

Barriers To and Attitudes Towards Promoting Husbands' Involvement in Maternal Health in Katmandu, Nepal

Abstract:

In recent years, couple-friendly reproductive health services and male partner involvement in women's reproductive health have garnered considerable attention. Given the sensitive nature of gender roles and relations in many cultures, understanding the context of a setting, potential barriers, and attitudes towards a new intervention are necessary first steps in designing services that include men. In preparation for a male involvement in maternal health intervention, this qualitative study specifically aims to (a) understand the barriers to male involvement in maternal health, and (b) explore men's, women's, and providers' attitudes towards the promotion of male involvement in maternal health. In-depth interviews were conducted with fourteen couples and eight maternal health care providers at a public maternity hospital in Katmandu, Nepal. Additionally, seventeen couples participated in focus group discussions. The most prominent barriers to male involvement in maternal health included low knowledge levels, social stigma, shyness/embarrassment and job responsibilities. Though providers also foresaw some obstacles, primarily in the forms of hospital policy, manpower and space problems, providers unanimously felt the option of couples-friendly maternal health services would enhance the quality of care and understanding of health information given to pregnant women, echoing attitudes expressed by most pregnant women and their husbands. Accordingly, a major shift in hospital policy was seen as an important first step in introducing antenatal or delivery couple-friendly services. The predominantly favorable attitudes of pregnant women, husbands, and providers towards encouraging greater male involvement in maternal health in this study imply that the introduction of such health education services would be both feasible and well accepted.

Keywords: Nepal; male involvement; couples; maternal health

I. Introduction

In recent years, couple-friendly reproductive health services and male partner involvement in women's reproductive health have garnered considerable attention. The promotion of such services, however, is complex and highly sensitive. Among the most prominent concerns are the imposition of Western standards on gender roles and ideals, the reinforcement or perpetuation of patriarchal domination, the safety and confidentiality of women, and the resource diversion from women's reproductive health programs. In preparation for a male involvement in maternal health intervention in urban Nepal, this qualitative study specifically aims to (a) understand the barriers to male involvement in maternal health, and (b) explore men's, women's, and providers' attitudes towards the promotion of male involvement in maternal health.¹

II. Background

Male involvement in reproductive health

In a recent extensive review of men's roles in women's reproductive health, Dudgeon & Inhorn (2004) examined studies in the fields of medical anthropology and public health and reported that the influence of men in decision-making and positive impact of including men in health services, has been found in the fields of family planning, sexually transmitted infections and HIV, abortion, and infertility. The authors pointed out the relative scarcity, however, of information on men's intentions and practices as they relate to pregnancy and childbirth, stating that, "more qualitative research...is needed to include men as a major part of women's social environments in both pre- and post-natal health" (Dudgeon & Inhorn, 2004, p. 1388). One of the few in-depth investigations of the roles of male partners in maternal health was conducted in rural Guatemala. Carter (2002) reported that, contrary to negative stereotypes about husbands' roles in maternal health, male involvement in maternal health in Guatemala was both relatively high and desirable. Some of the most commonly cited reasons for this involvement included the provision of love and support for wives and husbands' paternalistic tendencies, while factors such as low knowledge levels, work demands, and barriers imposed by midwives were important obstacles to male involvement. Little is known regarding barriers to and attitudes towards male involvement in maternal health in other settings, including South Asia.

Gender norms in Nepal

A wide array of castes and ethnicities, as represented by over seventy languages and dialects, make Nepal's population of 23 million people extremely diverse. This heterogeneity manifests itself in varying gender norms and customs throughout the country, particularly as the experience of gender has been suggested to differ by caste group (Cameron, 1998). Generally, women in Nepal have a low social status that often directly and indirectly manifests itself in women's poor health outcomes. The 2001 Nepal Demographic & Health Survey (Nepal 2001 DHS) indicates that 36% of women in urban Nepal have no formal education, considerably higher than the 14% of men lacking such education. Women experience low decision-making power, particularly in regards to decisions that directly impact their own health. According to the most recent Nepal DHS (2001), 60% of urban women had no say in making decisions about their own health care. Instead, these decisions were, by and large, dominated by their husbands (Nepal 2001 DHS), a pattern confirmed in several studies of Katmandu Valley populations (Mullany, Hindin & Becker; Matsuyama, 2002).

Rationale for Study

A recent report summarizing the findings from male involvement studies in Nepal concluded that “addressing men’s roles in supporting safe motherhood through behavior change communication activities” is a top priority in reproductive health programming (Engender Health, 2004, p. vii). Such programming cannot move forward unless more is known regarding potential barriers to husbands being positively involved in their wives’ maternal health and about women’s and men’s attitudes towards the promotion of male involvement, particularly in regards to whether and how women would like to see their male partners involved during pregnancy, labor and delivery. Finally, the attitudes of health service providers must be assessed in order to engage in effective dialogue about the implementation of services that include males.

This qualitative study, conducted in preparation for a trial of male involvement in antenatal care, will describe barriers to and attitudes towards male involvement in maternal health in urban Nepal, as described by pregnant women, husbands, and maternal health care providers.

III. Methods

Setting

Prasuti Griha Maternity Hospital (PGMH), the largest maternal health care center in Nepal and predominant maternal health provider in Katmandu Valley, is a government-funded hospital with a total catchment population estimated at 1.1 million people and 16,000 annual deliveries (MIRA/UNICEF, 2000). Roughly 40% of women attending their first ANC visit are accompanied by their husbands on the day of the visit (Antenatal Registration Records, PGMH). Local research assistants (RAs), including two male auxiliary health workers and three female nurses, were trained in qualitative data collection methods.

Data Collection

In-depth-interviews (IDIs) and focus group discussions (FGDs) were conducted with married, second-trimester pregnant women receiving antenatal services at PGMH. Women who were widowed, divorced, separated, single, or under 18 years of age were ineligible. Pregnant women were approached for participation while waiting in line for their ANC checkups at PGMH. To adequately represent the clientele, purposive sampling was conducted according to women’s parity and partner’s presence at the hospital. In order to provide matched couples data, husbands of female participants were also recruited to participate in IDIs and FGDs either at the hospital (if present on the day of the wife’s recruitment) or in the home (if absent on the day of the wife’s recruitment). Health care providers were recruited from within the antenatal ward of PGMH.

Informed consent was administered confidentially and received from all participants before the start of the IDIs or FGDs. The qualitative data collection instruments were thematically structured around the guiding research aims and were developed in conjunction with local collaborators.

With the exception of a few interviews with husbands in their homes, all wives’ and husbands’ interviews and discussion groups were conducted separately and simultaneously with same-sex research assistants (RAs) and tape-recorded in private rooms within the hospital. For confidentiality reasons, the Local Study Coordinator, who had no previous affiliation with the hospital or its staff, conducted the providers’ interviews. For all IDIs, only the interviewer and the respondent were present, and for FGDs, a moderator and note taker were present throughout

the entire discussion. IDIs lasted approximately 60 minutes, while FGDs lasted approximately 75-90 minutes.

Data Analysis

Upon completion of all FGDs, the RAs transcribed all recorded discussions into Nepali. The Project Coordinator and Local Study Coordinator examined the transcripts to identify topics for in-depth investigation in subsequent interviews. All transcripts were translated into English by a local NGO specializing in maternal health research and entered in Microsoft Word (Microsoft Corp, Redmond, Washington). Transcripts were then matched by couple and reviewed by the author. Upon printing all transcripts in text format, the author thematically coded and sorted the transcripts, focusing on potential barriers and attitudes. Subsequently, the author systematically analyzed the transcripts, describing similar and contrasting viewpoints surrounding each theme and paying attention to specific patterns or differences between important groups of individuals (e.g., women with husbands present versus absent at ANC). Preliminary results were shared and discussed with the Nepalese collaborating researchers.

IV. Results

Table 1 summarizes the categories of study participants. Fourteen couples and three additional women (whose husbands could not be located at home) participated in the IDIs, and seventeen couples and six additional women (whose husbands were unavailable to participate due to job constraints) participated in the FGDs. Eight health care providers working with pregnant women in the Maternity Hospital were interviewed. As nurses and doctors in the antenatal ward of the hospital are predominantly female, the current sample consisted of seven females, ranging in position and experience from nurse to senior doctor, and one male doctor. Demographic characteristics of pregnant women and their husbands are presented in Table 2.

Barriers to male involvement in maternal health

1. Low knowledge levels

While husbands' interest levels and attempts to support pregnancy health were relatively high, low knowledge levels appeared to pose a significant obstacle to becoming actively involved. In general, both male and female respondents' knowledge surrounding pregnancy was limited, particularly in relation to complications or danger signs during pregnancy, labor or delivery.

When asked to describe what they knew about pregnancy health issues, husbands most often replied with a series of questions, as exemplified in the following response:

“I want to know what should be done during pregnancy, what foods should be taken, what medicines should be given, what should be done during the postpartum period, etc. I also want to know what should be done if a delivery takes place at home.” --21 year-old waiter

Providers, in general, echoed the responses of numerous men and women, describing the husbands of their female patients as being uneducated or misinformed about health matters, a factor they felt helped to perpetuate poor health practices:

“They [husbands] have no health education, no nutrition education, not even about immunization – they don't know anything! Nowadays, husbands should

know what they have to do to take care of their wives - they must know, otherwise after going back to the house, they will act the same way..." –female nurse in-charge

2. Societal stigma

Approximately half of all FGD and IDI participants shared sentiments about ways in which societal mores discouraged and/or belittled husbands' attempts at involvement during pregnancy. One man described how:

"I know the society criticizes me when I carry water container and let my wife walk empty hand or let her stay in the bed. When I bring vegetables and help my wife my community makes fun of me saying that I work for a woman." --25-year old service industry worker

According to several participants, several Nepali phrases or idioms have been coined for husbands who are viewed as 'too' supportive or involved with their wives. Several husbands described the term *joitingre* ("hen-pecked"):

"If the husband tries to help his wife, the society will call him hen pecked (*joitingre*). The society discourages husbands who listen to their wives. They say the husband should not wash wife's clothes; it is her job." –24-year old teacher

When asked to further define this term, participants said it was used to describe a man who 'always obeys his wife,' 'takes orders from his wife,' or 'does what she says.' Another husband described an idiom used to describe a man in this position: *swasniko mutma bageko*, or a man being 'swept away by the urine of the wife.' This participant further explained this term to mean a husband who pays too much attention to his wife's needs and follows her orders instead of attending to his own needs.

Discouragement of supportive male behaviors was often associated with older generations and some women described how their elders complained how younger women in contemporary Nepal are too demanding or needy:

"They say the older generation brought up many children without the husband's help, but nowadays pregnant women ask for many things," explained a 22-year old housewife.

Providers also felt that traditional gender norms and associated stigma were substantial factors, even within families:

"In joint families, the mother-in-law and sister-in-law...might say all sorts of things, like ridicule and tease a male when he is trying to get involved and he might become discouraged by this," explained the male doctor.

Several participants, however, described how men overcame these obstacles, usually by ignoring or dismissing individuals who discouraged their supportive behaviors. For instance, one woman described how:

"When my husband helps me the villagers talk about it and I tell him that I can work on my own. But my husband says let the villagers talk; he would not stop helping me. In the family too some members talk about him helping me, but he doesn't stop." –23-year old housewife

In a similar vein, most couples agreed that times were changing and male involvement in contemporary Nepal was becoming more accepted. One husband described:

“The people in my community motivate me to help my wife. Nowadays the villagers hold the belief that the wife should be helped in pregnancy; this is a changed attitude.” –20-year old businessman

Several providers also alluded to the ‘changing times,’ and how the younger generations in contemporary Nepal behaved differently than older generations:

“In earlier days, husbands used to be more conscious about their communities - they were scared that other people might tease him if they are involved in their wife’s pregnancy health. But now, this new generation is not like that. They do not care what other people say or watch them doing. Even if his mother objects, increasingly now he comes to us and tries to get information,” explained a senior consultant doctor who has worked at PGMH for over 30 years.

Another female provider similarly explained:

“I think husbands nowadays are being encouraged by their society also – it has changed after the effect of modern society, by watching television, and reading...the influence of the outer world, other countries, this has helped them to change.”

3. Shyness / Embarrassment

Embarrassment or awkwardness in learning about pregnancy health appeared to be a less significant, though still important barrier to husbands’ involvement. Among these participants, the initiation of discussion over these topics, in particular, remained a challenge for some couples.

One senior nurse felt that shyness surrounding traditional gender norms was a major obstacle. She explained:

“Because of our traditions...even a wife feels shy to tell her husband that she is pregnant! Our tradition has made us a bit introverted and we feel more shy and we are not so exposed to other outside ideas. They tell their mothers-in-law or sisters-in-law about their pregnancy, instead of their husbands.”

In contrast, several providers felt that shyness was no longer as much of an obstacle as it would have previously been. “Nowadays, they feel free to talk and ask questions, they are not discouraged,” stated another female provider who has worked at PGMH for over 20 years.

Several men felt that it was their position to initiate discussions about maternal health with their wives, for instance:

“Some women feel shy. We should take initiative in asking such women to learn about her condition...” –25-year old businessman

but some husbands also acknowledged difficulty in doing so, such as:

“She feels uncomfortable since she cannot tell me clearly about how she feels. I have to guess about what she says or feels.” –24-year old farmer

While some communication barriers between couples were found in regards to instigating conversations together, most male and female participants agreed that husbands were not, and should not, be embarrassed or feel awkward to learn about their wives' pregnancy health status. One 24-year old housewife explained how:

“there is nothing for him to be embarrassed about when he is concerned for my health. He asks me what has happened, how I am, etc – I also want him to be concerned for me.”

4. Availability / job responsibilities

Work obligations or job responsibilities did not appear to be a major obstacle to male partner involvement in this population. While some men and women described how the husband's schedule was limited due to his job, this reason was cited considerably less than the others outlined above and was equally mentioned by individuals, regardless of husband's presence or absence at hospital. Similarly, only one provider expressed that she felt husbands' work obligations were a major obstacle to men being involved in their wives' health.

5. The role of the mother-in-law

Although not a barrier in itself, the authors felt that the strong influence of mothers-in-law in the Nepal setting warranted some investigation into the dynamics between mothers-in-law versus husbands as providers of maternal health related support.

While the FGDs and IDIs revealed that the role of the mother-in-law during pregnancy was also important, her primary responsibilities appeared to center around assistance with delivery and in providing nutritious foods, household help, and emotional support during the postpartum period.

It is also important to note, however, that mothers-in-law were sometimes viewed as barriers to pregnant women's health. Many providers described how mothers-in-law were often very proud of what they had accomplished without medical intervention, and accused the younger generations of doing things too differently, namely in seeking health services at hospitals or clinics, for example:

“Patients do not have many complaints about their husbands, but they complain about their mother-in-laws. In earlier days, they delivered at home so they do not want their daughter-in-laws to go to the hospital – they say they gave birth to 8 or 9 babies at home...” –senior doctor with 28 years experience at PGMH

Furthermore, only one-third of female participants actually lived in the same household with their mothers-in-law and few providers actually came into regular contact with the mother-in-law of a patient, explaining:

“Most of the clients here come to the hospital with their husbands, occasionally with their sisters-in-law, and only rarely with their mothers-in-law.” –senior nurse in-charge

6. Hospital policy

In general, providers described their interactions with husbands as being fairly limited, given the hospital's restrictions on husbands' entrance into most areas of the hospital and relatively short hours of operation. For instance, the male doctor described how:

“There are husbands who wait outside for us to talk about their wives’ health status, but they do not get the chance to talk to us since we do not give time to them.”

In describing their frustration with being excluded by hospital policy, several husbands reiterated these providers’ views. For instance, a 26-year old businessman described how:

“I have many questions - If my wife has labor pain suddenly, where should I take her and how should I take her?...but as a male, even in the hospital, we cannot ask any questions... and when my wife is admitted [for delivery], I am not allowed inside.”

Lack of staff, time, space, and privacy were the primary reasons that providers gave for the current hospital policy’s exclusion of husbands from both ANC checkups and delivery.

“There is such a crowd in the ANC outpatient department that we cannot manage the time...also there is limited room for ANC checkup, each room is divided by a curtain and even if husband comes inside, others might feel disturbed. There is no privacy...” –male doctor

Attitudes towards the promotion of male involvement in maternal health

1. The inclusion of husbands in antenatal care services

a. Clients -

The majority of both wives and husbands, regardless of whether the husband was present or absent at the hospital on the day of the FGD or IDI, expressed favorable attitudes towards having husbands involved in pregnancy health, particularly in ANC health education services.

Numerous male and female respondents referred to how communication about health between spouses may be improved if the husband were included in ANC education services.

One man’s comments captured the essence of several responses:

“I want to be educated because anything can happen and I should be prepared for it. The woman does not usually tell what has happened to her and we have to ask her about her conditions. It is no problem for me to inquire about my wife and to learn about pregnancy, I just do not know what to ask.” –30-year old businessman

Another frequently cited reason for wanting to have the husband present during the ANC visits had to do with the quality of the interaction between the mother and doctor, as well as the services subsequently received. While only one woman discussed this, over one-third of the husbands described how their presence during the ANC visit would improve the interaction of their wives with the medical staff. For instance, one husband explained:

“I think my presence would be better for the treatment of my wife, it would make the doctors be more careful.” –21-year old restaurant worker

Several women also felt that the inclusion of husbands would make it easier for her to increase their understanding, for instance:

“If the checkup is with him, then both of us will understand the problems. Then I will not need to explain to him later on.” –22-year old housewife

One female participant explained her reasons in a different way, related to her own retention of information provided by the medical staff:

“when we tell our husbands [what the doctor/nurse said], we may make mistakes. But when you [nurse/health worker] tell them, it would be different. The husbands will also understand better.” –22-year old housewife

Support from the husband was also seen as an important aspect of including the husband in the ANC visit.

Some men also explained that being present during the ANC checkup itself would present an important opportunity for him to learn more about his wife’s condition, such as one husband described that:

“It would be better to give treatment to my wife in front of me...Some matters that the doctors tell wives are not shared with the husbands – I have seen some women getting thinner and thinner but they do not tell their husbands about their problem. In order to avoid such a problem, I would like to sit before my wife while getting treatment and get advice from the doctor.” –25-year old waiter

Shyness or awkwardness, as well as confidentiality, on the part of women were the primary reasons that several participants cited for not wanting husbands present during the ANC checkup. Even when some men expressed a desire to be included, they could usually recognize (and were correct) in realizing the wife’s feelings; for instance, one husband described how:

“It would be better for me if both of us were together for her checkup...but as my wife is sometimes embarrassed, it may be more convenient if she is treated alone.” –24-year old restaurant worker

Only one participant cited a confidentiality-related reason for not wanting the husband present at the checkup:

“For me, it is better if my husband is absent when I am examined. If my husband is there, I will not be able to tell the doctor what I would like to. This will also worry my husband as he does not know about woman’s problems.” –19-year old housewife

b. Providers -

Providers were unanimous in their support of couple-friendly ANC education services in theory; how to effectively implement such services however was a source of debate. The primary obstacles to the implementation of couple-friendly services were shortages in manpower and hospital space. While most providers felt that working with individual couples was the most ideal avenue for health education and counseling, large group education and counseling sessions for husbands, including mass media and video formats, was viewed as the most feasible way of implementing couple-friendly services in the long run.

In regards to the ANC checkup, several doctors discussed how allowing the husband to be present during checkups could potentially make their jobs as providers easier. The male doctor explained:

“It is better...because we can explain to the husband about the condition of the wife and we can tell them what they have to do immediately. Like if we need to see

an ultrasound, and we can tell them both, it would be more effective – if we tell a woman only, she just goes to her husband and he might just say that it could be done elsewhere or another day, so we cannot get the results immediately. Therefore, it would be very useful to have both together.”

A senior registrar nurse agreed, stating:

“It would be so much easier if we have this. Some husbands now get so angry with us because they do not know what we are doing to their wives...so if they are also aware, then we can tell them all the situations, problems that might come, and they can understand properly.”

Not communicating directly with husbands may also hinder women’s receipt of care, according to some providers. The male doctor spoke of a recent experience for him:

“For example, we tell a patient with high blood pressure that she needs to be admitted but she denies saying that her husband is not here and she has to ask him first. I remember once I told a woman that she needs to be admitted immediately, and she told me that she has to ask her husband who is downstairs first and later she came and told me she could not find him, so she could not stay.”

Providers sometimes also felt that communication itself was easier and more effective with men.

“Many doctors prefer to tell both the husband and wife because it makes their jobs easier,” explained a female doctor, “they feel communication can be easier with men – often women have difficulty understanding or answering questions, but men often know more and can communicate better – lots of benefits would come this way and he may be able to explain to her.”

Several providers felt strongly that men should be more educated on maternal health issues, and unless they were given these messages directly, their support levels may remain low or unchanged. One provider explained

“If we were to offer couples services together, it would be better...nowadays, husbands should know – now even after coming here, they haven’t learned anything.” –senior nurse in-charge

A few providers specifically mentioned requests from pregnant women to inform husbands about health practices during pregnancy.

“When we tell the patient only,” a female doctor explained, “they want us to tell their husbands or other family members about taking rest. Otherwise, they might not believe her. Mainly for the rest, they want us to tell their husbands. Their husband or mother-in-law might think that because she doesn’t want to work, she’ll make it up (what the doctor said).”

Similarly, another female provider stated:

“if wife alone comes for ANC, she goes to her house and tells her husband, but the husband might not believe her. But if he is together it will be more effective for the wife.” (PID1 #6),

Only one provider described experiences in which patients requested specifically *not* to include their husbands in the ANC checkup. The provider explained:

“For example, sometimes we find a woman with a previous abortion which she might have kept secret from her husband and requests us not to tell her husband.”

The majority of providers described providing services to pregnant women with their husbands in their private practices and felt this policy was very helpful to both them as providers, and to the patients. If the initiation and commitment were there, providers felt it was possible to introduce such services at the hospital:

“at least if they come for the first ANC visit, if they can give that time, wives can come alone for the rest of their visits...if he is together, it would be very good and effective for his wife, they will listen and understand better – we could at least start there.” –senior female consultant doctor

2. Husbands’ presence in the delivery room

a. Clients -

When asked to describe their feelings towards having the husband present in the delivery room while the woman was giving birth, couples, in general, split along two lines. Either both members were quite enthusiastic about having the husband present, or both members were uncomfortable with the idea.

The vast majority of the female IDI and FGD participants stated that the husband’s primary role during delivery was to bring them to a hospital or a health facility. Approximately half of the couples explained that, if given the option, they would prefer to have the husband present during delivery.

Female participants primarily cited two reasons for wanting the husband’s presence: witness and support. Many women described wanting the husband to be present during delivery to witness her pain. First, witnessing the suffering of the wife appeared to be an important element in bolstering the husband’s appreciation for a smaller family size. For instance, one woman described:

“He will know how women suffer while giving birth. Many men do not understand the problem – I think two children are enough, but men go for four or five children, as they do not know about the pain...if he is present, he will know the pain,” –20-year old housewife

Pregnant women and providers described that husbands’ witnessing the suffering of the wife was also important in that it provided an opportunity for the woman to ‘earn’ her husband’s love, as exemplified by the following comments:

“I like it if my husband stays with me... because he will know how difficult it is to give birth...and after seeing, he might love me more in the future.” –20-year old housewife

“if the husband will be present during delivery, then husband will also think ‘oh how painful delivery is!’ and I think they might develop empathy, and they will start to love the wife and children...If they don’t see or if they are outside and after

the delivery, they call to him and say that the baby is born, the husband will think, 'Oh, this delivery is so easy, no problem!' and so they will not love their wife." – female provider

Support was the other primary reason women wanted their husbands to be present during delivery, and this support often manifested itself in greater comfort in communication during the labor and delivery process. For instance, several women described how the husband's presence was different from other relatives.

"If there are any problems it is easier to share with the husband than with the mother-in-law or others," and "embarrassing things can be shared with the husband while this cannot be done with others." –26-year old housewife

Increased ease of communication and support was also cited by numerous husbands as one of the most important reasons they should be present during delivery.

One husband described his feelings as:

"I know my wife can express herself more freely with me than with anybody else... In foreign countries, the husband stands beside the wife during the delivery and he holds her hand. My wife asks me why in our society it is not allowed." – 25-year old waiter

Several women and men felt husbands should stay in the delivery room in order to help in case of an emergency or to learn more about his wife's and child's health status. One 20-year old housewife explained:

"Several problems may arise to which he should pay attention. Other people do not know the situation. For the sisters [nurses] in the hospital, the husband's presence is important and convenient."

In stark contrast to the above examples, around half of all couples were against having the husband present in the delivery room. Numerous women reported feeling uncomfortable or embarrassed having their husbands witness them in pain.

Husbands, on the other hand, often expressed feelings of wanting to stay in the delivery room, but being discouraged by societal mores, traditional practices or attitudes, including hospital policies. Several husbands described how, traditionally, only females are present in the delivery room; therefore,

"if a man is present, it would be like a crow in the herd of herons," (FGD #4-5) explained a 34-year old service industry worker.

Several other men also described feeling intimidated or unwelcome.

"If I stay there, it may be that my wife's pain is slightly reduced...The husband would like to stay there and help solve the problems. The society, however, does not allow us to stay there," explained a 30-year old businessman.

Some men presented more traditional reasons for not wanting to attend the delivery, and felt it was best to be nearby, such as one husband who said:

"people say that if a male sees the pregnant woman delivering the baby, the labor pain prolongs." –24-year old restaurant worker

b. Providers -

The majority of the providers felt that allowing husbands into the delivery room was a good idea in theory and felt it was feasible in practice; however, several providers also foresaw logistical problems that would hinder implementation of such a policy.

Several providers felt that husbands were ill-equipped in knowledge and/or experience, or emotionally, and would therefore require some preparation before allowing them into the delivery room. A few providers mentioned logistical obstacles, such as too little space in the delivery room, and one female doctor described privacy issues as being a problem (eg, “there could be another female patient lying in the next bed, who may feel discomfort”).

Approximately half of the providers alluded to delivery practices in other countries, and discussed how they thought the husband’s presence could provide important support to the woman. One explained:

“If we allow him in this ward, they can help with care and help to serve the woman, it is good, we think they can also help make our own loads lighter” –female nurse

Some providers described that the husbands’ presence at the hospital compound itself during the delivery provides an important source of support for their patients.

“Some patients want to call for their husbands during the delivery...even though he is not allowed to enter inside and he is just outside waiting, I think his wife still will receive psychological support,” described the male doctor.

V. Discussion

Understanding the context-specific barriers to and attitudes towards the introduction of a new health or behavior change activity is a crucial step in designing appropriate and applicable interventions. The findings presented in this paper provide important new information regarding barriers that, until now, have prevented men from providing more positive support and involvement during their wives’ pregnancies. The results also suggest that education services could mitigate these obstacles by providing information to increase knowledge levels and decrease stigma, and by initiating communication over sensitive subjects. The predominantly favorable attitudes of men, women, and providers towards encouraging greater male involvement in maternal health imply that the introduction of such health education services would be both feasible and well accepted.

Limited knowledge about healthy behaviors and actions to take during pregnancy, delivery, and the postpartum period appears to be a significant barrier to the realization of supportive behaviors played by husbands. Despite reportedly high levels of interest in pregnancy health, numerous respondents, particularly males, described a frustration about not knowing what ‘questions to ask,’ or what ‘actions to take’ in regards to their wives’ maternal health. Several providers, husbands, and wives described how the lack of health education services available for men in general was detrimental to the health status of some women.

While a large number of male and female participants described how traditional Nepalese society stigmatized husbands that played a supportive or helpful role during their wives’ pregnancy, many participants reported that they (or their husbands) dismissed these negative societal views. As Nepal becomes more modernized, according to respondents, supportive behaviors of men towards their wives are becoming more accepted. Social response biases may

have influenced descriptions of how men seemingly shrug off taunts or discouragement from their own communities, and/or women may have been reluctant to portray their husbands in a critical light. The majority of male and female participants in both personal interviews and discussion groups, however, reiterated common themes, suggesting attitudinal changes that are increasingly accepting of male involvement in maternal health.

Communication barriers between husbands and wives were found to be present with respect to reproductive health. Several husbands, in particular, discussed attempts to initiate health discussions with their wives that left them frustrated – women, it seems, are more shy to initiate or take part in some of these discussions than men. The willingness of husbands, as well as the communication barriers found in some couples, suggests that offering couples' services may provide an opportunity for 'breaking the ice,' so to say, in broaching these important topics.

Job responsibilities of husbands did not appear to be an important barrier to men playing more supportive or involved roles during pregnancy. Confirming these findings, a survey conducted among this same population of ANC seekers and their husbands found no differences in employment rates between husbands present versus absent at the PGMH ANC clinic (Beenhakker, 2005). Extending ANC clinic hours would nevertheless most likely allow for more male partners to become actively involved in attending ANC with their wives.

Traditionally, mothers-in-law have acted as the primary caretaker of pregnant women, particularly during delivery and the postpartum period. The description of the mother-in-law in these terms, however, does not imply that this is the role currently being played by mothers-in-law in contemporary Nepalese families in this setting. As young Nepalese men and women move to urban areas, extended relatives and in-laws are less likely to reside in the same house with them after marriage and only one-third of participants in this study actually resided in households with the mother-in-law either during pregnancy or permanently. Additionally, the majority of female participants described feeling more comfortable with their husbands than with their mothers-in-law, both in regards to expressing their fears, concerns, or pain, but also in receiving emotional support. Thus while mothers-in-law potentially constitute another important target of health education interventions, they are both less likely to be present in the home, and less likely to be present at the hospital than husbands in this setting, making them more difficult to reach and include.

The majority of women and men stated that, if given the option, they would prefer that the husband be allowed to attend both ANC education sessions and checkups with the wife. The primary reasons for desiring the husbands' inclusion were because it may improve the health services received by the pregnant woman, it might help to increase communication within the couple, it provided an opportunity to learn about the health condition of the mother and baby, and it would provide support to the wife. While participants were more divided in regards to the presence of the husband in the delivery room, it appeared that almost all couples would prefer having the option. Only a small group of both men and women opposed the idea of including husbands, feeling that the husband's presence would be awkward or hinder the provision of services somehow. The responses of these individuals indicate the need for sensitivity in any changes to service delivery. Couples' services are clearly not appropriate for everyone, and an emphasis must be placed on providing the option of such services to women. Similarly, the safety and confidentiality of women must always be taken into account in designing such services.

Providers foresaw some obstacles, primarily in the forms of hospital policy, manpower and space problems, in the implementation of couples-friendly ANC services at the hospital. However,

the providers also unanimously felt that the inclusion of such services would enhance the quality of care and understanding of health information given to pregnant women, echoing attitudes expressed by most pregnant women and their husbands. Though the introduction of husbands into the delivery room was seen as a somewhat complicated transition, the majority of providers felt that it was an ideal goal to work towards, particularly because husbands could offer vital emotional support, and perhaps logistical support, to the wives throughout the delivery process.

Accordingly, a major shift in hospital policy was seen as an important first step in introducing ANC or delivery couple-friendly services. Maternal health policy-makers' and providers' biases have been found to be a barrier to including men in reproductive health services in several other countries (e.g., the hours of operation are limited to working hours, when husbands cannot attend; not allowing men into clinics or delivery rooms, etc.) (Turan, Nalbant, Bulut & Sahip, 2001; Khan, 1998). Findings from the providers' interviews at PGMH indicate that the implementation of couples' services appears feasible, though it would require creative thinking regarding space, staff, and resource limitations, in addition to proper training aimed at leadership development and attitude shifts.

Tapping into cultural attributes as potential positive forces is an important approach to introducing new interventions in different settings. Carter (2002) found that in rural Guatemala, paternalism was an important reason for husbands' being involved in their wives' health. These findings suggest that urban Nepalese husbands may hold similar views, for instance explaining that women would receive better quality health care if they (the husband) was present or that they could help to explain the doctor's recommendations to their wives. It is important to highlight that many women provided similar responses: that, for instance, they would prefer their husbands be present because they can help them to understand health recommendations, or can help them to maneuver and receive the health services they need. In several cases, women openly equated their husbands' involvement (or lack thereof) with the degree of love he felt for her, and expressed a desire for him to become more involved so that she could feel more 'loved.' Paternalism and love may be inextricably intertwined in the eyes of some individuals, a notion that male involvement and women's health researchers and programmers must be sensitive to. Certain understandings of masculinity may in fact provide an important pathway to targeting males in health interventions. Appealing to men as 'responsible partners' whose help is needed to reach the endpoint of 'healthy families' may, for example, provide an effective approach for targeting men in the Nepal setting and merits further research.

Studies are increasingly finding that men comprise appropriate target audiences for women's reproductive health interventions, particularly given the low knowledge levels of men and the imbalance in decision-making between men and women in many societies (Mullany et al, 2005; Sternberg & Hubley, 2004; Singh, Bloom & Tsui, 1998). Though it may therefore be suitable to target men in a variety of settings, caution must be exercised in generalizing the findings on barriers and attitudes towards male involvement from the urban Nepal context to other areas. Given the sensitive nature of gender roles and relations in many cultures, understanding specific contextual factors in a setting are necessary first steps in designing services that include men. Additional qualitative research undertaken as part of this project examined how males and females would be most comfortable incorporating men into maternal health education services (i.e., same-sex peer groups, couples groups, individual couples, or individuals). The majority of both men and women at Prashuti Griha Maternity Hospital expressed interest in receiving services as individual couples (Beenhakker, 2005). As barriers,

attitudes and preferences will vary by setting, the conduct of in-depth qualitative research is necessary before designing services for males and/or couples.

¹Given that marriage is nearly universal among pregnant women (95%), out of wedlock birth is rare in urban Nepal (Nepal 2001 DHS), and this study's particular focus on husbands, the term 'male' is used to denote the husband of the pregnant woman.

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Table 1. Study participants, by categories.

| Category | Sex | Husband status | Parity status | # FGD participants | # IDIs participants |
|-----------------|------------|-----------------------|----------------------|---------------------------|----------------------------|
| Wife | Female | Present | 0 | 6 | 5 |
| Wife | Female | Present | ≥ 1 | 5 | 4 |
| Wife | Female | Absent | 0 | 4 | 4 |
| Wife | Female | Absent | ≥ 1 | 4 | 4 |
| Husband | Male | Present | 0 | 6 | 5 |
| Husband | Male | Present | ≥ 1 | 5 | 4 |
| Husband | Male | Absent | 0 | 4 | 3 |
| Husband | Male | Absent | ≥ 1 | 1 | 2 |
| | | | | | |
| Provider | Female | --- | --- | --- | 7 |
| Provider | Male | --- | --- | --- | 1 |

Table 2. Demographic characteristics of study participants.

| Characteristic | FGD participants | | IDI participants | |
|--|-------------------------|-----------------------|-------------------------|-----------------------|
| | Males (n=17) | Females (n=23) | Males (n=14) | Females (n=17) |
| Age (mean, SD) | 26.3 (4.4) | 22.8 (3.4) | 27.3 (5.8) | 22.7 (4.7) |
| Gestational age (mean, SD) | NA | 28.0 (7.0) | NA | 26.8 (4.8) |
| Primiparous (%) | NA | 52 | NA | 53 |
| Household size (mean, SD) | NA | 4.7 (2.7) | NA | 5.1 (4.1) |
| Live with mother-in-law (%) | NA | 37 | NA | 35 |
| Education level (%) | | | | |
| <i>None</i> | 12 | 26 | 7 | 18 |
| <i>Primary (grades 1-7)</i> | 29 | 30 | 36 | 41 |
| <i>Secondary (grades 8+)</i> | 59 | 44 | 57 | 41 |
| Occupation (%) | | | | |
| <i>Housewife</i> | NA | 83 | NA | 82 |
| <i>Service</i> | 41 | 9 | 42 | 18 |
| <i>Business</i> | 35 | 4 | 21 | 0 |
| <i>Handicraft / labor</i> | 12 | 4 | 21 | 0 |
| <i>Agriculture</i> | 6 | 0 | 15 | 0 |
| <i>Student</i> | 6 | 0 | 0 | 0 |
| Caste | | | | |
| <i>Newar</i> | 20 | 18 | 29 | 29 |
| <i>Brahmin</i> | 38 | 26 | 14 | 23 |
| <i>Chettri</i> | 19 | 21 | 45 | 36 |
| <i>Other</i> | 24 | 35 | 14 | 12 |
| Travel time to hospital – minutes (mean, SD) | NA | 51.5 (42.6) | NA | 45.9 (23.4) |