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Original Article

Male Involvement in Reproductive, Maternal and Child Health Services: A Qualitative Study in Dhading District of Nepal

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Abstract

This study attempts to explore the involvement of fathers of children under two years of age in Maternal and Child health care in the Dhading district of Nepal. Four focus groups discussions with 38 fathers were conducted. Six

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major themes emerged from the analysis as follows: Access to health facility; knowledge on ANC and PNC visits; helping the pregnant and lactating mother; family decision-making; male parent's preference of health facility and the male's suggestions on how to improve the health care system for MCH care. The results revealed that priority was given to faith healers for health services; male parents were less aware of the importance of ANC and PNC visits and that social stigma negatively impacts the help given to the pregnant and lactating mother. Most of the participants were helpful and supportive of their wives during pregnancy and lactating. The mistrust created by the unavailability of health workers in the health facility, long distances to the health facility with roads inaccessible to ambulances and a lack of human resources in the village were all reasons for home delivery. Involvement of the male in health care activities and providing them with health education opens a window of opportunity to help achieve Maternal and Child health-related goals.

Keywords: *Male Involvement, Maternal and Child Health, Antenatal Visit, Postnatal Visit, Qualitative Research*

Introduction

The family life cycle provides the framework for different stages of development for families, including the challenges that the family faces (Walsh, 1996). Most of the research related to pregnancy focuses on wives, mothers, family members' support, husband's involvement, ANC and PNC visits and decision making. Pregnancy and the birth of a child often impact the quality of the marital relationship in the family (Mitnick et al., 2009). In Western culture, the role of fathers has changed from simply being a breadwinner to being a partner who is involved in all aspects of his wife and child's life (Chesley, 2011; Pleck, 1998). Wives also report better postpartum adaptation and higher relationship satisfaction when they perceive their spouse to support their maternal health (Powell & Karraker, 2019).

Maternal health refers to the health of women during pregnancy, childbirth, and postpartum, and it is an essential component of reproductive health

(Olugbenga-Bello et al., 2013). Reproductive health is the key to building human capital for the future of both the nation and the world. While the close relationship between mother and children has been acknowledged, resulting in the concept of Mother and Child Health (MCH), little attention has been paid to the role of fathering (Jahn & Aslam, 1995). Many studies have reported the positive effects of a father's participation in improving MCH care (Alio et al., 2011; Ghosh et al., 2010). Lack of involvement of the male in women's reproductive health may result in higher maternal and infant mortality rates. The male's meaningful engagement in the antenatal and postnatal periods is important for both maternal and child health care. The positive role of fathers in the reproductive health and rights of women (Singh et al., 2014), which is also considered as a human health rights priority (Lewis et al., 2015), is emphasised in the International Conference on Population and Development (ICPD) and the Fourth World Conference on Women. Although the willingness of fathers to participate in women's health has increased in recent years (Levtov et al., 2015), the policies for recognising the role of fathers in the health of the mother, infant and child exist in the health system of only a few countries. Studies show that, even in regions where these policies exist, such policies have not been implemented (Ergo et al., 2011).

Male involvement in MCH care in Nepal has only been highlighted within family planning, where it is seen as a male-friendly reproductive health intervention. Women are the key to maintaining the quality of life in the family. They are the consorts to attain peace, sustainable development, and prosperity in nations, which are impossible to achieve in the absence of women's meaningful engagement in every facet of human-life prosperity. The perceptions and views of male counterparts to pregnancy, childbirth and postpartum care, as well as their relationship with health facilities, are not fully-supportive and facilitative. The male partner can play the role of facilitator in MCH for increasing women's access to and use of perinatal care as well as increasing their awareness of and participation in delivery preparation programs (Department of Health Services, 2016). The husband is the sole decision-maker in a patriarchal society like Nepal. There are issues of decision-making

regarding e.g., where the women and children are taken when they are sick and how a father helps in this process. Although men are aware of antenatal care and hospital delivery, participation in activities related to MCH has been found to be negligible (Kadam & Payghan, 2013). During the pregnancy, lack of involvement by males may be due to lack of education, cultural traditions, and lack of proper counselling. The male counterparts have to transform their views and perceptions to take care of their partners during the relatively vulnerable times of pregnancy, postpartum and lactating. Therefore, this study intends to assess the involvement of males in the maternal and child health services in South Dhading of Nepal.

Socio-Cultural Practice of Maternal and Child Health in Nepal

Traditionally, children are considered a symbol of both social and economic wellbeing (Adhikari, 2010). People celebrate ritual sacraments for birth, and invitees bless the newly born baby with fruitfulness to increase in number, so filling human dwellings from one generation to the next. People give blessings in the name of their clan-God so that the baby would live a long life. The father's role is crucial in managing the ritual function as he welcomes invitees and receives the blessings of priests and seniors. In rural settings, the faith healer or priest of the community are the first choices for chanting to the pregnant women. People also believe that sacrificing a bird, chicken or a goat to their deities leads to the prosperity of the family. Visiting health facilities is the secondary choice of rural communities. There are different reasons for infant mortality, but people are culturally and religiously rooted and interpret the mortality of a human as fate (Bista, 1991). The main determinant of infant mortality in Nepal is associated with socioeconomic status (Khadka et al., 2015). Geographical difficulties and poor transportation are also considered to be possible barriers to the underutilisation of maternal health services in rural areas (Lamichhane et al., 2017). In rural Nepal, males usually go to other countries for employment in order to support the family (Blanc, 2001). This has become a normal socio-cultural trend since the Maoist Insurgency in Nepal. Males who cannot afford to go to other countries remain in the village and find daily wages-based work in local markets. Maintaining the family,

organising domestic matters, child care and farming are all the common cultural practices of a Nepali woman. Baker and Liu (2006) found that the time it takes to walk to the clinic has a negative impact on primary health care utilisation. A report published by Harvard University about PNC reports that husbands were more likely to attend a postpartum visit within two weeks of delivery (Kearns et al., 2016).

Theoretical Framework

Symbolic Interaction (SI) is fundamentally a theory of human nature. The symbolic environment that was felt to be wrongly pessimistic and overly individualistic (Aksan et al., 2009; McCall, 2020) was used as the theoretical framework in this study. Symbolic interaction examines the meanings emerging from the reciprocal interaction of individuals in a social environment with other individuals and focuses on the question of "which symbols and meanings emerge from the interaction between people?" (Aksan et al., 2009). Blumer argues for three symbolic interaction perspectives: *meaning* provides symbols to debate; *language* provides meaning to humans by use of symbols and *thinking* changes the way individuals interpret symbols (as cited in Setyobudi, 2019). SI theory presents the sociological views of social reality (Larsen & Wright, 1986), a process in which actor A derives satisfaction from his relationship with actor B in order to further the achievement of A's goals (Ben-Sira, 1976). In this study, the social reality was explored to develop a theory for the process of and barriers to male involvement during ANC and PNC visits to arrive at suggestions for improving the effective involvement of males in the future.

Methods and Materials

A qualitative study was designed to explore the involvement of males in maternal and child health services of Nepal. The study involved fathers who had children less than two years of age. About 38 fathers with under two-year children were gathered in four different locations of Dhading district. Four Focus Group Discussions (FGD) were conducted, such as FGD 1 (12 fathers), FGD 2 (11 fathers), FGD 3 (8 fathers) and FGD 4 (7 fathers). For ethical reasons, we have assigned each FGD a number instead of using the village's real name. Four focus group discussions were conducted in four different locations of the district. The FGD

guidelines were designed with expert assistance. Informed consent was obtained from the participants before the focus group discussion. Four moderators and four note-takers spent four days in each site (village) for the intensive information collection. The discussions were recorded with concurrent note-taking by note-takers. The supervisor observed the process and provided suggestions at the time, in the field, to enumerators when needed. In addition, a researcher supervised the four groups carrying out FGD on different dates, as planned, and provided suggestions to both supervisor and enumerators. The discussion and interviews were recorded with concurrent note-taking, which concentrated on the six different areas, namely: access to the health facility; knowledge on ANC and PNC visits; helping the pregnant and lactating mother; family decision making; the male's preference of health facility and the male's suggestions to improve the health care system for MCH care. The FGDs were transcribed verbatim in the Nepali language, and the transcriptions were then translated into English within 2-3 days by the research team members. The transcripts were also checked against the original field notes for accuracy.

Each transcript was accompanied by notes describing the setting and its ambience, how the session developed and any particular incidents which occurred during the process of FGD (including any omissions or differences from other discussions or interviews) and the issues identified in the interview, as well as the researcher's thoughts about the session. To ensure confidentiality and anonymity, each participant was allotted a participant number recorded in the notes and transcription, and only that number was used during the data analysis. Data coding and data entry were performed by trained researchers using a thematic analysis approach, which is the most commonly used method in healthcare research. In this approach, each transcript is read carefully and frequently to identify particular patterns, themes, concerns or responses expressed repeatedly by the participants. Deductive codes were developed prior to the study, based on the study themes, and inductive codes were added during data analysis. Quotes illustrating the findings were identified and are presented in the study's findings.

Results

The findings related to the six different areas investigated in the study and are dealt with in the following sections:

Male's Guidance to a Faith Healer as Priority

The participants considered faith healing as their first priority for health services. From the statements below, it can be assumed that participants consider the faith healer as a powerful person. An open-ended question was asked to fathers, "Where are women and children usually taken when sick?" Most of the men reported, *"...taking mother and child to faith healers in the first place."* The husband and family members still believe that the faith healer is the first choice for health services. This is an indigenous system of diagnosis, treatment, and experimental procedures in which illness is seen as external to the body and caused by malevolent powers (Khatry & Eliade, 2011). The faith healers are considered powerful people who can heal their sick children. Similarly, the male participants from another village said, *"We take...to the nearest church for prayer."* There is a Church in that village and an increasing population of followers of Christ in that community. The Pastor prays for the sick mother, and they are healed. We can understand from these two cases that even literate fathers of children and mothers are obliged to follow the cultural system and practices rather than visiting health facilities. Treatment by faith healers can save money and time. "*Taking to faith healer at first can save money and time,"* as expressed by fathers of another village. Participants were found to seek treatment from a health facility in the case of serious injury, and some of the fathers said they take advice from their seniors as to whether to take mother and child to a health facility or not. The fathers shared a cultural perspective that faith healers are the first priority rather than visiting health facilities.

Male's Awareness on ANC and PNC Visits

Questions were asked to help assess the awareness regarding ANC visits. These showed that most of the fathers were aware that ANC existed in their communities. Some of them were positive that their female partners attended 4 ANC visits, according to the government 4 ANC protocol, during the pregnancy. Also, some participants had

in fact, suggested that their wife visit the ANC clinic during pregnancy. However, most of them were unaware of the importance of ANC and PNC visits and expressed that "*only in the emergency situation, when a problem arises, I take my wife for a checkup in health facility*" (FGD 2). They also expressed that, since the health facility is far away from the village and it takes a long time to get there, "*I take them only when there is a problem that cannot be cured at home*" (FGD 11). Regarding the PNC visit, fathers of FGD 3 said: "*that only when a problem, such as abdominal pain, haemorrhage, jaundice, fever, arises the women are taken to health facilities for PNC checkup*" (FGD 3). Concerning the mandatory visits for PNC checkups, fathers expressed, "*We don't know much about the importance of PNC checkups*" (FGD 10). The practice of attending PNC checkups seemed very low because they thought that visiting the health facilities was only required when there was a problem. As evidenced in these four areas, fathers are still lacking education on postnatal care which is available through health facilities and non-governmental organisations.

Male's Helping Pregnant and Lactating Mother

Pregnant women need support with all aspects of pregnancy and lactation. On the subject of helping women, participants were asked about the ways they help pregnant and lactating mothers in their families. Due to economics and traditions, community people think that women are obliged to fulfil all daily duties. In line with providing help to their women, we opened up discussions with the question, "How do you help pregnant and lactating mothers in your family?" Most of the participants were helpful and supportive to their wives during pregnancy and lactating. Work carried out by women were related to household chores such as cooking, washing clothes and fetching water, among others. These are all basic tasks that anyone can easily understand how to provide help with to a pregnant and lactating mother. Only a few of the men said that they considered it as their duty to help. Interestingly, *"because of the fear of being taunted or other social stigmas, only [few] helped their wives during pregnancy and postpartum"*. The husband was rarely allowed to go near his wife soon after delivery as she is then considered unholy.

Male's Opinion on Decision Making Process

Decision-making, though, seems to be the role of the male in Nepalese society. However, decisions during pregnancy and the lactating period are made either by the woman herself or, more commonly, by another female in the house, such as mother-in-law or sister-in-law. The involvement of the male partner in decision making seemed limited, "*The period of pregnancy and lactation needs to be dealt by female themselves so I give them the decision-making authority" (FGD 9).* Similarly, FGD 6 members said, "*Wife decides about all matters during this period"*. Participant Q of FGD 5 also said that due to his outdoor business his wife decides for herself about ANC and PNC visits. A male of FGD 6 expressed the extreme view that, "*It is shameful to be too much involved with wife during those periods especially when you live with joint family, so, in my family usually my mother makes decisions regarding pregnancy and lactation care."* Similarly, another participant of FGD 4 said that his mother makes all the decisions in their family regarding this matter. Only a few participants said that the decision-making process during pregnancy is mutual. For example, a participant of FGD 2 discusses with his wife about ANC and PNC duties. As we know, Nepali society is dominated by the male perspective, and, in this context, one of the participants of FGD 7 says that his wife asks for his opinion before making any decisions, including visits for ANC. Taking suggestions and making collective decisions in the family definitely plays a positive role for pregnant mothers and their newborn infants and helps them take care of their own health (Shyam Sundar Budhathoki et al., 2017). Also, the wellbeing of mother and baby depends on the care during pregnancy (Kariuki & Seruwagi, 2016). The practice of household decision-making with a husband's mandatory involvement leads to meeting government standards.

Male's Preference for Health Facility for Delivery

In the FGD, preferences of health facilities for delivery were discussed with the question, "Where did you take your spouse for delivery?" Most participants indicated that the delivery was in a Health Center or District Hospital. Some of the participants stated that it was their obligation to choose home delivery *"because of tons of house works and cannot go to the health*

facility in advance" (FGD 6). Another reason for home delivery expressed by a male of FGD 3 was that due to the long distance to the health facility and the well-preparedness, a birth at home would also be good and safe for them. Another male in the group discussion added that long distances and poor accessibility demotivated them for ANC follow up.

A male of FGD 1 complained that there is an *"absenteeism of health workers"* and unavailability of helping manpower at the village to transport the pregnant women to a health facility, and so they are obliged to prefer home delivery. Stretchers are used to carry pregnant women and patients to the health facility, but these days, there is a scarcity of available youths in the villages to carry the ill or injured for emergency health care. One of the participants of FGD 4 shared that it was very difficult to gather youths to carry my pregnant wife to a birthing center. So, in effect, many locals do not have the option to visit health facilities. A male of FGD 2 argued that when he was out of the country, his family could not gather people to take a pregnant woman to a health facility and so finally, his wife gave birth at home. One of the fathers shared a bitter experience, *"...returned to home from a health facility as the health professionals deemed that the due date was not yet but right after that, the next day, delivery took place at home"*. Such experiences foster mistrust of health professionals.

While discussing preferences of health facilities for delivery, the majority of participants stated that they prefer institutional delivery, although, in reality, there were many obstacles that came in the way of them having their preference. The reasons for home deliveries instead of institutional deliveries was that the health facility was too far away and that there was a lack of health staff available at the facility. Besides this, there is also a lack of ambulance services in areas reachable by road.

Male's Suggestion to Improve Health Care System for MCH Care

In the FGD of all four groups, the participants were asked to provide any suggestions for further improvement of the health care system for pregnancy and the postpartum period. They highlighted four important issues: nutrition, education - awareness of ANC and PNC visits, the immunisation schedule, and health education for fathers. In FGD 2, a male expressed a need to focus on *"conducting the nutrition education targeting each mother of each household"*. ANC and PNC orientation was usually provided

to pregnant women by the health workers but FGD 8 fathers suggested providing this kind of orientation to males as *"that would encourage the males to get involved in caring for their partners"*. Awareness of the immunisation schedule for males can aid in fostering a more caring attitude toward their children. Males of FGD 2 further suggested, "*health education for a father's group regarding MCH care seems essential, as caring for mother and children is the responsibility of the male partner too"*. A social reality that was recognised was that providing orientation to males along with their pregnant women meant that partners could interact more helpfully, thereby supporting each other for health outcomes.

Discussion

The participants consider the faith healer as a powerful person and their first choice for health services. Faith healing is an indigenous system of diagnosis, treatment, and experimental procedures and the Nepalese see illness as external to the body, caused by malevolent powers and believes that healer will release the soul or balance the system and make it function normally (Khatry & Eliade, 2011). The participants also discussed that there is the practice of consulting with seniors of the community when going to a health facility. So, even literate fathers of children and mothers are expected to follow the cultural system and practices prevalent in their community rather than visiting health facilities. Many researchers consider that Asian, African and South American cultures are primarily collectivistic (Baines, 2009).

Nepal is also considered a collectivistic society (Dahlin & Regmi, 1997), which is evident in the close, long-term commitment to the member' group', be that a family, extended family, or extended relationships. While the participants seemed aware of ANC and PNC visits, the importance of the ANC and PNC visits still remains unclear among them. The practice of visiting health facilities only in an emergency condition still exists in the community (Bist et al., 2021). In addition, distance to a health facility was found to be a major barrier. One study stated that the walking time to the clinic negatively impacted primary health care utilisation. While the participants seemed unaware of the importance of PNC checkups, a report published by Harvard University about Nepal's PNC stated that "husbands were more likely to attend a postpartum visit within two weeks of delivery" (Baker & Liu, 2006; Mangeni et al., 2012) which contradicts the findings of this study.

The effective mobilisation of human resources by health and non-

governmental organisations will make it more possible to disseminate health knowledge. The workload of female partners centres mainly around household chores. Participants discussed work-sharing experiences with their female partners in all aspects of life during pregnancy and lactation and managed nutritious foods for them. However, the ideology of women's work and men's work and the incapability of men learning household work is deeply rooted in the Nepalese economic and traditional systems, which makes women feel obliged to fulfil all daily household duties by themselves (Poudel, 2019). Few participants considered it their duty to help their wives during the pregnancy and postpartum periods in this way, while some didn't do so because of the fear of being socially stigmatised. In the context of Nepal, mostly female are expected to talk, share and entertain pregnant and lactating mothers as husbands rarely approach their wives post-delivery due to religious creeds and the stigmatic ideology of the Hindu religion, which state that it is unholy to help a newly delivered wife (Bist, 2014; Thipaud-Rebaud, 2011). Although it is imperative for women to involve their husbands in the decision-making process and for the husband to accompany their women to the health facility, this period is critical for both mother and child; the women themselves mainly led the decision-making process regarding MCH care.

One study argues that women should teach the husbands and the rest of the family, as they are the main decision-makers, and there can be unforeseen and complicated incidents (Sharma, 2004). Another study did a rapid review and found two interesting health outcomes about decision making. Firstly, women who participated in household decision-making and discussed health issues with their husbands were more likely to use maternal healthcare services. Secondly, women who received health education along with their husbands were more likely to take care of their own health. There are risks in one person making decisions on their own regarding health care services. The mandatory involvement of husband and family members in the decision-making process leads to meeting the standards set by the government (Budhathoki et al., 2017). Poverty may make it easy for males to make wrong decisions or not to make any decisions on matters relating to the health of their female partners even when there is an obvious need for an urgent and appropriate decision to be made (Kadam & Payghan, 2013). A study done in Benin City concluded that education was a key determinant for change in male knowledge and behaviour (Obi & Okojie, 2016).

Mutual agreement fosters one spirit to achieve at least self-health care.

Additionally, the wellbeing of mother and baby depends on the pregnancy care that the mother will be receiving during her pregnancy. Therefore, involving all family members in decision making is essential (Kariuki & Seruwagi, 2016). The preference for selecting a health facility was challenged by: workload in the home: distance to the health facility; unavailability of capable health workers; lack of ambulance services due to no road access and unavailable human resources at home for managing the transportation of women to the health facility. The scarcity of youths in the villages is affecting people's health status directly or indirectly. A large proportion of the youth leave the country for employment (Bossavie & Denisova, 2018; Parajuli et al., 2020), so locals have no possibility of visiting health facilities. As SI indicates, this is the social reality of how the social meanings are interpreted and found from the focus group discussion. As per the suggestion provided by participants in the FGDs, nutrition education is important for each mother and the caregivers of their respective households. ANC and PNC orientation sessions are highly demanded by the fathers' group in order to help them be actively involved in health care improvement.

Disclosure Statement

The authors declare that no potential conflict of interest exists.

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