

Gender and Safe Motherhood: Case Studies

Case Study 1: Involving Men in Maternity Care in South Africa¹

Program Goal:

Expand the antenatal and postpartum care components of a program aimed at improving women's and men's reproductive health, especially use of family planning and sexually transmitted infection (STI)/HIV protective behaviors.

Proposed Program Strategy:

Increase men's involvement in maternity care services.

Available Background Information:

STIs, Family Planning, and Pregnancy

The 1998 South Africa Demographic and Health Survey reported high utilization (94%) of antenatal care by pregnant women. Yet, although STIs are a major public health problem, pregnant women rarely receive information on this topic.

The limited information given by health providers on reproductive health, including STIs and condom use, is primarily aimed at women. However, women are often not financially or culturally positioned to discuss or to make decisions about sex or condom use with their partners. At the same time, they may be expected to modify their or their partner/s' risk behavior for STIs. In most cases, this cannot be done without some degree of partner involvement.

Regarding family planning, many couples and providers in South Africa consider family planning (FP) a women's issue. Despite this, there is a widespread perception of men as barriers to free and educated decisions on whether and when to use contraception and which methods best suit couples' needs.

In the context of pregnancy, evidence from the region suggests that every woman is vulnerable to STIs during pregnancy. A study in Nigeria,² for instance, found that it is not uncommon for male partners to have a sexual network of non-regular partners during the postnatal period; condom use with non-regular partners is low and even lower with regular partners.

¹ This case study is drawn from B. Kunene, M. Beksinska, S. Zondi, N. Mthembu, S. Mullick, E. Ottolenghi, I. Kleinschmidt, S. Adamchak, B. Janowitz, and C. Cuthbertson. 2004. *Involving Men in Maternity Care: South Africa*. Washington, DC: Population Council; and Elizabeth Rottach, Sidney Ruth Schuler, and Karen Hardee. Forthcoming. *Gender Perspectives Improve Reproductive Health Outcomes: New Evidence*. Washington, DC: PRB for the IGWG. Sections of these publications were directly excerpted and slightly modified to form this case study. However, this case study itself should not be taken as representative of the original publications and/or the specific intervention evaluated.

² T.O. Lawoyin, and U. Larsen. 2002. "Male Sexual Behavior During Wife's Pregnancy and Postpartum Abstinence Period in Oyo State, Nigeria." *Journal of Biosocial Science* 34(1): 51-63.

Men's current role in maternal health

Tsui and others³ state that it is often family members, and not the woman alone, who make decisions about obstetric care. They further note that in many cases men control the cash reserves, or their permission needs to be obtained for obstetric care.

Men in South Africa generally do not accompany their partners to family planning, antenatal, or postnatal care services and are not expected to attend the labor of their partner or birth of their child. In addition, men are rarely exposed to public reproductive health services as they often seek care for STIs in the private sector, and condoms can be obtained from clinics without contact with providers.

Healthcare providers in the public sector too often have limited skills to implement male-friendly services, particularly in the areas of maternity care and family planning. In South Africa, unpublished data from focus group discussions indicate that some of the nurses as well as women clients were concerned about male involvement, as culturally, men were not expected to participate in maternity care. The structure of public antenatal clinics does not promote attendance as a couple, and this is further reinforced by a provincial policy guideline that suggests that women should be attended in groups.

Reactions of women and men to increased male involvement

Research indicates that men themselves, as well as their partners, would prefer that they play a more active role during pregnancy, delivery, and infant care but that societal and health system norms often inhibit them from doing so. Most programs have not been successful in involving men in making more equitable and collaborative reproductive health decisions for couples and providing them with the essential information and skills for this to happen.

Exemplary indicators

Select indicators for communities prior to any intervention include the following:

1. Percent of male partners participating in programs at maternity clinics: 2.0%
2. STI knowledge

	Percent of Women	Percent of Men
Do not know any STI symptom in women	19%	10%
Do not know any STI symptom in men	30%	30%

³ A.O. Tsui, Wasserheit, J.N. and Haaga, J., eds. 1997. "Reproductive Health in Developing Countries: Expanding Dimensions, Building Solutions." Panel on Reproductive Health, National Research Council. Washington, DC: National Academy of Science.

3. Partner communication

Topics Discussed	Percent of Couples
STI	64%
Sexual relations	75%
Family planning	70%

4. Risk behavior and condom use by male partner in previous six months

Behavior	Percent of Men
Sex with non-regular partner	17%
Condom use during last intercourse with non-regular partner	61%
Condom use during last intercourse with regular partner	30%

Case Study 2: Social Mobilization and Government Response in India⁴

Program Goal:

Increase the knowledge and use of reproductive health and family planning, as well as maternal healthcare.

⁴ This case study was drawn from the following sources: Elizabeth Rottach, Sidney Ruth Schuler, and Karen Hardee. 2010. *Gender Perspectives Improve Reproductive Health Outcomes: New Evidence*. Washington, DC: USAID IGWG and Population Action International, International Center for Research on Women [ICRW]. 2006. *Social Mobilization or Government Services: What Influences Married Adolescents' Reproductive Health in Rural Maharashtra, India? Briefing Kit, Improving the Reproductive Health of Married and Unmarried Youth in India*. Washington, DC: ICRW; ICRW. 2006. *Influence of Men and Boys on Youth Reproductive and Sexual Health: Husband's Involvement in Maternal Care in Rural Maharashtra, India*. Washington, DC: ICRW; and R. Pande, K. Kurz, S. Walia, K. MacQuarrie, S. Jain, G. Sodhi, A. Barua, and J. Prasad. 2006. *Improving the Reproductive Health of Married and Unmarried Youth in India. Final Report of the Adolescent Reproductive Health Program in India*. Washington, DC: ICRW. Sections of these publications were directly excerpted and slightly modified to form this case study; however, this case study itself should not be taken as representative of the original publications and/or the specific intervention evaluated.

Program Strategy:

Community-based mobilization and government health services.

Background Information:

Age of marriage and childbearing statistics

Rates of adolescent marriage and early childbearing in India are among the highest in South Asia. In India, median age at marriage among women ages 20–24 is 16.7 years. Almost all young women ages 25–29 (95%) are married. The majority of men also marry young (72% of men ages 25–29). However, men are typically older than women when they marry. In rural India, 40 percent of girls (ages 15–19) are married, compared with 8 percent of boys the same age.

Childbearing for women in India is also early. Among married women in their reproductive years (ages 20–49), the median age at first birth is 19.6 years. Nearly half of married women (ages 15–19) have had at least one child.

Reproductive health and family planning information and care for young women

Because sexual and reproductive health education for unmarried girls is taboo, young women who marry at an early age are likely to be uninformed about sexual and reproductive health issues, including contraception, pregnancy, STIs, and disease prevention. Even after they are married, because of social taboos surrounding reproductive and sexual health, young married women are often too embarrassed to voice their needs and instead forego health services. In rural Tamil Nadu, for instance, 53 percent of married women ages 16–22 reported symptoms of reproductive tract infections (RTIs), but two-thirds of them did not seek treatment, largely because of perceived stigma and embarrassment.

Moreover, after marriage, many women also face limited mobility and decisionmaking power. Young married women typically are at the bottom of the social hierarchy and must depend on family elders for access to healthcare information and services. In particular, husbands and mothers-in-law often play a significant role in young wives' lives and control their health-seeking behavior. A household is not likely to pay attention to, or spend money on, a new bride's reproductive health needs unless they explicitly interfere with her ability to work or reproduce. As a result, many young married women have limited access to reproductive healthcare, family planning services, and maternal healthcare.

Reproductive health and family planning information and care for young men

Less information exists about young men. Information that does exist suggests that young men are also not aware of or are ashamed to seek information or services for their own reproductive health issues. In rural Tamil, for instance, men who have STIs are associated with "having a wrong relationship," meaning an extramarital affair or sex with a sex worker. As such, men only seek STI treatment when symptoms become severe.

Access to maternal healthcare

The same factors that limit women's access to reproductive health information and services also limit young women's access to prenatal and obstetric healthcare. In one study, a mother-in-law noted:

...Nowadays these girls go to the doctor, take medicines, and make a lot of fuss about pregnancy...I am not convinced about all this care and medicines. These girls take all these medicines but cannot do their routine work. The slightest exertion makes them start having tremors and weakness. The earlier tradition of doing hard work during pregnancy was much better.

—Mother-in-law, Maharashtra

There is also a strong belief that a woman who has just given birth should not be allowed to leave the home, even if she needs postnatal care.

Regarding men's involvement in maternity care, community norms label maternal care as a "woman's affair." In Ahmednagar, Maharashtra, for instance, only half the men who said that husbands should accompany their wives for antenatal and postnatal care actually did so; the proportion fell to one-third for delivery.

Exemplary indicators

Select indicators for communities prior to any intervention include the following:

Maternal Health Knowledge and Attitudes

Area	Percent of Women, Community 1	Percent of Women, Community 2
Need for perinatal care	36%	46%

Husband's Involvement in Routine Maternal Healthcare

Routine Care	Antenatal Care	Delivery	Postnatal Care
Knows about need for care	77%	86%	69%
Feels responsible to accompany	81%	86%	68%
Accompanied woman for care	54%	29%	51%

Study 3: Community Mobilization to Improve Access to Emergency Obstetric Care in Indonesia⁵

Program goal:

Increase access to emergency obstetric care.

⁵ This case study is adapted from Debbie Caro, 2009; and Statistics Indonesia, National Family Planning Coordinating Board, Ministry of Health and Macro International. 2007. *Indonesia Demographic and Health Survey*. Calverton, MD: Macro International.

Proposed program strategy:

Improve institutional support for emergency obstetrical care via collaborative planning mechanisms at the community and regional levels.

Background information:

Age of marriage and childbearing statistics

While early marriage and pregnancy are declining in Indonesia, women continue to marry and give birth at young ages. More than one in five women have their first pregnancy before age 20.

Disparities in age at first birth continue to exist between urban and rural women and between women of different educational and income levels. On average, urban women start bearing children more than two years later than rural women. Women with more education and women from wealthier families also begin childbearing later than less educated women and women from families with lower incomes (Statistics Indonesia et al., 2007).

Access to emergency obstetrical care

A study of 12 Indonesian hospitals indicated 92 percent of maternal deaths result from delays in referral and case management, while 40 percent of women die on the way to the hospital. Delays result both from the decision to seek care and delays at facilities to getting women and newborns with complications referred to the next level of care.

Delay 1: Recognizing warning signs and deciding to seek care

The decision to seek care is greatly influenced by women's and their families' perceptions of the lack of quality care at clinics and hospitals, as well as by concerns about costs.

Further, many women prefer to give birth at home, because of expectations that they resume their domestic responsibilities soon after giving birth. Because of this expectation, many women also prefer to be attended by traditional birth attendants (TBAs) rather than by community midwives or physicians, because TBAs typically offer help with cooking and childcare postpartum.

Delay 2: Identifying and reaching a medical facility

In the 2007 Demographic and Health Survey (DHS), women report that distance from their homes to health facilities poses one of the most significant barriers to accessing healthcare. "Younger women, women with many children, women who are no longer married, those who live in rural areas, women with no education, and women from the poorest households are more likely to report problems in accessing healthcare than other women" (Statistics Indonesia et al., 2007; 44).

Further, because community midwives tend to be either young or old women, and thus have low status in the community, they are often located in dangerous or isolated areas where they are difficult to access. Midwives also do not always have the resources to travel to the homes of clients, especially those in remote areas.

Delay 3: Receiving adequate and appropriate treatment

Once women reach public health facilities, they experience additional delays caused by a failure of providers to perceive the urgency of the complications, inappropriate care, and lack of trained providers and supplies.

Because of midwives' low status (including their status as women), they are not treated respectfully by health authorities; and their referrals or recommendations may not be taken seriously.

Existing structure for community input into government decisions

The musrenbang is a deliberative multi-stakeholder forum that identifies and prioritizes community development policies. It aims to be a setting for negotiating, reconciling and harmonizing different priorities and goals between government and nongovernmental stakeholders and reaching collective consensus on development priorities and budgets. Fora take place at the village, sub-district, and district levels through a planning process that is both "bottom up" and "top down."

Exemplary indicators

Select indicators for communities prior to any intervention include the following:

Of women who had given birth in the last five years, percentage that had discussed a particular delivery preparation topic with their spouses (Statistics Indonesia et al., 2007)

Place to deliver	Transportation	Delivery Assistance	Payment	Blood Donor	No Topics Discussed
68.5%	43.1%	68.8%	64.4%	8.3%	22.1%

Of ever-married women, percentage who reported that they have big problems in accessing healthcare for themselves when they are sick (by problem identified) (Statistics Indonesia et al., 2007)

Getting Money for Treatment	Distance to Health Facility	Having to Take Transport
25.1%	15.3%	13.3%

Case Study 4: A Human Rights Approach to Improving Emergency Obstetric Services in Peru⁶

⁶ This case study was adapted from Deborah A. Caro, Elena Esquiche, and Lynne Freedman. Forthcoming. *Peru: Human Rights and the Reduction of Maternal Mortality in Action: The Femme Project in Ayacucho, Peru.*; and Physicians for Human Rights. 2007. *Deadly Delays: Maternal Mortality in Peru, A Rights-Based Approach to Safe Motherhood.* Cambridge, MA: Physicians for Human Rights.

Program goal:

Improve availability, utilization, and quality of clinical care in obstetric emergencies.

Proposed program strategy:

Improve quality of emergency obstetric care in public health facilities, strengthen management of healthcare services, and institutionalize a human rights perspective as the organizing principal of healthcare.

Background information:**Social inequality and human rights**

Approximately 47 percent of Peru's population is indigenous. While the national maternal mortality ratio (MMR) is 185 per 100,000 live births, some regions have much higher rates of maternal death, including Puno and Huancavelica, with MMRs of 361 per 100,000 and 302 per 100,000, respectively. These disparities reflect deep economic and social inequalities between urban and rural and indigenous and non-indigenous populations.

The Peruvian Constitution states that all citizens have the right to health. This obligates the State to respond to the healthcare needs of its citizens. However, many indigenous communities perceive the health system to be a colonizing force that does not respect local populations and customs. This perception of the health system challenges the notion that women do not access emergency obstetric services simply because of limited decisionmaking power but "demonstrates that they make a conscious decision to resist discrimination by avoidance, as they do not feel empowered to alter the discriminatory system" (Caro et al., 2009).

Institutionalized gender inequality in the health system

Studies in Peru have shown that social inequality, and especially gender inequality, is institutionalized in the public health system at multiple levels.

Health providers often displayed discriminatory attitudes toward laboring women and their cultural backgrounds. For instance, clinicians did not address women by name but instead called them demeaning names like *mamita* (little mother) and *hijita* (little daughter), which emphasize differences in status between provider and client. Providers did not always respect women's agency or cultural traditions by allowing them to give birth in a standing position or by honoring their requests to remain partially clothed during exams. Sometimes, health providers were found to yell at women who came to the clinics with complications after a long delay.

In addition to discriminatory attitudes, rigid protocols and procedures made it difficult to respond flexibly to a woman's needs and to her personal and cultural preferences. For instance, a woman's partner or other family members were not allowed in labor and delivery areas of the clinics, and there was no food available to women during and after labor.

Another gendered dimension of institutional barriers to acceptable obstetric care relates to the infrastructure of health facilities. Clinics, even those that had recently been remodeled, were not equipped to support upright birthing positions, in violation of Peruvian law. Clinics did not have interpreters to facilitate communication with women who spoke indigenous languages. Patient flow procedures did not make use of space in the clinics in ways that protected women's privacy. There were no places for family mem-

bers (who had travelled from rural areas to accompany a woman to the health facility) to stay overnight. Maternity waiting homes, meant to facilitate rural women's access to trained birth attendance by providing a place to stay near a health facility in the days leading up to her delivery, were under-resourced and not well maintained.

The health system in Peru was extremely hierarchical and autocratic, meaning that lower-level staff had little influence in shaping policies, protocols, and budget priorities. Further, because lower-level staff were not respected by their superiors, clinicians like nurses and midwives who were closest to laboring women (and more likely to be women themselves) had little incentive to make medical suggestions in the interest of women, and their opinions were not likely to be taken seriously if they did. Supervisory relationships across different levels of clinical staff were characterized by suspicion and punishment, rather than by mentoring and shared accountability. Quotas for antenatal visits and institutional births were set in the name of productivity but instead were arbitrary and resulted in negative consequences for patients and providers. Front-line workers were penalized for maternal deaths, even when they were not at fault for the death, creating perverse incentives for clinicians to avoid treating women presenting with complications. Health workers reported deep frustrations with the way the health system was run and staff turnover was high.

Exemplary indicators

Select indicators relevant to the intervention include the following:⁷

- In Peru, there are around 6,000 health facilities (including hospitals). Only 700 of these are equipped to accommodate standing birth positions, and most of those 700 are lower-level facilities, like health centers and clinics.
- In 2008, facilities reported 23,000 standing births. This number increased in 2009 to 22,000 standing births between January and September 2009.
- There are currently 405 maternity waiting homes in Peru.
- On average, 325 women make use of maternity waiting homes each month.

⁷ These indicators are national-level indicators reported by the Peruvian Ministry of Health in January 2010.