took their paternal leave.

In light of our findings, our recommendation to the Norwegian government is to consider carrying out a study on male involvement in reproductive health and early childhood care. While interviews will be conducted on women in the Norwegian health care system, they should consider funding sensitization programmes to disseminate information to the general public on the benefits of involving men in reproductive health services and early childhood care among others.

1.0 INTRODUCTION

Background

The involvement of prospective fathers in reproductive health is not new; it has existed for several decades in many parts of Europe including Norway. During the 1960s and 1970s, men were encouraged to take part in parent groups and to participate during labour and to take a more active role in caring for their infants. The primary intention was to give greater support to the pregnant partner before, during and after birth (Plantin, 2007).

The growth of the women's movement on the labour market in Norway and other European countries has contributed to a strong focus on fatherhood, since the possibilities of increasing gender equality in society required increased involvement by men in family life. Some groups have since been established which support male involvement in reproductive health and child care. For example the MenCare a global fatherhood campaign which is aimed at promoting male involvement in caregiving and maternal health for the benefit of women, children, society and men themselves (MenEngage Alliance, 2009).

The impact of male involvement in reproductive health and child care in European countries has shown to yield great benefits for both the mother and child and the man himself. It has demonstrated significant potential in encouraging men's positive roles in building gender equality and improving men's and women's health (MenEngage Alliance, 2009).

In 1994, the United Nation's International Conference on Population and Development (ICPD) established the importance of involving men in the challenge of improving sexual and reproductive health. The emphasis was placed on developing efforts which would increase the man's involvement in parenting (UN- ICPD, 1994).

Nordic countries have been providing good welfare services to its citizens, they have most welfare services in common, among which is aimed at promoting gender equality and male participation in reproductive health and child care (The Nordic Council of Ministers, 2006).

In Norway, the increased participation of women on the labour market in the early 1970s was later accompanied by policies aimed at reconciling the combined role of wage-earner and mother. The law on gender equality was enacted in 1978 which was meant to enable both women and men to participate in working life, social life and family care equally (Øie, 2007).

Norway is now promoting fatherhood where men's responsibility is not only economic provision but also psychological, emotional and physical care of children (Halvorsen & Stjernø, 2008).

Africa has for a long time respected and followed their culture of the difference in gender and gender roles. This is because traditionally man has been viewed as head and provider of the family, while reproductive health matters and care of children has been the responsibility of the woman. In Sub-saharan Africa, the role of men in reproductive health and child care has not so much been realised. However, the introduction of millennium development goals number 3-gender equality, 4- child health and 5-maternal health has seen the promotion of male involvement in reproductive health and early childhood care. Therefore, programmes aimed at promoting male involvement in reproductive health and early childhood care have since been introduced to help men change their attitudes towards gender equality, reproductive health and child care (MenEngage Alliance, 2009).

Zambia like other African countries is also striving to promote gender equality and male involvement in reproductive health. Zambian societies are traditional and many foster patterns of health seeking behaviours that delay or limit beneficial contact (Global Health Initiative Strategy, 2012). Social barriers in gender inequality exist where women cannot make a decision concerning their health and that of the child without the consent of their partner (Global Health Initiative Strategy, 2012). Such inequalities have affected the lives of women and children drastically and contributed to maternal mortality and infant mortality associated with failure to make decisions early enough. To address the issue of male involvement in reproductive health, the government of Zambia has since introduced a number of programmes at health facilities and in the community aimed at promoting gender equality and male participation in reproductive health and early childhood care. For example, men who accompany their partners for reproductive health services and or take their children for growth monitoring would be given first priority, this is to encourage them to go again to the health facility and in the long run acquire some information on issues of gender, reproductive health and early childhood care. Looking at this in the long term perspective, it would mean that men will begin to drift from the socially/ culturally known gender norms and role e.g. men as bread winners and women as care givers (White, V., et al. 2003).

However, no information is available from Zambia to evaluate the programmes and this makes it difficult to assess the impact.

STATEMENT OF THE PROBLEM

In the last decade, attention to the role of men in reproductive health has dramatically increased. It is now widely recognised that men are key agents where a wide range of sexual and reproductive health practices is concerned. Reproductive health goes beyond the health sector, and may be more than a woman's health issue. Men play an important role in the reproductive health of women, either within marriage or consensual union (Groenewold, et al. 2004). Greene, et al. (2004) stated that involving men has been a prominent part of the shift from family planning to the broader reproductive health agenda. Men constitute an important asset in efforts to improve women's health. Efforts to involve them in ways that transform gender relations and promote gender equity contribute to a broader development and rights agenda (Greene, et al. 2004).

Childbearing and parenthood continue to have a stronger impact on women's daily lives than on men's. The gendered division of care, work and household responsibilities has negative consequences for women's position in the labour market. The division of responsibilities within households between men and women is not equal, though men also participate in house work; women still do most of the house work and take most of the available parental leave (Gender in Norway, 2010).

In Zambia, where gender inequality still exist and men are decision makers in the homes; the important role they play in reproductive and child health is increasingly being recognised, especially with the advent of (Human Immune Virus and Acquired immunodeficiency Syndrome (HIV and AIDS). More attention is being focused on including men in reproductive health and decision making especially in the Prevention of Mother to child transmission of HIV (PMTCT) programmes. Therefore, involving men play an important role in influencing decisions made by women concerning their own health; they also have a role to play in house work and family care together with their partners. From observation as nurses this has yielded better results. However, more still needs to be done and the researchers hope to learn from Norway how best to integrate the male partners in promoting gender equality, reproductive health and early childhood care.

Operational Definition of Terms

Reproductive Health: Reproductive health in this study is the care given to the woman during pregnancy, childbirth and postnatal period.

Early Childhood: The routine care of children below 1 year of age.

Male involvement: The physical participation of men in issues of reproductive health and early childhood care

Purpose of the Study

- To explore the experiences of nurses concerning male involvement in reproductive health and early childhood care in Norway and Zambia.
- To find out from men who are fathers and grandfathers about their participation in reproductive health and early childhood care.
- To explore the influence of programmatic factors on male involvement in reproductive health and early childhood care in Norway and Zambia.

Tentative Research Questions

- What motivates men to participate in reproductive health and early childhood care in Norway and Zambia?
- What challenges do men face in their participation in reproductive health and early childhood care?

2.0 LITERATURE REVIEW

According to Boswell and Cannon (2008), literature review is a well written synthesis of information about a topic that includes a discussion on the research that has been done and the evidence gathered; the methodologies, the strength and weaknesses of findings and the gaps that require more knowledge.

In order to understand and appreciate the current male involvement in reproductive health and early childhood care in Norway, it is important to review the history of the welfare state and how it has influenced the current trend of male involvement in reproductive health and early childhood care. The review of literature will also discuss about male involvement in reproductive health services and early childhood care in Zambia.

Welfare in general is provided by individuals and families, labour market, public services and voluntary sector. The industrialisation of Europe, particularly in the later part of the 19th century required a different welfare balance. In many European countries, government viewed

with growing concern the social consequences of industrialization (Halvorsen & Stjernø, 2008). According to Halvorsen & Stjernø, (2008) Nordic countries have been pioneers in provision of good welfare services to its citizens; they have most welfare policies in common, a relatively egalitarian income distribution, and a competitive economy with strong growth.

The Norwegian welfare state can be traced back from the 19th century following the World War II. The welfare system in Norway is concerned with taking care of its inhabitants from the cradle to the grave with special commitment to children among others. To support this phenomenon, the government put in place policies to enhance good welfare system for its citizens. Policies in maternal, child health care and family planning were implemented as far as 1940. It was aimed at promoting the health of the mother and children as well as limit the number of children for economic growth (Austveg & Sundby, 2005). The child benefit policy was introduced in 1946. It is paid to families to cover some of the costs of having children and the child is eligible from the month after birth until the month before the child turns 18 years (Ministry of Children, Equality and Social inclusion, 2011). Maternity leave was introduced in 1956, it was intended to give women an opportunity to spend more time with their children. It was gradually expanded in the early 1980s from 18 weeks to 42 weeks with 100% compensation, and in 1993 to 52 weeks with 82% compensation (Halvorsen & Stjernø, 2008).

Female participation in the labour market increased in the early 1970s mostly on part-time basis, and in 1980 women entered full-time jobs in numbers. The women's entry into the labour market was later accompanied by policies aimed at reconciling the combined role of wage-earner and mother. Henceforth, in 1975 the law on day care was approved by the Government and more day care facilities were established across the country. By 2008 there was full coverage of day care for children 3 to 6 years; this arrangement has provided a basis for female employment and a high labour market participation of both parents with small children (Øie, 2007). During the same period 1970s, the proportion of women in higher education increased and gender emancipation moved onto the political agenda. These changes in family structure influenced the welfare state as well, and in 1978 a law on gender equality was enacted by parliament (Halvorsen & Stjernø, 2008). This was meant to enable both men and women to participate in working life, social life and family care equally (Øie, 2007). The gender equality Act of 1978 did not only create changes in Norwegian family life, but also

culture, politics and economic life. Norway is now promoting fatherhood where men's responsibility is not only economic provision but also psychological, emotional and physical care of children (Halvorsen & Stjernø, 2008). The information above therefore, confirms that Norway has already achieved the Millennium development goal number 3 concerned with promoting gender equality and empowerment of women.

The Norwegian government enacted the family policy in 1987. The family policy include paid parental leave of 47 weeks that can be shared between parents, were the first 6 weeks after birth of the child are reserved for the mother for health reasons (Ministry of Children, Equality and Social inclusion, 2011). The father's quota of parental leave was introduced in 1977 based on the idea of shared parenthood. Of the 56 weeks, 10 weeks are reserved for the father to participate in caring for their child during its first year of life. Today in Norway about 90% of fathers make use of the parental leave (Ministry of Children, Equality and Social inclusion, 2011). The most common arguments for introducing parental leave and also encouraging men to take leave are: to promote a better gender balance and equity in the family and in the labour market for both men and women; to counteract declining birth/fertility rates, to increase the well-being of children and to increase women's economic independence (Plantin, 2007). Today in Norway, women are in employment due to the emergence of a strong public welfare system which saw among others the establishment of kindergartens to enable both parents reconcile the demands of family and working life (Halvorsen & Stjernø, 2008).

Zambia is a traditional society; and in a traditional society, according to Giddens (1984) authority is based on age and gender. When it comes to matters of reproductive health, men have more authority over women and are considered to be decision makers. This may affect the lives of women and children negatively. This is a huge concern because maternal mortality and infant mortality are still very high in Zambia. Maternal mortality is at 440/100,000 live births and infant mortality rate is at 76.2/1000 (Ministry of Health Zambia, MDG Report, 2013). One of the contributing factors to maternal and infant mortality is delay in making decisions concerning treatment and care (Ministry of Health Zambia, 2010). Depriving women freedom to make decisions concerning their health and that of their children is oppressive in some way. According to Freire, (1993) oppressed people can be liberated through education. Freire cited the principle of social justice, equal access, liberation

and empowerment as necessary to help individuals and communities address the larger economic causes of oppression and poor health.

In Zambia, male involvement in reproductive health and early childhood care is influenced by social cultural norms, beliefs, attitudes and perception of the community which is also as a result of the large power distance that exist.

Therefore, it is important to educate the community on the benefits of gender equality and male involvement in reproductive health and early childhood care for them to change and transform their environment. According to

Reproductive Health at a Glance Zambia, (2011) gender equality and women's empowerment in Zambia are important for improving reproductive health. Higher levels of women's autonomy, education, wages and labour market participation are associated with improved reproductive health outcomes (Reproductive Health at a Glance Zambia, 2011). In view of this, male involvement is very cardinal as men take control of resources. The Zambian informants who were interviewed were in Norway for studies and were the only ones available. Therefore, they did not give information of typical Zambian men since they are educated and they promote gender equality and male involvement in reproductive health and early childhood.

Men and Reproductive Health

According to Plantin (2007), Maternity and child health care can be seen as one of the most important health developments regarding reproductive health in Europe today. It offers the possibility to support women and children before, during and after pregnancy as well as a wider range of health interventions such as immunizations. According to World Health Organization (WHO) 2003 report, research shows that a considerable number of negative conditions can be avoided if the pregnant woman gets social and psychological support not only from a qualified child health care provider but also from a social network especially the partner of the pregnant woman. Norway is a high modern society which embraces both individualistic and collectivistic cultures (Neuliep, 2006). Although it embraces both types of cultural characteristics, most families have adopted the individualistic culture where people live as individuals, look after themselves and their direct family only. Norway has a good economy and embraces equality as a strong norm (Neuliep, 2006). Therefore, this entails that there is equal distribution of power in decision making between men and women. Men

participate in matters of reproductive health freely and children are socialised with equality in gender roles from childhood.

Norway being a welfare state has a health care system built on the principle of equal access to services (Halvorsen & Stjernø, 2008). This entails that women would still get better health services even without the involvement of men because women have the power to make decisions concerning their reproductive health.

However, today in Norway like in many other European countries, mother and child health services have made efforts to involve the man. Often the man is invited to accompany the partner for regular prenatal check-ups as well as parent training being offered to couples.

Parental training is meant to prepare the couple psychologically for the birth of the baby. This has yielded good results in promoting male involvement in reproductive health. A study conducted by Madsen et al., (2002) referred to in Plantin, 2007 in Denmark, reported that 80% of fathers participated in prenatal preparation courses and prophylactic consultations. While a similar study by Support in parenting (SOU), 1997 in Sweden reported 90% participation by expectant fathers. However, evaluations show that men who have taken part in these groups are very positive towards this form of training.

According to Draper, (1997) there has been an increase in the number of men participating in the parent training offered by mother and child care services. At the same time there has also been a dramatic increase in men's attendance at birth over the past couple of decades, at least in the Scandinavia. A Danish study by Madsen et al., (2002) reported that more than 95% of fathers attend delivery at the hospital because they wanted to.

Men play an important role of supporting the women psychologically during birth which is important for the transition to motherhood. It also helps the man to develop a relationship with the child as early as possible. Berry, (1988) reported that a number of studies have also shown that the presence of the man in the labour room shortens the labour and reduces the epidural rate. Enkin et al., (1995), found that most women are satisfied with the support they receive from their partners and often exceeds the support from the midwife. Plantin, (2007) also reported that the more the father engages himself during the birth and postnatal period, the stronger is his attachment to the baby. Henceforth, a father with a strong attachment to his baby may also participate more in the child's growing up.

Zambia is among the pre modern societies which embraces collectivistic culture. According to Neuliep, (2006) collectivistic societies are characterised by extended primary groups such as the family and neighbourhood, people are not seen as isolated individuals, they are seen as interdependent on others and they promote tradition and their primary value is harmony. In a collectivistic society, there is value for social reciprocity, dependence and obedience. A person's behaviour is guided more by shame than by guilty. As such there could be resistant to change as people would want to live in harmony and protect their tradition and relationships that exists.

Zambia has a large power distance culture. Neuliep, (2006) defines power distance as the extent to which the less powerful members of institutions and organizations within a country expect and accept that power is being distributed unequally. This is seen even in institutions such as families where the less powerful mostly women should be dependent upon the more powerful, mostly the men.

Gender based power relations have a direct effect on the ability of partners to acquire information, make decision and take action related to their reproductive health safety and well-being, for example, a woman and her partner may not agree on the desirability of pregnancy or the use of contraception (Population Council, 2001). The information above confirms that Zambia has not achieved the Millennium development goal number 3 concerned with gender equality and empowerment of women. However, according to the structuration theory by Giddens, (1984) social structure/family is the medium of human activity as well as the result of those activities. Social structures create possibilities to change human behaviour, therefore, behaviour cannot be restricted it can always be changed (Giddens, 1984). A study conducted by Dudgeon & Inhorn, (2004) on male involvement in reproductive health revealed that in poor countries male involvement during pregnancy has shown to reduce the number of low birth weight babies resulting from inadequate nutritional intake during pregnancy since men mediate their access to economic resources. While it is possible and happening in Europe, in Zambia it is not very common for men to be present at birth due to traditional and cultural practices. However, in Zambia where the authors are residents, strategies have been put in place to try and promote gender equality and encourage men to participate in reproductive health and early childhood care.

Men and Early Childhood Care

According to studies done in European countries, the father's positive involvement in childrearing is associated with health outcomes in the social, emotional and cognitive functioning of the child from infancy onwards (Lamb, 2004). The father's participation in childrearing and family work appears to have relevancy for other domains as well and has been related to greater marital satisfaction in both partners (Levy-Shiff, 1994), improvements in mother-child relationships, (Feldman et al.,1997), and father's own psychological health and self- development (Palkovitz, 2002).

According to MenCare Global report, (2012) as fathers get more involved and share the care and domestic work burden, women's economic empowerment advances.

Women can (re)enter the workforce, go back to school and pursue goals outside the home. A study by Johannson, (2010) in the Swedish Institute of Labour Market Policy Evaluation report states that a mother's future earnings increase on average 7% for every month that the father takes paternity leave. In Norway, 80% of all women aged 25 to 66 years are in the labour force and approximately 75% of them have children below 3 years of age. This has been made possible with the availability of shared paid parental leave and a father's quota which enables men and women to combine work and family life (Ministry of Children, Equality and Social Inclusion, 2012).

Studies conducted by MenCare, (2012) reported that a positive caregiving influence from men in the household are more likely to have gender-equitable attitudes, more likely to participate in care work and less likely to use violence against a female partner later in life. This would also mean that children brought up in a gender-equitable and non-violent environment are more likely to develop gender equitable attitudes and be non-violent to their partners in life. The MenCare Global report, (2012) also revealed that, by being involved from the beginning, men are setting the foundation for close relationships with their children. In the same vein children who have emotionally close relationships with their fathers are more likely to demonstrate empathy, be involved with their communities and show better mental and emotional health.

In Zambia, paid paternal leave is 5 days for public service workers. Most fathers do not utilise it while others may not even know about it. Working mothers are entitled to a three months

maternity leave to stay home after the birth of the baby. At the end of the three months leave, working mothers may have to find a care taker to take care of the baby while she is at work. Fathers concentrate much on their role of breadwinner while some fathers may only help take care of the baby after working hours. However, most fathers have shown great interest in taking care of children from the age of 18 months when the child is able to walk. Most of the educated men in Zambia understand and support gender equality and reproductive health. According to Giddens, (1990) modernisation affects our day to day life. Men and women in Zambia are now getting more and more educated and women are also in employment. This therefore, entails that people are slowly moving from a traditional society to a modern society. Educated men and women are able to access information on gender equality, reproductive health and early childhood care from the internet, radio, television and also from books.

3.0 RESEARCH DESIGN AND METHODOLOGY

The research design is the overall plan for obtaining answers to the questions being studied and for handling various challenges to the worthy of the study evidence. (Polit & Beck, 2010, pp.74). Qualitative research is a broad term used to describe research that is focused primarily on human experience through exploring attitudes, beliefs, values and experiences (Whitehead, 2007). Qualitative research is more in-depth and holistic than quantitative, generating rich material on which to base the findings of a piece of research (Polit & Beck 2010).

Data Collection Methods

Data collection tool/method may take the form of a questionnaire or interview schedule, checklist, projected device or some other type of tool for eliciting information (Polit and Beck, 2006). The researchers in this study will use a semi-structured interview schedule for data collection. A semi-structured interview schedule is one that contains structured and unstructured as well as open-ended questions. In semi-structured interviews, researchers prepare in advance a written topic guide which is a list of areas or questions to be covered with each participant. The interviewer's function is to encourage participants to talk freely about all the topics on the list and to tell stories in their own words. This technique ensures that researchers obtain all the information required and gives people the freedom to respond in their own words, provide as much detail as they wish and offer illustrations and explanations.

Care should be taken not to ask closed-ended questions. The goal is to ask questions that give respondents an opportunity to provide rich detailed information about the phenomenon under study (Polit & Beck, 2008, pp. 394).

Advantages of using Semi-structured interview schedule

1. Questions can be prepared ahead of time. This allows the interviewer to be prepared and appear competent during the interview.
2. Semi-structured interviews also allow informants the freedom to express their views in their own terms.
3. Semi-structure interviews can provide reliable, comparable qualitative data (Cohen D, 2006).

Disadvantages

1. It is difficult for the interviewer to interview, record and listen at the same time.
2. Interviews take time to be complete and even longer to transcribe into a written record of what was said (Walsh & Wigans, 2003, pp. 93).

Population

Population in research is a collective term used to describe the total quantity of cases of the type which are the subject of your study.

A population can consist of objects, people, or even events e.g. schools, miners etc., (Walliman, 2005, pp. 274). In this study, our study population comprised of nurses and midwives providing reproductive health services and men who are fathers and grandfathers in Norway and Zambia.

Sampling

A sample is a subset of a population selected to participate in a study (Polit and Beck, 2010). Purposive sampling was used in this study. In purposive sampling, the samples are selected in deliberate manner. The goal or purpose for selecting the specific study units is to have those that will yield the most relevant and plentiful data given your topic of study (Yin, 2011). Of high priority in this regard, these units should include those that might offer centrally evidence or views, especially given the need for testing rival explanations (Kuzel, 1992 in

Yin, 2011). The sample consisted of nurses and midwives providing reproductive health services within Sogndal and men who are fathers and grandfathers from Norway and Zambia. The sample size was determined by saturation. Saturation is the collection of qualitative data to a point where a sense of closure is attained because new data yield redundant information (Polit and Beck, 2010).

Data Collection Technique

Data collection technique is the actual method of how the data will be collected (Polit and Beck, 2006). The researchers conducted the interviews in a conducive and private place, comfortable for the researchers and the respondents. In this study, one of the researchers was conducting the interview while the other was taking notes with the consent of the respondents.

Ethical Consideration

According to Polit and Beck (2010), ethics is a system of moral values that is concerned with the degree to which research procedures adhere to professional, legal and social obligations to the study participants.

They include principles of respect for persons, beneficence and justice that are relevant to the conduct of research. It is required that the development and implementation of research should be ethically and culturally acceptable. The respondents have the right to know the risks involved in participating, the purpose of the research, and the nature of the study situation and the results of the study. The researchers obtained written permission from the relevant authorities e.g. university authorities through the supervisor before starting the project (refer to Appendix 3 and 4). The study was approved by the relevant authority before data collection. A written consent form (refer to Appendix 1) was formulated and approved by the supervisor which contained the nature of the study and all legal obligations such as the right to withdraw from the study etc. During the study, the nature of the study was explained to the participants and confidentiality was assured. The researchers introduced themselves to the respondents after which the respondents were asked to sign a consent form which gave the researchers permission to conduct the interview (refer to Appendix 1). The completed semi structured interview schedule (refer to Appendix 2) was kept under strict security conditions to avoid unauthorized access to the information.

Pilot Study

A pilot study is a smaller version of a proposed study conducted to develop and refine the methodology, such as treatment, instruments, or data collection process to be used in a larger study, (Burns and Grove, 2005). A pilot study can be used to improve a project, assess its feasibility, improve its clarity, eradicate problems and refine methodology (Polit & Beck, 2010). The pilot study was done on one man and one nurse in Sogndal and included all steps expected to take place in the main study. The pilot study helped the researchers identify and make changes to the interview schedule. For example question number 14 had to be included in the questionnaire which reads “How has your participation in reproductive health services and early childhood care benefited you and your family ” (refer to Appendix 2). The pilot study also helped the researchers estimate how long an interview would take. In this study, each interview took approximately 20 minutes. The pilot study helped the researchers determine the feasibility of the study and reliability of the data collecting tool.

4.0 DATA ANALYSIS

Qualitative analysis is the organization and interpretation of narrative data for the purpose of discovering important underlying themes, categories and patterns of relationships (Polit & Beck, 2012). The purpose of data analysis is to organize, provide structure to and elicit meaning from data (Polit & Beck, 2012). In this study, qualitative data were collected using an interview schedule in which the notes were taken in the field. Data were analyzed using content analysis, which is the process of organizing and integrating narrative qualitative information according to emerging themes and concepts (Polit and Beck, 2010).

Qualitative content analysis involves breaking down data into smaller units, coding and naming the units according to the content they represent, and grouping coded material based on shared concepts (Polit & Beck, 2012). In this study, the 2 researchers carried out the content analysis individually after which they met to compare and discuss the information given in this document. The data were collected from the field using structured interview schedule. The data were read through several times to obtain a sense of the whole. The data were then divided into meaning units that were condensed. The condensed meaning units were abstracted and labeled with codes. The various codes were then coloured and the data were read through again in order to identify data that relate to each other. The codes were compared based on differences and similarities and sorted into categories and sub-categories

which constituted the manifest content. The 2 researchers then met to read through and discuss the data in the tentative categories. The 2 researchers agreed and disagreed on the content of the data and sort clarification. A process of reflection and discussion resulted in agreement on how to sort the codes. Finally, the underlying meaning, that is, the latent content of the categories was formulated into themes in order to explain the relationships as well as answer our objectives. The themes interpret and elaborate the findings of our data as discussed below;

Twelve (12) informants were interviewed. Three (3) of the informants were nurses/midwives from Sogndal, with an average working experience of 6 months to 32 years in reproductive health services. Nine (9) of the informants were fathers including one (1) grandfather. Of the nine (9) informants, five (5) were from Norway and four (4) from Zambia. Four (4) of the Norwegian informants were married with 1 to 4 children with an average age range of 1 year to 15 years. The only Norwegian grandfather had two (2) children aged 41 and 42 years, with 4 grandchildren with the youngest aged 4 months.

Two (2) of the Zambian informants were married with 1 to 2 children aged between 11 months and 6 years, one (1) was single with 1 child aged 3 years and the other informant was widowed with 1 child aged 8 years.

During the analysis, the researchers identified the following 4 themes:

Reproductive Health Programs for men

When asked about any programs available to encourage male participation in reproductive health, both nurses and Norwegian fathers talked about the 3 evening classes on parenthood offered by the health Centre in Sogndal. All the Norwegian informants confirmed having attended the 3 sessions on parenthood offered by the Health Centre. This information is supported by a statement from one of the nurses who said *“they always come as a couple when they are expecting their first child and are ready to learn, we offer group, couple and individual counselling”*.

However, this information is in exception of the grandfather who said such a program was not there during his time. He said that he had to learn most of the things concerning child care on his own. Different from the Norwegian informants, the majority of Zambian informants said that they were encouraged by reproductive health programs aired on Zambian television and

radio. One man said *“I just learnt from the program “your health matters” on ZNBC and radio”*.

Work and family care

When asked about the utilization of parental leave, some of the Norwegian informants reported having taken their parental leave. This information is in line with the responses from all the nurse informants who said that most men prefer to take their parental leave, usually 6 months after the birth of the baby. One (1) of the informants said *“I shared the parental leave with my wife and it was good being home with the baby”*.

This statement is supported by information from one (1) of the nurses who said *“most men bring their children for control especially after 7 months of age when they are on parental leave”*.

However, the majority of the Norwegian informants said that they did not take parental leave instead had to reduce on their working hours in order to help with house work and caring for the baby and other children at home. One (1) man said *“I only took 4 weeks leave when the baby was born and it reduced my work by 10% in order to help my wife care for the baby”*.

This information is supported by a statement from one (1) of the nurses who said *“it depends on individual choice others prefer to adjust their work schedule instead of taking parental leave”*.

In line with this, all the nurses reported that some men do not accompany their partners for antenatal care because they are usually at work.

However, the grandfather reported not having taken any leave to take care of the baby. He said *“I did not have parental leave; it was not there that time so I just planned it myself”*.

He also said *“At that time I was studying at university at the same time doing military training....so I had to adjust my school program in order to help take care of the baby because my wife was also working”*.

On the other hand, none of the Zambian informants reported having taken their 5 days paternal leave entitled to them after birth of the baby. Similar to the Norwegian informants, majority of the informants said that they had to make adjustments to their school or work schedule in order to help the partner take care of the baby. One (1) informant said *“I did not*

take paternal leave; I had to do my work at awkward hours because I had to participate in housework and caring for the baby”.

While another informant said *“I did not take paternal leave, my wife was always there for the baby I only supplemented care after working hours”.*

Family Life

All the Norwegian informants revealed that they participate in house work as well as changing diapers, feeding and bathing the baby. One (1) man said *“I did everything apart from breast feeding.”*

This information is supported by a statement from one (1) nurse who said *“during the home visits, reports and observations have shown that men do help with housework as well as caring for the baby and the other children so as to allow the partner rest and recover”.*

The grandfather revealed that he played a big part in caring for the baby because his partner was also working. He said *“I did most of the housework than most fathers in my time, I used to take the baby for control and I remember changing diapers in front of the Doctor and other women at the Health Centre and the women were surprised”.*

The majority of the Norwegian informants reported that participating in reproductive health services and early childhood care was good for them because it strengthened the relationship with their partner, baby and the older children. For example, one (1) man said *“it has helped build a close relationship with my wife and my children”.*

Another man said *“it has also strengthened the bond and relationship with my children....it is for a good future”.*

This information was supported by a statement from one (1) of the nurses who said *“some men do accompany their partners to the Health Centre for antenatal and control of the child, and now we are seeing more men bringing their children for control”.*

The grandfather reported that participating in reproductive health services was good for him because it strengthened his relationship with his wife, the baby and the other children. He said *“I felt it was necessary for me to do it because we were all working.....I feel it was good to develop a good relationship with my wife, the baby and the other children”.*

Similarly, the majority of the Zambian informants reported having participated in housework and caring for the baby by feeding the baby, changing diapers and playing with the baby. One man said *“I took care of my son by feeding him, changing his nappies and playing with him when the mother was busy”*.

Not different from what the Norwegian informants said, the majority of the Zambian informants also reported that participating in reproductive health services and early childhood care was good for them because it strengthened the relationship with their partner and the baby. One man said *“it strengthened the bond and relationship with my wife and baby”*.

Personal Level

All the Norwegian informants said that they enjoyed their participation and derived some personal benefits in caring for their partner and the child. Their participation made them feel proud as fathers and it improved their relationship with their partner and children.

One man said *“I feel so close to my baby and this makes me feel proud as a father”*.

This information is supported by a statement from one nurse who said *“men are so confident and seem to be enjoying their participation in early childhood care”*.

The grandfather said that he was happy to have participated and that he gained some experience in looking after the baby and also improved his relationship with the baby and the other children. He said *“I still look after my grandchildren even now and my children are happy about it”*.

Most of the Zambian informants said that their participation drew them closer to their families and also made them to be responsible fathers. One (1) man said *“bonding with the children.....they naturally bond with their mother so I realized I had to work hard to achieve that, My participation makes me feel close to my child”*.

While another man said *“my participation relieved my wife of the stress of looking after the baby alone”*.

When asked about what motivated men in their participation in reproductive health services and early childhood care, most of the Norwegian and Zambian informants said that they wanted to improve as well as strengthen their personal relationships with their partner, baby

and the other children. At the same time, some of the Norwegian informants said that they considered it a privilege as they did not experience such when growing up.

5.0 DISCUSSION OF FINDINGS

Experience of Nurses concerning male involvement in reproductive health services

Involving the males in reproductive health and early childhood care is very important as men constitute an important asset in efforts to improve women's and children's health (Greene, et al. 2004). Findings of our study revealed that men are getting more and more involved in matters of reproductive health. The majority of Norwegian men accompanied their partners for antenatal check-up at least 2 to 3 times during pregnancy. However, our study also revealed that not all men do accompany their partners for antenatal check-up this is because some of them are usually at work. Our study revealed that some of the Zambia men had accompanied their partners for antenatal check-up at least once during pregnancy. From the 2 researcher's perspective, the majority of Zambian men are not keen to accompany their partners for antenatal check-up possibly for fear of being marginalized. This is because previously, discussion groups at antenatal clinic were often dominated by women and often reflected the norms of motherhood hence men thought it was not part of them.

This situation is however slowly changing as men especially the educated ones are beginning to be involved in matters of reproductive health.

It is important to involve men at all stages during pregnancy and provide them with necessary information. For example, a study conducted by Finnbogadottir et al., (2003) on fatherhood in Europe, found that most expectant first-time fathers in their study not only had a feeling of unreality during pregnancy but also experienced feelings of insufficiency, inadequacy, anxiety and insecurity. This indicates the importance of also recognizing the men's situation and their need for support to handle their transition to fatherhood.

Our study also showed that the majority of Norwegian men do accompany their partners for delivery at the hospital and that are usually present in the labour room to offer support to their partners. A similar study conducted by Plantin, (2008) on fatherhood, reported that more than 95% of prospective fathers are present at the birth in the Scandinavia. On the other hand, our

report showed that the majority of the Zambian men had accompanied their partners for delivery of the baby but were not present at birth. According to the researcher's observation and experience as nurses in Zambia, this could be because traditionally men are not allowed to observe a delivery, at the same time many women might feel uncomfortable to labour in the presence of their partner. According to Giddens, (1990) when tradition dominates individual actions do not have to be analysed or thought about so much because choices are already prescribed by the traditions and customs, that is, precedence set by previous generations. However, with growing concern in the campaign for safe motherhood and gender equality, men are now being educated in reproductive health services and are slowly moving away from the traditional way of living to getting involved in reproductive health and early childhood care. This could also be attributed to the effects of globalization. People are now becoming knowledgeable, make informed decisions and are able to act and analyse the effects of their actions, thus striving towards modernity. Fathers play an important role to offer psychological, emotional and moral support for the woman's transition to motherhood.

A number of studies conducted in Europe have shown that the presence of a labour companion reduces the pain, panic and exhaustion of the woman (Somers-smith, 1999; Kennell et al, 1991). According to Lupton & Barclay (1997), the presence of the man gives a feeling of enhancing the relationship between the prospective parents. This is in line with the findings of our study where the majority of the Norwegian informants said that they were present during labour to offer support to their partners. They also confirmed that their presence strengthened their relationship with their partners.

Our study revealed that it is common and regarded as normal in Norway for men to support their partners after the birth of the baby. Men offer support in terms of bathing the baby, feeding, changing diapers as well as doing some housework.

The study further showed that there has been an increase in the number of men taking their children for control. This shows that men are very involved and would like to develop a good relationship with their children from childhood. The study revealed that this is common when the mother is working or in school and also usually after the age of 7months when most fathers take their parental leave.

Our study also revealed that some men in Zambia do participate in early childhood care by feeding the baby, changing diapers as well as bathing the baby when the mother is busy. This is not common in Zambia. The 4 Zambian informants that were interviewed were in Norway for studies at the time of interview. They were interviewed because they were the only Zambian fathers available in Sogndal, Norway at the time of interview. However, their responses may not give a true reflection of the typical Zambian fathers because they are among the educated that know and support reproductive health services. Even if change is taking place in Zambia where men are getting involved in reproductive health services, the majority are still behind and traditional.

According to the 2 researcher's experience in Zambia, it is not common for men to be involved in early childhood care such as bathing the baby, feeding and changing diapers as well as doing some housework. This is because traditionally it is regarded as a woman's role. Previously, when a woman had a new baby, she would go and stay with her relatives for a number of months or her relative would come over to assist her with house work and caring for the baby. However, this practice is slowly going into extinction because men are now slowly getting involved in reproductive health services and early childhood care. This could be attributed to the effects of modernisation as men and women are being empowered with information in a modern society (Giddens, 1990).

According to Giddens, (1990) modernity is marked by an appetite for the new, though a typical characteristic of modernity is not an embracing of the new for its own sake but the presumption of wholesale reflexivity. Although both men and women generally welcome greater involvement by male partners in reproductive health matters, men who attempt to become involved in women's and children's health may face barriers that arise from norms about appropriate gender roles. However, it is important for men to be involved in reproductive health and early childhood care so as to strengthen the bond and relationship with their partner and baby.

Both Ferketich & Mercer (1995) and Sullivan (1999) in their studies draw the conclusion that the more the father engages himself during the birth and postnatal period, the stronger is his attachment to the baby and will participate more in the child's childhood upbringing.

Reproductive health programmes for men

The results of our study showed that men who are fathers and expectant fathers are often invited to come along to the regular prenatal check-ups as well as parental training offered to couples at the health facility in Sogndal. According to the results of this study, the majority of men in Sogndal do attend these 3 evening sessions of parental training though it is very common with the first pregnancy. On evaluation of the data from the Norwegian informants, men who have taken part in these 3 evening sessions are very positive towards this form of training. A similar study conducted by Madsen, et al., (2002), on male involvement in prenatal preparation courses in Denmark showed that 80% of men attend this course. Another similar study conducted by SOU (1997) in Sweden, showed that 90% of men attend this form of training. Our study revealed that most of the Zambian men got information on male involvement in reproductive health from the radio and television health programmes. According to Giddens, (1990) modernisation affects our day to day life. Men and women in Zambia are now getting more and more educated and women are also in employment. This therefore, entails that people are slowly moving from a traditional society to a modern society. Educated men and women are able to access information on gender equality, reproductive health and early childhood care from the internet, radio, television and also from books.

Work and family life

Concerning utilization of parental leave, our study findings revealed that some of the Norwegian informants took their parental leave. However, the majority did not take parental leave instead opted to adjust on their working hours in order to help with housework and caring for the baby. Results of this study also showed that most of those who took parental leave were public service workers. The study further showed that men who took parental leave appreciated it for they had enough time of being home with their baby. However, findings also showed that even the men who did not take parental leave adjusted their working hours in a manner that gave them enough time to be with their baby. Most of those who did not take parental leave were self-employed, hence were at liberty to take days off duty and be home with their baby whenever necessary. This could be attributed to the effects of globalisation and modernity.

According to Giddens, (1984) in a high modern society, people are educated and they believe the future is created by hardworking. Therefore, the men had to balance between taking care of the baby and working to generate income.

The study also showed that the grandfather did not take parental leave because it was not yet introduced at that time. Instead he had to adjust his school program in order to help with housework and caring for the baby. Possibly the grandfather could be referring to the time when Norway was undergoing some political change to support gender equality in the 1970s. This is because parental leave in Norway was only introduced in 1987 and also revised in 1993.

Findings also showed that an increased number of men took their children for control during their parental leave. This could be because they had enough time to be home with their family and children.

Coming to the Zambian perspective, men in the public service are entitled to 5 days paternal leave. Findings of our study reviewed that none of the Zambian informants took paternal leave. Similar to the Norwegian situation, the majority of the informants opted to adjust their school/working hours in order to take care of the baby as well as assist with housework. From the researcher's perspective of the Zambian situation, taking care of the baby is a woman's role because most women are not in employment, they are housewives; men only supplement care when the partner is busy. This observation was confirmed by one of the informants who said that he did not take paternal leave because his wife was always there for the baby, hence he only supplemented care after working hours. In many traditional society settings female family members provide assistance, information and care for pregnant and recently delivered women (Population Council, 2011). It is however, important for men to take paternal leave so as to spend time with their children as well as develop a close relationship with their baby. Parental leave also promote a better gender balance and equity in the family and the labour market for both men and women (Halvorsen & Stjernø, 2008).

Family Life

Findings of our study revealed that all the Norwegian informants participated in housework as well as caring for the baby. The study also showed that the grandfather participated in housework as well as caring for the baby more than his fellow men during his time. As earlier stated, he could have been among the men who pioneered the political movement for gender equality in Norway in the 1970s, hence his active participation. The study also showed that it

was normal for Norwegian men to participate in housework and taking care of the children since the introduction of the law on gender equality (Halvorsen & Stjernø, 2008).

Findings also revealed that Norwegian men including the grandfather were proud of their participation in reproductive health services and early childhood care because it strengthened the bond and relationship with their partner, baby and the older children.

In a high modern society like Norway, increased educational attainment which often creates the desire for more modern lifestyle has also shown to impact men's participation as fathers as well as in other domestic activities (UN, 2011).

Similar to the Norwegian situation, our study showed that the majority of Zambian informants participated in housework and taking care of the baby. This could be because the informants were among the educated people who knew the importance of participating in housework and taking care of the baby. However, from the researcher's perspective, this is not a typical picture of the Zambian men. These men could be trying to exercise power by acting contrary to what society expect of them in terms of gender roles. According to Giddens, (1987) "power is the transformative capacity", or the ability to make a difference in the world. This therefore, entails that as people get educated they acquire more information and power to transform their environment.

Personal level

Our study findings revealed that all the Norwegian informants enjoyed their participation and derived some personal benefits in caring for their partner and children. The study further showed that their participation made them feel proud as fathers and it improved their relationship with their partner and children. The study also showed that the grandfather was proud of his participation and that he gained enough experience in looking after children. He also indicated that his children are proud of his experience because he is still looking after his grandchildren even now.

Not different from the Norwegian situation, our study also showed that the Zambian men were proud of their participation in housework and taking care of the baby. This is because it drew them closer to their families and also made them responsible fathers. The study further showed that their participation also relieved their partners of the stress of looking after the baby alone.

From the researcher's perspective, it is very important for Zambian men to get involved in reproductive health services and early childhood care because their participation does not only have an impact on the woman and the child. According to Population Council, (2001) unequal power relations can have a detrimental effect on men's sexual health as well and may also lead them to have incorrect assumptions and make uninformed decisions.

Challenges

The findings of our study revealed that most of the Norwegian informants had no challenges. However, the results also show that some informants felt it was more demanding and did not manage well because their parents did not participate as they were growing up. These informants could have been born before the introduction of gender equality in Norway. The study also shows that the grandfather faced the challenge of postponing some of his programs in order to take care of his partner and baby. Possibly this is because parental leave was not yet introduced during that time.

Unlike the Norwegian situation, the study revealed that all the Zambian informants faced some challenges in their care. The study shows that the majority of the informants had to make adjustments in their work or school program in order to take care of the baby and partner. This could have been because they did not take their paternal leave; however, the 5 days for paternal leave would not have been enough for them to provide enough care.

The findings of this study correlates with the results of the study conducted by Back Wiklund and Bergsten (1997 in WHO,2007) on modern parenthood in Sweden which revealed that fathers with young children are stressed in different ways by the problems of combining work and family life.

6.0 STRENGTHS AND WEAKNESSES OF THE STUDY

Qualitative data collection method was used to collect detailed information from the informants about the topic under study. All informants were willing to participate in the study; this made it possible to use snow ball kind of sample selection. The researchers shared roles during the data collection which enabled them to record information accurately from the informants during the interview. All the participants/ informants were willing to participate and the Norwegian men said they were looking forward to getting the results of the study

However, the researchers faced some limitations such as language barrier. Some Norwegian informants were not confident enough to express themselves in English as it is not their primary language. When it came to information from Zambia, the informants were currently living in Norway for studies.

7.0 CONCLUSION

The involvement of prospective fathers in reproductive health is not new; it has existed for several decades in many parts of Europe including Norway. The growth of the women's movement on the labour market in Norway and other European countries contributed to a strong focus on fatherhood, since the possibilities of increasing gender equality in society required increased involvement by men in family life. Involving men in parental training sessions has proved to be very beneficial for couples with the first pregnancy. Information dissemination on male involvement in reproductive health and early childhood care remains cardinal especially to pre modern societies such as Zambia and other Africa countries where matters of gender equality have not yet been embraced by many. According to Giddens's theory, power varies in terms of individual's ability and access to resources in the backdrop against social rules, norms or rules. With regards to reproductive health and child health in Zambia, women's participation in the labour force, accessing resources such as education and health care services is strongly influenced by the power they hold. This means that if Zambia is to attain a state of modernity and gender equality then the gender power relations would change. The involvement of men in reproductive health matters in Zambia has been seen as an important step in achieving key millennium development goals; gender equality, reduction of maternal mortality and infant mortality including reducing the impact and prevalence of HIV/AIDS. Efforts have been made by the Government and the health care system to educate and encourage men to move away from the traditional practices that restrict their participation in reproductive health and early childhood care.

According to Freire, (1993) traditional societies can be educated through cultural synthesis where leaders from one area go to another area to learn about other people and their culture. In this case, Zambia can learn from Norway on strategies to promote gender equality and male involvement in reproductive health and early childhood care. However, some strategies may not work well in Zambia because Zambia is a pre modern society with inadequate resources compared to Norway a high modern society with a strong economy. A number of studies have

cited so many benefits of involving men in reproductive health as follows; men can give an important psychological and emotional support to the woman during pregnancy and delivery, involving men in early childhood care has shown to strengthen the bond and relationship with their partners and children, involving males in reproductive health contribute to a better health and well-being for themselves as well as for their partners and children.

Men who have participated in reproductive health and early childhood care have expressed satisfaction and have gained experience in childcare. Parental leave is another helpful aspect of promoting male involvement in reproductive health and early childhood care. Today in Norway more men make use of the parental leave. There is need for Zambian men to utilise their paternal leave so as to spend time with their baby as well as participate in housework.

8.0 RECOMMENDATION

The following are our recommendations:

Norwegian health care system

- They should consider carrying out a large scale study on the benefits of involving men in reproductive health and early childhood care.
- A study should also be conducted to evaluate the benefits of involving men in reproductive health and early childhood care were interviews will be conducted on women.

Zambian Government

- The Government should provide adequate funding to the Ministry for Gender and the Ministry of Chiefs Affairs for sensitization programs to enable them disseminate information on the benefits of gender equality.
- The Government should consider revising paternal leave to 30 or 60 days in order to enable men participate in housework and early childhood care.
- The Government through their various ministries should sensitize the men on paternal leave as well as encourage them to utilise it.
- The Government should consider improving the infrastructure in maternity wards in order to provide adequate space for men to accompany their partners during labour.

Zambian health care system

- The Ministry should design a program on parental training for couples with a first pregnancy as some of the people may not have access to the health programs offered on radio and television.
- Should consider sensitization programmes to disseminate information to the general public on the benefits of involving men in reproductive health services and early childhood care.
- Midwives working with maternal and child health should continue to encourage pregnant women to come with their partners for antenatal care so that men can also benefit from the health education being offered.
- Midwives working with reproductive health services should continue providing a quick service to men who bring their children for control in order to encourage them to continue.

9.0 REFERENCES

- Austiveg, B, and Sundby, J, (2005). *Reproductive Health Matters*. vol 13, issue 25, pg 23-33 (available at www.sciencedirect.com accessed on 09.02.12)
- Berry, L. (1988). “*Realistic expectations of the labour coach*. *Journal of Obstetrics Gynaecologic and neonatal Nursing*. 17(5): 354-355.
- Back, W., M. & Bergsten, B., (1997). *Modern Parenthood: A study of family and Gender Flux*. Stockholm.
- Boswell, C., & Cannon, S, (2008). *Introduction to Nursing Research: Incorporating Evidence Based Practice*, 3rd Edition, (Available online at: www.books.google.no, accessed on 6.4.13.)
- Cohen, D., & Crabtree, B. (2006). *Qualitative Research Guidelines Project*. (Available at: <http://www.qualres.org/HomeSemi-3629.html>, accessed on 4.02.13.)
- Draper, J. (1997) “*Whose welfare in the labour room? A discussion of the increasing trend of fathers’ birth attendance*”. *Midwifery*, 13, 132-138.
- Dudgeon, M. & Inhorn, M. (2004) “*Men’s influences on women’s reproductive health: medical anthropological perspectives*”. *Social Science & Medicine*, 59: 1379-1395.
- Enkin MW, Keirse MJ, Renfrew MJ, Neilson JP (1995) “*Effective care in pregnancy and childbirth: a synopsis*”. *Birth*. 1995 Jun;22(2):101-10.
- Feldman R, Greenbaum, CW, Mayes, L.C, ad Erlich HS., (1997). *Change in mother-infant interactive behavior: Relations to change in the mother, the infant, and the social context*. *Infant Behavior and Development*.;20:151–165.
- Ferketich, S, L. & Mercer, R, T., (1995). *Paternal-infant attachment of experienced and inexperienced fathers during infancy*, *Nursing research*. 44 (1): 31-37.
- Finnbogadóttir, H., Crang Svalenius, E., and Persson, E. (2003). *Expectant first-time fathers’ experiences of pregnancy*. *Midwifery* 19: 96-105

Freire, P., (1993). *Pedagogy of the Oppressed*. The Continuum International Publishing Group Ltd, USA.

Giddens, A., (1984). *The Constitution of Society: Outline of the Theory of Structuration*. University of California Press, Los Angeles.

Giddens A., (1990). *The consequences of modernity*. Polity press, CA

Greene, M., et al, (2004). *Involving Men in Reproductive Health: Contributions to Development*. United Nations Millenium Project.

Groenewold, G., et al, (2004). *Gender and the Role of Men in Reproductive Health*, Netherlands Interdisciplinary Institute.

Halvorsen, K and Stjernø S, (2008): *work, oil and welfare: the welfare state in Norway*, Ait Trrykk Otta AS Norway.

Information on Gender equality and Gender Research in Norway, (2010). (Available at; www.gender.no/Topic/13, Accessed on 6.4.13.)

Johannson, E-A. (2010). *The effect of own and spousal parental leave on earnings. Working Paper*, 2010:4. Uppsala, Sweden: Institute of Labour Market Policy Evaluation.

Lamb, M.E., (2004). Ed. *The Role of the Father in Child Development*, 4th edition. Wiley; Hoboken, NJ.

Levy-Shiff, R. (1994). *Individual and contextual correlates of marital change across the transition to parenthood*. *Developmental Psychology*. 1994 ;30:591–601.

Lisbeth, B, Knudsen,(2002), *Journal of Population and Social Security (Population)*, Supplement to Volume 1, pp 145.

Lupton, D. & Barclay, L. (1997). *Constructing Fatherhood. Discourses and experiences*. London: Sage Publications.

Madsen, et al., (2002). *Father's involvement with infants*, Copenhagen

MenEngage Alliance Global, (2009). *Working with Men and Boys for Gender Equality*.

MenCare (2012). *A Global fatherhood Campaign; what fathers have to do with it*.

Ministry of Health Zambia, (2010). *Campaign on the Accelerated Reduction of Maternal Mortality in Africa*. Lusaka

Neuliep, J.W., (2006). *Intercultural Communication: A Contextual Approach*. 3rd Edition, SAGE Publications, London.

Øie, K. E., (2007). *Gender equality: A key component of a modern growth strategy*. Ministry of Children and equality, Norway. (Available at: [www.regjeringen.no/nb/dep/bld/aktuelt/taler artikler/politisk ledelse/tidligere_s](http://www.regjeringen.no/nb/dep/bld/aktuelt/taler_artikler/politisk_ledelse/tidligere_s), accessed on 1.2.13.)

Palkovitz, R. (2002) *Involved fathering and men's adult development: Provisional balances*. Erlbaum; Mahwah, NJ:

Plantin, L, (2007). *Fatherhood and health outcomes*. The case of Europe. WHO, Europe.

Polit D.F. & Beck C.T. (2010). *Essentials of Nursing Research: Appraising Evidence for Nursing Practice, 7th edition*. Wolters Kluwer Health | Lippincott Williams & Wilkins, Philadelphia. pp 74.

Polit & Beck, (2008). *Nursing Research: Generating and Assessing Evidence for Nursing Practice, 8th Edition*, Lippincott, Williams and Wilkins, Philadelphia. Page 412-413.

Polit D.F. & Beck C.T., (2006). *Essentials of Nursing Research: Methods Appraisal and Utilization, 6th edition*, Lippincott Williams & Williams, Philadelphia.

Reproductive Health at a Glance Zambia, (2011). *World Bank Report*.

Sullivan, J, R., (1999). *Development of father-infant attachment in fathers of preterm infants*. Neonatal network 18 (7): 33-39.

Sweden Association for Sexuality Education (rfsu): *Young Men as Equal Partners*. (Available at; <http://www.rfsu.se/en/Engelska/International-Programmes/Implemented-Projects/YMEP-Tanzania-Kenya-Uganda-and-Zambia/> accessed on 07.02.13)

The Nordic Council of Ministers, (2006). Copenhagen, Denmark (available at www.norden.org accessed 08.02.12)

The Norwegian Ministry of Children, Equality and Social inclusion, (2012). *Family Policy*, (Available at: www.regjeringen.no/en/dep/bld/Topicc/family-and-cohabitation/family-policy, Accessed on 1.2.13.)

United Nations Education Scientific Cultural Organisation (2012). *Early Childhood Care and Education*. (Available at: www.unesco.org/new/en/education/themes/strengthening-education-systems/early-childhood/browse/1/ accessed on 10.02.13)

United Nations-ICPD (1994). *International Conference on Population and Development*, Cairo.

Walliman, N. (2005). *Your Research Project, 2nd Edition*, SAGE Publications Ltd., London, pp 274.

Walsh, L., & Wiggins, L, (2003). *Introduction to Research: Foundations in Nursing and Health Care*, Thornes Ltd, Croatia, pp 98.

Whitehead, D. (2007). *Common Qualitative Methods In Nursing & Midwifery Research: Methods and Appraisal for Evidence-Based Practice, 3rd edn*. (Schneider Z., Elliott D., LoBiondo-Wood G. & Haber J., eds), Mosby Elsevier, Sydney, pp. 106-121.

WHO (2007). *Fatherhood and health outcome in Europe*. WHO, Europe.

Yin, R., k. (2011). *Qualitative Research from Start to Finish*. The Gilford press, USA.

Appendices

Appendix 1: Consent form

We are Nurses from Zambia doing Global Knowledge at Høgskulen i Sogn og Fjordane, Faculty of Teacher Education. As part of our examination in Global Knowledge we are required to undertake a research study and our topic is: **“Exploring male involvement in Reproductive health and early childhood care in Sogndal, Norway”** in this study, Reproductive health means care of a pregnant woman, birthing and post-delivery care. Early childhood is the period from birth to one year of age.

CONSENT FORM

I understand that my participation in this study is entirely voluntary, and I may withdraw from the study at any time i wish. I understand that my participation in this study will not benefit me in terms of financial and material gains, and that all information provided will be kept confidential. However, this information may be used in presentations in nursing and gender issues.

The study has been explained to me. I have read and understood this consent form and all questions have been clarified. I therefore, agree to participate.

Signature of participant	Date

Signature of investigator	Date

Appendix 2: Interview Schedule

SOGN OG FJORDANE UNIVERSITY COLLEGE

FACULTY OF TEACHER EDUCATION AND SPORT

GLOBAL KNOWLEDGE 301

INTERVIEW SCHEDULE

TOPIC: A STUDY TO EXPLORE MALE INVOLVEMENT IN REPRODUCTIVE HEALTH SERVICES AND EARLY CHILDHOOD CARE IN NORWAY.

Serial Number: _____

Date: _____

Nursing experience

Objective: To explore the experiences of nurses concerning male involvement in reproductive health in Norway

1. For how long have you been working as a nurse/midwife?
.....
2. For how long have you been providing reproductive health services? Reproductive health services in this case means- antenatal care, delivery and postnatal services.
.....
3. What has been your experience with male involvement in reproductive health services?
Antenatal care.....

Delivery.....

Postnatal.....
4. What has been your experience with male involvement in early childhood care?
Children’s clinic (below 1 year).....

Objective: To explore the influence of programmatic factors on male involvement in reproductive health and early childhood care.

5. Are there any programmes meant to motivate men to participate in reproductive health services and early childhood care that you are aware of?

Give examples.....

Objective: To find out from men who are fathers and grandfathers about their participation in reproductive health and early childhood care.

Demographic Data

6. What is your marital status?
7. How many children do you have and what are their ages?
8. When your partner was pregnant, how did you support and take care of her health needs?

9. When your child was a baby, how did you contribute to the care of the child till the age of 1 year?

Objective: What motivates men to participate in reproductive health and early childhood care in Norway?

10. What challenges are you facing/did you face as a man in caring for your partner during pregnancy, birthing, after birth and in caring for the baby until the age of 1 year?

11. What has been motivating you to participate in the care of your partner during pregnancy, birthing, after birth and in caring for the baby until the age of 1 year?

12. Are there any programmes that you feel have been of help in your role as father in promoting reproductive health services?

13. How do/did you combine work and child care when your child/children were babies?

14. How has your participation in reproductive health services benefited you and your family?

Appendix 3: Permission Letter – Pilot study

Høgskulen i Sogn og Fjordane
6856, Sogndal
Norway

10th March, 2013

The Head Nurse
Sogndal Health Centre
6856, Sogndal
Norway.

RE: PERMISSION TO CONDUCT A PILOT STUDY IN SOGNDAL

We are Exchange students from Zambia and currently studying global knowledge at Sogn og Fjordane university collage.

As part of the Examination in global knowledge, we are required to carry out a research project. Our topic is “Exploring male involvement in Reproductive health and early childhood care in Sogndal Kommune, Norway. We therefore request for your permission to conduct interviews on one nurse from Sogndal health centre in order to test our interview schedule. We intend to carry out this exercise on 01 / 03/2013.

If you need further details and clarification, you can contact our project supervisor Randi Jepsen at the Faculty of Health Studies on telephone number 57722577, email randi.jepsen@hisf.no

Your assistance in this regard will be highly appreciated.
Yours faithfully,

Lungu Rabecca (RN/ RM/) and Milimo Joyce (RN)

GLOBAL KNOWLEDGE NURSING STUDENTS (2012- 2013)**Appendix 4: Permission Letter – Main study**

Høgskulen i Sogn og Fjordane
6856, Sogndal
Norway

10th March, 2013

The Head Nurse
Sogndal Health Centre
6856, Sogndal
Norway.

RE: PERMISSION TO CONDUCT A RESEARCH STUDY

We are nurses from Zambia on exchange programme studying global knowledge at Sogn og Fjordane university college.

As part of our examination in global knowledge, we are required to carry out a research project. Our topic is “**Exploring male involvement in Reproductive health and early childhood care**” in Norway. We therefore, write to request your office for permission to interview midwives at your institution starting from 11th to 23rd March 2013.

If you need further details and clarification, you can contact our project supervisor Randi Jepsen at the Faculty of Health Studies on telephone number 57722577, email randi.jepsen@hisf.no. Find attached the copy of our interview schedule.

Your assistance in this regard will be highly appreciated.

Yours faithfully,

Lungu Rebecca (RN/ RM/) and Milimo Joyce (RN)

GLOBAL KNOWLEDGE NURSING STUDENTS (2012- 2013)