

RESEARCH ARTICLE

Editorial Process: Submission:02/01/2018 Acceptance:05/25/2018

Muslim Husbands' Roles in Women's Health and Cancer: The Perspectives of Muslim Women in Indonesia

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Abstract

Background: Breast and cervical cancers are the most common cause of cancer death among women in the world. These cancers are detectable early, however only a few women participate in cancer screening especially in developing countries, including Indonesia. Family, culture and religion can influence why women have screening. Husbands, in Muslim families have a significant role in the family's health including their wife's reproductive health. However, information about Muslim husbands' roles in wife's health especially cancer is limited. **Objective:** The purpose of this study was to determine Muslim husband's roles in women's health and cancer from the perspectives of Muslim women. **Methods:** This study was a qualitative study using a descriptive exploratory approach. Purposive sampling was used to recruit 20 Muslim women, 10 from urban areas and 10 from rural areas of West Java Province, Indonesia. Women were interviewed using a semi-structured interview schedule. Data from the interviews were analyzed using the Comparative Analysis for Interview technique. **Results:** The study found two main themes emerged from the analysis: Muslim husbands' extensive roles in promoting women's health and Husbands' have limited actions with regard to cancer screening. This study also found similarities between rural and urban women's opinions that in general husbands actively supported promoting women's health. **Conclusion:** Muslim husbands focused on encouraging women to have healthy lifestyles, however, a lack of support from husbands related to cancer screening. This behaviour could be a hindrance to Muslim women's participation in prevention and the early detection of cancer. There is a need to improve Muslim husbands' awareness in women's cancer.

Keywords: Muslim husbands' roles- perspectives- women's health and cancer

Asian Pac J Cancer Prev, 19 (6), 1703-1709

Introduction

Breast and cervical cancers are the most common cancers related to women's reproductive health and contribute to women's mortality in the world. Many women, especially those in Asian countries such as India, Oman, and Nepal lack awareness of reproductive health (Al Khasawaneh et al., 2015; Ranjit et al., 2016; Vinita and Rajendran, 2007) and of breast and cervical cancer screening. Lack of awareness can influence women's participation in cancer screening (Majidi et al., 2017; Mukemet et al., 2015). Given that some women's cancers are preventable and others are treatable if diagnosed early, understanding what influences women's decision making to participate in cancer screening is important.

Women's participation in cancer screening and treatment in Indonesia is low (Anwar et al., 2018; Ekanita, 2013; Kim et al., 2012; Lantu and Saraswati, 2013; Putri, 2011). Anwar et al., (2017) surveyed 5397 women in Indonesia aged 40 and older without a history of cancer regarding their awareness of cancer screening

(Pap smears and mammography) and their cancer screening activities. The study found that only 1058 (20%) of the women were aware of Pap smears, of which 297 had never had the procedure, and only 251 (5%) respondents were aware of mammography. Factors that influenced screening uptake included higher educational achievement and higher family income. Other factors known to influence women participating in screening and treatment of breast and cervical cancer in Indonesia are family, especially husbands, and social culture (Anggraeni and Benedikta, 2016; Arkiang, 2016; Kim et al., 2012; Marlina, 2015; Musyriqoh, 2013).

The majority (87.1%) of the Indonesian population (252,200,000 people) follow Islam (Suryanto, 2013). Women's health behaviour can also be influenced by religion/spirituality (Allen et al., 2014; Benjaminset al., 2011; Carreno et al., 2006). Religion also impacts on husband wife relationships. From an Islamic perspective, a Muslim husband has many obligations as the head of the family including: treating his wife with kindness, honour, patience, equitably, respecting her feelings, helping with

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the households tasks and taking care of the children; fulfilling her material and non-material needs; and collaborating in family decisions (Departemen Agama, 2009; Ibrahim and Songwathana, 2009). In addition, the relationship between a husband and wife in Islam is very close, as noted in the Holy Quran, surah Al Baqarah verse 187: You are garment to them, and they are a garment for you. This means that both a man and a woman in a Muslim family can influence each other including health aspect. To date, little is known in Indonesia about Muslim husbands' roles in women's health and cancer.

This paper reports on the findings of a study that explored Muslim women's perspectives of their Muslim husbands' roles in their health and cancer. This study is part of a larger study that explored Muslim husbands' roles in women's health and cancer from the perspective of husbands, wives and health professionals (Widiasih, 2017).

Materials and Methods

Research Design

This study used a qualitative description exploratory approach. The goal of qualitative description is to generate a summarisation of everyday events experienced by individuals or groups of individuals (Sandelowski, 2000). An exploratory study begins with a phenomenon about which little is known; and the methods are designed to explore the nature of the phenomenon, manifestations, factors that are related, and factors that led or contribute to it (Polit and Beck, 2014). Ethics approval was obtained from the Human Ethics Committee of Victoria University of Wellington, New Zealand. Key ethical issues addressed were confidentiality, autonomy, and safety. In Indonesia, this study obtained a site permission letter from the National and Political Unity Board (BKBP), an institution that has legalisation to give permission to researchers to approach the community.

Setting and Participants

The research setting was the West Java Province of Indonesia where 97% of the citizens are Muslim. Participants were recruited using the purposive sampling method. Recruitment was aided by community leaders who recommended women in their area to participate in the study. Women were recruited from urban districts of Bandung (the capital city of West Java province) and rurally from the Pangandaran district. The inclusion criteria were that women had to be married, Muslim, and aged between 20 and 60. Participation was voluntary. Twenty women, 10 from urban areas, and 10 from rural areas consented to participate in the research.

Data Collection and Analysis

The data were gathered using semi-structured interviews with married Muslim women. An interview is an effective method to explore human's behaviour (Carter, Bryant-Lukosius, DiCenso, Blythe, and Neville, 2014). Data collected included the participants filling in a social demographic survey. The interviews were guided by a schedule that was developed from the Health Belief Model (Duran, 2011) and the Help Seeking Behaviour

and Influencing Factors Framework (O'Mahony and Hegarty, 2009). Open-ended questioning was used to explore the married Muslim women's perspectives about husbands' roles. Questions explored women's perceptions about their husbands' actions and behaviour in their health, and their husbands' roles related to preventing cancer and their participation in screening. The duration of the audio-taped interviews ranged from 30-60 minutes. Following transcription, the data were analysed using the comparative analysis for interview (CAI) technique for the descriptive exploratory study. 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.

Trustworthiness of this study

This study applied five criteria for developing trustworthiness: credibility, dependability, confirmability, and authenticity (Polit and Beck, 2014). To achieve credibility, the interview was recorded, and following theme development extracts of quotes were obtained as evidence for the theme. Dependability and confirmability were achieved using audit trails and the semi-structured interview guide ensured that all women were asked questions on similar topics. Authenticity was addressed by the recruitment of an adequate sample size. Transferability of these findings is determined by the reader. It is supported by having sufficient description of the research

Results

Characteristics of participants

Table 1 presents the characteristics of the women participants. The majority of participants were housewives. The older group (> 41) had been married for an average of 27.8 years (range 11-38), and the younger group (\leq 40) an average of 14.2 years (range 6-22). One participant from the urban area had uteri cancer in 2013, another participant from the rural area had had lymphatic cancer since 2010. Five participants had family members with breast, cervical and brain cancer. The rural participants had fewer children (1-2 children) than the urban participants (2-3 children). Participants' highest education level ranged from elementary school to university. Urban participants were from middle income (n=5) or low income areas (n=5). The women were either Javanese (n=8) or Sundanese (n=12).

Two main themes emerged from the analysis: Muslim husbands' extensive roles in promoting women's health and Husbands' have limited actions with regard to cancer screening.

Muslim husbands' extensive roles in promoting women's health

Participants from rural and urban areas shared that husbands have a prominent role in promoting women's health. However, in regards to cancer prevention such as the HPV vaccination, none of participants talked about it; however, they reported their husbands support in preventing diseases such as diabetic and vaginal bleeding

Table 1. Characteristics of Married Women Participants

No	Group	Age	Child No	Years Married	History Cancer	Friends with Cancer	History Family Cancer	Education	Occupation
1	R1	> 41	2	34	No	Yes	No	SHS	Housewife
2	R2	> 41	2	31	No	Yes	No	ES	Housewife
3	R3	≤ 40	1	6	No	Yes	No	SHS	Housewife
4	R4	≤ 40	1	22	No	Yes	No	SHS	Housewife
5	R5	≤ 40	2	17	No	Yes	No	JHS	Housewife
6	R6	≤ 40	2	20	Yes	Yes	No	SHS	Housewife
7	R7	> 41	2	11	No	Yes	Yes	UN	Government Officer
8	R8	> 41	1	35	No	Yes	No	ES	Housewife
9	R9	> 41	2	38	No	Yes	No	SHS	Employee
10	R10	≤ 40	2	19	No	Yes	No	UN	Employee
11	U1	≤ 40	2	13	No	Yes	No	JHS	Housewife
12	U2	≤ 40	3	8	No	Yes	No	UN	Housewife
13	U3	≤ 40	1	6	No	Yes	No	SHS	Housewife
14	U4	> 41	2	27	No	Yes	No	JHS	Housewife
15	U5	> 41	3	31	No	Yes	Yes	SHS	Housewife
16	U6	> 41	2	24	No	Yes	Yes	UN	Housewife
17	U7	≤ 40	2	17	No	Yes	No	JHS	Housewife
18	U8	> 41	2	31	No	Yes	No	SHS	Housewife
19	U9	≤ 40	3	15	No	Yes	Yes	SHS	Housewife
20	U10	> 41	3	27	Yes	Yes	Yes	UN	Business woman

R, Rural; U, Urban; ES, Elementary School; JHS, Junior High School; SHS, Senior High School; UN, University.

based on women's illness history. Husbands roles in promoting health included supporting women by giving women time, encouraging a healthy diet, participating in family planning, and supporting women's emotional wellbeing.

Providing time for women's personal and social activities

Women from urban and rural areas shared information about their personal activities and social activities that were supported by their husbands. Personal activities referred to activities the women could do independently. Some women shared how their husband encouraged them to be active and would sometimes accompany them when they went outside to refresh their minds from the daily activities at home. For example, one husband encouraged their wife to do morning activities, "Mah [calling his wife] you should do like this, jogging, and avoid too much sleep in the morning" (WU5). In contrast, an urban women who has a history of cancer, shared that her husband reminded her to control her daily activities at work or at home. "Honestly, my husband is fussy about my activities, because I am a workaholic since young, he always says, please don't be too tired, take a rest please" (WU10). Husbands actively support women's personal activities such as vacation, sport, house tasks, and daily activities as part of maintaining their wives' health. While the participants themselves had positive experiences, some were aware that their women friends could not attend any health or social activities because their husband would not allow it.

In terms of women's activities in the community, women said that their husbands supported them to join social activities such as a health Cadre:

Alhamdulillah [thanks God], he had positive

responses. For example, I attended a full day of the family planning workshop. He supported me. I knew other women sometimes experience difficulties getting permission from their husbands to join any activities, but it did not happen to me. (WR3)

The woman with lymphatic cancer had the same experience. She shared that because of her health problem, sometimes her mood and physical condition fluctuated; thus, her husband encourages her to meet her friends or attend a women's forum such as a religion weekly gathering. At the forum, women meet friends and talk about everything including their knowledge of religion, health problems, and sometimes food management. Being involved in community activities was reported more often by women from rural areas.

Reminding women of the importance of nutritious food

Women described that their husbands are very concerned about healthy food for the family. They provide multi vitamins to maintain women's health, and remind them about unhealthy habits, "Please don't eat spicy food, it's not good for your digestion health, and no smoking please, I am a smoker since young" (WU9). Similarly, another urban woman said that husbands reminded them about nutrition and selected food for them and their children; "My husband got information from his Chinese boss that young girls should eat vegetables and drink milk to prevent women's diseases, this he suggested to me and my daughter" (WU7).

Husbands not only reminded women about healthy food but they also provided money to buy the food. "My husband covers family's monthly expanses including food" (WR4). In addition, some women from both urban and rural areas shared that their husbands advise them to drink

Jamu regularly [traditional drinks that people believe have a good effect when women drink it]. “Mah [calling his wife] you have not drunk Jamu for a long time right? Let’s go to the Jamu shop” (WR10). The husbands believed consuming herbal drinks would not only make the women’s body fit, but would also prevent some disease. The rural woman with a history of Myoma uteri explained that her husband believed the herbal drink prevented the recurrence of her disease so he provided many types of leaves for his wife and then asked his wife to cook them.

Participating in the Family Planning programme

The participation of Muslim husbands in the family planning programme was reported by participants. A cadre from a rural village said that she knew many men who participate in the family planning programme “I know there are men’s contraception methods and some men in the Pamarican area joined a free vasectomy program from the BKKBN [National Population and Family Planning Board]” (WR9). In addition, urban men participated to maintain women’s health, and some couples had regular medical check-ups as a couple.

He provided health insurance for us, all family members, we have two health insurance from two different insurance companies, private companies, not from the government, my husband and I do annual medical check-ups at an International hospital in Bandung. (WU6)

Providing psychological support

Rural and urban women reported psychological support from their husbands. A rural woman shared that her husband actively supported her when she faced a problem in her workplace. He provided feedback related to my job, “I talked to him about everything, mostly about family or the children’s school, like this or that” (WR10). Another rural woman reported that she talked about anything related to her health, especially about reproductive health. “As a couple, we are very open, we shared anything, especially me, when I had a health problem I talked to him first, for example pain, contraception, and vaginal discharge” (WR6). The woman with a history of uteri cancer reported her husband’s concern to prevent a recurrence of her disease.

I still take the medicines regularly since the uterine surgery. Sometimes I felt sick of taking the medicine and when it runs out I do not tell my husband. One day my condition deteriorated and he noticed there was no medicine. After that experience he always controls my stock of medicines. (WU10)

His support motivated her to keep healthy.

Limited of husbands’ actions with regard to cancer screening

Although husbands have a number of roles in promoting women’s health, only five participants, all from urban areas, reported their husbands had ever shown concern about early detection of cancer. The husbands’ actions included providing money or insurance, accompany women, or advising the women to have screening. The five women had all received advice

from their husbands about go for cancer screening. One woman shared “I had experience with abnormal vaginal discharge, Pak [her husband] what do you think? [I asked my husband] I have vaginal discharge often, ah...Mah [his wife] please go for Pap smear” (WU7). This woman followed the advice. Two other women expressed regret for not listening to their husbands. An urban woman whose husband works in a pharmacy company shared that her husband encouraged her to have early cancer detection tests but she did not immediately do as her husband suggested. Similar behaviour was reported by an urban woman who was later diagnosed with cancer;

My husband said please go to the doctor immediately. I answered aah. this is only a mild symptom don’t worry. Maybe if I had followed his advice and had gone to the health service, my condition would not be as bad as it is today. (WU10)

The data highlight the similarities between rural and urban women’s opinions related to men’s actions in promoting women’s health. Husbands actively support and encourage women to have healthy lifestyles. However, they are less active and give less advice regarding early detection of women’s cancer especially in rural areas. None of the women shared experiences about preventing cancer via the Human Papilloma Virus vaccine, and other cancer screening methods including mammograms or the Visual Inspection with Acetic acid test.

Discussion

The findings revealed the extensive Muslim husbands’ roles in promoting women’s health generally; however, the husbands’ actions related to prevention and early detection of women’s cancer were limited or absent. Husbands paid attention to women’s activities as individual or community members. Those activities had positive advantages for women such as making friends and sharing health knowledge with others. These findings are consistent with a study of Taiwan women who reported that joining social activities in the community increased their health knowledge that useful for their life for example attending a health education programme (Yang et al., 2015). Husbands actions of limiting outside activities or overly control all woman’s activities can restrict women’s activities and roles in community (Mainuddin et al., 2015; Qureshi and Shaikh, 2007).

The finding that husbands provided money and were concerned about nutrition and healthy food for their family, is in contrast to a qualitative study of the eating behaviours of Chilean women. Galvez et al., (2015) found that their husbands control the choice and purchase of food and many prefer fatty foods which are detrimental to the health of all in the family. The difference in findings, indicates there may be different understandings about health and nutrition. In Indonesia, Muslim husbands commonly provide money for the family’s needs or purchase goods including food, and wives manage the menu and do the cooking. Providing advice about healthy food is evidence of husbands following Islamic teaching. The Holy Quran, surah An Nisa verse 34 states that Muslim men are the protectors of women, and responsible

for earning livelihood for the family.

Husbands involvement in and support for family planning is in line with other studies that found the extensive roles of men in family planning (Ijadunola et al., 2010; MacDonald et al., 2013; Orjiet al., 2007). Their involvement is evidence that the family planning programme in Indonesia is achieving the success. Examining the attributes of this programme may be useful for influencing the uptake of cancer prevention programmes. In contrast to Indonesia, a study in Kenya found that husbands do not understand their family planning responsibilities because culturally men consider these are women's responsibilities (Onyango et al., 2010). Studies in the US have found that while the majority of men and women believe in gender-equality in making health decisions, women are the decision makers (Grady et al., 1996). Husbands' support for family planning has the potential to enhance women's and children's health.

The finding that only a quarter of women discussed HPV vaccine may reflect that the HPV vaccine is a relative new compared to other vaccines that are part of the Indonesian government immunisation programmes. In Indonesia, this vaccine is available mainly in private hospitals or clinics, and there are no subsidies from the government, it is expensive for Indonesian (\$200 - \$400 NZD). In contrast in New Zealand, this vaccine is free for teenagers as part of the country's health programmes. Parents are required to give consents for such programmes, and the consent process means they receive information about such vaccinations. It is not known if the Indonesian Government will make this vaccine mandatory. In the meantime it is likely that only those with health insurance will learn about it.

Results from this study indicated that urban women received support from their husband's for cancer screening. This was especially among the middle income and highly educated women. These results are in line with an study studies that found better family income and education influence men's awareness of cancer screening (Witharana et al., 2015). While the majority of rural women and urban women from down town areas had less support from their husbands related to cancer screening. This finding is linked to a study investigated Latino males which found that the majority of the males had little knowledge about cancer and were unfamiliar with screening (Trevino et al., 2012). Even though no study has clearly explained the relationship between factors motivating women to have cancer screening and cancer experience. A study among nurses from Singapore, who attended cancer screening, found that a motivating factor for them to have screening was their previous experience with cancer and screening (Tay et al., 2015).

Women however have also been found to sometime reject men's advice for screening because they think their symptoms are only a minor health issue, or they consider that you need to have symptoms to be tested. This finding shows a similar trend to Taha et al., (2012) study which found that 64 women (aged 20 to 65 years) who involved in the study did not carry out Breast Self-Examination or seek mammograms because they did not feel any symptoms and they feel safe from breast cancer. The finding that

some women from urban areas with middle incomes had Pap smears sometimes because of the support and encouragement from their spouses is not new (Baheiraei et al., 2013; Keating et al., 2011; Taha et al., 2012; Thiel et al., 2009).

It is however of concern that some women who participated in this research did not participate in cancer screening, and only a few women from rural areas had had Pap smears. Factors in addition to a lack of influence by husbands that may have influenced this behaviour concern information, accessibility to health services, health services facilities, and income. Such factors influence men and women similarly. There is a need for more research to better understand barriers put in place by Muslim husbands' regarding cancer screening.

Limitation and implication

The sample in this study was 20 Muslim women from West Java province. Thus, this sample does not represent the millions of Muslim women in West Java or other regions in Indonesia as the sample only came from two districts of the West Java province. There is a possibility that Muslim women from other districts or other regions in Indonesia have different perspectives of Muslim husbands' roles in women's health and cancer as Indonesia is a multicultural country. However, this study does provide insights into Javanese and Sundanese Muslim husbands' roles in women's health and cancer, the two largest tribes in Java Island. This study will be useful for nurses and the Indonesian government especially the Ministry of Health, as the study highlights it is important that information is provided about husbands and men's roles in encouraging and supporting women to participate in cancer screening.

Conclusion and recommendations

Husbands' participation in women's health varies, but mainly concerns promoting women's health. Women from urban areas received more support from husbands than women from rural areas especially related to cancer screening. It is likely urban husbands had better understanding with regard to their roles in cancer screening. Husbands' actions to women's health may influenced by many factors including their health knowledge, beliefs, experience and the health information. Even though husbands' support is not the only factor that influences women's participation in cancer screening, improving married Muslim men's knowledge would increase their awareness of the importance of women accessing screening. To address the husbands' awareness of women's cancer, there is a need to develop health information programmes that are targeting husbands as well as women.

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