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Husband's role in handling pregnancy complications in Mangochi district, Malawi: A Call for Increased Focus on Community Level Male Involvement

Abstract

Objective

The objective of the current study is to provide information about husbands' role in decision-making and healthcare seeking in cases of pregnancy complications in Mangochi district, Malawi with an analysis of qualitative interviews using the concepts of "capital" and "field" from Bourdieu's social field theory.

Study design

Twelve husbands and wives who had experienced pregnancy complications and six key informants from a semi-rural area of Mangochi district were interviewed individually. Thematic analysis was conducted based on the concepts of capital and field in Bourdieu's social field theory.

Results

Husbands have significant economic and symbolic capital in decisions about healthcare seeking during instances of pregnancy complications as a result of their roles as father, head of the household and main income earner. Lack of money is the only acceptable reason for husbands to deny their wives healthcare. Husbands have limited access to knowledge of maternal health, which can compromise their decisions about seeking healthcare. Joint decision-making within families can be bypassed to allow for prompt healthcare seeking in emergencies.

Conclusions

Husbands are important decision makers regarding seeking healthcare for pregnancy complications because of their economic and symbolic power and despite their limited access to knowledge of maternal health. Maternal healthcare seeking practices would benefit from wives gaining an empowered role as well as improved knowledge of maternal health among husbands.

Introduction

Reduction of maternal mortality at the community level

Maternal deaths accounted for 303,000 deaths worldwide in 2015. Indirect causes of maternal deaths are infectious diseases and nutritional conditions that are mostly preventable and predictable [1]. It is difficult to reduce maternal deaths resulting from direct causes related to pregnancy complications such as haemorrhage, hypertensive disorders and sepsis because timely admission to healthcare facilities where skilled care is available is required. These requirements set high demands for not only the accessibility and quality of health services but also timely seeking of healthcare [1, 2]. Maternal deaths often occur soon after admission to a healthcare facility; this situation indicates that women arrive when their situations are already severe [3]. The World Health Organization (WHO) has identified five main factors that prevent mothers from seeking timely care: poverty, distance, lack of information, inadequate services and cultural practices [1].

Malawi has one of the highest maternal mortality ratios in the world at 634 maternal deaths per 100,000 live births in 2015, despite recent positive developments [4]. Almost all women receive antenatal care, and most deliveries (88.9%) take place in health facilities. However, admission often takes place too late, quality of care is suboptimal and community involvement is limited [5, 6]. Traditional birth attendants (TBAs) cannot substitute for emergency obstetric care, and Malawi is redefining TBAs' role in maternal healthcare [6, 7]. Although social norms, gendered belief systems and practical barriers hinder men's involvement in maternal health, the country highlights empowerment of men to contribute to timely referrals as a key approach to reducing maternal mortality [6, 8].

Men in Malawi are traditionally socialized to be superior in family decision-making and they are responsible for providing financial support to the family. Financial support is a masculine way for men to take part in pregnancy, while helping the wife in household chores or

attending maternal health services requires that men are ready to enter into the female domain [8]. A qualitative study from a rural, low-income area in Southern Malawi showed that gender-based cultural scripts make household decision-making husband-dominant in financial and sexual matters, while women dominate decision-making in matterns concerning domestic chores and childbearing, especially in matrilineal areas [9].

The collective dimension of decision-making in seeking healthcare for pregnancy complications is not well understood, since research has largely focused on individually oriented behaviour change communication theories [10]. Additionally, little is known about the role of men in this process. The objective of the current study is to provide information about husbands' role in decision-making and seeking healthcare for pregnancy complications using the concepts of capital and field from Bourdieu's social field theory [11].

Field and Capital in Bourdieu's social field theory

The concepts of field and capital in Pierre Bourdieu's social field theory concern the balance of power in a network of individuals with a common interest [11]. The concepts are used in the current study as tools to investigate husbands' role in seeking healthcare for pregnancy complications.

According to Bourdieu "field" is a "set of objective, historical relations between positions anchored in certain forms of power or capital" (...)"The field is simultaneously a space of conflict and competition" [12, p 16-17]. Actors struggling for power occupy the positions. The power balance is often misrecognized and considered legitimate by the actors. The field is characterised by "'illusio", the recognition of a common goal and rules of the game [12]. "Struggles" are defined as debates of opinion with entangled power positions that seek to transform or preserve the power balance. They concern key questions within a field [12].

"Capital" is similar to power; it refers to sums of assets – such as competencies, skills and qualifications – put into use, and it is both a means and an end to games in a field. Bourdieu

distinguishes between four types of capital: economic capital concerns economic resources; social capital refers to social relations to others that help players gain authority; cultural capital is legitimate knowledge; symbolic capital concerns social prestige and honour [11, 12].

In the present study, the field is composed of the network of positions involved in taking care of women during pregnancy and childbirth at the community level. We analyse the significance of different types of capital in the decision-making on healthcare seeking for pregnancy complications with a special focus on husbands. We also analyse the field and its actors and characteristics ("illusio", "struggles" and "misrecognition of the power balance") to understand the context in which decisions are made.

Methods

Study design, setting and data collection

A qualitative study was conducted using individual in-depth interviews (IDIs) [13] and a thematic analysis was employed [14] based on Bourdieu's concepts of "capital" and "field" [11].

The area in which the study was conducted in Mangochi district, Malawi is semi-rural. The main tribe is the Yao, who follow the Islamic faith and are traditionally matrilineal. The main source of income is fishing, and women commonly depend on their husbands for income. Mangochi district has the lowest education levels in the country for both women and men, but its scores for women's empowerment are average [15]. Free maternal healthcare is provided at public and private hospitals within a 15 km distance, but attendance involves significant food and transportation costs for families. The families rely on bicycles, rented cars, and an occasionally available ambulance for referral transport [16].

The data consists of 24 IDIs with twelve husbands and wives of married couples, who had

experienced pregnancy or delivery problems within the last five years. The 12 wives had experienced the following pregnancy complications: Prolonged labour (4), abnormal position of baby (4), small pelvis (2), twin pregnancy (1), miscarriage (1), malaria (1). In addition, IDIs were carried out with six key informants with contextual knowledge; two TBA, a village chief and his wife, and the mother and uncle (head of clan) of one participant (wife). The participants were recruited by purposive sampling with assistance of two village headmen.

Interviews took place in a secluded location in the village. A local male research assistant with experience and training in conducting IDIs held the interviews in the local languages of Chiayo or Chichewa. The woman principal investigator, a Finnish medical doctor, was also present. The interviewer and principal investigator met with all participants prior to the interviews to provide information and obtain oral consent. The husbands and wives were interviewed separately and in direct succession. A semi-structured interview guide was pre-tested in individual interviews and informal discussions with men and women from nearby villages. The interview guide covered husbands' and wives' stories of their pregnancy complications as well as all participants' general perceptions of husbands' role in decision-making and seeking healthcare for pregnancy complications. Preliminary analysis guided the subsequent interviews to clarify any emerging questions.

Participants offered detailed accounts of their experiences that were treated as subjective perspectives [17]. However, two husbands had limited recollection due to absence, and three couples gave highly contradictory accounts. The interviews were recorded on tape, transcribed and translated into English by another research assistant. Quality control achieved through double translations of four interviews by a third research assistant showed satisfactory quality of the translations.

The Malawi College of Medicine Research and Ethics Committee (COMREC) gave ethical approval for the study (05/06/446, 2006).

Data analysis

We chose a social theory linked analysis based on Bourdieu's concepts of "capital" and "field" to investigate the power balance in decision-making, because it may remain hidden in more inductive designs [18]. The analytical process was built on an approach described by Boyatzis [14]. The process and definitions of the concepts are presented in Table 1. All of the interview transcripts were divided into meaning units, looking for content on the role of husbands and decision making in pregnancy complications. Theory-based themes were developed for Bourdieu's concepts of economic, cultural, symbolic and social capital as well as his concepts that describe the field; actors, illusio, misrecognition of power balances and struggles. In the analytical process, codes and categories were developed by constantly going back and forth between the inductive meaning units and the deductive theory-based themes [14]. Responses from husbands, wives and key informants were also considered separately to identify differences in the perspectives.

Results

The results of the analysis of the qualitative interviews with husbands, wives and key informants based on Bourdieu's theoretical concepts of field and capital are presented under themes reflecting actors in the field of pregnancy and illusio; the four different types of capital of the husband; struggles; and misrecognition of the power balance. Supporting quotations from the interviews are included. Husbands' different types of capital are presented in Table 2.

Actors in the field and illusio: Husbands, families and healthcare professionals work together

The field is the network of positions involved in the care during pregnancy and childbirth. The actors who occupy the positions are the husband and wife, their nearby living relatives, the family elders, health professionals, the TBA and sometimes friends.

Illusio, which refers to the rules and common goal in a field, implies that all actors in positions display a willingness to support the health and wellbeing of pregnant women. This support includes first and foremost readiness to contribute to prompt seeking of healthcare in emergencies and the provision of additional nutrition and care. The illusio contains the idea that difficulties, such as the struggle to source money and transportation must be endured. This perspective was primarily brought up by the husbands. Those who do not share this illusio are excluded. The illusio allows all actors to take part in decisions to seek healthcare, but shared decision-making could be bypassed in emergency situations if necessary.

> *"[His wife wanted to go to hospital with malaria, he agreed]. We [husband and wife] did not discuss with the relatives. I just took her to the hospital and let them know afterwards. We had no time to discuss because of her condition at that time. There was no way". (Husband 8)*

Cultural capital: Husbands struggle to access knowledge about pregnancy complications

The relevant cultural capital (legitimate knowledge) in the field is the knowledge and skills to manage pregnancy complications, which forms the field's highest attainable power. This power is primarily possessed by healthcare professionals and to a lesser degree by TBAs and older women. Most husbands and wives express that the health professionals' knowledge clearly surpasses the value of traditional health knowledge, female elders' lived experiences and TBAs' skills, but the key informants highlight traditional healthcare providers' skills in managing delivery problems caused by witchcraft.

> *"The nurses advised my wife to wait at the hospital until delivery. (...) I don't know why. I*

thought that since they know their job, they sensed something. Maybe they though that what happened previously [miscarriage], could happen again. (…) I was very happy and accepted". (Husband 7)

Compared to women and healthcare workers, men have very limited maternal health knowledge. It is rarely sufficient to give them decision-making power in relation to complications. Knowledge of what happens during delivery is culturally considered a female domain and many husbands and wives accept male ignorance. In particular, it is accepted that first time fathers and mothers would be totally ignorant about maternal health.

"My mother-in-law had experience of these things, so she knew what would happen if my wife wasn't taken to the hospital quickly. (...) I agreed with her. I could not deny, for I knew nothing about delivery, and she knew better. This is why I accepted. Had it been that I knew more, I would have accepted or refused pending on what I knew". (Husband 2)

However, many husbands and wives express a need for husbands to know more about maternal health. The wives want men to know about blood donation and women's suffering during delivery, while husbands want knowledge of maternal health to act correctly in case of pregnancy complications. All interviewees emphasize the dangers of extra-marital sex, and key informants see little need for increasing men's knowledge.

"I want to know more about delivery. (…) If anything goes wrong, I can advise her [wife] what to do". (Husband 7)

Husbands rely on their wives for knowledge about maternal health. Ideally, men want to learn from their fathers, but in practice, traditional systems of passing knowledge from grandparents to young men involve little beyond offering advice on avoiding extra-marital sex. Some women believe that men learn about maternal health in men's initiation ceremonies; this response is quite different from men's accounts.

> *"I want to know issues concerning health problems in pregnancy. (...) I could have asked my grandpa, had it been he was still alive, things about pregnancy and how to take care of it. (…) There's no-one [to ask from now]". (Husband 10)*

Economic capital: Husbands' control of money authorizes them to make decisions about seeking healthcare

Husbands are often the sole earners of money and, as a result, in charge of economic capital. In a setting in which poverty limits access to economic resources husbands become important decision makers concerning pregnancy complications.

> *"The one who decides where to go with [delivery] problem is the husband. (…) My parents agree, because he is the one who brings money in our family. He is the one who will pay everything at the hospital". (Wife 6)*

Husbands can allocate resources to maternal health seeking as they see necessary. They are expected to spend what they can afford, and seek assistance for remaining costs. Only if husbands have no economic means at all will the next closest relative with resources become economically

responsible. Wives can be in charge of family resources only if their husbands are working far away. By spending on their wives' health husbands can demonstrate their love. Unwillingness to spend indicates a rupture in the relationship.

"A husband needs to find money for the pregnant wife to go to the hospital [for malaria treatment]. If you don't have money you need to ask your relatives, and if they have, they assist. (...) In my family we helped each other. My mother-in-law paid half". (Husband 5)

"He [husband] went to work and afterwards he came to give the money to me here [at the hospital after delivery]. (...) I was satisfied to say my husband loves me, because he was giving me assistance and visiting me at the hospital". (Wife 6)

Husbands who support their wives gain recognition from peers and family members as well as increase their symbolic capital. The opposite applies to negligent husbands.

"His fellow men say 'Oh! You man, how come you don't take care of your wife, yet you earn a lot? You are not good at all'. He is laughed at and he is referred to as a fool because of his failure to take care of his wife" (Village chief)

Lack of money is the only acceptable reason for a husband to deny hospital delivery or delay the start of antenatal care without losing respect. The couples accept that poverty limits spending on maternal health.

"A husband needs to take care of his wife and child depending on what he earns. Like my

husband, he works at the lake and brings home what he gets. We are satisfied with what we get". (Wife 3)

Symbolic capital: As heads of household, husbands decide on family matters such as pregnancy care

Symbolic capital represents prestige in society; it is predominantly husbands and clan elders who share this capital. Husbands' symbolic capital comes from their positions in the family and society as the man, father, and the head of household, who is knowledgeable, revered and trusted. Symbolic capital is husbands' second most important source of capital, but it does not give them the right to deny their wives healthcare in the same way that a lack of money does.

"The husband decides [on health care seeking in pregnancy complications] because he is the head and the only one who decides what to do in a family. He has the power over the wife. (...) I am not interested in my uncle [head of clan] making decisions over my husband because I have my own family and he has his". (Wife 9)

To preserve symbolic capital, men have to fulfil their roles as husbands and fathers by demonstrating a willingness and ability to provide long-term support to mothers and babies. If husbands are away for work during pregnancy and delivery, they can maintain most of their authority by providing continuous financial assistance. However, in instances of complications, husbands are expected to be present to take part in their wives' suffering and visit the women at the hospital to reconfirm their fatherhood and guarantee assistance, love and care.

"I visited her [at the hospital after a Caesarean section] because she is my wife and I missed her a lot. (...) I also realized that the child came from my body, so there was no way to leave her there without visiting her. I loved her very much". (Husband 8)

Husbands' symbolic power is diminished in families in which wives hold independent positions and challenge their husbands' dominance.

"[If her husband refused her to attend health care with pregnancy problems] I will tell my mother about what my husband said. (...) My mother will be surprised, saying does he need to kill you. (…) Later our marriage will end because he wanted to kill me". (Wife 8)

Husbands also have less symbolic power in families that strongly adhere to matrilineal traditions, since women are seen more as minors who belong to their parents.

"I was refusing to take my wife to the TBA [instead of hospital], but the mother-in-law insisted she should go. She said that she delivered her first child at the TBA and my wife should follow that. I accepted because she was the mother of my wife and she has the power over her daughter". (Husband 1)

A weak relationship also diminishes husbands' symbolic capital. However, men's extra-marital affairs are tolerated, and do not necessarily result in a loss of status.

Social capital: Husbands' social networks only have the power to assist with transportation

Social capital is defined as significant social relations, and it is primarily the network of female relatives living nearby and TBAs who possess this capital. TBAs are significant because of their knowledge of maternal health and links to healthcare professionals. The social capital gives the women and the TBAs the right to provide care and practical assistance to pregnant woman, but only some decision-making power. Husbands' social connections to male peers allow them to arrange referral transport and little else. However, many husbands wish for stronger male peer networks that could also help in managing pregnancy complications.

Husbands' close relationships to their wives form their most significant social capital. The husbands are entitled to commence action when pregnancy complications occur.

> *"It was good my husband came [when I was having problems delivering at the TBA] because when he came everything was okay. He went to hire a car, which I don't think would have happened if he was not around. My mother could not manage that and I don't think her relatives could. (...) Maybe the TBA could have called an ambulance. It was good he came because my father is dead and I had nobody to do the work of a man. Maybe I could have died". (Wife 3)*

> *"[Laughter] sometimes labour may start in the night and I will wake him [husband] up and state everything I am feeling. So he goes to my parents and tells them about my problem. So it is good to have him around". (Wife 5)*

Struggles: Exclusion from maternal healthcare challenges husbands' power

Struggles that refer to debates in the society that seek to transform or preserve the power balance, emerge concerning men's exclusion from maternal healthcare. It is predominantly key informants

who want to preserve the current balance in which men are absent from or act passively in the context of maternal healthcare. However, husbands in particular regret men's exclusion from maternal healthcare and the lack of spousal communication about delivery.

"I was told that my wife was going for operation. (...) I thought of asking why, but the relatives of my wife told me not to ask. They said no, just leave it". (Husband 3)

"I was getting all the information [about my wife's pregnancy complication] through my mother-in-law [at the hospital]. (...) I would have liked to see her, very much. But we are not allowed". (Husband 2)

Another struggle concerns the symbolic power balance between wives' and husbands' families. The respondents express that the matrilineal tradition of the Yao gives wives' relatives symbolic capital in the field of pregnancy and the children are seen as belonging to wives' family. Yet many families who live in husbands' villages allocate more power to his relatives.

"The wife needs to adhere to what the husband decides. She needs to be loyal to the husband, not her parents whom she has separated with". (Husband 6)

"Even if she [daughter or sister's daughter] lives in her husband's village, if there's a pregnancy complication, he consults my family for a good decision". (Uncle, head of clan)

Misrecognition of the power balance in which wives are dependent on their husbands

Pregnant women have very little capital of any type and very little power in decisions about seeking healthcare for themselves. They are treated as minors in decisions concerning pregnancy complications. In disagreements, they are required to obey their husbands, unless they can find

powerful supporters of their opinions among elderly relatives or healthcare workers. The hierarchical structure of the society that makes wives dependent on husbands is largely misrecognised. Wives' dependent position is generally taken for granted, which contributes to its persistence. Power imbalances become evident if husbands do not provide assistance and wives are left with limited options for survival. The question of women's autonomy does not take form of a power struggle because only pregnant women themselves promote autonomy, and their position is weak. However, a few women challenge the situation and make decisions about their own bodies and health, even when they risk divorce as a result of acting against their husbands' wills.

"You can't say no to what your husband has ordered [to deliver at home instead of at hospital]. He is the head of the family, the one who makes decisions. (…) But a wife can report that to the brides-man [middleman] or a relative who calls him, and he takes the advices and accepts you to go to the hospital". (Wife 6)

"[If her husband denied hospital delivery] I would go anyway, because I am the one with the problem. My husband may think that I have defied him, perhaps he can think of a divorce. But I don't think one can lose her life because of a family. I will first go to get treatment, then later on we can discuss". (Wife 7)

Discussion

This qualitative interview study of husbands' role in making decisions about seeking healthcare for pregnancy complications in a semi-rural area in Malawi revealed that husbands are important decision makers because of their economic resources and role as head of household. The power

imbalance that gives wives little say in healthcare seeking is largely unrecognised and, as a result, upheld in society. However, lack of money is seen as the only reason why a husband can deny his wife's healthcare. The highest decision-making power is assigned to knowledgeable and skilled maternal healthcare professionals, while husbands have very limited access to maternal health knowledge. The key informants in this study express little need for increased male involvement, compared to the men and women, which indicates that the full significance of husbands' participation may only become evident through the experience of pregnancy complications.

The significant role of the husbands in making decisions around pregnancy complications is based on their economic capital, which is needed to cover referral and hospital costs, as well as on their symbolic capital, which in practice means support to women and children in the long term by guaranteeing their position in society. The husbands' power over their wives in seeking maternal healthcare and the misrecognition of this power imbalance must be related to the cultural context of Malawi, in which gender inequalities are significant in decision making and accessing productive resources in other spheres of life [19]. Only one third of women feel that they can make decisions about their own healthcare [15]. Addressing the female dimension of poverty, in which women lack both economic means and decision-making power can improve maternal health outcomes [15, 20, 21], and this development can and should coincide with increased and improved male involvement.

Lack of money was the only acceptable reason for a husband to deny his wife the opportunity to seek skilled care, which indicates a need to find solutions for timely healthcare seeking that are effective in the least privileged settings and families. Hierarchical decision-making patterns did not create an obstacle in timely healthcare seeking; this result is in line with some previous studies [20]. Other studies have found decision-making patterns and cultural practices to be major barriers [21, 22]. Lack of maternal health knowledge among husbands, TBAs and family members was considered to delay or prevent healthcare seeking in some situations.

The power and appreciation given by husbands and wives to maternal healthcare

professionals in this study is somewhat unexpected in a low-income country context [23]. The finding is most likely explained by the specific sample of couples who had experienced severe pregnancy complications that could not be treated in the community but were treated successfully by healthcare professionals. The more significant role that key informants assigned to traditional healers and TBAs supports this theory. Similarly, the emphasis on timely healthcare seeking as a means to support the health and wellbeing of pregnant woman can be explained by the sample of interviewees as well as the study's focus on men, who traditionally arrange referrals.

Methodological discussion

The use of Bourdieu's concepts helped to illustrate how the power balance influences decision making around pregnancy complications. However, the concepts field and capital focus on social interactions; incorporating individual determinants of decision making would have required the use of additional concepts, such as the habitus, which Bourdieu uses to explain the pre-existing, historically constructed characteristics of individuals that condition them to behave in a certain way [12]. For example, many men explained how their inner strength that came from a religious worldview and the satisfaction of becoming a father influenced their decisions. We also found, that the power balance is not always misrecognized like Bourdieu suggests [11].

In-depth interviews with husbands, wives and key informants were useful for investigating the different points of view of men and women as well as people with and without experience with pregnancy complications. For example, the analysis revealed that men and women had different expectations of what men should know about maternal health; these differences are important when designing maternal health interventions [24]. Although the study included separate IDIs for husbands and wives to facilitate free expression, the reliance on male interviewers may have caused some women to feel shy about speaking. Efforts were made to minimize this effect by including the female investigator and securing a safe and comfortable interview setting chosen by participants.

The sampling process purposively looked for couples who had experienced pregnancy complications. However, we relied on the assistance of village headmen, and their understanding of pregnancy complications and possible other preferences influenced how the interviewees were chosen. As expected, discrepancies were found in the men and women's stories. Men expressed more comprehensive male involvement than their spouses did. This result was interpreted as an indication of social desirability bias on the men's part; they may have wanted to present themselves in favourable terms in an interview situation [25]. It is also possible that men's role in delivery complications remains hidden from women in a society in which women and men act in separate spheres.

Conclusion

We conclude that husbands are important in making decisions to seek healthcare for pregnancy complications because of their economic and symbolic power positions grounded in male dominance in society. However, men have limited access to maternal health knowledge. We recommend that the female dimension of poverty, in which women lack both economic means and decision-making power, should be addressed to improve maternal health seeking practices and that men be given direct access to targeted maternal health knowledge in order to enhance male involvement.

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Table 1: Example of analysis of an extract of an interview at various analytical levels

Analytical level	**Meaning unit**	**Condensed meaning unit**	**Code**	**Category**	**Theme**
Definition	*Unit of text that talks about one aspect*	*Core content of a meaning unit*	*Common attribute for meaning units*	*Lower level category of theme*	*Bourdieu's theoretical concept*
Type of reasoning	*Inductive*	*Inductive*	←→		*Deductive*
Example from an interview text	*The one who decides where to go with [delivery] problem is the husband. (…) My parents agree, because he is the one who brings money in our family* *(Wife 6)*	*Husband's decision is agreed to, because he earns and pays*	*Husband with money decides*	*Deployment of economic capital*	*Economic capital*

Table 2. Types of capital that husband possesses in field of pregnancy: themes, categories and codes

Categories	***Themes***			
	Economic capital	**Cultural capital**	**Social capital**	**Symbolic capital**
Assets that enable husbands to gain capital	Codes: • Earned money • Saved money • Economic support from relatives • Loans	Codes: • Maternal health knowledge • Knowledge of maternal health services • Traditional knowledge of maternal health	Codes: • Male peers who can assist with transport • Relatives or TBA nearby assist with care • Close relationship with wife	Codes: • Fatherhood • Head of household status • Affectionate partner role
Barriers that hinder husbands in gaining capital	Codes: • Poverty	Codes: • Rupture of traditional networks for men • Men's exclusion from maternal healthcare • Expectations of men's passive role	Codes: • Men's exclusion from maternal healthcare • Separate male and female spheres in society • Weak male networks	Codes: • Poor quality of marital relationship • Absence of husband • Independent position of wife • Matrilineal tradition
Deployment of capital in field	Codes: • Allocate family resources for health • Decide on health seeking • Show emotions	Codes: • Take action in complications • Negotiate health seeking • Advise wife	Codes: • Take action in complications	Codes: • Decide on health seeking • Take overall responsibility for wife and baby's wellbeing