

ORIGINAL RESEARCH

Exploring Health Professionals' Perceptions of Husbands' Responsibilities in Muslim Women's Health



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Abstract

Background: The husband has an important role in women's health. However, the information related to their roles is limited, including from the perspectives of health professionals. The health professionals' support and behavior have influenced men's and women's health behavior.

Purpose: This study aimed to determine the health professionals' perceptions of husbands' roles and behavior in women's health, especially in the Muslim community.

Methods: A qualitative descriptive approach applied in this study. Data were collected using the interview method. Ten health professionals from rural and urban areas of West Java, Indonesia, with a range of experience engaging with Muslim husbands involved in this study. Semi-structured interviews were recorded and then transcribed by the researchers. The transcribed data were analyzed using the comparative analysis for the interview technique.

Results: Four main themes were identified: (1) Contextual factors impact husbands' roles in women's health; (2) Extensive roles of Muslim husbands in women's health; (3) Husbands and others involved in decisions about women's health; and (4) Level of health literacy affects husband's actions in women's health and cancer.

Conclusion: Health professionals perceived that husbands' roles in Muslim women's health are pivotal, especially in supporting health treatments in health services. Little information was obtained about husbands' support in cancer prevention and early detection. Nurses can take the lead in improving Muslim husbands' understanding of women's health and cancer and raising their awareness of cancer screening for their wives.

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1. Introduction

Health professionals have a role in facilitating access to and positive experiences in women's health. Women in developing countries such as Indonesia are challenged with sociocultural problems, marginalization, and health problems that may endanger their quality of life (World Health Organization, 2017). Women, especially married women, have comprehensive family roles, including taking care of their children, husband, and other family members. Although women are precious in the family, they are often challenged with many health issues because of their gender status. The top 10 women's health issues worldwide, including Indonesia, were non-communicable diseases such as cancer, maternal health, reproductive health; social problems such as violence against them, mental health; communicable diseases such as human immunodeficiency virus (HIV), sexually transmitted infections (Bustreo, 2015). However, there are limited national data of women's health in Indonesia; the data provided are mostly related to maternal health, no specific disease report in women's health problems.

A study has identified many factors that influence women's health behavior, including women's knowledge and information, awareness, attitudes, socio-demographic features, economic barriers, religion and beliefs, and health providers and service arrangements (Nabieva & Souares, 2019). In addition, a study with participants from several ethnicities of Sunni and Shia Muslim communities found that religion and beliefs, including Islamic teaching, impact positively and negatively on men's and women's health behavior (Alghafli et al., 2014). Even though 87% of Indonesians are Muslim, there are no studies conducted in Indonesia that have assessed Muslim

husbands' roles in women's health. There is a possibility that Islamic teaching influences how Muslim husbands behave regarding women's health, as men have an important role in their family, including health.

According to the Holy Quran (Muslim holy book), a husband is fully responsible for his wife, including her health. Muslim husbands have to treat their wives with good behavior as mentioned in the Surah An Nisa verses 19 and 34 (Ministry of Religion Republic of Indonesia, 2015). They are the protectors of their wives and daughters and also responsible for preparing *akherat* (of life after death) as written in the Surah At Tahrim verse 6 (Ministry of Religion Republic of Indonesia, 2015). Muhammad, the prophet, provided an example related to Muslim husbands' behavior toward their wives, children, parents, and other members of the family, including caring for them kindly, appreciating, supportive, and protecting their wife including women's body parts, safeguarding, and believing them (An-Nawawi, 2020).

Health professionals are an important aspect of health services, including women's health and husbands' decisions regarding their wives' health. Health professionals' support and behavior have been identified as motivators and barriers to men's and women's health actions (Marlow et al., 2013). Health professionals are health educators and motivators of screening (Kim et al., 2012). However, other studies identified that health professionals could negatively influence women's health behavior as results of language barriers (Torres et al., 2013), poor communication (Ma et al., 2012), and their limited capability in carrying out health procedures (Lor et al., 2013). Studies about health professionals' roles and behavior were conducted, yet limited study explores health professionals' views of patients and family behavior.

Health professionals are at the forefront of health services in Indonesia. Studies in Indonesia found their roles in health services such as health education, services, and treatment (Handayani, 2013; Nurhayati, 2016). Furthermore, Nurhayati (2016) identified several health service barriers women face in Indonesia especially in rural areas, such as no general practitioner (GP) and limited facilities. Not surprisingly, the studies found that health professionals are the main sources in providing health services, including women's health. When available, health professionals mostly have a close relationship with patients and their families: husbands, children, or parents. However, little is known about health professionals' perspectives on Muslim husbands' roles in women's health. Understanding health professionals' perspectives and experiences would help develop interventions to improve women's health and health services engagement. This study aimed to determine the health professionals' perceptions of husbands' roles and behavior in women's health, especially in Muslim community.

2. Methods

2.1 Research design

This study applied the descriptive qualitative approach to describe health professionals' views related to Muslim husbands' roles and responsibilities in women's health. This approach focuses on explaining people's attributes, conditions, and experiences as part of a qualitative research design (Polit & Beck, 2014).

2.2 Setting and participants

This study was conducted in five health services located in two districts in West Java Province as the representative of the urban (Bandung City) and the rural districts (Pangandaran district). The five health services were four Primary Health Care (PHC) services and a national referral hospital. This study's participants were 10 health professionals, including six midwives, two nurses, and two GPs. The head of PHC aided participants in recruitment for the PHC settings and the nurse coordinator for the hospital setting. The inclusion criteria were that health professionals had to be involved in women's health services and programs. Another criterion was a minimum of one year experience in women's health area; it is expected that participants have experience in observing husband's behaviour in supporting their wives' health in health services. Even though participants were recommended by the head of PHC or the nurse coordinator, they had to provide voluntary written consent to be a part of this study.

2.3 Data collection

There were two steps to data collection; participants filled in a social-demographic survey related to their educational background, years of work, profession, and workplace. Secondly, the

principal investigator (RW) interviewed participants using a semi-structured guideline and recorded in the audio-recorder tool. The interview guideline was informed by the theory Basic Model of Religiosity and Health (BMRH), the Health Belief Model (HBM) and the Help-Seeking Behaviour and Influencing Factors Framework (HSBIFF). Questions explored health professionals' perceptions of Muslim husbands' actions and behavior in women's health, influencing factors in husbands' behavior, and health professionals' views of husbands' roles related to women's health prevention, including women's participation in cancer screening. The duration of interviews was about 30-60 minutes. The data collection processes were completed in April 2017.

2.4 Data analysis

Following transcription, the data were analyzed using the comparative analysis for the interview (CAI) technique for the descriptive qualitative study (Widiasih & Nelson, 2018). The CAI is divided into four main steps, including pre-coding of each interview, coding using NVivo 10 software of each interview, data comparison across interviews and codes, and theme formulation across interviews and codes. These analysis steps were developed based on two integrated methods of qualitative analysis (Polit & Beck, 2014). The analysis results were presented in themes, and a quotation of participants' perspectives follows each theme. We used the terms participants, health professionals, and clinicians alternately in the findings report.

2.5 Trustworthiness

Polit and Beck's (2014) trustworthiness criteria, including credibility, dependability, confirmability, and authenticity, were applied in this study. To achieve credibility, the interviews were recorded; the interview processes were documented in a daily journal, and followed data analysis to find themes. The theme presents in the report with extracts of quotes. The quotes were obtained as evidence for the theme. Dependability and confirmability had been done by audit trails; themes were independently verified and discussed with the research team. Authenticity was delivered by an adequate and app sample, and having participants provide examples of experiences to support their perspectives. Transferability was determined by the reviewer and was supported by having a sufficient description of the research. This study approach aimed to generate a summarization of everyday life experienced by health professionals, so the focus of the study was to gather various data until they were saturated. No member checking process was applied as the study focused on the data's variation, not the specific meaning of participants' information as in other qualitative approaches such as the ethnography study. However, the researcher applied the four principles of trustworthiness in this study.

2.6 Ethical considerations

The ethics approval was released by the Human Ethics Committee of Victoria University of Wellington, New Zealand with a reference number of 21192. This study is part of a large project developed in New Zealand (Widiasih & Nelson, 2018). Key ethical issues were respected for personal autonomy, confidentiality, and safety. Indonesia's government also supported this study via the National and Political Unity Board (BKBP), a formal organization that permits researchers to approach the community. They released a letter of site permission approval for this study. This study was voluntary; the potential participants obtained informed consent and asked for their approval before participation.

3. Results

3.1 Characteristics of participants

Table 1 describes the demographic characteristics of the participants. The urban participants were two midwives who worked in PHC, two midwives from outpatient services of a national referral hospital, and a specialist maternity nurse from a gynecology ward. Midwives had graduated from the level III diploma in midwifery (equivalent to 3 year tertiary education), and the nurse was a master's and specialty degree in maternity nursing. They worked in their workplace for about 6 years on average, with a range of 2-10 years. The rural participants were two doctors, two midwives, and a nurse. The doctors and nurse worked in PHC, and the midwives worked as *Bidan Desa* (a midwife who delivers health care, especially to women and children in a village) as part of the PHC services. The rural participants had worked for 17 years on average,

with a range of 11–23 years. There were two main differences between the urban and rural clinician groups. The urban participants had, on average, 10 fewer years in practice than the rural participants, and there were differences in their experience of providing women's health services, for example, cervical cancer screening procedures.

Table 1. Characteristics of participants

No	Length of work	Workplaces	Profession
HU1	4	PHC	Midwife
HU2	2	PHC	Midwife
HU3	4	Hospital	Midwife
HU4	8.5	Hospital	Midwife
HU5	10	Hospital	Nurse
HR1	16	PHC	Doctor
HR2	23	PHC	Nurse
HR3	17	PHC	Doctor
HR4	11	Community	Midwife
HR5	17	Community	Midwife

Notes. HU: Urban participants; HR: Rural participants

3.2 Emerging themes

Data analysis from health professionals' perspectives found four main themes: Contextual factors influence husbands' roles in women's health; Extensive roles of Muslim husbands in women's health; Husbands and others involved in decisions about women's health; and Level of health literacy affects husband's actions in women's health.

3.2.1 Contextual factors impact husbands' behavior in women's health

The contextual factors include age, occupations, ethnicity, faith, and education levels, which were recognized by clinicians as men's internal factors that influence their behavior to wife's health. Both urban and rural participants have reported differences between older and young men in treating their wives in health services and talking with health professionals. In rural settings, "...women would depend on their children, not their husband, maybe because the husband also already old" (HR1). Other reasons for this delegation were rural older men were not familiar with public transportation in Bandung city where the referral hospital was located; they lacked familiarity with the referral hospital administration system and had difficulties understanding the clinician's explanation. Older men were reported to show more interest and care in their wives' health than the women's children or younger husbands. Most men were reported to remain faithful to their wives when they were in the advanced stage of cancer.

The type of occupations influenced men's actions when their wives were sick. The majority of rural men are farmers, while urban men have a variety of jobs, such as businessmen, employees, soldiers, and government officers. "I don't think these [rural] men would take their wives for treatment to a PHC because in the village, 80–90% are farmers; they say they're too busy as they go to the paddy field around 6 am to -12 noon" (HR5). The urban Health professionals also shared that job types are difficult to manage when helping their wife to the PHC or a hospital because of no permission from their office or working overseas (HR4). In addition, business people could usually make time to help their wives in visiting health services.

Culture and religion have influenced husbands' actions in their wives' health. Health professionals reported that religious men take care of their wives appropriately, for example, they are beneficial when his wife was hospitalized in the hospital. The religious man was indicated by men's behavior, clothes, and beard.

"In my view, a husband has broad roles in his wife's health and care. The roles may depend on his religiousness particularly, when coping with a severe condition or dying of his wife. I talk about a severe disease case, Ma'am; when a husband knows about their responsibilities in the Islamic teaching, then he will treat and take care his sick wife appropriately." (HU2)

The Islamic teaching stated husbands' responsibilities to their wives, including protecting her *aurat* and preventing this area from being touched by other men. However, in terms of the health professional gender, none of the participants shared experiences about men requesting female health professionals for their wives. Health professionals said male health professionals in PHC commonly refer women's patients to female health professionals, especially reproductive problems.

A clinician shared that men's formal education affects their knowledge, health understanding, and behavior regarding one of the women's health problems, cancer (HU4). The participants shared that well-educated men had different behavior to those men who were less well educated. Well-educated men took a significant interest when their wives in the stages of diagnostic and treatment. They knew how to take care of their wives and provide time to listen to her opinions or decision (HU5).

3.2.2 Extensive roles of Muslim husbands in women's health

All participants stated that Muslim husbands' men actively participated when their wife was sick. Their actions provided psychological support, money, and discussing the wife's health with health professionals about diet, medications, treatment (HU1, HU3, HU4, HU5, HR2, HR4, HR5). They also wanted to know about tips and tricks to keep their wives in motivation in the long therapy. However, participants had opinions that husbands showed different behavior related to the prevention and early detection of women's cancer.

"In my view, the rural people, especially men, were not concerned about early detection. In a rural area, like this area, women keep silent for their sick, as long as she walks it means healthy; women think they only need more time to take a rest. Yet, when the health conditions become severe, husbands are confused. They lack of knowledge and also actions." (HR3)

Even though husbands provided help and support to their wives with health issues, they appear to pay little attention to health prevention and screening.

3.2.3 Husbands and others involved in decisions about women's health

Health professionals perceived that husbands are actively involved in women's health decision-making in several ways. First, women rely on men's decisions mostly because of financial reasons.

"I faced a problem when a patient woman must refer to a hospital. I waited the decision for hours. I thought it was because of no permission from the family. In fact, it was because of money. My husband asked me about the reason for referral and the therapy processes in the hospital. I described the interventions and times. I explained that I need do administration stuff regarding the referral processes as I will send to the hospital in Bandung or Purwokerto. The family discussed it for a long time." (HR1)

The rural area participant reported that men with a financial problem visited the local government or community leaders asking for their help or the government's health subsidy (HR2). While wealthy people mostly go directly to hospitals. Participants also reported that women's reasons for following their husbands decide that they consider men's decisions the best and believe in Islamic teaching (HU1, HR3). A midwife participant noted that according to the religious teaching, women had believed that following men's advice is good as the husband is her leader and have responsibilities to the family.

Secondly, women and men have discussed healthcare and decided whether they follow the therapy process or not. The third was women made decisions by themselves. The fourth was the patient and family rely on health workers' recommendations. Mothers, parents in law, older brothers or sisters, children, relatives, leaders in the community, and religious leaders were reported by participants, especially those from rural areas, as other factors that influence husbands' decisions related to their wives' health. Health professionals perceived that husbands are actively involved in women's health decision-making in several ways. First, women rely on men's decisions mostly because of financial reasons.

“...I need to refer a woman patient to hospital, then I asked to the family. Commonly, it took time for them to decide whether they agree or no. Different behaviour when a woman visited the Primary Health Center with her child, and I said that your Mom need to go hospital, the child could not make a decision at the time, he called his Ma’am’s older brother, father, and other relatives, if the situation was emergency, I decided to send the patient as soon as possible to hospital by myself.” (HR1)

Community leaders helped men make decisions. A rural midwife participant reported that the word hospital scares men and women. Sometimes, men ask her to delay the referral because husbands need to discuss with the donor or helper, commonly the local community leader. A rural medical participant also noted that a lack of experience about the hospital services made rural people afraid, anxious, and looks for external supports.

3.2.4 *The level of health literacy affects husbands' actions in women's health*

The majority of participants from both areas agreed that men have a limited understanding of women's diseases, such as cervical cancer, which might influence their actions because men offered little support in illness prevention. They noted that health education programs about women's health, especially women's cancer for husbands, are limited.

“We had a Pap smear program and health education programs that were funded by a women organization last year. It was the one we have done because the budget is limited, only targeted women, no husbands, and it is difficult to develop health education programs or other programs in women's health.” (HU1)

The only program that involves men was the family planning program. However, although health professionals invited them to the program, most men did not attend the invitation. They said the invitation time was not suitable for their free time.

The health education program of women's health by involving husbands is not a priority for PHC, especially women's cancer. A rural participant communicated the focus of health prevention and promotion programs in the PHC related clean and healthy lifestyle, TB Programs, and HIV AIDS. Two urban PHC participants shared a similar opinion about the minimum health education programs for men about women's cancer, yet men were invited to attend prenatal classes. The health education program in the hospital is targeting patients and their families. The content was mainly about medications and other treatments, and less content about illness preventions. Health workers approved that cancer knowledge is significant for men's understanding of women's health as spouses; both men and women appreciate and care for each other, including health.

A medical participant in a rural area said that community leaders are potential sources in improving husbands' health knowledge.

“One of the potential resources is the leaders of the local government; in this sub-district, there is a meeting of local leaders, monthly including community leaders, religious leaders to socialize the government programs. Before we start the formal meeting, health professionals can share health information; then, they can share it with people in their areas. It is good, I think, rather than nothing.” (HR1)

Midwives and nurses from rural areas revealed that leaflets, TV programs, movies, and other electronic media were options for husbands' health education.

4. Discussion

4.1 *The impact of husbands' contextual factors on their roles in women's health*

The comparative analysis in this study found different actions and attitudes by older and younger, and types of jobs, whether farmers, employees, or businesspeople, influenced husbands' behavior in women's health. These findings, in line with a study by Hasson-Ohayon et al. (2014) study, highlighted a significant difference between older and younger spouses in levels of depression in women with breast cancer. A prospective cohort study of urban and rural women in

Lithuania regions also found that young and poorly educated women were more exposed to HPV than older and more highly educated women (Gudlevičienė et al., 2010).

From this study, the researchers assumed that health professionals were aware that living in rural or urban areas influences men's accessibility to health services and information about women's health and cancer. Living in rural areas in Indonesia is a struggle because of limited health facilities, human resources, and bad infrastructures, for example, damaged roads, electricity issues, and transportation problems. These access issues and the experience of the financial burden of hospitalization may influence rural people's health outcomes. This finding provides additional information for the Indonesian government about the gap between urban and rural, including health, especially women's health.

4.2 Massive roles of Muslim husbands in women's health

According to this study, health professionals' experience various husbands' roles in women's health. Previous Indonesian's study had assessed husbands' roles in several specific areas, for example, husbands' support during breastfeeding (Pratami, 2016), family planning (Kusmindari et al., 2016; Setiadi, 2015), and cancer screening (Aggraeni, 2016; Arkiang, 2016; Marlina, 2015). Not only in Indonesia, but studies with focus on husbands' support were also conducted in several Muslim dominated countries: Egypt and Jordan (Hamdan-Mansour et al., 2016; Ohashi et al., 2014; Taha et al., 2013). Those studies' participants were women or husbands; none of the studies gathered information from health professionals.

This study's findings have added new insight into husbands' roles from different perspectives, including clinicians' perspectives in broad women's health, including prevention actions and supportive actions. They perceived that husbands' roles are essential; however, some husbands were not fully supportive of their wives' health. This finding is in line with previous studies that husbands' awareness of women's health needs to be improved when women face a serious or terminal illness; men can provide maximum support (Maree et al., 2013). Such support makes a significant contribution to women's daily emotional and physical welfare, including women with cancer (Gremore et al., 2011). Health professionals shared limited information about men's participation in promoting women's health; the finding possibly reflects that health promotion activities are mostly done at home, which health professionals would not see.

4.3 Women's health decision-maker

Health professionals' perceptions and experiences were that women commonly involve their husbands in their health decisions. Studies from non-western countries are about women's autonomy in health decisions in maternal health and family planning (Osamor & Grady, 2016). Mboane and Bhatta (2015) have mainly found that involving husbands in women's health was associated with women's behavior in the maternal check-up and family planning choices. A study in Angola by Prata et al. (2017) that assessed husband/partner support related to family planning and modern contraceptive found a significant influence of husband/partner in women's decision making. The study discovered that husband's/partner's approval was significantly associated with women's contraceptive self-efficacy and contraceptive use, and not significantly related to socio-demographic factors and spouse communication. Increasing communication between both husband and wife would help women's understanding of husbands' approval.

Limited studies assessed husbands' involvement in cancer screening (Kim et al., 2012). Our study finding indicates that the Muslim husband is the potential to help women in improving their health. We found that women involve their husbands in decisions because of the influence of Islamic teaching. A verse in the holy Quran states that a Muslim wife's responsibility is respecting and obeying her husband (Surah An Nisa verse 34). Health professionals should therefore consider husbands having comprehensive involvement in women's health. Providing various alternative media and health interventions about women's health for husbands would improve their involvement in supporting their wives' health.

4.4 Health literacy and husbands' actions

The finding that Muslim husbands often had limited health literacy about women's health, especially cancer, is similar to studies conducted in other Muslim countries such as Saudi Arabia and Malaysia (Al-Amoudi & Abduljabbar, 2012; Al-Naggar et al., 2012). A Latino study also found that most men had little knowledge about cancer and were unfamiliar with screening (Trevino et

al., 2012). In contrast, an exploratory study of 24 Muslim married men in Jordan found the men understood that early detection is the best way to control breast cancer, and they encouraged women to do that (Taha et al., 2013). Men in Jordan may know more about women and women's cancer than those in Indonesia for two reasons. The first is the population size; Jordan has approximately 7,594,000 people and Indonesia 257,564,000 (WHO, 2015). Getting a shared message to a smaller population will be easier. Secondly, Jordan spent 798 international dollars on health per capita in 2014, whereas Indonesia only spent 299 international dollars per capita (WHO, 2015). The expenditure difference in Jordan is likely to contribute to increased health education. In addition, unlike Jordan, Indonesia does not maintain a cancer registry.

According to the HSBIF theory, knowing health and illness influence health-seeking (O'Mahony et al., 2011; O'Mahony et al., 2013). This study's findings informed that health professionals perceived the lack of husbands' knowledge could contribute to the low uptake by women of cancer screening and treatment, given the Muslim husband's significant position in the family. In the absence of such knowledge, people are unlikely to seek screening when well or seek assistance when they have symptoms as they do not understand what they mean. Addressing the knowledge gap will require health education programs in Indonesia to encourage screening and teach people that early diagnosis of abnormality can improve health outcomes. Providing a variety of health education for men and women is very important given the men's various backgrounds regarding knowledge, experience, and socio-demographics. Developing men's health centers and men's health forums such as fairs or peer group discussions that also provide information about women's health may be a way forward.

5. Implication and limitation

This study provides new insight into assisting men and families in rural areas to overcome the obstacles faced when attending hospitals in main centers. Developing outreach clinics in rural settings and appointment systems in the hospital is important, as the current system that means the first people to present daily get seen is a burden for rural people. Rural families also need people to assist them in navigating the hospital system. Mechanisms for helping people to navigate the referral hospitals are also needed. Nurses, for example, could teach administrators to orient people. There is also a potential role for community volunteers.

Even though the Muslim husbands' behavior, as reported by health professionals, maybe similar to those of other religions, nurses, midwives, and other health professionals can take the lead in improving Muslim husbands' understanding of women's health and cancer, raising their awareness of women's cancer and screening, and enhancing the quality of health services for women. This will require nurses and midwives to provide health education programs informed by Islamic teachings for Muslim husbands about women's cancer. The Islamic approach means approaching men via their Islamic activities, for example, providing flyers about women's cancer and screening in the Mosque because it is compulsory for Muslim men to attend the weekly Friday prayer. Flyers could help the men access information about cancer and screening, including their roles in supporting and encouraging women to attend health services. Other methods for distributing information are visiting men's community groups, including sports clubs and farmers associations.

This study has a limitation that the participants were all female as they were the leaders of women's health programs, recommended by the heads of the PHCs, and were considered experts in their field. The information they provided was comprehensive and appropriate to achieve the aim of this study. However, male health professionals' perspectives of husbands' roles in women's health may differ. Further studies that involve male health professionals' perspective is needed to achieve a maximum variation of the qualitative data.

6. Conclusion

This study provides health professionals' perspectives on husbands' roles in women's health. They described husbands' extensive roles in women's health, and husbands are essential for improving women's health. Health professionals need to recognize that husbands' actions are part of their responsibilities as guided by Islamic teaching; husbands are not always the decision-maker; rather, couples have many ways of managing decision-making. This study indicates that rural husbands faced more barriers than their urban in accessing women's health information and health services. As participants in this study were all female health professionals, there is a need

for a further study that involves male health professionals to gather comprehensive data for this study topic.

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Conflict of interest

None

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