Men in Maternal Care in India: Evidence from Large Scale Survey

Summary: *Male involvement in maternal health care is an important determinant of maternal health, especially in a male driven society like India. This study aims to understand the variations and determinants in women's antenatal care visit, institutional delivery and freedom in health care decisions in India and three socioeconomically backward states, by husband's knowledge, attitude, behaviour towards maternal health care and gender violence, using recently published National Family Health Survey IV, (2015-16). Men's knowledge about pregnancy-related care and positive gender attitude enhances maternal health care utilization, while husband's presence during antenatal care markedly increases the chances of women's delivery in institutions. Though India has shown remarkable improvement over last decade regarding male involvement in maternal care, some of its poorer states need thrust in this context. Dissemination of knowledge about maternal care among husbands and making the husband's presence essential during antenatal care may help secure better outcome of maternal health.*

Introduction:

Tradition, norms and values govern Indian social behaviour. Reproductive and child health are personal matters to an Indian woman. Males are less involved in it (WHO, 1998), though they wield more authority in the domain of women's health care decisions (Population Council, 2005; Walston, 2005). Within the household, women have restricted roles: cooking, taking care of the family and rearing children. Thus women's involvement in maternal health in a patriarchal society like India is a big challenge. Until male partners are mobilized to participate in reproductive health care and encourage women to avail themselves of health care facilities during and after pregnancy, achieving high coverage of antenatal care or safe delivery by skilled birth personnel, as stated in SDG 3 and 5, will remain a day dream. Women are often unable to access prenatal, natal and postnatal health services for a variety of reasons, including lack of control over the household's finances, transport problems, poor knowledge and family restrictions. Reasons cited range from 'spouse could not take time off work' to 'could not leave children and other dependants to travel to the nearest clinic or hospital'. These reasons illustrate the urgency of the need to include men in MCH and RCH care. Since it has been established that the attitude and level of involvement of the husband in his wife's health and morbidity during the reproductive phase plays a prominent role, there have been policy efforts to involve men actively in maternal health care (UNFPA, 1998). Barua et al. (2004) state that there are several ways in which men's participation has been conceptualized, for instance: (1) men's involvement in decisions about family size and family planning; (2) men's responsibility to reduce risky sexual behaviour and prevent spread of

sexually transmitted infections; (3) men's support for the reproductive health of women; (4) men's own reproductive health needs (Drennan, 1998; Pachauri, 2001). There have been a number of studies on the husband's role in desired family size (see Becker & Costenbader, 2001) and contraceptive use (see Becker, 1996; Balaiah, 1999). Yet, few studies on the husband's involvement or agreement have been extended into the arena of maternal health, particularly in relation to safe motherhood and birth preparedness practices (Mullany, 2010). Bloom and others found that, in India, men know little about pregnancy and related care, though they are the gatekeepers to care (Bloom et al., 2000). There are a number of gaps in the existing literature regarding men's role in maternal care, especially in India. First, while studies on men's reproductive attitude and behaviour have grown in number, they are dominated by problem-oriented approaches (Greene & Biddlecom, 2000). For instance, the HIV epidemic has encouraged researchers to understand male sexual behaviour, sexual health problems and condom use, while continued high fertility has dragged attention to the decision-making process and spousal communication. Second, most of the existing studies place emphasis on the husband's knowledge of danger signs in obstetric emergencies (Bhalerao, 1984; Thaddeus & Maine, 1994; Bender, 1995; Khan, 1997; Becker & Robinson, 1998; Singh, 1998; Ormel, 1999; Bloom et al., 2000; Ransom, 2000; Beegle, 2001). Third, many studies have focused on small samples (see the study of Bhalerao, 1984; Nagawa 1994; Bender, 1995; Kaune & Seoane, 1998; Ratto, 1998; Raju & Leonard, 2000; Bloom et al., 2000; Celeb, 2001; Das et al., 2002; Celeb et al., 2002, 2004; Barua et al., 2004; Srivastava, 2011). Yet, few studies have investigated the actual role men play in maternal health care. A major gap in the literature on men's involvement in reproductive health is in the predictors of women's health care utilization by husband's perceptions and attitudes about prenatal–postnatal care (Dudgeon & Inhorn, 2004) using large-scale representative data. In the Indian context, research to date is mainly area specific and based on intervention. In recent years, the Government of India has made new commitments of its own resources to improve health, especially maternal and child health. In 2005, the Prime Minister launched the National Rural Health Mission (NRHM), a $US9.5 billion programme aimed at providing essential health services to poor families. Based on the ICPD Cairo (1994) recommendations, the current MCH programmes in India have included men. In the last two decades, the plans have re-emphasized the importance of male involvement, yet without any clear policy directives and a monitoring system to measure the achievements of the programme in enhancing male participation in women-related health programmes (Srivastava, 2011).

Except Chattopadhyay's study (2011) using NFHS III (2005-06), no other study exists in India to date, using NFHS IV data, to comprehend the outcome of the husband's positive role in the wife's safe pregnancy and delivery. In this study, a wide range of questions have been asked to married men to bring to light their knowledge and attitude towards their (husband's and wives) reproductive health. Thus, the findings of the work, based on a nationwide large scale survey, can potentially help policymakers to formulate policy frameworks for incorporating men in MCH.

In this context, the paper aims to understand the husband's role in maternal health care in India, with specific reference to four worst performing states: Bihar, Madhya Pradesh, and Uttar Pradesh. The specific objectives are:

1. To assess the role of husband in utilisation of antenatal care and institutional delivery in India and selected socioeconomically poorer states.
2. To understand the role of husband - wife relationship and wife's decision making in health care utilization in India and selected states.

Methodology:

The unit level data from National Family Health Survey (NFHS) - IV (2015-16) has been analysed. NFHS IV is a nationwide survey, collecting information from 20267 husbands and 112122 wives. We looked into the recent trend of male involvement in maternal care in India and three selected states by using couple file. Men's attitude, behaviours related to family planning, ovulatory cycle, pregnancy and delivery related knowledge, gender violence are explored. Outcome variables in this study are determinants of utilisation of antenatal care, institutional delivery and wife's decision making on own health care. In NFHS IV, whose wives have given birth in last 5 years been asked, "when wife was pregnant with the last child, did she have antenatal check-up?" Next question was posed as: "where you present during antenatal check-ups?" Considering both questions, a variable on presence/non presence of husband during antenatal check-up was computed. If the check-up was not done, men were asked, "what was the main reason why she did not have the antenatal check-up?" Similarly detail questions are posed to husbands on delivery and related care knowledge.

Regarding women's health care decision in NFHS-IV the question asked to women is: 'Who usually makes the health care decision?' The answer codes are: mainly you, mainly husband,

you and your husband jointly and someone else. In this analysis, the first and the third response were coded as 1 (that is, respondent own or jointly with husband), and the rest as 0 (that is, someone else).

Exposure variables have a direct impact on use/non-use of ANC, institutional delivery and health care decision-making by the wife. We considered a series of exposure variables pertaining to husband's basic background and knowledge- exposure- Attitude related variables. In NFHS-IV, a series of questions were put to husbands whether at any time when the wife was pregnant, any health provider or health worker told him about the signs of pregnancy complications like vaginal bleeding, convulsions and prolonged labour; whether, at any time during the pregnancy, any health provider or health worker spoke to the husband about the importance of delivering the baby in a hospital or health facility and the importance of proper nutrition for the mother during pregnancy. Besides considering the above variables in calculating 'husband's knowledge about pregnancy and delivery', the other variables taken into account for the summative index are: whether any health provider or health worker spoke to the husband about family planning or delaying the next child, whether anyone explained to the husband the importance of breast-feeding the baby immediately after delivery, keeping the baby warm immediately after birth, cleanliness at the time of delivery and use of a new/unused blade to cut the cord. So the index of 'husband's knowledge about pregnancy and delivery' includes seven questions.

In NFHS IV, ever-married women were asked about seven types of physical violence, two types of sexual violence and three types of emotional violence by their current or most recent husband. In a non-violent husband–wife relationship, it is assumed that women should not face any type of violence. Here physical violence includes pushing, slapping, twisting the arm, punching, kicking, choking or burning, attacking with weapon; sexual violence includes coercion in sexual intercourse or any sexual act; and emotional violence incorporates humiliation or insult in the presence of others, with a threat to hurt or harm. Also , violence are categorised as severe and less severe, basis of intensity of the event.

Questions were put to the wife in NFHS-IV regarding her decision-making in major household purchases, purchase of daily household needs and visits to her family and relatives. Out of these three decisions, if the wife did not make even one, it was coded as 'no', while in the case of the wife made the decision solely or with others, it was coded as 'fully'. The rest were considered partial decision-making.

The NFHS-IV also asked married men about their opinion on wife beating. The question put forward was: 'Sometimes a husband is annoyed or angered by things that his wife does. Is a husband justified in hitting or beating his wife in the following situations: if she goes out without telling him, neglects the house or children, argues with him, refuses to have sex with him, does not cook food properly, is disrespectful towards the in-laws or he suspects her of being unfaithful?'. A summative score was computed to understand the husband's justification of wife beating. The score was 0 if in any of the above statements the husband was not justifying beating the wife. The higher the score, the stronger is the husband's justification in this regard. The score was kept as 0 for not justifying wife beating and 1 (more than 0) otherwise in the regression analysis. Covariates Husband's and wife's socioeconomic background, i.e. age, place of residence, husband's education, couple's religion, caste and wealth index, along with number of children ever born, were controlled in the multivariate analysis.

Results:

There is substantial improvement in male involvement in maternal health care in India over the last decade. When half of the husbands were present in ANC check up in 2005-06, it is 67 percent in 2015-16. Similarly larger improvement is observed for institutional delivery that has increased from 45 percent to 83 percent. For decision making in own health care too, wife's decision making ability has increased from 62 to 75 percent in India. However, two important findings are that- rural India is lagging far from urban India and three distinct states analysed in this study need special attention. Bihar, one of the poorest and socioeconomically backward states, needs substantial improvement in this regard. Only 44 percent men in Bihar and 55 percent men in Uttar Pradesh were present in any of the ANC visits of wife. Similarly, just about 70 percent husbands in these two states opted for institutional delivery.

The reasons for not opting ANC visit, as cited by husbands are mainly high cost of ANC and irrelevance of ANC. While for non institutional delivery, two main factors, as opined by husbands are high cost and distant health centre for delivery. State variation is evident in delivery care. When majority husbands reported that due to too far health facility, they are unwilling to go for institutional delivery, it is for cost factor husbands of Bihar and Uttar Pradesh are not going for institutional delivery. Not even half of the husbands are aware of course of action if mother had pregnancy complication. Such percentage is abysmally low for

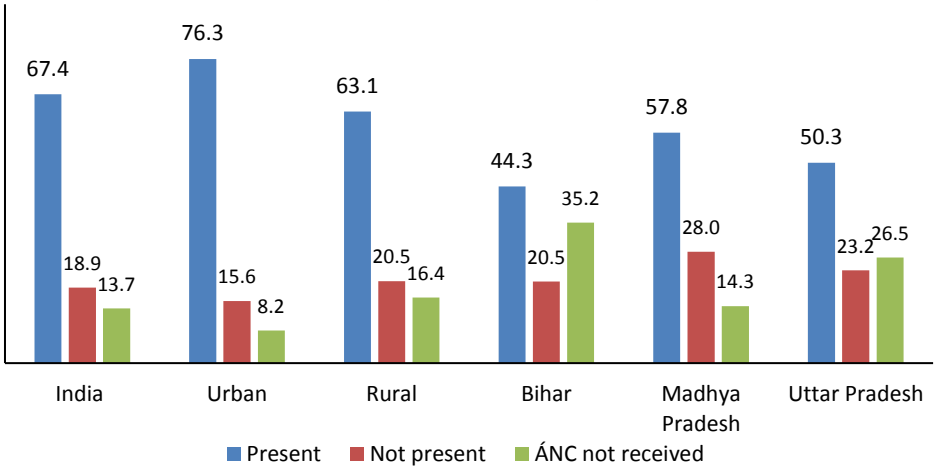
Uttar Pradesh (27%) and Bihar (32%). About 37 percent husbands in India, 58 percent in Uttar Pradesh and Bihar, did not get any advice related to place of delivery of child.

Regression models reveal that at all India level, husband's knowledge related to pregnancy care, better education, respectful attitude towards wife (non violent relationship), better household wealth, exposure to mass media, lower parity substantially enhances maternal health care utilization and health care related decision making power of wife. Men's presence in ANC is one of the important determinants of institutional delivery. Likewise, a decent husband –wife relation in conjugal life and husband's knowledge plays strong role in higher use of maternal health care.

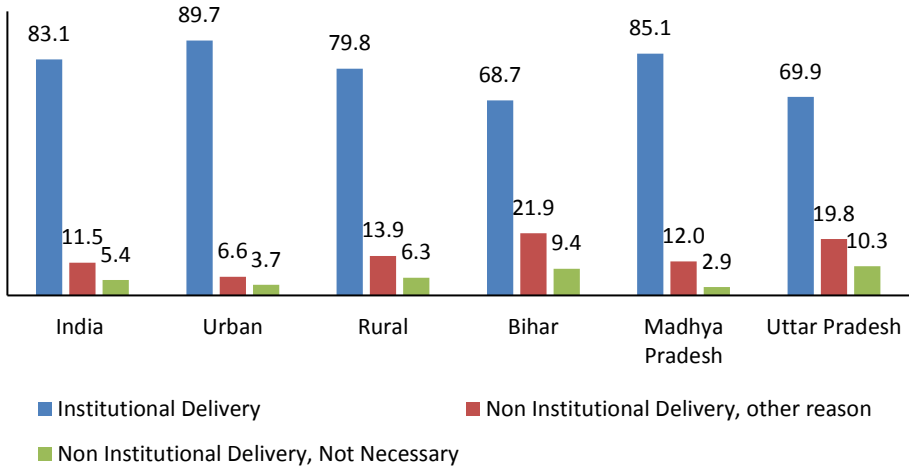
There is sufficient evidence that ignorance, indifference and lack of concern on the part of men act as hindrances to fulfilling MCH goals. Household dynamics of power relations are critical in this respect. Empowering women and giving equal importance to men are necessary, along with proper dissemination of knowledge among men. Thus men's support in every respect is a necessary prerequisite for sound maternal health care. There should be concerted action to step up efforts to educate men about reproductive and maternal health. Thus, programmes should be implemented based on the understanding of gender dynamics, on how decisions are made and implemented, on the changing needs of both genders and their interaction. Much more needs to be known about the relations between men and women in particular contexts where programmes will be set up in order to make an effective change.

Tables and Figures:

Husband present during ANC



Men's Practice and Opinion in Delivery



Decision for Wife's healthcare taken by Wife

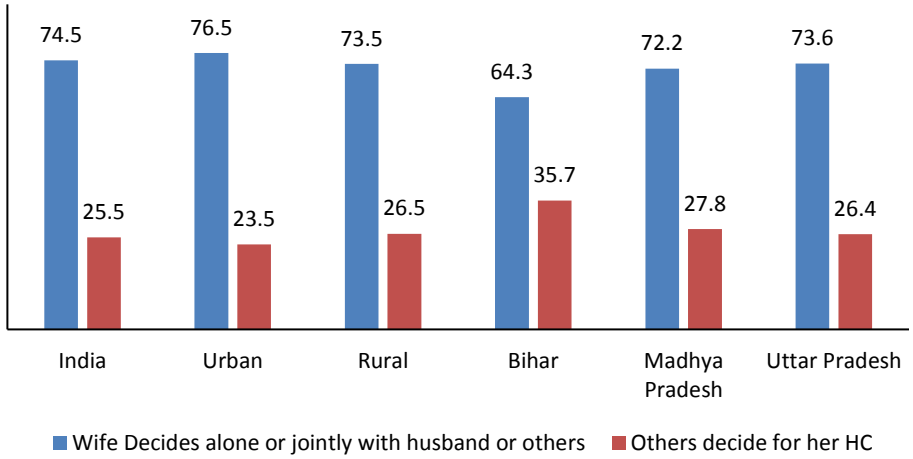


Table 1: Progress in involvement of Men in Maternal Care; India **2005-06 to 2015-16**

	Husband's presence in at least one ANC	**Wife delivered in health Institution**	**Wife takes decision regarding her health care**
2005-06	50.4	44.6	62.2
2015-16	67.4	83.1	74.5

Table: 2 Reasons for not receiving ANC, as reported by husband, in three selected states- 2015-16

Reason for not receiving any ANC (among those whose wife did not have ANC check-up)	**India**	**Urban**	**Rural**	**Bihar**	**Madhya Pradesh**	**Uttar Pradesh**	**India (n)**
Family related reasons	*2773*	552	2221	*486*	*291*	*776*	2773
Respondent did not think it was necessary/did not allow	21.3	24.1	20.6	23.3	22.3	21.5	591
Family did not think it was necessary/did not allow	19.3	24.6	18.0	20.4	15.5	14.2	536
Child's mother did not want check-up	11.2	10.0	11.5	8.4	13.4	11.7	311
Has had children before	2.5	2.9	2.4	3.3	2.1	1.5	69
Program related reasons							
Costs too much	25.1	22.5	25.7	25.5	19.6	29.3	695
Too far/no transportation	4.8	1.1	5.6	3.5	6.9	5.4	131
No female health worker available	2.5	1.8	2.7	2.5	3.1	1.9	70
Other/Don't Know	13.3	13.0	13.4	13.2	17.2	14.4	370

Table 3: Non Institutional Delivery by reasons cited by Husband in three selected states

2015-16

Reason for not delivering most recent child in health facility	**India**	**Urban**	**Rural**	**Bihar**	**Madhya Pradesh**	**Uttar Pradesh**	**India (n)**
	3422	692	2730	*433*	*304*	*882*	3422
Family related reasons							
Not the first child	4.8	4.0	5.0	3.2	2.0	5.9	164
Father did not think it necessary	7.3	11.0	6.4	7.6	5.3	8.0	251
Mother did not think it necessary	11.2	12.1	11.0	11.1	5.6	11.9	385
Family did not think it necessary	13.4	12.9	13.6	11.3	8.9	14.2	459

Program related reasons							
Cost too much	19.1	21.4	18.5	21.5	19.1	20.3	654
Facility closed	8.8	9.1	8.7	12.0	14.8	4.2	300
Too far/no transportation	16.0	8.4	17.9	12.9	27.0	8.8	547
Don't trust facility/poor quality service	4.7	5.6	4.5	5.8	3.6	6.5	162
No female provider	2.4	3.0	2.3	3.9	1.6	2.4	83
Other/Don't know	12.2	12.4	12.1	10.6	12.2	17.8	418

Table 4: Knowledge and awareness of Husband related to maternal care- 2015-16

	India	**Urban**	**Rural**	**Bihar**	**Madhya Pradesh**	**Uttar Pradesh**	**India (n)**
Pregnancy related care	20268	6743	13525	1383	2039	2925	
Awareness about complications	59.8	64.3	57.5	53.5	53.3	41.8	12114
informed about course of action if mother had pregnancy complication	46.9	52.3	44.2	32.0	38.4	26.7	9503
Advice during pregnancy							
Place of delivery	63.7	68.1	61.4	43.7	52.1	41.8	12904
Nutrition	70.2	76.3	67.2	52.8	57.1	46.3	14237
Family Planning	58.2	65.5	54.6	41.0	49.5	34.8	11798
Advice on care after delivery	3422	692	2730	433	304	881	
Cord care	33.1	34.1	32.8	29.6	21.7	23.5	1132
Breastfeeding	43.5	43.6	43.4	42.7	28.6	31.7	1488
Need to keep baby warm after birth	39.4	38.1	39.7	38.7	29.6	27.0	1347

Table: 5: Odds ratios showing determinants of male involvement in maternal health care and decision

	ANC Care	**Institutional Delivery**	**Decision making regarding health care of Wife**
Men's participation during ANC care			
ÁNC not received			
Present		3.984***	
Not present		2.706***	
Husband's knowledge on the components of pregnancy and delivery	1.579***	1.210***	0.969***
Husband's Attitude towards wife beating			

Not Justified®			
Justified	0.822***	0.966	1.125***
Wife's Decision Making			
No decision®			
Partial	0.975	1.104	
Full	0.952	0.937	
Experienced any less severe violence by husband/partner			
No®			
Yes	1.012	0.945	1.136***
Experienced any sexual violence by husband/partner			
No®			
Yes	0.971	1.161	1.147*
Experienced any severe violence by husband/partner			
No®			
Yes	0.850*	0.828**	1.419***
Age Gap between Husband and Wife			
age gap is 2 years and less®			
3-5 years	1.115**	1.000	1.045
6 and above	1.197***	0.891*	1.026
Husband's education level			
No education®			
Primary	1.095	1.354***	0.946
Secondary	1.352***	1.580***	0.859**
Higher	1.895**	2.353***	0.645***
Gap in Education between husband and wife			
HW same education®			
husband more educated	0.889**	0.776***	1.237***
wife more educated	1.018	1.008	0.879**
Place of Residence			
Urban®			
Rural	0.919	0.821***	1.075
Wealth Index			
Poorest/poorer®			
Middle	1.383***	1.390***	1.000
rich and richest	1.714***	1.844***	1.089
Exposure to Mass Media			
No exposure®			
Yes	1.273***	1.216**	0.923
Age of Husband			
less than 25 years®			
25 to 34	0.973	1.249**	0.871*

35 and highest	0.917	1.327***	0.764***
Children Ever Born			
less than 2®			
3 and highest	0.693***	0.512***	1.023
Caste			
SC/ST®			
OBC	1.049	1.491***	1.341***
General	1.215***	1.186**	1.188***
Constant	**0.385**	**0.520**	**0.346**
N	14164	14164	14244

Sig Level: * 1%, **5%, *10%**

ANC presence:
0 'ÁNC not received/not present'
1 'Present'.

Institutional Delivery :
0 No
1 Yes

Decision making:
0 'Wife Decides alone or jointly with husband or others'
1 'Others decide for her health care'.