(Mis)measuring Men's Involvement in Global Health: The Case of Expectant Fathers in Dakar, Senegal

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Research

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Abstract

Background

In 2018, USAID published a report based on Demographic and Health Surveys data on the relationship between men's involvement and women and children's health outcomes. Based on the data collected, USAID's analysis implies that Senegalese men are not involved in women and children's health.

Methods

Twenty-two months of ethnographic research from 2012 to 2018. Research participants included 32 pregnant women and 27 expectant partners recruited from three maternity wards by convenience sampling, plus chief physicians, nurses, midwives, employees of the Ministry of Health and Social Action, and employees of nongovernmental organizations in the health sector. Research methods included participant observation, semi-structured interviews, free-list and pile sort exercises, and various visual ethnographic methods. Data were evaluated using rhetorical, textual, and cultural domain analysis.

Results

This research demonstrates that expectant fathers are involved in prenatal care in ways that USAID does not track through DHS.

Conclusion

Context independent reporting on men's involvement is potentially harmful and obstructive to improving maternal and child health when the problem that is targeted is not a problem at all. State and non-state organizations investing in men's involvement campaigns would save money and resources by amplifying men's strengths (an asset-based model) rather than seek to educate them toward Eurocentric conceptions of fatherhood and masculine care (a deficit-based model).

Background

In 2018, USAID released a report titled "Does Men's Involvement Improve the Health Outcomes of their Partners and Children?" (henceforth "DHS 64"). In order answer their question, the authors define "men's involvement" using three independent variables: "correct knowledge, positive attitudes, and supportive behaviors toward the health of their partners and children" (Assaf and Davis 2018:xi). These variables are operationalized and derived from the most recently available DHS data from 33 countries as follows:

Table 1
Independent Variables (Assaf and Davis 2018)

Independent Variable	DHS-derived Indicator
Knowledge	Correct knowledge of fertile period
	Correct knowledge of fluid intake for child with diarrhea
Attitude	Agreement with, “Contraception is a woman’s business and a man should not have to worry about it”
	Agreement with “Women who use contraception may become promiscuous”
Behavior	Present during ANC visit
	Discussed family planning with a healthcare worker
	Joint decision on how to spend men’s earnings

These independent variables were compared to the following outcome variables: unmet need for family planning, contraceptive prevalence for modern methods, four or more visits for antenatal care, first ANC visit before four months pregnancy, delivery in a health care facility, completing three doses of DPT vaccine, and treatment for diarrhea.

In the year that DHS 64 was published, [author] was conducting 12 months of ethnographic dissertation research on men’s involvement in prenatal care in Dakar, Senegal. In the case of Senegal, Assaf and Davis found that men were unlikely to adhere to the above notions of involvement (with few exceptions). As it relates directly to [author]’s research, the report finds that men are not likely to be present during antenatal clinical visits or discuss family planning with a healthcare worker. While [author]’s ethnographic data support both of these findings, as well as the rest associated with “attitudes” and “behaviors” (but did not explore the indicators associated with “knowledge”), they do not support the implicit conclusions of such global health logics that Senegalese men are therefore uninvolved in women and children’s health. The numbers simply do not tell the whole story.

Methodology

This article comes out of ethnographic research conducted over 22 months in Dakar, Senegal from 2012 to 2018. Research participants included 32 pregnant women and 27 expectant partners recruited from three maternity wards by convenience sampling, plus chief physicians, nurses, midwives, employees of the Ministry of Health and Social Action, and employees of nongovernmental organizations in the health sector. Research methods included participant observation, semi-structured interviews, free-list and pile sort exercises, and various visual ethnographic methods. All interviews were conducted in French, Wolof, or Peul, transcribed in French, and thematically coded using MaxQDA 12. Data were evaluated using rhetorical, textual, and cultural domain analysis.

Results

The Entourage

In Senegal, pregnant women have an *entourage* (Fr. “people who surround”) usually made up of their *goro* (mother-in-law), *njèkke* (eldest sister-in-law, maybe two), some close friends, and the expectant father – all of whom likely live under the same roof. Pregnancy, itself, is a taboo subject and is therefore not to be discussed with or even shown to anyone beyond that inner circle for fear that bad luck or evil spirits could befall the pregnancy, the pregnant woman, the unborn fetus, or the newborn child. The only exception that can be made is for healthcare providers (e.g., midwives, physicians) and state-trained neighborhood birth workers (called *bajenu gox*).

The entourage acts similarly to what the medical anthropologist John Janzen (1987) identified as a “therapy management group” (TMG). Therapy management, Janzen highlights, involves diagnosis, selection, and evaluation of treatment, as well as support of the sufferer, while the therapy management *group* is that which emerges around a sufferer to take charge of those responsibilities. Unlike the TMG, the entourage which surrounds a pregnant Dakaroise does not step in *because* she is incapable of making decisions for herself, nor is she considered a “sufferer,” nor pregnancy an “illness.” The entourage emerges as a matter of emotional support, physical safety, and financial security. It also acts as a vehicle for the transmission of intergenerational obstetric knowledge, such that an entourage may necessarily become more hands-off with each successive pregnancy (so long as previous pregnancies have had consistently positive outcomes). The responsibilities of prenatal care are distributed to individuals in the entourage, therefore no one person is wholly responsible for her care. Some tasks can be shared by multiple people in the entourage, while some are the sole responsibility of one individual.

What Men are Expected to Do

The entourage has two specific expectations of expectant fathers: that they demonstrate (1) financial and (2) emotional support. Financial support, called *sersé larzañ* (“find the money” in Dakarois French), is, according to midwives, the most important job of anyone in the entourage. Wages are low and employment can be difficult to find, so for the working-class men who participated in this research (and who make up the vast majority of the Senegalese population), finding money consumes a great deal of time and effort. It can involve working multiple jobs and one-offs, often in manual labor (which can be dangerous and without any labor rights, much less health insurance), as well as calling expatriated relatives in Europe or North America to seek financial assistance [author citation].

Financial support funds all manner of expenses during pregnancy: it is the money that buys a taxi fare to take her to her prenatal exams so that she doesn’t have to inhale the diesel fumes of the busses and *car-rapides*; it is the money that buys her a consultation ticket for those exams and pays for her prescriptions and vitamins; it is the money that puts food on the table and keeps the lights on and pays the woman down the street to come and do the laundry and clean the house so that she doesn’t have to; it is the money that will buy the ram which will be slaughtered at the *ngente*, or naming ceremony, seven days

after the child is born so that God will bless the child; it is the money will pay for the multiple taxi fares and consultation tickets on the day of the delivery because she will undoubtedly be told to go from hospital to hospital while she is in labor because, indeed, the average number of hospitals visited on the day of the delivery for my respondents was four with a maximum of six, but was never less than two; it is the money that will pay the hospital bill and, if necessary, bribe the right people to put down their cellphones and do their damned jobs. If there is ever a surplus of money, it will buy her little gifts and special treats throughout the pregnancy so that he can keep her in good spirits and reassure her that she is not alone. Financial support also translates into emotional support, as women report feeling more secure when their partners demonstrated financial support.

Midwives also acknowledge that not all men can pay for all of these expenses, and that the inability to demonstrate consistent financial support does not make one “uninvolved.” There are other non-financial forms of emotional support that can keep her in good spirits. Emotional support can take many forms, although who can undertake those forms is often determined by relationship to the pregnant woman as well as the gender of the caring person. In the case of expectant fathers, popular forms of emotional support are to look out for her wellbeing by enforcing certain behavioral and nutritional prescriptions and proscriptions given in the clinics, making sure she is taking any medications she may need, and reminding her of her clinical appointments. Some women reported that they appreciated when their husbands called them multiple times a day to check in. What may seem overbearing to outsiders was reported by pregnant women as a demonstration of care and interest in her health and wellbeing.

What Men are Not Expected to Do

The expectations of the entourage are often determined by the gender of the entourage member and their relatedness to the pregnant woman. At the same time, pregnancy is a form of what is called *affaire-u-jiggeen*, or “women’s business” (in Wolof). Men are not only not expected to get involved in the ways that women are involved, but they can also be actively shut out from certain activities. Expectant fathers’ mothers are the senior women of the entourage and therefore call the shots (although there are some interesting political frictions that can emerge between her and her daughters that fall beyond the scope of this article). These mothers may either aggressively bar their sons from attending antenatal clinical visits (for example), or passive-aggressively question their sanity, masculinity, or African-ness for even suggesting they may attend. On this latter point, overly active expectant fathers are sometimes teased for being similar to “Europeans” or “white people.” The domain of “women’s business” is not unilaterally constructed by men as a way of avoiding effeminate activities, rather it is co-constructed by women as a matter of maintaining their autonomy. It protects not only pregnancy, but domestic labor and meal preparation as well.

Discussion

Why don’t men attend ANC visits? First, men are busy trying to find money. Maternity wards are often crowded and waiting can last hours (even if there was an appointment). Families cannot afford for men to take off that amount of time when every income generating activity counts. Second, men are socially

barred from attending. It is critical to understand that just because he doesn't go with her, that doesn't mean she goes alone. This is the purpose of the entourage system of distributed care responsibilities.

Finally, and this answers the question about why men don't talk to healthcare providers about family planning: men who *do* attend ANC visits often don't feel welcome and are sometimes actively made to feel unwelcome. The few men who do attend ANC visits tend to be better educated and with more stable employment. They can afford to take the time off and they're actively interested in what healthcare professionals have to say. Again and again, however, men have reported that they have less than ideal interactions with junior midwives (who make up the vast majority of the midwifery workforce) who are described as "never getting off their phones" or "actively ignoring me." It was common, in all of the births I attended, to check in with men about the progress of labor only to hear, "I don't know. The nurses won't tell me anything."

Conclusion

Senegalese men are involved in women and children's health in ways that the DHS does not track and therefore, according to USAID reports, they are uninvolved. This characterization was a surprising revelation to the Senegalese physicians, midwives, mothers, fathers, and Ministry of Health officials in [author]'s research. From this study, we learn two things. First, universalized measures of men's involvement are so broad as to be impractical for intervention. They tell us nothing about the relationship between men's actions and women and children's health when men are not the only people involved in women and children's health. Like "culture," kinship is not fixed nor bounded - even in nuclear families. It is important to widen the scope of interrogation to include all meaningful relationships in someone's life, perhaps approximating what I've described here as an entourage or Janzen's TMG.

Second, measures of men's involvement can only be meaningful in locally specific, context dependent analysis and practice. In Dakar, men's involvement includes financial support, emotional support, health translation, health surveillance, at-home education, and religious leadership. Pregnant women, their mothers-in-law, and midwives all agree that these responsibilities are critical to the health and wellbeing of women and children, and yet almost none of them serve as indicators of "men's involvement" in global health literature, nor can they be measured by current indicators in the DHS.

Works Cited

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Declarations

Ethics approval and consent to participate: All phases of this research were approved by the Institutional Review Board at Washington University in St. Louis and the *Comité National d’Ethique pour la Recherche en Santé* at the Senegalese *Ministère de la Santé et de l’Action sociale*.

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