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Mixed Success Involving Men in Maternal Care Worldwide

In most locales around the world, whether in developing or developed countries, men are little involved in their partners' health care during pregnancy. Research has shown, however, that women would like their partners to be more involved and that, in many cases, men are interested in being involved. Increased male participation could yield health benefits for men, women, and children. In recognition of this situation, the Population Council's Frontiers in Reproductive Health program conducted two "Men in Maternity" studies in disparate settings—one in India and the other in South Africa—to engage male partners in health services during the antenatal and postpartum periods. Although the intervention in India was more successful than the one in South Africa, valuable lessons were learned in both countries.

India

In India, women depend heavily on men for access to health care. Men are the key decision-makers regulating women's access to health care services even though they have limited knowledge on this matter. Between 2000 and 2003, the Population Council and the Employees' State Insurance Corporation (ESIC) of India conducted the Men in Maternity study at six of ESIC's Delhi clinics, assigning three to carry out the intervention and three to act as controls. At the experimental clinics, women and their husbands received joint counseling on pregnancy care, family planning, and infant care, and same-sex individual or group counseling on sexually trans-

mitted infections (STIs), correct condom use, and other topics. They also received antenatal testing and, if necessary, treatment for syphilis. Couples were seen during the pregnancy and at six weeks postpartum. At control clinics, pregnant women received standard care, which included very little counseling on pregnancy danger signs, family planning, or other reproductive health issues.

"Involving men in maternal care is feasible and acceptable."

A total of 581 pregnant women at experimental clinics and 486 at control sites were interviewed when they came for their first antenatal visit. Follow-up interviews were conducted in couples' homes at six months postpartum: 327 women and their husbands from the intervention group and 302 women and their husbands from the control group were interviewed at this time.

The postintervention survey showed that couples in the experimental sites communicated significantly more about family planning (84 percent versus 64 percent) and reported more joint decisionmaking on the issue (91 percent versus 71 percent) than did couples attending the control clinics. Use of family planning by women and men six months postpartum was also significantly higher in the intervention sites. Significantly more men in the intervention

group knew that condoms provide protection from both STIs and pregnancy. Gender-based disparities remained: twice as many men as women in the experimental group knew of the dual protection provided by condoms (89 percent versus 48 percent).

"Involving men in maternal care is something that couples want, both women and men," says Council researcher Leila Caleb Varkey, who worked on the Indian intervention. "Men take more contraceptive responsibility if they have adequate information and counseling about condoms. Our research shows that it's possible in crowded clinics to integrate services for men and women. Both clients and providers appreciate the time spent in counseling."

According to ESIC, expenditures on the reproductive health intervention were feasible and affordable, consisting mainly of purchases of supplies and materials. No new staff members were required and changes in staff routines were possible without increasing work hours.

ESIC has expanded the program to ten clinics since the study ended and plans to extend it to its 34 clinics and five hospitals in Delhi by 2005. The Frontiers in Reproductive Health program is providing technical assistance to improve ESIC's training and supervisory capacity and will monitor and evaluate the program's progress for one year.

South Africa

According to UNAIDS, HIV testing at antenatal clinics has demonstrated a consistent and sharp increase in infection among pregnant

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Bengali Perceptions of Adult Mortality Trends Distorted

Nostalgia for the “good old days,” a familiar sentiment in the developed world, may be common in the developing world as well. Recent research in Bangladesh and the Indian state of West Bengal has revealed that, despite well-documented progress in health and an acknowledged improvement in child mortality rates, many rural Bengalis firmly believe that adult health and survival have declined in recent years. Demographers Sajeda Amin, of the Population Council, and Alaka Malwade Basu, of Cornell University, encountered this attitude while conducting interviews on women’s and men’s motivations for reproduction. They were intrigued and decided to further explore this surprising worldview.

The data analyzed in this study were drawn from a larger study of reproductive change. The researchers conducted 32 focus-group discussions, each with six to ten rural respondents of the same sex and religion, in nine rural districts (four in Bangladesh and five in West Bengal).

Contradictory perceptions

Data from the World Health Organization show that between 1901 and 2000 in Bangladesh and West Bengal, death rates declined and life expectancy increased for every age group. Respondents unanimously agreed that child mortality had fallen dramatically in recent times. They pointed to several reasons for improved child survival: immunization against childhood diseases, anti-tetanus vaccination for pregnant mothers, the expansion of medical care facilities for women and children, door-to-door service delivery by health care workers, and a move to treat childhood ailments with modern medicine rather than traditional healing practices.

In virtually every interview the researchers conducted, however, they found that the respondents believed that adults today die earlier than they did in their fathers’ and grandfathers’ time. Nearly all the respondents identified a decline in food quality and quanti-

ty, along with population growth and moral degeneration, as causes for this drop in longevity.

The respondents stated that because of population growth, less food is available than in the past. Food is also less healthful now because it is produced for the market rather than for subsistence. Hence, it is grown with less care and with poisonous fertilizers and

More important than the reasons for this outlook are its possible consequences.

pesticides. Furthermore, the lifestyle required for producing marketable food leads to stress, which in turn leads to illness and such risky behaviors as drug abuse, contended respondents. In the past, interviewees asserted, people were more God-fearing and pious. The past was not just a time of abundant, healthful food; it was also a time when people were “good.”

The researchers point to several possible explanations for this outlook. Memories of famines and disease epidemics could have contributed to a general perception that survival is threatened. Or, the bare subsistence experienced by many respondents could compare poorly with the lifestyle of abundance and indulgence depicted in local folklore and mythology. Improvements in skill with numbers and mathematics may account for some of the feeling that people are not living as long as in the past. Today, if a recently deceased man is known to have been 60 years old at his death, he will be thought to have died young in comparison to his forebears who are believed incorrectly to have lived to be 80, 90, and 100.

Finally, the moral decline often mentioned by respondents suggests that apprehensions about modern lifestyles may explain the perceived increase in adult mortality. Children are too young to be held morally accountable. Therefore, it is justifiable to appreciate the survival advantages that modernity has afforded them. But the moral degeneration of adults can only be endured if it is accompanied by some kind of punishment, such as decreased survival.

Consequences of this outlook

More important than the reasons for this outlook, however, are its possible consequences, says Amin. The perception of an uncertain future could have a variety of influences on people’s behavior. Researchers need to investigate these potential consequences more fully. The contrasting perceptions of the prospects for child and adult survival, for example, may have helped sustain fertility decline. “If more children are expected to survive to maturity, parents can afford to have fewer offspring,” explains Basu. “And if people do not expect to live as long as their forefathers did, they may also be less concerned about having children to support them in their old age.”

This worldview may also influence the way that women and children are treated in society. “On the one hand, if people believe they have little to lose, they may be more permissive with women and children and allow riskier behavior,” says Amin. “On the other hand, if people think the world is more risky and ‘bad,’ they may be more protective and less apt to give women and children freedoms.” ■

SOURCE

Amin, Sajeda and Alaka Malwade Basu. 2004. “Popular perceptions of emerging influences on mortality and longevity in Bangladesh and West Bengal,” *Population Studies* 58(3): 357–363 (also published as *Policy Research Division Working Paper* no. 186. New York: Population Council, <http://www.popcouncil.org/pdfs/wp/186.pdf>).

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Unsafe Behaviors Most Common among Poor Women

Around the world, HIV infects about 1 percent of 15–24-year-olds, but in KwaZulu-Natal, South Africa, more than 14 percent of people in this age group are infected, according to a 2003 population-based survey by Lovelife and the Reproductive Health Research Unit in Johannesburg. Young women are at particularly high risk of infection. South Africa has three infected 15–24-year-old females for every infected male of the same age. Poverty may play a key role in HIV risk. Approximately 57 percent of people in South Africa were living below the poverty income line in 2001, according to the Southern African Regional Poverty Network. Population Council health economist Kelly Hallman investigated the effect of socioeconomic disadvantage on the sexual behaviors of young women and men in KwaZulu-Natal, the most populated South African province. Hallman is a member of the Council's "Transitions to Adulthood in the Context of AIDS in South Africa" study team. She found that poverty is more consistently correlated with unhealthy sexual behaviors among females than among males.

The team studied two districts within KwaZulu-Natal: Durban Metro and Mtunzini Magisterial District. These districts represent the spectrum between urban and rural areas. The team surveyed all willing young people aged 14–24 years within these districts, using interviewers who were the same ethnicity, gender, and general age as the respondents. The investigators asked young people about many aspects of their lives, including schooling, work, sexual and reproductive health behaviors, HIV/AIDS knowledge, childbearing, and marriage. Researchers also talked to heads of households, usually parents, about family composition, living conditions, economic status, and HIV/AIDS attitudes. "Transitions to Adulthood in the Context of AIDS in South Africa" was the first panel study in South Africa to focus on adolescents.

Poverty, gender, and sexual behavior

Hallman found that economic disadvantage significantly affected a number of sexual

behaviors and experiences of young females and males, and that the behavior of young women was more substantially influenced by poverty than was the behavior of men.

"When discussing risky sexual behaviors that might be influenced by low socioeconomic status, many people think only of exchanging sex for money, goods, or favors," says Hallman. "The data show, however, that a wide range of risky behaviors is affected by poverty." Although being from a poorer household does increase the likelihood of a young woman's exchanging sex, Hallman's analysis showed that it also raises her chances of experiencing nonconsensual

"Poor young women need strategies for building economic and social assets."

sexual sex. Poverty increases young women's chances of having multiple sex partners. It lowers a young woman's chances of abstinence following earlier sexual encounters and condom use at last sex and reduces the age at which young men and women have their first sexual encounter. It also increases the risk of early pregnancy.

The data show that impoverished young people, especially young women, are the most disadvantaged in discussing sensitive topics, such as condom use, with their sexual partners. The study suggests that this situation may result from a lack of negotiating skills. Analysis of these data by other members of the team showed that only 82 percent of low-resourced schools, versus 92 and 97 percent of medium- and high-resourced schools, had at the time implemented a government-mandated "life skills" program, of which negotiation skills are a key component.

Higher levels of education among members of the household generally decrease the odds of risky sexual behavior, particularly the chances that a young woman will exchange sex or experience forced sex. Looking at other variables, Hallman found that poverty was more important than orphanhood in influencing risky sexual behaviors.

The study revealed that poorer young women and men—but particularly young women—had less access to television, radio, publications, and other media sources that might contain family planning or safe sex messages.

"Even with information and good communication skills, young people living in underprivileged settings may still be more likely to find themselves in situations that are conducive to high-risk behavior," says Hallman. Investigations by other researchers, for example, have shown that when women in South Africa raise the topic of condom use with a sexual partner, they risk emotional, physical, and "economic" abuse. In this setting, many sexual relationships provide economic security. Poor young women may have much to lose by raising such sensitive issues.

Hallman found that gender and income have crucial influences on behavior: the negative effects of poverty were often larger and of greater statistical significance for females than males. "Enhancing poor young women's negotiation and communication skills is a starting point," explains Hallman, "but they also need strategies for building economic and social assets so they are in stronger bargaining positions within relationships." ■

SOURCE

Hallman, Kelly. 2004. "Socioeconomic disadvantage and unsafe sexual behaviors among young women and men in South Africa," *Policy Research Division Working Paper* no. 190. New York: Population Council.

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Maternal Health Education Needed in Pakistan

The period of time after a woman gives birth, during which her uterus shrinks and other physical changes that occurred during pregnancy are reversed, is a crucial yet under-researched element of maternity. Although the pregnancy has ended, serious diseases or disabilities associated with pregnancy—such as infection or heavy bleeding—are still possible. In fact, some traditional practices may increase the likelihood of these maladies. Similarly, the neonatal period is critical for infants, and some traditional practices may put their health at risk as well. Population Council researchers Fariyal F. Fikree (director, regional health programs, Cairo office) and Jill M. Durocher collaborated with Tazeen Ali of the Aga Khan University and Mohammad H. Rahbar of Michigan State University to study these topics. They explored postpartum and neonatal health, traditional beliefs and practices, and care-seeking behaviors among new mothers in poor areas of Karachi, Pakistan.

The investigators combined qualitative and quantitative research methods. In July and August 2000, they conducted five focus-group discussions of eight to ten participants each and 15 in-depth interviews. Women in the focus-group discussions and those who were interviewed were young and older postpartum mothers, those who had many children and those who had only one, and trained and untrained traditional birth attendants. From August to November 2000, the researchers also conducted a survey among 525 Muslim women who were six to eight weeks postpartum in five impoverished settlements in Karachi, Pakistan.

Postpartum health

The investigators found that maternal care was adequate; more than three-quarters of recent mothers sought antenatal care, and more than half delivered their babies in a hospital or maternity home. Only 16 percent of women who had delivered their babies in a health care facility had been counseled to attend a postpartum clinic, however. Of these, only 26 percent actually attended.

The most clinically significant symptoms during the immediate postpartum period, heavy vaginal bleeding and high fever, are potentially fatal if women do not receive appropriate and timely care. About half of the women in the study reported at least one symptom of illness, with 21 percent experiencing high fever, 14 percent having heavy vaginal bleeding, and nearly 10 percent reporting foul-smelling vaginal discharge (see Table 1). Women did not know the underlying biological cause of their ailments; they frequently attributed them to “weakness.”

Traditional practices

The researchers also discovered that traditional practices that might cause infection or exacerbate bleeding were common during the delivery and recovery. For example, women described traditional birth attendants massaging the vaginal walls with mustard oil during labor to ease delivery. Nearly 18 percent of women said that in order to facilitate uterine shrinkage or to prevent infection, family members or birth attendants had prepared herbal powders or sticks for insertion into the vagina or rectum. Additionally, although many new mothers are concerned by heavy vaginal bleeding, elders and traditional birth attendants often perceive such bleeding as beneficial. They believe that menstrual blood, which they consider impure, is retained during pregnancy and released afterward. Thus, they encourage new mothers to eat foods that are thought to increase postpartum bleeding.

Care-seeking behaviors

Women generally sought care initially from close relatives or traditional healers. However, if they continued to suffer, they eventually approached a Western-trained health care provider. One woman described her experience, “I first went to the *dai* [traditional birth attendant] for a massage for body pain. Then I went to a holy man for holy medication. Eventually everyone goes to the doctor to be cured.”

Table 1 Descriptive frequency of symptoms among 280 recently delivered women reporting a perceived morbidity during the puerperium (low socioeconomic settlements, Karachi, Pakistan, 2000)

Symptoms ^a	(n)	(%)
Backache	61	21.8
High fever	59	21.1
Fever	58	20.7
Heavy vaginal bleeding	39	13.9
Low abdominal pain	36	12.9
Weakness	34	12.1
Vaginal discharge (foul-smelling)	27	9.6
Anemia	23	8.2
Severe headache	18	6.4
Dizziness	14	5.0
High blood pressure	5	1.8
Infection in tears/stitches	4	1.4
Others ^b	44	15.7

^aMultiple responses; does not add to 100%; some women reported symptoms of more than one illness.

^bOthers include: unspecified others, perineal pain, constipation, body pain, urinary burning, tiredness, uterine prolapse, uterine infection, low blood pressure.

Source: Fikree et al. 2004.

Delays in seeking appropriate care may stem from the common belief that certain symptoms are not only normal but desirable. Similarly, “many women believe that heavy vaginal bleeding and foul-smelling vaginal discharge occur from weakness caused by the rigors of labor and delivery and should therefore be endured,” states Fikree. The delay in care-seeking might be compounded, the researchers said, by male-dominated decisionmaking. More than 85 percent of women in the study sample said that they could decide to visit a clinic for a sick child or for themselves. However, study participants’ answers to other key questions indicate that they may not have the freedom necessary to complete this task. Nearly 65 percent said that they needed to get permission to visit a clinic, especially for themselves, and more than

78 percent reported that they needed permission to travel in a bus or rickshaw.

Feeding the newborn

The investigators also asked women about practices used in the care and feeding of their newborns. In Pakistan and other areas of South Asia, routine care of the newborn, including traditional feeding, bathing, and cord care practices, may prove harmful.

The majority of women—55 percent—fed their children initially with traditional substances such as honey, *gbutti* (an herbal paste), water, green tea, or other foods (see Table 2). Studies have shown that breast milk is the best first food for babies and that such “prelacteals” may be harmful to infants. Honey, for example, may contain the dormant spores of a bacteria that causes a rare but very serious condition called infant botulism.

The vast majority of mothers, 99 percent, went on to breastfeed their newborns regularly, with 14 percent of mothers introducing breastfeeding within the first half hour and nearly 30 percent within the first hour after birth. Nearly 8 percent of newborns, however, were not breastfed for two or more days after birth. And 71 percent of mothers supplemented their infants’ regular food with the traditional substances listed above.

Mothers had various reasons for these feeding practices. For example, one mother said that she gave her newborn water mixed with sugar and salt so that the baby would urinate frequently. “By urinating, the heat inside the baby’s body is released and then the baby feels hungry. This is necessary for the newborn’s health.” *Gbutti* and honey are thought to reduce colic and gastrointestinal problems. Another mother explained, “*Gbutti* helped to clean the stomach, released the pain, and allowed the stool to be passed.” Some consider withholding breast milk for the first few days to be beneficial because of a perceived impurity in the breast milk. “My mother-in-law said that the first milk is dirty because it has been stagnant for nine months. So, I let this milk come out, and I gave my baby buffalo milk with a bit of water mixed in it for three days,” said one mother.

The researchers noted the success of mass media educational campaigns in promoting breastfeeding. A traditional birth attendant told

Table 2 Descriptive frequency of traditional newborn-care practices among 515 mothers (low socioeconomic settlements, Karachi, Pakistan, 2000)

Traditional newborn-care practices	Yes (%)	(n)	No (%)	(n)
Give prelacteals as first feed ^a	55.0	(283)	45.0	(231)
Delay first feed	30.9	(159)	69.1	(356)
Give supplementary feeds	71.3	(367)	28.7	(148)
Bathe immediately after birth ^b	82.1	(416)	17.9	(91)
Massage with mustard oil	67.8	(349)	32.2	(166)
Instill nasal/ear drops	28.2	(145)	71.8	(370)
Apply traditional substances to cord	57.3	(295)	42.7	(220)

^an = 514; missing information for one woman.

^bn = 507; excludes 8 women who replied “don’t know.”

Source: Fikree et al. 2005.

the investigators, “Now they say on television that one should give breast milk to the baby. So, we tell the women that doctors have told us that the child should receive mother’s milk first of all.”

Caring for the newborn

Certain traditional care practices may be harmful for the baby. Nearly 87 percent of mothers said that their infants were washed immediately or within a half hour of delivery, an action that can result in hypothermia, dangerously low body temperature. This was done to remove the vernix—the protective material that covers the skin of a fetus and is considered dirty or harmful. A large majority of women applied various substances to the umbilical stump to promote healing. A substantial minority used antiseptics or antibiotic ointments or powders, which are beneficial. More than half, however, treated the stump with mustard oil, coconut oil, *surma* (which contains antimony, a metallic element), or other traditional substances. When applied to an unhealed umbilical stump, these materials may lead to sepsis, a potentially deadly infection of the blood. Daily massage with mustard oil is another common newborn-care ritual that may induce sepsis.

On the basis of their findings, the researchers suggest that health care providers view antenatal care visits as opportunities to educate women about the biomedical causes of serious postpartum illnesses, such as heavy bleeding or high fever, and about benign and beneficial feeding and care practices for the newborn. Physicians can also use these visits as

opportunities to encourage women to attend routine postpartum checkups.

However, Fikree and her colleagues contend, it is not appropriate or feasible to recommend interventions that depend entirely on the biomedical model. They suggest that their results have illustrated the fundamental role that traditional beliefs and practices play in the health-seeking and care-giving behaviors of new mothers in these areas of Pakistan. “We recommend that care givers help women to differentiate between benign and harmful practices. Total seclusion after childbirth may harm mothers and infants, for example, while rest is beneficial. Harmless traditional practices can be encouraged in counseling sessions and through information dissemination, and risky ones discouraged,” says Fikree. “In this way we can maintain traditions in a healthier way.” Women receive information from family members, elders, and traditional birth attendants, the investigators found, so these groups as well as pregnant women and mothers of newborns should be targeted with educational messages. ■

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women tested between 1997 and 2003, with 28 percent of pregnant women in South Africa testing HIV-positive by the latter date. Although women are increasingly tested for HIV at antenatal clinics, men rarely seek reproductive health and HIV-testing services. Moreover, certain sexual practices during and after pregnancy may increase HIV risk. Many women, for example, abstain from sex before and after delivery. During this time, men may have other partners. "Involving men in maternal care in South Africa could provide opportunities for men and women to discuss reproductive health and learn about HIV risks in a setting mediated by a health care provider," explains Busi Kunene, intervention researcher from the University of Witwatersrand's Reproductive Health Research Unit.

Instituting this program in South Africa—where the Population Council collaborated with the Reproductive Health Research Unit, the KwaZulu-Natal Department of Health, and Family Health International—posed challenges unlike those in India. At the clinics used in India, which are affiliated with the men's workplaces, men frequently accompany their wives on their initial visits. It was at these visits that male partners were approached to participate in the intervention. The clinics used in the South Africa study had no affiliation with the male partners' workplaces, and men, when invited, often found it difficult to miss time at work to attend antenatal and postpartum appointments. Most of the women were not married to and did not live with their partners, thus making it more difficult to contact these men.

At the six experimental clinics in the South African province of KwaZulu-Natal, 995 women and 584 of their male partners were interviewed and enrolled in the intervention. At six control clinics, 1,087 women received services following current Department of Health practices and guidelines.

"Despite the obstacles, the project showed that involving men in maternal care is feasible and acceptable," says Population Council investigator Saiqa Mullick. "At least one-third of couples in the South African intervention attended counseling sessions. In this area prior

to the intervention, it was extremely uncommon for men to attend sessions."

Additionally, women in the intervention group were significantly more likely than women in the control group to be assisted by their partners when they experienced difficulties in their pregnancies. The increase in knowledge about the dually protective nature of condoms was significantly higher among women attending intervention clinics compared with women at the control clinics. And a significantly higher proportion of intervention couples discussed such key issues as STIs, sexual relations, baby immunization, and breastfeeding. "The increase in communication is an important antecedent to behavior change," asserts Population Council researcher Emma Ottolenghi, who participated in both studies.

No other effects of the intervention were detected in South Africa. The researchers speculate that had the intervention been in place for a longer period or been supported by mass communication efforts to encourage men to come to the clinic, a more substantial transformation may have occurred. On the basis of the results of the Men in Maternity study and other studies in KwaZulu-Natal, the provincial Department of Health is revising its antenatal and postnatal care guidelines and developing new policies. Involving male partners has been identified as a key issue. *Frontiers in Reproductive Health* and the Reproductive Health Research Unit are collaborating with various agencies to develop the policies and guidelines. ■

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