Male Involvement in Maternal Health

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SHORT REVIEW

Abstract

Traditionally, programs related to maternal health are regarded as purely a woman's domain. Nevertheless, the role of the male as the decision maker in the household gave way to the recognition of the male's role in maternal and reproductive health. This paper aimed to provide a review on male involvement strategies and their impact on maternal health based on related studies, discuss the strategies in the Philippine context and suggest interventions given the current state of the Philippine health care system. These strategies utilize the decision-making role of the male by positing itself on the reproductive, sexual and maternal health aspects encompassing important factors, such as birth spacing, first pregnancy, family planning, utilization of skilled birth attendants (SBAs), and delivery in health facilities, antenatal and postpartum care and nutrition. However, negative repercussions include stigmatization of single mothers and reinforcement of the notion of a man's control over a woman's body. Given the current state of the Philippine health care system, the suggested interventions try to veer away from it as much as possible. These include integration of the male involvement strategy into the Pantawid Pamilyang Pilipino Program (4Ps), coursing it through a public-private partnership (PPP) and non-government organizations (NGOs), involvement of educational institutions, strengthening of the health service delivery at the grassroots level, reinforcement of existing laws, and research on its institutionalization. With carefully-planned strategies that recognize existing gender norms and other socio-cultural factors, male involvement in maternal health could be a possible catalyst in decreasing the Philippine maternal mortality rate (MMR).

Keywords: *male involvement, maternal health*

Introduction

Traditionally, programs related to maternal health are regarded as purely a woman's domain. All phenomena attributed to pregnancy, housekeeping, and child care are established feminine roles in almost all cultures [1]. The interventions to address maternal health needs were solely focused on women—family planning, pregnancy, childbirth etc., excluding men from the picture. Nevertheless, the role of the male as the decision maker in the household gave way to the recognition of the male's role in maternal and reproductive health. The 1994 International Conference on Population and Development (ICPD) Programme of Action in Cairo and the International Conference on Women in Beijing emphasized the "...men's shared responsibility and active involvement in responsible parenthood, sexual and reproductive behavior..." (paragraph 4.27), shifting the treatment of maternal and reproductive health programs to another paradigm [2].

The article of interest is part of the Women-Centered Universal Health Coverage Series, posted in a blog hosted by the Maternal Health Task Force and USAID/TRAction. This series discusses the importance of utilizing a woman- centered agenda to operationalize universal health coverage [3].

Set in Uganda, the post is entitled "Male involvement in maternal health: helpful or harmful?". The country launched a male involvement strategy in 2014 in response to research on the benefits of male involvement in reproductive and health care on the health outcomes of mothers and newborns. The primary purpose of this strategy is to include men in all areas of family's health, including nutrition, water and sanitation, among others. However, the strategies turned out to have unforeseen outcomes on the woman's access to care.

The title of the article itself outrightly expressed the main maternal health issue. Maternal access to care is hindered by

the strategies to seek male involvement. That is, instead of the expected positive impact of implementing the strategies, unexpected burdens are placed upon the mother.

This paper aimed to provide a review of the issue on male involvement strategies and its impact on maternal health based on related literature, discuss male involvement strategies in the Philippine context and suggest interventions given the current state of the Philippine health care system.

Male Involvement Strategy: Nature and Magnitude of the Issue

The main premise of the male involvement strategy is the role of the male partner in decision making in the household, influencing all aspects of family life, including health and nutrition decisions [4].

As pointed out in [3], the strategy used to seek male involvement in maternal health care has implicated an unexpected burden to the expectant mother. First, the interpretation of the policies for implementation of the strategy is left to the health providers and non-government organizations (NGOs). The main goal is defeated as the health providers and NGOs seemed to strive more to reach targets and produce desirable outputs, such as number of couples testing for human immunodeficiency virus (HIV) than focusing on giving quality care for mothers and emphasizing the role of the male partners in the process. Second, the "responsibility" of catching men who have long evaded the health system has been passed on to the expectant mothers.

Some lines of investigation such as that in Malawi [5] documented incidents of refusal of the health staff to provide medical attention to a woman and refusal of medical care by the woman due to non-attendance of male partner during antenatal care (ANC) visits.

To contextualize this in the Philippine setting, it is only appropriate to describe the gender gap between males and females in the country and the role of men in decision making on different aspects of household management.

According to the Global Gender Gap Report 2014 of the World Economic Forum (WEF), the Philippines ranks ninth overall in global equality [6]. It also ranks first in Asia (score=0.7814) and first in terms of educational attainment (score=1.0000) and health and survival (score=0.9796). The highest possible score, indicating full equality, is 1, while the lowest possible score, 0, indicating absolute inequality. This implies that there is a narrowing gender gap between males and females in the country and both genders are enjoying equality for education, health and survival. The close gender gap can be an advantage in the implementation of male involvement strategies.

Figures 1 to 3 illustrate the distribution of decision making between males and females in the household based on the National Demographic and Health Survey (NDHS) of 2008 and 2013 conducted by the Philippine Statistics Authority (PSA) (formerly National Statistics Office or NSO) [7,8].

The preceding figures illustrate the women's control over own earnings (Figure 1) and over husband's earnings (Figure 2). In 2013, about four in 10 women had main

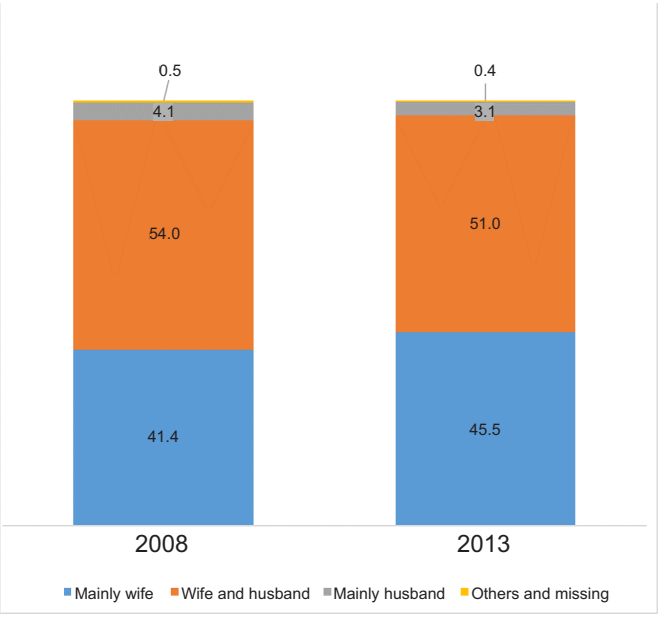

Figure 1. *Women's control over own earnings: NDHS Philippines 2008 and 2013*

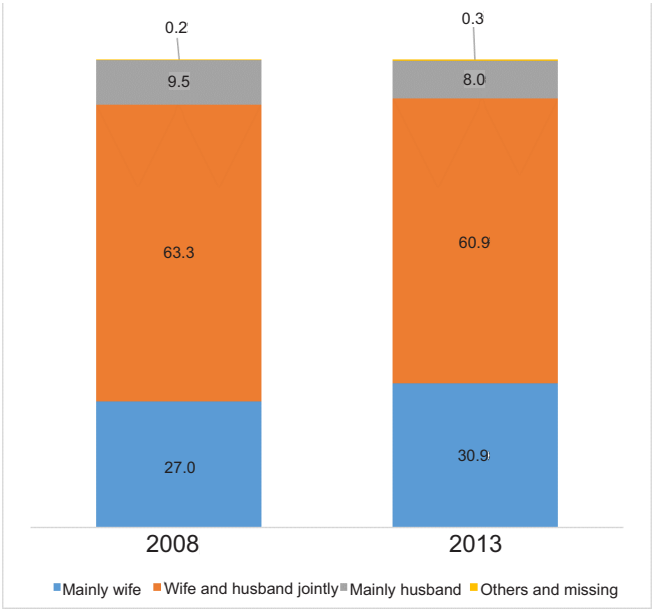

Figure 2. *Women's control over husband's earnings: NDHS Philippines 2008 and 2013*

control over their own earnings (45.5%) and about three in 10 had control over their husband's earnings (30.9%). More than half of the respondents (51.0%) stated that control over the woman's earnings was jointly shared by wife and husband and about three in five women (60.9%) stated that control over the husband's earnings was shared between wife and husband. As can be seen in the figures, there was a 4.1 percentage point increase in the proportion of households with the wife mainly having control over own earnings and 3.9 percentage point increase with the wife mainly having control over husband's earnings between the years 2008 and 2013.

Figure 3 suggests that more than half (51.7%) of Filipino women had autonomy in terms of decision-making on their own health care; whereas only 3.3 percent said that decisions regarding their own health care rested mainly on the husband. Joint couple decision making was also predominant, accounting for 44.7 percent of decision-making in the household.

Comparing 2008 and 2013 results, there was a slight increase in the proportion of women who had autonomy in decision-making, from 44.0 percent to 44.7 percent (Figure 3). These increases corresponded to a decrease in the proportion of joint control and mainly husband control of both earnings.

The NDHS results provide a snap shot of the dynamics of decision making between couples in a typical Filipino household. Generally, there was a higher proportion of women who had independence over decisions concerning earnings and health care. This is in stark contrast to other countries where man's dominance in governance in aspects of household management is felt [9,10]. It can be surmised that in the Philippines, decision making in the household is relatively closer to being egalitarian. However, this autonomy in decision-making does not necessarily equate to good health-seeking behaviors and maternal health practices. This is a window of opportunity to educate the expectant mother and involve the male partner. In effect, both will be educated and would be knowledgeable of the woman's condition and act accordingly; providing encouragement and support to avail of maternal health services for better health outcomes.

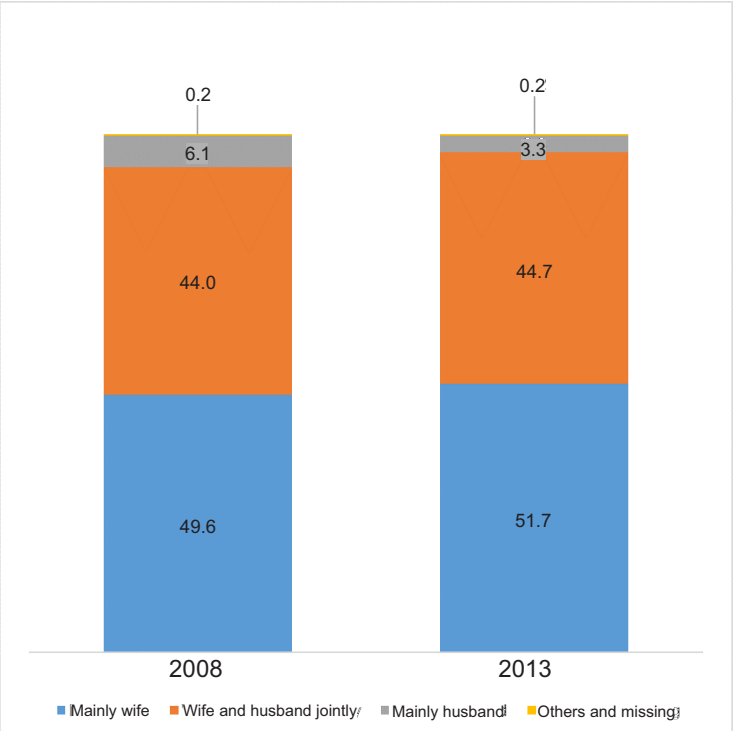

Figure 3. *Women's participation in decision-making on own health care: NDHS Philippines 2008 and 2013*

The relevance and feasibility of the implementation of male involvement strategy in the Philippines warrant further studies. Gender-directed policies and legislations pertaining to the recognition of male roles in the family could be examined. Republic Act No. 8187 or the Paternity Leave Act of 1996 is "an act granting paternity leave of seven (7) days with full pay to all married male employees in the private and public sectors for the first four (4) deliveries of the legitimate spouse with whom he is cohabiting and for other purposes" [11]. Numerous studies on a generous parental system which involves longer paid parental leave have shown that parents were given better opportunities for balancing work and family life and more positive health outcomes [12].

In the Philippines, male involvement in maternal health has not been extensively studied save for a number of literature on the decision-making role the men partake in family planning [13,14,15].

Nevertheless, at least one policy and a law related to male involvement strategies exist. The Department of Health (DOH) Administrative Order No. 2006-0035 or the National Policy and Strategic Framework on Male Involvement in Reproductive Health (MIRH) stipulates that "it shall set direction as to how MIRH will be implemented in a comprehensive, systematic and holistic manner". The objectives of the policy include provision of strategic framework for male involvement in reproductive health (MIRH), emphasis on active and purposive involvement of male in all aspects of RH, provision of policy direction for DOH offices and attached agencies, local government units (LGUs) to prioritize activities related to MIRH, provision of guidance to partners in the health sector for identification of priority

areas for support, and provision of guidance to DOH concerned offices and other relevant agencies for facilitation of implementation of MIRH services in DOH and LGUs [16].

MIRH is also stipulated in Republic Act no. 10354 or "The Responsible Parenthood and Reproductive Health Act of 2012" where male responsibility and involvement and men's reproductive health are included as elements of reproductive health care [17].

It should be emphasized that the thrust of the aforementioned policy and law only covers the reproductive aspect of maternal health in general and does not include other aspects, such as antenatal care, postpartum care and HIV testing.

Male Involvement Strategy and Its Impact on Maternal Health

The Millennium Development Goal (MDG) 5 aims for the improvement of maternal health. One important measure is the reduction of maternal mortality by 75 percent throughout the world. Achieving this will need "male involvement in countries where it matters most" [18]. Male involvement strategies for maternal health are particularly relevant in countries where strict gender norms are observed and followed and have relatively high mortality rates in general. Singh et al [19] reported that the delays that primarily cause maternal deaths were often because of women seeking support from their male partners, especially in terms of funds. Thus, reinforcing the need to involve the males in these countries so they could carry out informed decisions, such as preparation for delivery and emergency care, is deemed necessary.

A number of literature have studied positive and negative impacts of the strategy on maternal health. As presented by the article, strategies formulated to involve the male seemed to do more harm than good, particularly on expectant mothers, affecting both single and married/cohabiting mothers. However, the negative repercussions may be greater on single mothers and women whose male partners were not available to accompany them because of certain circumstances. There are also instances where women inaccurately report or lie by omission on sensitive issues such as their sexual activities because of the fear of judgment and violence. The worst-case scenario is if not planned carefully, the strategy may reinforce that a man has full control over a woman's body which will totally defeat the purpose of the strategy. Involving males in making maternal health care decisions is entirely different from men having total control over all decision making related to women's health, as this only implies that men should be partners and co-participants in the process.

With this, the repercussions include missed antenatal check-ups, untreated sexually transmitted infections with an increased risk of transmission, and risk of intimate partner violence.

A briefing paper by Davis *et al.* [21] provided evidence to support these claims. Positive results on sexually transmitted infections (STI) or HIV results could lead to violence or divorce. In Tanzania, half of the women who were encouraged to bring their partners for couple counselling for HIV in antenatal clinics did not come for subsequent antenatal appointments. In Malawi, a policy of "first and fast" service was instituted to accommodate women with working husbands during ANC visits. It turned out that the policy was deemed unfair for the unaccompanied females, as they were not prioritized and not provided fast service, which contribute to the culture of stigmatization. In the long run, these unaccompanied females may choose not to seek ANC checkups because of the treatment given to them as a consequence of the policy.

Nevertheless, the positive impacts of the male involvement strategy seem to outweigh the negative ones. These include increased coverage of antenatal care, increased utilization of skilled birth attendants (SBAs) during childbirth and increased facility-based deliveries, increased use of contraceptives, improved nutritional status of pregnant and lactating mothers and positive impact on the mental and psychological health of mothers. The overall impression is that involving males in maternal health care enables them to make informed decisions and provide encouragement to their female partners to receive care because of the benefits [22], thus, reinforcing positive health-seeking behaviors.

In Nicaragua, a positive behavior change was observed among men who attended ANC checkups with their female partners by bringing them to maternal centers, seeking consultation from midwives and participating during labor and delivery. The male partners also realized the importance of proper health-seeking behaviors, especially when encountering danger signs during pregnancy [23]. Essentially, a male's awareness and understanding of the health needs of a woman during pregnancy enables him to make informed choices, such as improved utilization of maternal health services [19,24,25] and provision of

assistance and arrangement for transportation during pregnancy emergencies and reduction of workload during pregnancy [21,26]. Ampim [27] presented the importance of the male's attendance to antenatal and postnatal clinics, such as financial support; reminders; respect, support and protection at the clinic, which may indirectly influence maternal mental health. In a more recent study by Yargawa and Leonardi-Bee [25], decreased odds of postpartum depression among females whose partners were involved during pregnancy and postpartum was found.

Ultimately, male involvement strategies recognize the decision-making role of the male in the household. The strategy utilizes the male's role in decision making on the reproductive, sexual and maternal health encompassing important factors, such as birth spacing, first pregnancy, family planning, utilization of skilled birth attendants (SBAs) and delivery in health facilities, antenatal and postpartum care and nutrition. However, male involvement strategies may have the tendency to reinforce a man's control of a woman's body; thus, policy formulation and implementation should be treated with caution. Still, joint-decision making among partners is still the better option than decision making alone, and was found to be associated with a higher likelihood of birth delivery in health facilities [28], use of contraceptives, and preparation for birth and desired family size [21].

With carefully-planned strategies that recognize the existing gender norms and other socio-cultural factors, male involvement in maternal health could be a catalyst in decreasing the Philippine MMR. Statistics show that in 2013, about 3,000 Filipino women [29] died of pregnancy or other birth-related events, equivalent to eight women dying every day or one woman dying every three hours. As it is, the targets for MDG Goal No. 5 which is the improvement of maternal health is far from being achieved, with the MMR of the country remaining at 221 (95% confidence interval: 182–260) in 2011, even with the existing efforts of the government, such as the integrated maternal and newborn child health and nutrition (MNCHN) program [30]. As of March 2015, the pace of progress in achieving other maternal health indicators, such as proportion of births attended by skilled health personnel, contraceptive prevalence rate and adolescent birth rate [31] is slow. Further studies and assessment of its relevance should be undertaken first.

In countries where the male involvement strategy is implemented, programs were categorized into three types [21]: “men as clients,” “men as partners,” and “men as agents of positive change.” The “men as clients” type focuses on the use of health services for own health; “men as partners” encourages better couple communication and "men as agents of positive change" recognizes the role of gender roles in catalyzing social change.

Male Involvement Strategy in the Philippine Setting

In the Philippine setting, the implementation of this strategy should take into account the current state of the health system in the country. Romualdez *et al.* [32] summarized it in six phrases: workforce shortage, inefficiency in service delivery, lack of supplies, a decentralized scheme, independence and dominance of the private sector and the conspicuous disparity in health outcomes between the rich and the poor. Basically, every building block of the Philippine health system structure is in a poor state.

Realizing this, the proposed interventions try to veer away from the health system as much as possible, so as not to aggravate the existing situation. It has been pointed out that the main objective of male involvement strategies is to recognize the role of the male partner in decision making in the household. This role is crucial as it influences maternal health practices and behaviors that are known to have causal association with maternal mortality, with maternal mortality as an objective measure of maternal health. The interventions suggested are focused on the most vulnerable group of women belonging to households with low socioeconomic status (SES), but not at all discounting the more economically-viable population.

As mentioned, there is a dearth of local data on male involvement strategies in the country, thus, the actual magnitude of the issue in the Philippines cannot be determined. Therefore, these interventions are on the implementation of male involvement strategies in general, taking into account the possible drawbacks as evidenced by the situation in other countries where it is implemented.

The first intervention is integrating male involvement strategy on the existing Pantawid Pamilyang Pilipino Program or more commonly known as 4Ps of the Department of Social Welfare and Development (DSWD). This program provides cash grants to beneficiaries upon compliance with a set of conditions [33]. The objectives are two-pronged: social assistance which is synonymous to short-term poverty alleviation and social development which involves investment in human capital and can be classified as a long-term solution. Male involvement strategy could be integrated in this existing program, thereby satisfying both the social assistance and

social development objectives. The male partner is encouraged to accompany the woman in at least 70 to 80 percent of antenatal visits or encouraging the male partner to attend a weekly or monthly seminar on pregnancy and maternal health to make him involved. If he was able to comply with the antenatal visits and attendance to the seminars, additional compensation is given. Compliance with these conditions is equivalent to additional compensation. However, non-compliance does not mean a reduction on the monetary benefit they receive. A punitive measure is not suggested for it might be more counterproductive in the long run.

Another suggested intervention is partnership with a non-government organization. Some reports estimate the number of registered non-profit NGOs in the country as 60,000 . These NGOs have different areas of interests and, therefore, different sets of advocacies. The idea is to seek partnership with an appropriate NGO whose primary advocacy is improvement of maternal health. Other possible NGOs to partner with include gender equality NGOs and infant health NGOs. The idea is to develop and implement a program that involves male involvement in the community, targeting the rural areas and doing a community trial of different types of male involvement strategies.

The private sector could also be involved in implementing the strategy through private-public partnership (PPPs). Through coordination with health care providers, an incentive in the form of a discount or a corresponding free service could be given to the couple if they opt to involve the male partner during antenatal appointments.

Schools and educational institutions could also be involved by developing information, education and communication (IEC) materials on maternal health and nutrition with males as the target audience. In this manner, messages on maternal health are communicated in such a way that will elicit a favorable response for the males because of its their relevance to them. Moreover, educational institutions can capitalize on the creative intelligence of students to develop materials that cater to both the male and female gender.

Another intervention is strengthening health service delivery in the grassroots level by continuous capacity building of health workers, especially the frontline health workers, such as barangay health workers (BHWs) and barangay nutrition scholars (BNSs) in rural areas through seminars and/or trainings and other forms of continuing education regarding the role of the male partner. As frontline health workers, they should be able to communicate the importance of involving the husband or the male partner on the aspects of maternal health care.

Sixth is the reinforcement of the mentioned DOH Administrative Order 2006-0535 and the Republic Act 10354 by strict implementation and political will. This policy and law, albeit more focused on male involvement in the reproductive health exist for a reason. Furthermore, all these interventions should be evidenced-based. Research on the institutionalization of male involvement strategies is warranted. As the idea is relatively novel, studies on the relevance, feasibility and acceptability of the strategy is still needed.

Conclusion

A growing body of evidence illustrates the benefits of male involvement in maternal and reproductive health. With well-planned strategies that recognize gender norms and other socio-cultural factors, male involvement in maternal and reproductive health could be a catalyst in decreasing the Philippine MMR.

Even with a close gender gap between males and females, there still is a strong machismo culture in the country. Despite this, the Philippines remains to be a very family-centered society. Family always comes first, and this could work to an advantage, especially if the ultimate goal is to improve the overall health of mothers.

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