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Women's autonomy and husbands' involvement in maternal health care in Nepal

Deependra Kaji Thapa [a,*], Anke Niehof [b]

[a] Karnali College of Health Sciences, Kathmandu, Purbanchal University, Nepal
[b] Wageningen University, Sociology of Consumer and Households Group, Hollandseweg 1, 6706 KN Wageningen, The Netherlands

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ABSTRACT

Both increasing women's autonomy and increasing husbands' involvement in maternal health care are promising strategies to enhance maternal health care utilization. However, these two may be at odds with each other insofar as autonomous women may not seek their husband's involvement, and involved husbands may limit women's autonomy. This study assessed the relationship between women's autonomy and husbands' involvement in maternal health care. Field work for this study was carried out during September–November 2011 in the Kailali district of Nepal. In-depth interviews and focus group discussions were used to investigate the extent of husbands' involvement in maternal health care. A survey was carried out among 341 randomly selected women who delivered a live baby within one year prior to the survey. The results show that husbands were involved in giving advice, supporting to reduce the household work burden, and making financial and transportation arrangements for the delivery. After adjustment for other covariates, economic autonomy was associated with lower likelihood of discussion with husband during pregnancy, while domestic decision-making autonomy was associated with both lower likelihood of discussion with husband during pregnancy and the husband's presence at antenatal care (ANC) visits. Movement autonomy was associated with lower likelihood of the husband's presence at ANC visits. Intra-spousal communication was associated with higher likelihood of discussing health with the husband during pregnancy, birth preparedness, and the husbands' presence at the health facility delivery. The magnitude and direction of association varied per autonomy dimension. These findings suggest that programs to improve the women's autonomy and at the same time increase the husband's involvement should be carefully planned. Despite the traditional cultural beliefs that go against the involvement of husbands, Nepalese husbands are increasingly entering into the area of maternal health which was traditionally considered 'women's business'.

Introduction

The fifth Millennium Development Goal aims to improve maternal health and reduce maternal mortality by three quarters between 1990 and 2015 (United Nations, 2000). In 2008, approximately 358,000 women died due to pregnancy and childbearing causes and 83% of these deaths occurred in South Asia and Sub-Saharan Africa (WHO, UNICEF, UNFPA, & The World Bank, 2010). Although maternal mortality slightly declined in every region of the world (Hogan et al., 2010), the gains are still too little. Low utilization of maternal health care services during pregnancy, at delivery and in the postnatal period contributes to high maternal mortality and morbidity (Bulatao & Ross, 2003; Prata, Sreenivas, Vahidnia, & Potts, 2009). For 2008, UNFPA (2011) estimated the maternal mortality ratio of 380 per 100,000 live births in Nepal. According to the Nepal Demographic and Health Survey 2011, 58.3% of women receive ANC from skilled birth attendants and the majority of births (64.7%) still takes place in the home (MoHP, New ERA, & Macro International Inc., 2012).

A low level of women's autonomy is considered a factor that contributes to poor maternal health service utilization among Nepalese women (Sharma, Sawangdee, & Sirirassamee, 2007). The low social status of women in Nepal has hindered realization of national health and population policy targets (Tuladher, 1997). Women have an inferior position and have considerably less power than their male counterparts in making household decisions (Bennett, 1983; Morgan & Niraula, 1995) and even in decisions concerning their own health care (Blanc, 2001; Dudgeon & Inhorn, 2004), which puts them in a position to depend on their husbands for their health and well-being. Despite these facts, the role of husbands in maternal health is largely ignored by researchers and policy makers.

* Corresponding author. Tel.: +977 01 4470205.
E-mail addresses: thapa.deepen@gmail.com, deependra_thp@yahoo.com (D.K. Thapa).

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Husbands' involvement

The idea of increasing men's involvement in reproductive health care has received attention since the late 1990s (Bankole & Singh, 1998; Greene & Biddlecom, 2000). Much of the work on male involvement has concentrated on issues like family planning (Goldscheider & Kaufman, 1996; Prata et al., 2009), abortion (Rasch & Lyaruu, 2005; Silverman et al., 2010), sexually transmitted infections (Brewer, 2005), and breast-feeding (Earle, 2000; Stremler & Lovera, 2004). Comparatively few studies have been conducted on male involvement in maternal health care. Husbands' approval of and involvement in ANC has been shown to have a positive influence on ANC utilization (Biratu & Lindstrom, 2006). Husbands' help during pregnancy was associated with improved pregnancy health of rural Nepalese women (Wasti, Lim, & Pathak, 2012). A study in rural Bangladesh (Story et al., 2012) found that husbands' involvement was associated with professional care during delivery. In Pakistan, husbands' approval was an important determinant of institutional delivery (Agha & Carton, 2011). In India, a husband's knowledge of reproductive health and his presence during ANC were associated with professional care during delivery (Chattopadhyay, 2012). Mullany (2006) found that lack of knowledge about maternal health among Nepalese husbands impedes positive involvement in maternal health care. Husbands can also influence maternal health care utilization by contributing to developing a birth plan (Kakaire, Kaye, & Osinde, 2011). A randomized controlled trial on the impact of involving male partners in antenatal health education programs yielded increased postnatal health service utilization among women who were educated along with their husbands (Mullany, Becker, & Hindin, 2007). Involving husbands in health education programs enhances communication between partners and promotes health-seeking behaviour (Turan, Nalbant, Bulut, & Sahip, 2001). The studies suggest that male involvement is an important aspect of maternal health care utilization.

Women's autonomy

Autonomy is a multidimensional concept and therefore difficult to quantify (Malhotra & Schuler, 2002). Dyson and Moore (1983) defined it as *"the ability – technical, social, and psychological – to obtain information and to use it as the basis for making decisions about one's private concerns and those of one's intimates"* (p. 45). Early literature on women's autonomy focused on education, occupation, and demographic characteristics like age at marriage and age differences between spouses as proxies for women's autonomy (Abadian, 1996). More recently, autonomy has been defined as women's enacted ability to influence decisions, control economic resources, and move freely (Bloom, Wypij, & Das Gupta, 2001; Jejeebhoy, 2002). The separate but interdependent dimensions of women's autonomy are explained in Box 1.

Box 1
Dimensions of women's autonomy.

- Knowledge autonomy: education and exposure to outside world
- Household decision-making authority: women's final say in decisions concerning themselves and their family
- Movement autonomy: freedom of movement and the right to interact with others
- Economic autonomy and self-reliance: access to and control over economic resources
- Emotional autonomy: close bonds with spouses, and freedom from the threat of violence and abuse

Women's autonomy, though measured in different ways, has been associated with maternal health care utilization (Ahmed, Creanga, Gillespie, & Tsui, 2010; Baral, Lyons, Skinner, & van Teijlingen, 2010; Mistry, Galal, & Lu, 2009). Gupta (1995) provided an overview of women's autonomy and health outcomes from a life-course perspective. He concluded that women of childbearing age have the lowest level of autonomy, which had negative implications for their own health and the health of their children. Other studies have highlighted the importance of enhancing women's autonomy to improve maternal health service utilization in developing countries (Ahmed et al., 2010; Furuta & Salway, 2006). In 1993, the International Conference on Population and Development (ICPD) Programme of Action also noted that "improving the status of women also enhances their decision-making capacity at all levels in all spheres of life, especially in the area of sexuality and reproduction" (United Nations, 1994 paragraph 4.1).

Focus of the study

This paper focuses on two main questions. The first is about the extent of husbands' involvement in maternal health, more specifically, the advice and support given by husbands, birth preparedness of couples, husbands' presence at ANC and delivery, and socio-cultural beliefs about husbands' involvement. By giving support, taking responsibility and making resources available, husbands' involvement is hypothesized to have a positive effect on maternal health.

Second, we address the relationship between women's autonomy and husbands' involvement in maternal health care utilization. Women's autonomy regarding knowledge, household decision-making, freedom of movement, control over resources, and in the marital relationship, is also hypothesized to be positively related to maternal health care utilization.

Women's autonomy and husbands' involvement are connected because autonomy relates to the distribution of decision-making power and resources among members of the household, in particular between husband and wife. However, the relationship between the two is not clear. A study conducted by Mullany, Hindin, and Becker (2005) in Nepal showed that higher woman's autonomy as measured by sole final decision-making power was associated with significantly lower male involvement in pregnancy health, but a study in Guatemala found no association between gender dynamics as measured by the husband's authority index and his attendance at birth (Carter, 2002).

Theoretically, four situations are possible. First, an ideal situation in which women's autonomy and husbands' involvement are both positive and do not exclude but reinforce one another, resulting in optimal use of maternal health care facilities. In the second situation women enjoy a large measure of autonomy but their husbands do not aspire to be involved in their wives' health care. In the third situation husbands are involved because of traditional considerations of control and do not want to grant their wives more autonomy. In this case, husbands' involvement is an expression of women's lack of autonomy. In the fourth situation, husbands' involvement is low or nonexistent and women's autonomy is very limited, resulting in negative outcomes with regard to maternal health and health care utilization. Table 1 summarizes the four hypothetical situations just discussed.

It is important, both theoretically and practically, to assess the possible trade off between women's autonomy and husband's involvement so that interventions to improve women's autonomy and husband's involvement can be designed in such a way that they enhance both. This paper describes the forms of husbands' involvement in maternal health care and then analyzes the connections between women's autonomy and husbands' involvement in a rural setting.