Introductions

During the last three decades, in Malaysia, there have been progressive changes taking place in the delivery of maternity services. There has been a rapid transformation of traditionally orientated maternity care, to western maternity care, using western-trained health care providers. The (new) westernised maternity care system focuses on women bodies but not their minds. Little or no attention has been given to women’s psychological needs; spiritual cultural and religious. The psychological and social dimensions of pregnancy and childbirth which requires involvement of family, are usually referred to only in passing. Yet, their minds contribute to the physical well-being of their bodies (Oakley 1984a), elements which are part of the support system women need during pregnancy. The continuing increase in the medicalisation of pregnancy and birth, with developments in medical technology reinforced the social distance between the women and the providers, resulting in reduced social, emotional and psychological support received by pregnant women. Western research on the importance support system has been extensively studied. In Malaysia, very few study has been conducted which look at this aspect.

Literature review

A woman is an individual who has different cultural and religious beliefs and when pregnancy takes place they need many supports. Supports needed come in many forms; people, system, environment and practices (social & cultural and religious) they use or avoid during pregnancy. Thus in delivering maternity services, irrespective of who delivers and what type of care is deliver,
one important issue that needs to be taken into account is the woman, their needs and their safety. People can be family, elderly or any respected people in the village including traditional birth attendant (TBA). Though western providers are available, if they not providing the support women needed, the tendency is that women will look for alternative providers, who are untrained which can be detrimental to the women’s health, as observed in many developing countries.

In a culture where religion prohibits women going out unattended, and where they need approval from their husbands or families for any decision, women’s interest in attending maternity care is further diminished. Women, who are using purdah (veil), for example, might be unwilling to be seen by male doctors, and refused to be examined. The modesty of women who refuse to undress for a physical examination must be respected. Traditional practices such as prohibition or pantang as it called in Malaysia is another form of cultural support women required.

Sensitive providers with friendly environment are another form of support. Schott and Henley's (1996) book Culture, Religion and Childbearing in a Multiracial Society describes different cultures and beliefs of pregnant women in detail, and how health care providers can best deal with them acknowledging that is important to respect expectant mothers, whatever their religious and cultural background. Women should be addressed appropriately, welcoming them without any racial prejudice and avoiding appointments on a religious day of celebration.

Women do not appreciate impersonal behavior from professional providers, who are usually rushed for time. Specific reassurance, answers and empathy from western providers, rather than bland reassurance during a short visit (Macintyre 1982) can help to allay the feelings of uncertainty is also a form of support. Building a good rapport between women and their providers can overcome many obstacles to women attending antenatal care. Proper communication involves verbal and non-verbal interaction (Schott and Henley 1996). Inaccurate communication skills may produce an incorrect interpretation.

Malaysian and other Asian women, who are used to having female relatives and friends during pregnancy and birth, feel they are denied the privilege of family bounding when attending modern maternity care. Even though not verbally saying it, women felt besides being medically controlled, women feel they are also socially controlled. Women in general, are not allowed to make any decisions and choices about who can take charge of their bodies and are not given opportunities to express health concerns or allow their family to participate and practice safe cultural needs (Aishah 1994; Aishah and nurses 1990; Freyens, Mbakuliyemo, and Martin 1993; Jones 1993; Pelkonen, Perala, and Vehvilainen-Julkunen 1998).

Families always come first during pregnancy. They can be husbands, mothers, mother-in-law, and
relatives. And having a family along during pregnancy and birth is unavoidable, because that what pregnancy about to people of culture-family. In most of the developing countries, the socio-demographic, socio-economic and socio-cultural background are different from the developed countries and men are usually responsible for the women including when health are concerned. Thus men might not allow their spouses to visit unless they are sure that their spouses are being accompanied by someone close to them, either a female relative or a TBA. Most men in these countries usually trust traditional midwives to care for their spouses or at least be with their spouses when they seek care and give birth (Santow 1995; World Health Organization 1996b; World Health Organization 1996c). In Yemen and Egypt, for example, TBAs, daya, accompany women to hospital and are present at birth (World Health Organization 1996b; World Health Organization 1996c).

In Malaysian culture, as perceived by the western providers, husbands are not allowed with women even for a home birth, because pregnancy and birth belonged exclusively to women. In Malaysia, and other Asians and developing countries for home-birth, for example, even though men are ‘not allowed’ in the delivery room, they are in the house and part of team who wait for orders from the women in-charge. Men can get called at any time when they are needed by their spouse. Laderman’s study (1983) of Malays in Terengganu, proved that the Western theory of not allowing men was wrong. Despite women’s modesty, spouses, male blood relatives, and even bomoh could be allowed to be with women with limitations, as long as it did not disrupt the women’s modesty.

**Research Methodology**

It is a qualitative study which looked at the antenatal care services in 11 primary health care centers in the State of Johor, Malaysia. One hundred and twenty six pregnant women, 13 western-trained midwives and 12 traditional birth attendants, bidan kampung were recruited. Data were collected using focus group, in-depth interviews, field notes and observations. Though there were many findings resulted from this study, this paper however will only focus on the supports women voiced and wanted during their pregnancy, delivery and after birth.

**Findings**

The participants recruited are all pregnant women. Except for three Chinese and two Indian, all participants were Malay. The results indicated that supports during pregnancy and birth were considered essential to rural women. The support women needed ranged from help with housework, advice and reassurance concerning their pregnancy status, to spiritual and emotional support.
This scenario can be explained by the type of family structure people of rural Batu Pahat was having which was based on traditional family structure—the extended family. The extended family lived under one roof or within close vicinity involved immediate relatives and parents of husband and wife, as well as grandparents, aunts, uncles and cousins.

Following marriage the woman became part of her husband’s family or they were attached to his family, at the same time, remaining close to her own family. The close-knit family could be observed when many couples chose to stay within the extended family, mainly parents and parent-in-laws. Table 1 shows the living arrangement of the women.

### TABLE 1: Living situation

<table>
<thead>
<tr>
<th>Living with</th>
<th>n=116</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Husband and children only</td>
<td>57</td>
<td>49</td>
</tr>
<tr>
<td>Parents</td>
<td>37</td>
<td>32</td>
</tr>
<tr>
<td>Parent-in-law</td>
<td>22</td>
<td>19</td>
</tr>
</tbody>
</table>

The two prominent female figures frequently identified were mother (the pregnant woman’s mother) and mother-in-law (the husband’s mother). The female elders exert great influence over the women. These ‘wise women’ are needed for consultation and advice. The elders, especially the females, make important decisions during pregnancy. The elders have the most say and responsibility for the women during pregnancy, and for the birth, and care of the new-born. The men are responsible for the family as a whole, acting as the breadwinner for the family.

The male figure regularly consulted was the husband. Fathers and fathers–in-law had limited roles. Table 2 shows the people women identified as the person they regularly consulted. Besides the mothers, mothers-in-law and husbands, bidan kampung provided multiple support for the pregnant women. Bidan kampung supported the women physically, socially and morally.

### TABLE 2: Frequency of support received by women in Batu Pahat

<table>
<thead>
<tr>
<th>Person providing physical and moral support</th>
<th>The frequency of the support received</th>
</tr>
</thead>
<tbody>
<tr>
<td>Husband</td>
<td>Most frequently</td>
</tr>
<tr>
<td>Bidan kampung</td>
<td>Most frequently</td>
</tr>
<tr>
<td>Mothers and mother-in-laws</td>
<td>Most frequently</td>
</tr>
<tr>
<td>Friends and co-workers</td>
<td>Frequently</td>
</tr>
<tr>
<td>Neighbours</td>
<td>Frequently</td>
</tr>
<tr>
<td>Relatives</td>
<td>Occasionally</td>
</tr>
<tr>
<td>Fathers / male relatives</td>
<td>Rarely</td>
</tr>
<tr>
<td>Professional</td>
<td>Rarely</td>
</tr>
</tbody>
</table>
Professional support: midwives

Professional help and care from either midwives or doctors remained a patient-providers relationship and was based more on clinical aspects of care, rather than emotional or social support. Even then, the professional clinical care and treatment was very limited. Professional support was obtained mainly from midwives. This limitation existed during pregnancy and right through delivery.

‘But not in hospital, you will be all alone [more voices]. We will not be attending until it is about time to give birth’ [P3, Cg2].

Family Support: husband

The role of husbands in Batu Pahat is minimised, or stopped, at the women’s entry into the medical system. In the medical model, husbands are not in the picture or are only shadows to their wives. Women were alone throughout their pregnancy. In all of the 11 clinics, there were hardly any men seen inside with their spouses. If men were in the clinics they were outside the compound, which was a normal scene in public health facilities. Women wanted their husbands to be part of the process and know the progress of their pregnancies. The only way husbands received information on the pregnancy’s progress was through information obtained from their wives, which was limited.

‘I told my husband about the movement of the baby and when the baby moves. These were the kind of things I will let my husband know. He will be pleased if the baby moved’ [P1].

There was a switch in the roles of the husbands. If their husband’s role within the medical model is more passive, then within the family systems their passive roles are switched to a more active and maximised role. In Malay society, it is a rare opportunity to see husbands routinely undertaking housework or making any contribution towards child-care. However, this attitude usually changes when their spouses are pregnant. The husbands’ role is both physical and emotional. They assist with daily household chores and fulfil the emotional needs of their spouses.

‘He usually helps me with my house-works. Before I got pregnant, he seldom helped me. There were limitations to his work prior to my pregnancy’ [P3].

‘When I am feeling giddy and not able to cook, he will help me with the cooking and also help me here and there or whatever he could help around the house’ [P5].

Pregnant rural women in Batu Pahat received full physical and emotional attention from their spouses, which was something men did not usually do. For the nine month period of their pregnancy, most of their needs were met. Women were freed of most their housework during pregnancy and for 42 days following birth.
‘When I did housework, my husband helped a lot. He carried all the heavy stuff. He understood my condition. At night when my baby cried, he got up [to see the baby]’ [P7].

Husbands also have great influence on their wives’ decision regarding the type of care required. The husbands were consulted in choosing the providers that their wives would need. Even though they were not allowed in the clinic, they made an effort to send their spouses to the clinics and hospital.

‘My husband was my strong supporter. When I had my first child he advised me to have a hospital delivery’ [P2].

**Family Support: Mothers and mother-in-law**

The mothers and mothers-in-law had significant roles in the lives of pregnant women in Batu Pahat, irrespective whether they are Malay, Chinese or Indian. For the Malay pregnant women, the existence of mothers or mothers-in-law is exceptionally critical. Both the mothers are the persons who provide information and help women during pregnancy, birth and after delivery. The accomplishment of pregnancy is also the success of the mothers-in-law, but the failure of pregnancy is always the women’s failure. The mothers’ and mothers-in-laws’ role start on the day the women conceive. The mothers-in-law give extra care and pay more attention to women when they are pregnant.

‘My mother-in-law gave me special care now compared to before I got pregnant’ [P3].

‘For me my care will alternate between my mother and mother-in-law. One week I will stay with my mother-in-law!...most of the time I will be with my mother-in-law, because this will be her first grandchild’ [P2, Gg5].

Mothers and mothers-in-law took over the husband’s roles in his absence. Therefore, mothers’ and mothers-in-laws’ roles are as critical as the roles of the husbands throughout pregnancy.

‘My husband is not staying with me but I stay close to my parents. So it was my parents who gave me all the moral support that I needed. It will be my parents, except during weekends when my husband comes home. When he was around, I told him my aches and pains’ [P3, Gg8].

Women were lost, helpless and sad without the help from mothers or mothers-in-law. The sadness felt by women was noticeable during the interviews from their tone of voices and facial expressions.

‘I am staying with my mother-in-law but she is 70 years old and not strong enough to look after me, so I have to depend on my husband’ [sound sad]’ [P5].

The mothers and mothers-in-law too were the ones who ensured whether the pregnant women would have antenatal care or not. The decision to visit or not to visit the providers depends on the advice of the mothers or mothers-in-law. With mothers’ or mothers-in-laws’ approval, a visit to the
providers will be made:

Another importance support women appreciated and like was pantang. They have very strong believed in pantang which significant influence on their pregnancy, and birth outcome for both women and babies. Pantang practised usually based on advice women received from mothers and mothers-in-law. This applied to the Malay, Chinese and Indian women.

‘My mother would ask me to sambat [a Javanese word for prayer for help] so that when we put the cotton [inside the pillow] and sew it, nothing will happen. Our main aim was to make a pillow’ [P4 Malay].

‘...My mother-in-law said pregnant women must not sit on a small stool. She said, if we do that our baby might have a long head and will be difficult to come out. Another thing that she said was do not take pineapple and durian [a king of fruit]’ [P6, Indian].

‘.. elder women said if we need to hit or knock a wall, we have to take a broom and sweep the wall before hitting it. If not, you may have an abortion. This was [the advice] from the old people. My mother told me about this’ [P3, Chinese].

Mother or mother-in-law is also the main figure who prepared and sometime performed lenggang perut together with bidan kampung

‘Not yet. My pregnancy just turned seven months and I will go back to Kelantan, to have my ceremony over there. The ceremony’s usually performed in my mother-in-law’s house’ [P6].

The care after delivery is an important period for Malay women. Since women were not allowed to resume their routine work (including her personal care), mothers or mother-in-laws prepared appropriate meals, prepared medicated baths for them, bathed their babies.

‘I will have my baby in the hospital. My mother will take care of my food and prepared the food for me. She will also help me with my shower’ [P3, Gg1].

Mothers and mothers-in-law were the one who looked for bidan kampung to give body massage during the period of confinement. Body massage is a necessity for all Malay women after delivery. The massages restore the body and the reproductive organs to their maximum pre-pregnancy functions and shape. Urban women returned to the village where bidan kampung were more accessible, and to be looked after by their mother or mother-in-law.

‘For me, it was definitely my mother. That was the reason I am back here [from Kuala Lumpur]. I want my mother to after me. My mother-in-law is in Sarawak. As for massage I am not sure, whether I will have one or not. I did not book bidan kampung because my mother knew her [bidan kampung]’ [P3].

Except for some women who are new in Batu Pahat without any family member, mothers and mothers-in-law help to care for the babies afterward. Mothers and mothers-in-law continued to play a major role in women’s lives throughout pregnancy, birth and post delivery, including child-care for some women.

Other support: Friends and neighbors
Working pregnant women also received advice from friends and were taken off heavy work assigned to them. For women who were doing field work, they were relieved of the work during pregnancy, and undertook only administrative work.

“They know I am pregnant, so now they help me with my work. I do not do it alone. In my place of work, it was only the activities changed. My friends treated me the same, but I was exempt for fieldwork. For example during the National Day parade, I did not have to stand and parade. At work I did mostly clerical jobs” [P3].

Women who had no family nearby appreciated the help and the consultations received from neighbours. Neighbours were helpful to housewives. Being in a closely knit community, help could come not only from the same ethnic group but from other ethnic groups.

The only other men, women got help and received support from, is their own father, not father-in-law. Even then, fathers were hardly in the picture when pregnancies were concerned, even for those who were staying with their parents (mother and father). Only once the father was mentioned. One woman was fortunate to have her father chauffeur her to work

The most involved relatives in relation to pregnancy were the females. No male relatives were at any time consulted by the women. The female relatives that the women confided with were usually sisters or sisters-in-law. The consultations with female relatives were done in the absence of husbands.

**Support system and pregnancy outcomes**

Table 3 shows the outcome of births of the women. The combined groups are those women who are visiting government clinics and at the same time visiting *bidan kampong* for spiritual, emotional and psychological supports. The number of women who had caesarean births was higher in the government group (p=0.0466 and $X^2=3.096$)

<table>
<thead>
<tr>
<th>Mode of delivery</th>
<th>Government group</th>
<th>Combined group</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N=58</td>
<td>N=58</td>
</tr>
<tr>
<td>Spontaneous vaginal delivery</td>
<td>31 53</td>
<td>43 74</td>
</tr>
<tr>
<td>Caesarean section</td>
<td>12 21</td>
<td>5 9</td>
</tr>
<tr>
<td>No record / not delivered</td>
<td>15 26</td>
<td>10 17</td>
</tr>
</tbody>
</table>

**Discussion and conclusion**

Husbands played an important role in pregnancy. Their role was limited within the medical system, but they were useful around the house, meeting the needs of their spouses. They helped with
housework, sending the spouses to clinics or hospital and looking after the children. As for the female relatives, mothers and mothers-in-law were the prominent figures for most women, irrespective of whether they were Malay, Indian or Chinese. Mothers and mothers-in-law generally took control of the pregnancies, births, deliveries and post delivery care including child-care afterwards. However, the husbands’ roles become secondary support in the presence of mother and mother-in-law. Decisions on the type of care, place to visit, pantang, food preparation and child-care after delivery were ultimately in the hands of the mothers or mothers-in-law. Neighbours and friends were useful at times. For working women, friends at work were the main source of support. This support was either physical or in the form of advice. Most the friends that women confided in were those who were married and already had children. Neighbours were helpful for housewives. Male figures besides the husband were hardly needed by the women. Female relatives, mostly sisters or sisters-in-law, were consulted when mothers, mothers-in-law or husbands were unavailable.

There are four ways of providing social support that could benefit mothers. They are material, emotional, comparison and informational (Logsdon and Davis 1998). Material supports covers practical help in assisting with meals and housework. Emotional support in a form of cognitive, affectionate encouragement and feeling of togetherness was the most common women received. Providing useful and positive information is a form of informational support. Comparison support of advice and encouragement, received from family members, friends and neighbour, was useful along with informational support. The negative social support mostly was informational, which women received from friends or neighbour who had experience with pregnancy care and the medical system. Positive emotional support, from people who treat women with respect and a kind and thoughtful attitude during pregnancy will enhance the woman’s positive image after birth (Simkin 1996).

Getting a woman prepared and supported was important in order to keep the woman ‘together’ and to maintain her coping mechanisms and self-esteem, so bonding with her child could take place and to overcome sadness brought on by isolation. Gammon (1998), in a study on the effect of isolation resulting from hospitalisation, concluded that isolation through hospitalisation could have detrimental effects on psychological well-being. Logsdon and Davis (1998) wrote in a guide for mothers with high-risk infants that emotional support in the form of encouragement, affection, approval, feelings of togetherness and enhancing self-esteem, helped to prevent or decrease feelings of depression, which many women in Batu Pahat felt. The strong social support received could help women avoid maternity procedures such as delivery by caesarean section (CS). Women of who are well supported were having lower caesarean rate compared to women of the government group. Similar finding was noted by Jordan (1997).
Comparison support, as suggested by Logsdon and Davis (1998), must be a positive force for individual health behaviour to change (Aaronson 1989). The supporters need not only exhibit support, they also need to engage in the positive behaviour themselves. Aaronson (1989), who studied alcohol, cigarettes and caffeine abstinence, suggests that women do not perceived differences in the supportiveness of their family members, if the supporters are smokers. Women living with people who drank alcoholic and/or caffeinated beverages, drank more of these beverages themselves compared to those who did not have anyone engaging in these behaviours. Physically and socially, the well being of mothers and babies who were socially supported improved in an experiment study (Oakley, Rajan, and Grant 1990). Casper and Hogan (1990) study of supporting a family network, in terms of prenatal care, alcohol consumption, breast feeding, and birth-weight provided mixed outcomes concerning the effectiveness of the focus on family support. The study suggested that young mothers, who resided with their mothers or adult kins, or who had kin living nearby were less likely to seek prenatal care during the first trimester, or to avoid smoking and drinking. Mothers, who lived with sexual partners or husbands, were more likely to seek prenatal care or avoid smoking and drinking during pregnancy.

Even though families are a good source of support, professional support is also required (Logsdon and Davis 1998; Tarkka and Paunonen 1996) especially informational support, which was so lacking in Batu Pahat. Midwife support is the next support women preferred after family members and bidan kampung (Ball 1981; Bryce 1990). Logsdon and Davis (1998) said that nurses not only provided support, they also assisted mothers in identifying social support and individuals who could help her meet ongoing needs of infant care and finding this support should begin early in prenatal care. Ball (1981) says that midwives’ unique roles are useful not only to support pregnant woman, but also for her family. Even though first time and young women are shown to have more fear because of having to go through pregnancy for the first time, it is, however, important not to differentiate the kind of support provided (Tarkka and Paunonen 1996). Western women whose personal and psychological problems were seen as relatively big issues during pregnancy tended to be more temperamental and more prone to depression and tearfulness (Graham 1977). Graham’s study involved women’s attitudes towards pregnancy, the role played by the paramedics, the lack of support received, and a comparison of the different attitudes of primiparae and multiparae. Professionals, therefore, when providing support, have to recognise needs rather than the gravidity or age of the women. Studies elsewhere have shown that positive support, both from family and professionals, provided a favourable outcome for pregnant women and general illnesses (Aaronson 1989; Janes and Pawson 1986; Logsdon and Davis 1998; Oakley, Rajan, and Grant 1990; Tarkka and Paunonen 1996). Support is crucial in initiating and sustaining positive health practices and behaviour, such as alcohol intake and smoking during pregnancy (Aaronson 1989). The strong family ties of Asian immigrant women living in the West prevented them from coming forward for social support from local health workers. This behaviour made the western providers think that
these women did not require professional help, when they were actually the ones that need the help the most (Schott and Henley 1996). Suchman (1965), studying social group relationships and their effect on medical illness and medical care, says that the type of social group structure was not found to be related to either health status or source of medical care. Social groups as categorised by Suchman are a social group organization which includes ethnic exclusivity (community level), friendship solidarity (social group level) and family tradition and authority (family level). Oakley, Rajan, and Grant (1990) say that social support in pregnancy is unlikely to override the cumulative effects and problems of social disadvantage for women.

This practice as shown in this study was adopted from the western model in maternity services that isolated not only men, but also the whole family network from the system. This seclusion of pregnant women was made on the western providers’ assumption that it will breach the women’s modesty. In reality, it was a way for the providers to have a total control of maternity services. Physicians feel the presence of husbands invades their delivery or consultation room and ‘upstages’ them (Corea 1985). Another reason the physicians had for not allowing men to be with their spouses was that they felt their professional prerogative would be taken over and they did not want to give it up to strangers. In the western maternity care, men are allowed with their wives in the consultation room and into the delivery room.

However in Malaysia, changing is taken place whereby, a first step has been taken, when the Malaysian Minister of Health released a press statement announcing that every public hospital was to be a husband friendly hospital (Heng 1998). Berita Harian's (1998) article says, on the Minister’s statement, say that it must first have men’s consensus agreement. Lavender (1997) noted that husbands were useful to their spouses during pregnancy and delivery. Men, especially those becoming fathers for the first time, who are well prepared to provide support, their presence provides tension, because of the social expectations they must meet (Barclay and Lupton 1999).

Taken in the aspect of belief (Islam) and culture (Malaya), there are no set rules laid down by Islam or Malay culture preventing men from being with their wives during pregnancy and childbirth, inside or outside the medical world (Berita Harian 1998).

The only rule required is willingness and preparedness of both women and their male companions to participate. If men want to get involved, to support their wives, they need to be trained in what to expect when accompanying their partners. To do that requires the western providers to spend more time teaching and talking to the husbands over a period of time, during consultation of their spouses. And providers also need to be well versed in the Islamic philosophy of practising modesty of isolating men and the family in the medical world.
The presence of close female family members, especially mothers and mothers-in-law, are useful especially during birth, reciting prayers and *zikir* (utterance of the names of Allah) to reduce pain. Including Islamic ideology in the medical and nursing curriculum is one way to help the western providers to understand Islam and incorporate this into their work. Lastly the structure of most public hospitals needs to be improved. The hospitals are unsuitable, for the time being for men or any members of the family to be with their wives, daughters or daughter-in-laws.