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Negotiating Gender Roles and Male Involvement in Maternal Healthcare: A Qualitative Study of Low-Income Communities in Chiniot, Pakistan

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Abstract: *The global academic community has universally recognized that men's participation in maternal health care is a core element to improve women's access to antenatal, intrapartum, and postnatal services. However, Pakistan's patriarchal family structure has imposed long-term limitations on the development of local maternal health care. This qualitative study was conducted in low-income communities in Chiniot, Punjab Province, using purposive sampling and involving 20 husbands, 20 wives, and 5 healthcare workers. Data were collected through in-depth interviews and focus groups, and inductive thematic analysis was used to explore participants' perceptions and negotiation processes. The findings indicate that male participation in maternal health affairs exists but is characterized by clear selectivity. Men commonly provide financial support, transportation, medication purchases, and emergency assistance, yet rarely accompany pregnant partners to antenatal care appointments, offer emotional support, or share household chores. Maternal health care is widely regarded as a female responsibility, with men expected primarily to fulfill the roles of financial provider and decision-maker. Women's experiences of male involvement were mixed; some appreciated the support received from their husbands, while many reported discomfort with male presence due to modesty norms, privacy concerns, and fear of social judgement. Maternal-healthcare utilisation was further constrained by poor roads, transport costs, long distances, limited public services, and negative experiences with healthcare providers. The study concludes that encouraging men to attend health facilities with women alone is insufficient. Interventions should promote joint decision making, women's autonomy, dignity and respect during maternity care, gender-sensitive counselling by trained personnel, and improved access to maternal-health services while respecting women's privacy and their right to make free and independent healthcare choices.*

Keywords: Male Involvement, Maternal Healthcare, Antenatal Care, Gender Norms, Women's Autonomy, Qualitative Research, Pakistan

Introduction

Maternal health still constitutes a serious problem for the public-health and social-development agendas of many low- and middle-income countries. While provision of maternal-healthcare services has become more extensive worldwide, the accessibility of antenatal care, skilled delivery, emergency obstetric care, and postnatal care is still affected by such factors as poverty, gender inequality, geographical distance, and intra-household decision-making processes (Tayal et al., 2026). In Pakistan, maternal health is not only an individual but also a familial issue influenced by culture, women's mobility, finances, and health-care service provision (Agha et al., 2026).

While pregnancy and childbearing are traditionally considered women's responsibilities, women might not be able to make their own decisions regarding the timing of access to healthcare services (Huang, 2026). It is possible that husbands, mothers-in-law, and other elder members of the family may have an impact on transport arrangements, costs of services, type of treatment, location of birth, and timing of service seeking (Brown et al., 2026).

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The participation of males in maternal healthcare is defined as male involvement in the processes of decision-making, provision of emotional support, financial preparation, transportation, housework, attendance of antenatal appointments, and providing support during the labor process and postpartum care (Schuler, 2026). Studies have shown that male support can contribute to the use of maternal healthcare services and ensure timely access to health care facilities. Nevertheless, it is not to be considered as men's right to take control over the reproductive life of women. Male involvement should enhance women's rights to autonomy, dignity, confidentiality, and informed decision-making (Laurenzi, 2026).

In rural and poor areas of Pakistan, patriarchal gender roles define men as providers and decision-makers, while women are responsible for handling pregnancy, birth, childrearing, and housekeeping duties (Shah et al., 2026). In addition, patriarchal gender norms restrict men's active involvement in maternal healthcare services because men perceive antenatal visits and childbearing as women's affairs, while women do not feel comfortable talking about reproductive issues in front of their husbands (Bertola et al., 2026). Furthermore, health institutions are not ready to work with men by offering them counseling, confidential conversations, and male-targeted educational programs (Akule et al., 2026).

Even though male involvement is important, there have been few qualitative studies focusing on the ways that husbands, wives, and health care workers negotiate their roles in poor communities in Chiniot. In this study, I will focus on the kinds of male involvement in maternal health care, gender norms of involvement, and structural barriers to access.

Research Questions

1. What roles do husbands play in maternal health care services during pregnancy, delivery, and the postnatal period?
2. How do women and healthcare providers view the participation of husbands in maternal healthcare services?
3. Which gender roles and social structures affect male participation in maternal healthcare services?
4. What could possibly facilitate male participation in maternal health care?

Research Objectives

- To investigate the manner in which husbands take part in maternal healthcare.
- To investigate how women perceive spousal support for them throughout their pregnancy and birth processes.
- To investigate how gender norms affect men's participation in maternal healthcare.
- To investigate barriers within social and economic systems that hinder male participation in maternal healthcare.
- To develop gender-sensitive approaches for increasing male participation in maternal healthcare.

Literature Review

Conceptualising Male Involvement in Maternal Healthcare

Male involvement in maternal health is the engagement of men in the process of pregnancy, delivery, and after-delivery care. Male involvement includes preparations of finances, providing emotional support, transportation, communication with the healthcare professionals, decision-making, help in household chores, and encouragement of women's use of health services (Aline, Nsereko, Jewett, Levin, & Pillay, 2026). According to Abate, Duhn, Wilson, & Camargo-Plazas (2026), the involvement of males in the health sector should go beyond just attending health institutions.

Supportive male engagement has been found to positively impact maternal health service utilization and antenatal care attendance, as well as skilled birth attendance in various contexts. According to Baykemagn et al. (2026), male involvement may contribute to better maternal health outcomes due to more support for

seeking healthcare and birth preparation. Nevertheless, male involvement is differently interpreted and implemented depending on cultural context (Zahra et al., 2026).

Gender Norms, Masculinity, and Women's Autonomy

Maternal-healthcare activities are influenced by gender norms. In patriarchal societies, men may be responsible for financial management, mobility and important decisions regarding health. Women would be expected to take on domestic responsibilities and be involved in reproductive functions (Onnoghen, 2026). On the other hand, men could be socially expected to uphold the traditional masculinity that is associated with them. Activities such as helping out in domestic chores, attendance in antenatal clinics, and talking about reproductive health could be seen as improper and shameful for men (Schmitz et al., 2026). They might therefore shy away from engaging in maternal-healthcare-related activities despite the willingness to assist their partners.

It is therefore crucial to understand the role of women's autonomy in any discussion of male involvement (Nasri et al., 2026). Male involvement may be positive if it assists in enabling women to use maternal-health facilities, reduce the workload at home, and facilitate informed decision-making (Semahegn et al., 2026). However, it may become detrimental if it leads to male dominance in matters to do with women's bodies, health choices, and mobility (Nwosu et al., 2026).

Male Involvement and Antenatal-Care Utilisation

The importance of antenatal care includes monitoring pregnancies, detecting problems, giving nutritional advice, preparing for childbirth, and referring women to skilled birth attendance (Ridoy et al., 2026). But women's utilization of antenatal care might be affected by insufficient knowledge, problems with transport, financial problems, family disapproval, and inadequate quality of health care service (Strahl et al., 2026).

Men might affect the use of antenatal care through their involvement in providing funds, organizing transportation, accompanying women to clinics, and assisting women in decision-making (Baykemag et al., 2026). But research done in South Asia and Africa reveals that men are left out in maternal health education and may not know anything about the importance and need for antenatal care (Seraj et al., 2026). This might mean that pregnancy might just be taken for granted until there are problems with it.

Maternal Healthcare in Pakistan

Maternal health-care utilization among Pakistani women has been found to be influenced by inequalities based on socioeconomic status, being rural, low levels of education, lack of transportation, and differential control over decision-making in households (Ali et al., 2026). In some cases, women may need permission from their husbands or other significant individuals in the family to go to health-care institutions (Koivumäki et al., 2026). The mothers-in-law may also be an influential individual when it comes to pregnancy-related decisions, such as dietary intake, workloads, place of delivery, and the type of care used. Studies show that men often provide money but do not necessarily know much about maternal health-care needs (Gadapani Pathak et al., 2026).

Research Gap

It is well known from existing literature that male participation influences maternal health service utilization. However, not many studies have analyzed how male participation is negotiated in households on a daily basis among low-income neighborhoods in Chiniot. It is for this reason that the current study attempts to fill the gap in existing literature through the comparison of views held by husbands, wives, and health professionals.

Methodology

Study Design

In this study, a qualitative design was applied in order to investigate the experience and perception that the participants had regarding the involvement of males in maternal health care services. This is because of the need to understand how gender relations, family expectations, and structures influence maternal health care practices.

Study Setting

The research was carried out in poor rural areas in the Chiniot district of Punjab, Pakistan. The poor rural areas had characteristics such as low income levels, lack of transport, poor infrastructure, and utilization of public and private health facilities. Decisions regarding maternal health care were made by the husbands, mothers-in-law, and extended families.

Participants and Sampling

Purposive sampling was used to recruit participants with direct experience of maternal healthcare. The study included 45 participants:

- 20 husbands
- 20 wives
- 5 healthcare workers

Both husbands and wives had to come from families that had been recently involved in pregnancy, childbirth, antenatal or postnatal care. The healthcare providers were chosen because they had hands-on experience working in maternal healthcare settings.

The aim was to make sure that there was variance within the sample regarding age, family type, experience of maternal healthcare and involvement in the healthcare process. The data collection process went on until thematic saturation was achieved.

Data Collection

Data collection was carried out using in-depth interviews and focus group discussions. Interviews were conducted with both the husband and the wife separately to ensure that each one could voice his/her opinion freely and without the fear of providing socially desirable answers. Interview guides for husbands comprised 17 questions while those for wives comprised 10 questions.

The data collection process started with the conduct of a pilot study that involved two couples to fine-tune the interview questions. All interviews were conducted in Urdu as it was the language most comfortable for the participants. Each interview took around 30 to 40 minutes. With the permission of participants, all interviews were audio-taped and later transcribed.

Data Analysis

The data were analyzed using an inductive thematic analysis method. Using such an approach made it possible for themes to arise from the participants' experiences and not to be forced on predetermined categories. Inductive thematic analysis was conducted following the procedure proposed by (Guest et al., 2011).

The researchers read and re-read the transcripts in Urdu to gain an understanding of participants' experiences and language. Pertinent parts of the transcript were then coded according to the codes associated with awareness about antenatal care, finances, transportation, decision making, emotional support, domestic chores, cultural stigma, privacy, and systemic barriers within the health system.

These codes were later grouped into more general themes, which were refined and organized in such a way as to respond to research questions. The resulting themes captured both supportive and restrictive aspects of male participation in maternal healthcare.

Ethical Considerations

The research was carried out following ethical considerations such as voluntary participation, informed consent, confidentiality, privacy, and respect. All the participants were made aware of the aims of the study and that they had the freedom to withdraw from the study at any point. The names and any other identifying details of the participants were stripped away from any quotations and transcripts.

Findings

These themes included pregnancy as a woman's responsibility, husbands as providers rather than partners in caregiving, lack of male knowledge on antenatal care, emergence of negotiations on shared responsibilities, and structural constraints on access to maternal healthcare services.

Pregnancy as a Women's Responsibility

The participants often viewed pregnancy and childbirth as something that belonged more to women. Women were supposed to handle all the problems like physical pain, domestic chores, childcare and healthcare services, while the relatives, mostly the mother-in-law, advised and supported them.

The women understood the need for antenatal care when they experienced any weakness or other physical problems related to pregnancy. Still, they had little information about the timing of antenatal visits. For example, one of the women noted: *"When we are pregnant, we feel weakness. Therefore, during this time we should visit the healthcare facilities for checking up our bodies."* The women made their healthcare decisions based on the advice of their husbands, mothers-in-law and healthcare providers. Thus, we can say that maternal-healthcare decisions were not made only by women themselves but were also influenced by family relationships.

The male participants often regarded pregnancy as a usual process that does not demand special attention. For example, one husband said: *"Other than delivery, nothing else is going on regarding pregnancy."*

Husbands as Financial Providers Rather Than Care Partners

In most instances, instrumental help was the main kind of participation. In such cases, men contributed financially towards consultations, medicine, laboratory costs, transport costs, and birth costs. Furthermore, men organized transport when there was an emergency, and it became their mandate to choose between public and private healthcare facilities.

Financial assistance was a significant role played by men when women were pregnant. Men had an understanding that their major role was contributing financially without taking part in any healthcare consultations, house chores, or caring for their wives emotionally.

In emergencies, the presence of men became very significant since men organized transport, called relatives, arranged funds, and even decided whether to take their wives for consultation at public or private healthcare facilities. However, this was one of the ways in which inequality was evident in terms of resource distribution in households.

Most participants stated that private healthcare facilities were favored since they offered better services, skilled workers, and good equipment. However, it became financially draining. Some people ended up borrowing money or selling some things in order to cater for pregnancy and delivery costs.

Limited Knowledge and Passive Participation in Antenatal Care

Even though some husbands supported their wives in attending antenatal-care services, their participation was very passive. Husbands lacked knowledge concerning antenatal care, the importance of checking up during pregnancy, maternal nutrition, danger signs during pregnancy, and preparation for delivery.

Some men believed that antenatal care was important only when a woman had complications. Other men viewed antenatal care as pregnancy care, which was mostly associated with delivery and not during the pregnancy period.

Traditional beliefs also prevented the men from participating in antenatal care areas. For instance, some men viewed maternal health care as a women's issue and visiting women at health facilities as culturally unacceptable. This was illustrated by one of the male participants who said, *"It is not our culture but Western culture."* Even though men were accompanying their wives to the health facilities, they stayed outside the clinic. Therefore, their involvement in antenatal care was symbolic but not active. The men did not participate in consultations between the women and healthcare workers.

Women's Mixed Perceptions of Male Involvement

The attitudes of the women regarding male involvement varied. While some of the women appreciated husbands for their contribution in terms of finances, consideration, transport services, and assurance, other women found themselves uncomfortable with the presence of their husbands during the examination or delivery processes.

Feelings of shyness, modesty, privacy, and fear of being judged socially were frequently expressed. As was said by one of the healthcare providers: *"Most women feel shy with their husbands. They think about how others would see them."*

These results imply that women's wishes should not be overlooked in attempts to engage men in maternal health care practices. Involvement of the male partners should depend on the permission and comfort of the women.

Gendered Domestic Responsibilities and Emerging Change

Pregnant women continued to engage in both domestic and, in some cases, agricultural activities. In many cases, economic compulsion and tradition dictated that women reduce their activity level. Men did not take part in any household chores because household chores were regarded as women's duties. *"I can't help in household chores. It is shaming me,"* said one husband.

It illustrates how men felt pressured to live up to the traditional roles of men. The participation of men in cooking, cleaning, child-rearing, and even agriculture could be seen as a threat to the identity of men.

However, there were also examples of attitude change observed in the study. Some men treated pregnancy as a joint experience and were concerned about the well-being of their wives. One man said: *"Pregnancy gives me a chance to be together with my wife."* Emotions of men toward their pregnant wives were shown indirectly through fear, praying, worrying, and returning home earlier from work to be with wives during pregnancy. *"I was scared while working and was eager to get home to my wife,"* said one husband. Although emotional support was much less obvious than financial support, it was an area where male involvement started to emerge.

Structural Barriers to Maternal-Healthcare Access

Physical barriers impacted both the women's ability to access medical services and the men's capacity to assist them. The participants mentioned that factors such as distant location of the health centers, bad roads, expensive transport services, long waits at the centers, inadequate services available, and bad experiences with the health service providers contributed to their difficulty accessing services.

Transport played a key role in cases of emergencies where bad roads and inadequate transport caused delays and often led to resorting to deliveries at home. *"Everything depends on transport. Bad roads hinder everything,"* one participant said. Other complaints included problems such as overcrowding, bad service from the public health facilities, and corrupt practices.

Discussion

The results of the study clearly indicate that the male involvement in maternal healthcare in low-income societies of Chiniot is partial, contingent, and heavily influenced by gender roles. The husbands' participation in maternal healthcare was not absent but limited to socially acceptable activities for men such as financing, transport, decisions in case of emergency, and interactions with health institutions.

These results are consistent with earlier findings according to which men are more inclined to act as providers, whereas their involvement in antenatal consultations, emotional support, domestic tasks, and reproductive-health talks is lower. These tendencies are associated with a gender-based division of responsibilities according to which women should control their pregnancy and childbirth and men finance these processes and make decisions.

The results of the study indicate that the measure of male involvement cannot be reduced to their presence at antenatal care. Some men supported their wives by providing transportation, financial preparedness, medicines, and concern during emergencies. Nevertheless, more active participation of males is needed and involves several factors including awareness of antenatal care, decision-making, reduction of women's household workload, and respect for women's needs (Heugh, Peter, Jackline, & Ramecca, 2026).

Mixed views from women are particularly noteworthy. While some women liked it when husbands helped, others felt that it was inappropriate for men to be there during clinical visits and childbirth. Thus, the interventions should not force men to get involved without considering issues of women's privacy and social dynamics.

In addition, the study reveals how gender roles interplay with structural factors. Supportive husbands may have problems getting access to the transportation service, bad roads, health facilities far away and crowded public facilities. Hence, raising awareness among men is not enough. The intervention has to consider household gender relations and health facility access at the same time.

Thus, the program should take a gender-transformative approach. A gender-transformative approach implies encouraging men to respect women's rights, to do domestic work, to get ready for birth, to discuss maternal health needs, etc. The program will also require the involvement of mothers-in-law and other influential family members.

Recommendations

Based on the findings, the following recommendations are proposed:

1. **Initiate Couple-Oriented Antenatal Counseling Programs:** Health-care providers must initiate voluntary counseling programs for husbands and wives about antenatal care, danger signs, maternal nutrition, birthing preparations, and postpartum care.
2. **Designing Community-based Male Awareness Programs:** Programs educating men about maternal healthcare must be designed through community gatherings, workplaces, local leaders, mosques, and social welfare programs so that those men who do not visit health centers may be reached.
3. **Maintaining Women's Independence and Privacy:** In male involvement programs, women must be provided the right to receive maternal healthcare services independently.
4. **Mothers-in-law and Relatives' Participation:** In most cases, senior women play an important role in deciding on maternal health care; therefore, awareness programs must also involve mothers-in-law and other relatives.

5. **Promote Collective Domestic Responsibilities:** Interventions must challenge the idea that chores are the responsibility of women only, especially when pregnant.
6. **Enhance Transport and Referral System:** The local health administration should ensure that an effective transport and referral system is established for poor and distant women.
7. **Improve Respectful Maternity Care:** Healthcare professionals should be trained in how to communicate respectfully and without discrimination and in a gender-sensitive way.
8. **Maternal Healthcare Information:** Information regarding maternal healthcare should include the significance of antenatal care, proper nutrition, danger signs, institutional delivery, and postnatal care in simple Urdu language.

Conclusion

However, there are not many efforts made by men to engage in their wife's maternal healthcare process, but the trend is slowly changing. Men can offer support in terms of finance and logistics, especially when dealing with emergencies, but their participation in antenatal care sessions, offering emotional support, doing household chores and making reproductive decisions together is quite limited.

From this study, it is clear that gender norms have an impact on how maternal healthcare practices are carried out, since women are supposed to take responsibility for the physical, emotional and housework burdens associated with pregnancy, and men should only be seen as providers and decision-makers. However, men have started to realize that pregnancy is a joint effort and have become emotionally attached to their wives.

In order to increase male involvement, it is important to come up with a gender sensitive approach that encourages women's independence, joint household responsibility, respectful communication, men's knowledge about antenatal care and availability of maternal healthcare services.

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