Empowering Men For Improved Maternal Healthcare In India: A Study On The Impact Of Male Engagement

K. Sudheesh kumar[1*], Dr. K.H Bimolata Devi[2]

[1*]Research Scholar, Department of Population Studies, Annamalai University, Tamil Nadu, India.
[2]Associate Professor, Head of the Department, Department of Population Studies, Annamalai University, Tamil Nadu, India

***Corresponding author:** K. Sudheesh kumar
*Department of Population Studies, Annamalai University, Tamil Nadu, India Phone (or Mobile) No.: +91-9789512084, Email: sudheeshnair100@gmail.com

ABSTRACT

Background: The document provides an in-depth analysis of the role of husbands in maternal and child healthcare in India, focusing on their knowledge, attitudes, and involvement in antenatal care (ANC) and institutional delivery.

Methods: The data was collected from the fifth National Family Health Survey (NFHS-5) conducted in 2019-21, with a sample size of 19,765 males aged 15 to 59 and females aged 15 to 49. The study examines various socio-economic background characteristics of the sample population, including age, wealth quintile, place of residence, caste, and decision-making power. It also explores the husband's justification of wife beating and its impact on maternal healthcare, as well as the factors influencing the utilization of ANC and institutional delivery.

Results: Almost 98% of husbands were aware about understanding of pregnancy and childbirth, whereas only 23% were accompanying their children to healthcare facilities. Further, around approximately 27%, and 16.3% of respondents affirmed about the financial constraints in ANC and delivery in health facilities, respectively. These findings highlight the importance of raising awareness among key stakeholders, particularly husbands, to achieve Sustainable Development Goals related to maternal health in India.

Conclusions: Overall, the document aims to fill a gap in knowledge by examining the husband's involvement in maternal healthcare and emphasizes the importance of designing programs with a deep understanding of local gender dynamics. It provides valuable insights into the dynamics within households and calls for immediate policy attention to address the lack of knowledge among husbands concerning maternal and child healthcare matters.

Keywords: Husband, knowledge, Engagement, Reproductive health, India.

INTRODUCTION

The process of reproduction entails shared responsibilities for both, men and women. However, prevailing reproductive health practices often relegate reproductive and child health concerns as exclusively pertaining to married women in India. Despite men possessing awareness of the importance of reproductive health for the well-being of both mother and child, their participation in reproductive health initiatives remains limited[2], with men often exerting significant control over women's healthcare decisions[1]. Consequently, women frequently find themselves constrained to traditional roles predominantly focused on domestic duties such as cooking, familial caregiving, and child-rearing. These dynamics present substantial obstacles to their active engagement in maternal and child health (MCH), particularly within the framework of patriarchal structures prevalent in Indian society.

Achieving the ambitious objectives laid out in Goal 5 of the Millennium Development Goals (MDGs), such as widespread access to antenatal care (ANC) and safe deliveries attended by skilled professionals, remains a formidable challenge without the active involvement of male partners in reproductive healthcare and their support in facilitating women's utilization of healthcare services during and post-pregnancy.[3] Various barriers prevent men's access to prenatal, natal, and postnatal healthcare services. These barriers include reasons like husbands not considering it important and the high costs involved.

The integration of males into the reproductive and child healthcare system is a pivotal concern, particularly in emerging nations. This imperative was underscored in Cairo International Conference on Population and Development (1994), which advocated for the inclusion of men in reproductive and child healthcare initiatives. Subsequently, diverse strategies have been devised to foster male participation. These strategies encompass: (1) fostering men's involvement in determining family size and engaging in family planning decisions; (2) leveraging men's influence to mitigate risky sexual behaviors and prevent the transmission of sexually transmitted infections; (3) enlisting men's support in advancing women's reproductive health; and (4) addressing the distinct reproductive and sexual health needs of men. Notably, India has implemented policy measures aimed at engaging men in maternal healthcare endeavors.[2]

There are several studies that tried to illustrate the importance of male involvement in reproductive healthcare in developing nations[5-9]. Some studies also have reported the positive benefits of a husband’s knowledge of pregnancy

complications for maternal health i.e. increasing ANC, institutional delivery, postnatal care services, and reducing unhealthy practices[10-14]. A study has come up with the fact that male involvement is associated with a reduced odd ratio (OR) of postpartum depression among women[15]. Whereas, in a study by Bloom (2000) showed men as the gatekeeper to the maternal healthcare system[16]. Research has shown that men's participation can increase benefits for men, women, and children by ensuring the use of antenatal care (ANC), institutional delivery, and postnatal care (PNC).[1,4,17-18]

A study from Uttar Pradesh found that men's knowledge about reproductive health issues was limited, particularly regarding pregnancy and delivery complications.[19] Study from Gujrat found that there was very less reproductive health awareness among male migrant workers, for instance, around 80% of had no knowledge regarding ANC, 90% about natal care, and 96% about postnatal care services (Dehury and Kumar, 2016). Another study has found that husbands' knowledge of pregnancy complications positively impacts their wives' utilization of maternal health services in India (Jungari & Paswan, 2019).

To date, there are few research articles[3,20] available that comprehensively studied the husband's role in the wife's safe pregnancy and delivery. In the Indian context, most of the research has had a problem-oriented approach to avoid maternal death rather than any preventive approach. Apart from this, some studies were either area-specific[16] or restricted to samples with limited characteristics.[21-23] Following from the literature, this study aims to fill a gap in knowledge by looking at the husband's involvement in the wife's utilization of ANC and institutional delivery through his knowledge and attitude towards maternal healthcare.

DATA AND METHODS

The fifth National Family Health Survey (NFHS-5) conducted in 2019-21 is a set of cross-sectional, nationally representative surveys that collect information on a variety of demographic, socioeconomic, maternal, and child health outcomes, reproductive health, and family planning aspects. This national survey gathered data from males aged 15 to 59 and women aged 15 to 49. For this study's analysis, data from couple file has been utilised, wherein men whose last child was five years or less at the time of the survey were asked for information on maternal and child care, giving a sample size of 19,765 for India. The percentage distribution of all variable's were estimated as part of univariate analysis by using sampling weights. Moreover, all these percentage distributions were estimated with respect to socio-demographic characteristics.

RESULTS

Table 1 presents comprehensive data on the socio-demographic attributes of the participants, encompassing educational attainment, familial structure, socioeconomic status, residential setting, caste affiliation, decision-making autonomy, media exposure, and additional metrics. Speaking about age-gap between the spouses, we found that around 92% of women respondents were younger than their spouses, and around 3.6% husband were younger than their wives. About 68% of couples had *"less than two children"* ever born and 32% had *"three and more children".* Around 77% resided in rural locales. Notably, 24.5% of couples were situated in the lowest wealth quintile, while around 18% were in the highest quintile. Caste distribution revealed that highest proportion of couples belongs to *"Other backward classes"* followed by *"Schedule tribe"* and *"Schedule caste"* with around 23% and 20%, respectively.

Analysis of decision-making dynamics showed that 9% of wives lacked authority over *"contraception",* and around 20% had no influence on *"healthcare"* decisions. Further, we observed that around 13% of husbands lacked formal education, whereas 57% of their counterparts possessed *"Secondary"* level of education. Around 17% of husbands lacked exposure to *"Mass media"* and 16.5% preferred children with a gap of *"less than a year"*. Disturbingly, around 29% of wives reported experiencing spousal violence (i.e., *"violence by husband"*), though around 70% of husbands did not rationalize such behaviour. Around 98% of husbands had knowledge regarding *"pregnancy and childbirth"*. However, only around 23% accompanied *"their child to healthcare facilities"*.

Table 2 elucidates the reasons influencing absence of ANCs among women. It indicates that various factors, including familial and programmatic considerations such as financial constraints and logistical challenges, exert notable influence over the uptake of ANC services during pregnancy. It was surprising to observe that around 8% of mothers did not express personal reluctance toward ANC, however, around 21% respondents did not think that ANC to be necessary, and around 16% familial disapproval as a hindrance to attending check-ups. Additionally, economic concerns are prominent, with approximately 27% of respondents attributing the inability to afford ANC assessments to higher associated costs. Moreover, logistical barriers are prevalent, with 9% responding distance or transportation difficulties to healthcare facilities, and 3% found the absence of female health workers as a deterrent.

Table 3 This study elucidates the determinants influencing women's decision-making regarding the choice of delivery location for their most recent childbirth, with a particular emphasis on a spectrum of familial and programmatic factors. Familial determinants encompass past obstetric experiences and familial deliberations, while programmatic determinants encompass financial implications, physical accessibility of the facility, and confidence in its services. Among respondents, around 5% had felt that the current child not being the first child or we can say they had some prior childbirth experiences. However, around13% deemed facility delivery unnecessary, and around 12% reported familial disapproval of facility delivery. Additionally, 16.3% responded financial constraints, 7.5% encountered facility closure during delivery time, and about 23% experienced distance or transportation issues. Moreover, around 2% expressed distrust in facility services due to poor quality services, while around 3% noted the absence of female healthcare providers as a deterrent. (Table 3)

Table 4 indicates a notable proportion of husbands were apprised of subjects such as pregnancy complications, delivery care, and nutritional care, with varying percentages for other topics like cord care, breastfeeding, and neonatal thermoregulation. Approximately 76% of husbands were briefed on pregnancy complications by healthcare providers, with around 73%, 81% and 63% receiving information on delivery care and nutritional care, and about family planning, respectively. Regarding neonatal healthcare knowledge, roughly 49.5% of husbands were educated on cord care, 61.26% on breastfeeding, and 60.7% on neonatal thermoregulation. This dissemination of information holds significant potential in advancing maternal and child health outcomes by engaging husbands in the healthcare continuum. (Table 4)

DISCUSSION

In India, the traditional belief is that men serve as the guardians of households. Consequently, involving them in maternal health care is seen to bolster health service utilization, reduce maternal health complications, raise maternal self-esteem, and reduce complications during childbirth.[24, 25]

However, there's an opposing viewpoint that argues male involvement imposes constraints on women's decision-making autonomy.[26] Despite this contention, the literature in India lacks comprehensive data on husbands' knowledge, behaviors concerning maternal health care, and their stance on gender equality, primarily due to an imbalance in research focus towards women in reproductive health. India's diverse landscape includes states at varying levels of development, where despite advancements in Reproductive, Maternal, Newborn, and Child Health (RMNCH) coverage, some women remain hesitant to access maternal health services. To address this, present study delves into husbands' overall awareness and attitudes regarding maternal care, focusing on their perceptions of their own wives' needs. Earlier studies' findings suggest that enhanced knowledge of maternal and child health care, coupled with a positive attitude towards gender equality, could foster greater participation by husbands in maternal health care services such as ANC and institutional deliveries.[20]

The primary findings including obstacles to maternal and child health care utilisation in India are families' erroneous view of 'unnecessary' maternal health care, excessive expense, and health facility too far. Moreover, despite significant knowledge on maternal and child health (MCH), attitude towards the same weren't significant enough. These findings are consistently aligned with earlier studies.[27-30]

Achieving the SDG targets for maternal and child healthcare by 2030 becomes challenging when husbands are inadequately involved about maternal and child healthcare. For instance, the study found that more than three fourth of Indian husbands were aware about the signs of problems, course of action to be done if pregnancy becomes problematic, site of delivery, nutritional care, and family planning, but, their attitude and practices are still need to get improved. According to a RCT, educating both pregnant women and their male partners have a more significant overall effect on maternal and child health behaviours compared to educating women alone.[31] Therefore, it is crucial to enhance husbands' awareness and involvement in maternal healthcare.

CONCLUSION

In summary, achieving the goal-3 of SDGs pertaining improvement of maternal health, hinges on raising awareness among the key stakeholders often referred to as 'gatekeepers'. Overcoming challenges such as ignorance, indifference, and male disengagement is essential to meet the nation's maternal and child health objectives. Empowering women and emphasizing the role of men in maternal and child health are imperative steps. The primary objective is to translate this knowledge into action through behavioural changes and improvements in the healthcare system. Efforts should be intensified to educate families, particularly husbands, about reproductive and maternal health. To address this issue effectively, programs should be designed and monitored with a deep understanding of local gender dynamics, considering how decisions are made and executed within households.

DECLARATIONS

Funding: None.

Conflict of interest: None.

Ethical approval: This study has utilised the data from Indian demographic Health Survey (i.e., DHS) which is already available in public forum, hence no ethical approval is required.

REFERENCES

1. Walston, N. (2005). *Challenges and Opportunities for Male Involvement in Reproductive Health in Cambodia.* USAID.
2. Organization, W. H. (1998). Male Involvement in Reproductive Health: Incorporating Gender Throughout the Life Cycle. *1*. Technical Support Services System: Occasional Paper Series.
3. Chattopadhyay, A. (2012). Men in Maternal care" Evidence from India. (C. U. Press, Ed.) *Journal of Biosocial Science, 00*, 1-26. doi:10.1017/S0021932011000502
4. Barua, A. P. (2004). Caring men? Husbands' involvement in maternal care of young wives. *Economic and Political Weekly*, 5661-5668.
5. Kabakyenga, J. O. (2012). Influence of birth preparedness, decision-making on location of birth and assistance by skilled birth attendants among women in south-western Uganda. *PloS one, 7*(4).

6. Mullany, B. B. (2007). The impact of including husbands in antenatal health education services on maternal health practices in urban Nepal: results from a randomized controlled trial. *Health education research*, *22*(2), 166-176.
7. Wassie, L. B. (2014). Magnitude and factors that affect males' involvement in deciding partners' place of delivery in Tiyo District of Oromia Region, Ethiopia. *Ethiopian Journal of Health Development*, *28*, 6-13.
8. Mangeni, J. N. (2012). Male involvement in maternal healthcare as a determinant of utilisation of skilled birth attendants in Kenya. *East African medical journal*, *89*(11), 372-383.
9. Wai, K. M. (2015). Are husbands involving in their spouses' utilization of maternal care services?: A cross-sectional study in Yangon, Myanmar. *PloS one*, *10*(12).
10. Schaffer, M. A.-H. (1997). Effects of social support on prenatal care and health behaviors of low-income women. *Journal of Obsteric, Gynecologic, & Neonatal Nursing*, *26*(4), 433-440.
11. Starrs, A. M. (2006). Safe motherhood initiative: 20 years and counting. *The Lancet*, *368*(9542), 1130-1132.
12. Martin, L. T. (2007). The effects of father involvement during pregnancy on receipt of prenatal care and maternal smoking. *Maternal and child health journal*, *11*, 595-602.
13. Ramchandani, P. G. (2013). Do early father–infant interactions predict the onset of externalising behaviours in young children? Findings from a longitudinal cohort study. *Journal of chid psychology and psychiatry*, *54*(1), 56-64.
14. Redshaw, M. &. (2013). Fathers' engagement in pregnancy and childbirth: evidence from a national survey. *BMC oregancy and childbirth*, *13*, 1-15.
15. Sreelekshmi, F. S. (2010). Risk factors of postpartum depression among married mothers attending SAT Hospital. *Trivandrum. Aust Med J*, *3*, 222.
16. Bloom, S. S. (2000). What husbands in northern India know about reproductive health: correlates of knowledge about pregnancy and maternal and sexual health. *Journal of Biosocial Science*, *32*(2), 237-251.
17. Caleb Varkey, L. (2001). Involving Men in their Wives' Antenatal and Postpartum Care in India. *Population Council*.
18. Singh, A. &. (2007). Men's involvement in maternal care during pregnancy and child birth in rural Maharashtra. *Annual meeting of population association of America.*
19. Singh, K. K. (1998). Husbands' reproductive health knowledge, attitudes, and behavior in Uttar Pradesh, India. *Studies in family planning*, 388-399.
20. Chattopadhyay, A., & Govil, D. (2020). Men and maternal health care utilization in India and in selected less-developed states: evidence from a large-scale survey 2015-16.. Journal of biosocial science, 1-21. https://doi.org/10.1017/S0021932020000498.
21. Jungari, S. &. (2019). What he knows about her and how it affects her? Husband's knowledge of pregnancy complications and maternal health care utilization among tribal population in Maharashtra, India. *BMC pregnancy and childbirth*, *19*, 1-12.
22. Iliyasu, Z. A. (2010). Birth preparedness, complication readiness and fathers' participation in maternity care in a northern Nigerian community. *African journal of reproductive health*, *14*(1).
23. Bhatta, D. N. (2013). Involvement of males in antenatal care, birth preparedness, exclusive breast feeding and immunizations for children in Kathmandu, Nepal. *BMC pregnancy and childbirth*, *13*(1), 1-7.
24. Mersha, A. G. (2018). Male involvement in the maternal health care system: implication towards decreasing the high burden of maternal mortality. *BMC pregnancy and childbirth*, *18*(1), 1-8.
25. Yargawa, J., & Leonardi-Bee, J. (2015). Male involvement and maternal health outcomes: systematic review and meta-analysis. Journal of Epidemiology and Community Health, 69, 604 - 612. https://doi.org/10.1136/jech-2014-204784.
26. Mullany, B., Hindin, M., & Becker, S. (2005). Can women's autonomy impede male involvement in pregnancy health in Katmandu, Nepal?. Social science & medicine, 61 9, 1993-2006 . https://doi.org/10.1016/J.SOCSCIMED.2005.04.006.
27. Griffiths, P., & Stephenson, R. (2001). UNDERSTANDING USERS' PERSPECTIVES OF BARRIERS TO MATERNAL HEALTH CARE USE IN MAHARASHTRA, INDIA. Journal of Biosocial Science, 33, 339 - 359. https://doi.org/10.1017/S002193200100339X.
28. Singh, A. (2016). Supply-side barriers to maternal health care utilization at health sub-centers in India. PeerJ, 4. https://doi.org/10.7287/peerj.preprints.2362/supp-2.
29. Chakrabarti, A. (2003). Factors Governing Maternal Health Care Utilisation: Evidence from Rural India. Health Economics. https://doi.org/10.2139/ssrn.389280.
30. Ghosh, A., & Mistri, D. (2017). Obstacles in the Utilisation of Maternal Health Care Services in Murarai-II C.D. Block, Birbhum District, West Bengal, India. , 4, 40-61. https://doi.org/10.20896/SACI.V4I3.224.
31. Feyissa, T. R., & Genemo, G. A. (2014). Determinants of institutional delivery among childbearing age women in Western Ethiopia, 2013: unmatched case control study. *PloS one*, *9*(5), e97194.

Table 1: Socio-economic background characteristics of sample population.

Variables	Freqency	Percent
Age Gap		
Older husband	18284	92.51
Older wife	706	3.57
Same age	775	3.92
Total (N)	19765	100
Children ever born		
Less than 2	13460	68.10
3 & above	6305	31.90
Total	19765	100
Place of Residence		
Urban	4517	22.85
Rural	15248	77.15
Total	19765	100
Wealth Quintile		
Poorest	4845	24.51
Poorer	4473	22,63
Middle	3906	19.76
Richer	3641	18.42
Richest	2900	14.67
Total	19765	100
Caste		
Schedule caste	3827	20.47
Schedule tribe	4384	23.45
Other backward class	7291	39.00
General	3192	17.07
Total	18694	100
Wife decision power for contraception		
No decision	1140	9.00
Full	1188	9.38
Partially	10333	81.61
Total	12661	100
Wife decision for healthcare		
No decision	3980	20.14
Full	1346	6.81
Partially	14439	73.05
Total	19765	100
Husband Education		
No education	2626	13.29
Primary	2626	13.29
Secondary	11218	56.76
Higher	3295	16.67
Total	19765	100
Mass Media exposure		

No	3298	16.69
Yes	16467	83.31
Husband Child Preference		
Less than a year	1202	16.55
Within five years	5604	77.14
6+	94	1.29
Others	365	5.02
Total	7265	100
Wife experienced violence by husband		
No	11544	71.20
Yes	4669	28.80
Total	16213	100
Husband attitude to violence		
Not Justified	13917	70.41
Justified	5848	29.59
Total	19,765	100
Husband had information on pregnancy and delivery		
No	294	2.12
Yes	13,585	97.88
Total	13,879	100
Husband present at the time of antenatal check-ups		
Not present	2505	17.92
present	11472	82.08
Total	13977	100
Husband accompanied child to the Healthcare facility		
No	15229	77.05
Yes	4536	22.95
Total	19765	100

Table 2: Reasons for wife not receiving ANC check-up, according to husbands, India, (2019-21).

Reason for wife not having ANC check-up	**Frequency**	**Percent**
Family related reasons		
Mother did not want check-up	53	7.70
Respondent did not think it was necessary	146	21.22
Family did not think it was necessary/did not allow	112	16.28
Not the first child	18	2.62
Programme-related reasons		
Costs too much	189	27.47
Too far/no transportation	62	9.01
No female health worker available	21	3.05
Other/ don't know	87	12.65
Total	688	100

Table 3: Reasons for wife not delivering most recent child in health facility, according to husbands, India (2019-21).

Family related reasons	**Frequency**	**Percent**
Mother did not think it necessary	216	13.43
Respondent did not think it necessary	72	4.48
Family did not think it necessary	190	11.82
Not the first child	74	4.60
Programme-related reasons		
Cost too much	262	16.29
Facility closed	121	7.52
Too far/no transportation	369	22.95
Don't trust facility/Poor quality service	39	2.43
No female provider	55	3.42
Other/don’t know	210	13.06
Total	1,608	100

Table 4: Information provided to husband on maternal healthcare by healthcare providers, India (2019-21).

N	14,824
Pregnancy Complication	76.12
Delivery Care	73.70
Nutritional Care	81.09
Family Planning	63.49
N	1608
Cord Care	49.50
Breastfeed	61.26
Baby warm	60.70