# Caring Men?

## Husbands' Involvement in Maternal Care of Young Wives

*Analysis of a survey area in Maharashtra shows that a majority of husbands were knowledgeable about prenatal, delivery and postnatal care. Men were often excluded from participating in routine care because the medical system does not accommodate them and the community considers maternal care as exclusively women's domain. Young, newly married women experience pregnancy and childbearing in an environment where they have little or no autonomy in decision-making, finances or mobility to seek care. Thus, it may be crucial to get husbands involved, since they are often the decision-makers, the ones who have to accompany the young woman to a clinic and the ones who pay for care.*

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Reproductive health research, programmes and policies in the past have focused almost exclusively on women. In recent years, however, the reproductive health field has shifted its attention to include men's roles and involvement in women's reproductive health, recognising that men's attitudes, knowledge, and behaviour can strongly influence women's health choices [ARCH 2000; Drennan 1998]. Much of this effort has been devoted to the family planning field, with comparatively less emphasis on men's involvement in their wives' maternal health even though maternal health is a key part of women's reproductive health [Bloom et al 2000; Carter 2002; Singh et al 1998]. Moreover, most research and programmes have worked with adults, and far less is known about adolescent couples [Mamdani 1999]. This paper addresses these gaps by looking at men's involvement in maternal health in rural Maharashtra, India, among young couples in which the wife is younger than 22 years of age. Specifically, we examine the extent of, and factors associated with, husbands' knowledge, sense of responsibility, and participation in health-seeking for their young wives' prenatal, delivery, and postnatal care.

### Background

Reproductive health has largely been thought of as a woman's concern over the years [Becker 1996; Becker and Robinson 1998; Ferdinand 1996; Greene and Biddlecom 2000; Pachauri 2001]. Of late, however, there is increasing attention to the role of men in women's reproductive health as a result of growing realisation that men's attitudes, knowledge, and behaviour can strongly influence women's health choices [Barua and Kurz 2001; Beegle et al 2001; Bloom et al 2000; Navaneetham and Dharmalingam 2002; Population Council 1999; Schuler 1999; Singh et al 1998; Thaddeus and Maine 1994]. Attention to men's involvement in reproductive health received an impetus following the Programme of Action forged at the 1994 International Conference on Population and Development [Cairo Programme of Action 1994]. There are several ways in which men's participation has been conceptualised since then, 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; and (4) men's own reproductive and sexual health needs [Drennan 1998; Pachauri 2001].

Much of the emerging body of knowledge about male involvement in reproductive health is due to contributions from the family planning field [Balaiah et al 1999]. There is a much smaller body of literature on male involvement that specifically examines men's role in reducing maternal mortality and ensuring safe motherhood. As the prospective fathers, husbands are likely to be more intimately involved in their wive's pregnancy and childbirth than are other male relatives or elders. Yet we know little about how well-informed husbands are, or how involved they are, when it comes to routine maternal care.

Such literature as does exist focuses, largely, on men's knowledge of danger signs during pregnancy and on critical decisions around seeking care during obstetric emergencies [Becker and Robinson 1998; Beegle et al 2001; Bender et al 1995; Bhalerao et al 1984; Bloom et al 2000; Khan et al 1998; Ormel 1999; Ransom 2000; Singh et al 1998; Thaddeus and Maine 1994]. Some studies do address aspects of men's participation in routine, non-emergency prenatal care or support during delivery and postnatal periods [Bender et al 1995; Bhalerao et al 1984; Kaune and Seoane 1998; Nagawa 1994; Ratto 1998], and some address factors associated with men's involvement in routine maternal care, or the influence men's involvement may have on women's use of maternal care services [Barua 1998; Beegle et al 2001; Carter 2002]. Several studies support a widespread perception that men are poorly informed about matters of maternal care [ARCH 2000; Ahamed 1997; Apte 2000; El-Mouelhy et al 1994; Lakhani 2000; WHO 1996]. Literature also supports the notion that men are absent or insufficiently involved in maternal care [Bhalerao et al 1984; Kaune and Seoane 1998; Khan et al 1998; Nagawa 1994]. Only a few studies find that husbands are relatively knowledgeable and engaged in the maternal care of their wives [Carter 2002].

Studies in India show similarly mixed results. A study of men's knowledge about a range of reproductive health issues in Uttar Pradesh showed that men were less knowledgeable about warning

symptoms of pregnancy and delivery complications than other aspects of reproductive health [Bloom et al 2000; Singh et al 1998]. In contrast, a study conducted by Action Research in Community Health and Development (ARCH) in Gujarat found that men had high levels of correct knowledge on need for good nutrition and reduced workload during pregnancy, though they knew little about the details of antenatal care, iron tablets, or tetanus injections. In another study, also in Gujarat, husbands were found to be unaware of the care their wives received during pregnancy and delivery, and were not present to accompany their wives for clinic visits or delivery. However, the same study also found that men were concerned about their wives' antenatal care and helped around the house [Khan et al 1998].

There is some evidence that intervention programmes can influence the extent of men's knowledge and participation in their wives' maternal care [Bender et al 1995; Bhalerao et al 1984 Kaune and Seoane 1998; Lakhani 2000; Pal 2000]. In two separate studies in India, interventions targeted at men were associated with increased use of antenatal care services among their wives [Lakhani 2000; Pal 2000]. Though there is consensus that men's involvement in reproductive health and maternal care is desirable, several authors express reservations. Some note that encouraging men's involvement could enhance men's power as decision-makers at the expense of women's ability to make decisions about their own health or that it may be an unwelcome intrusion into what has traditionally been a 'woman's domain' [Ormel 1999; Ransom 2000]. Nevertheless, others argue that men's involvement can lead to increased use of services, reduced maternal mortality, improved birth outcomes, and overall better health for women.

A major gap in the literature on men's involvement in reproductive health is that it focuses almost entirely on adults, and largely overlooks adolescents as a group. In much of rural India, young women face pressure to bear children early in their marriages. Research shows that the risks of maternal mortality and morbidities tend to be greater among adolescent girls and young women by virtue of their age and primiparous status [Bhatia 1993; Kurz 1997]. Adolescent women's social and reproductive context can differ from adult women's in several critical ways, and studies suggest that adolescents' maternal care seeking will be different than adult women's [Navaneetham and Dharmalingam 2002]. Studies in India show that there is a strong culture of silence and shame around discussing reproductive health problems and seeking care [Barua and Kurz 2001]. Further, newly-married adolescent women often have less decision-making ability than older women and are in a subordinate position in the family Jejeebhoy 1998]. In such circumstances, other influential family members such as husbands are likely to figure prominently in decisions to seek care [Barua and Kurz 2001], and thus men's knowledge, attitudes, and participation in care may be as critical for younger women as women's own knowledge and attitudes.

Following from the literature, this paper aims to fill a gap in knowledge by looking at husbands' involvement in the prenatal, delivery, and postnatal care of young women (younger than 22 years) in rural Maharashtra and questions whether the portrayal of men as poorly informed or uninvolved holds true in this sample.

This paper is based on the findings of an adolescent reproductive health intervention research study being conducted from 1996 till 2005 in two blocks of Ahmednagar district in Maharashtra state, in western India. Maharashtra is considered as an economically developed state in India. It has much higher levels of female and male literacy than the country as a whole; however, the sex ratio is worse, and fertility and childbearing are similar to the national figures. Ahmednagar, located 120 kilometres to the north-east of Pune city, is the second largest district in Maharashtra. The district is predominantly agricultural with sugar cane plantations and related factories and is prone to severe droughts.

The two study blocks, Parner and Ahmednagar, are primarily rural, with populations of over 2,00,000. Almost all villages in both blocks have electricity and at least one protected source of water supply. Temporary outmigrations of young men to nearby cities like Pune and Bombay in search of jobs is common during drought situation. Both blocks have a variety of government and private health services. In the government health sector, Parner has one rural hospital, seven primary health centres (PHC), and 38 subcentres.[1] Ahmednagar has one district hospital, six PHCs and 36 subcentres. Ahmednagar block is also the headquarters for Ahmednagar district and houses a large army cantonment.

We use a combination of qualitative and quantitative information collected from young married women and their husbands.

In the first phase of the study (1996-1999), a qualitative formative research was carried out among young married women, their husbands and marital families, and health providers, to understand better the social, cultural and health-seeking context for married adolescent women. These data comprise 207 in-depth interviews among married adolescent girls (74), their husbands (37), mothers-in-law (53), PHC medical officers (7), auxiliary nurse-midwives from government health centres (25) and private doctors

**Table 1: Husbands' Socio-Economic Characteristics and Knowledge of Care and Possible Problems**

| | Knowledge of Need for Care | | | Knowledge of Possible Problems | | |
|---|---|---|---|---|---|---|
| | ANC | Delivery | PNC | ANC | Delivery | PNC |
| *Background characteristics* | | | | | | |
| *Husband's education:* | | | | | | |
| None/primary | 68.1 | 76.1 | 54.9 | 74.3 | 79.7 | 65.5 |
| Secondary (5-8 grade) | 70.3 | 80.2 | 64.0 | 84.7 | 77.0 | 60.8 |
| High school+ | 80.9 | 88.7 | 73.0 | 87.6 | 85.6 | 76.1 |
| *Wife's education:* | | | | | | |
| None | 65.7 | 75.2 | 59.1 | 73.7 | 76.6 | 62.8 |
| Till middle school (8 grade) | 75.8 | 86.4 | 64.0 | 85.7 | 81.5 | 68.8 |
| High school+ | 82.1 | 87.6 | 77.4 | 89.1 | 86.6 | 77.1 |
| *Husband's profession:* | | | | | | |
| Farmer/labourer | 74.4 | 84.0 | 66.5 | 83.6 | 81.8 | 69.4 |
| Service/business | 81.2 | 87.5 | 72.8 | 88.3 | 84.7 | 74.7 |
| *Household possessions:* | | | | | | |
| 0-1 | 75.6 | 81.8 | 63.9 | 85.4 | 79.9 | 67.9 |
| 2-3 | 78.9 | 86.3 | 71.9 | 85.1 | 84.0 | 73.7 |
| 4+ | 75.8 | 87.1 | 69.4 | 85.8 | 84.2 | 71.6 |
| *Household structure* | | | | | | |
| Joint/extended | 76.4 | 85.1 | 68.9 | 85.1 | 86.2 | 70.9 |
| Nuclear | 80.4 | 86.2 | 68.1 | 87.0 | 82.4 | 74.6 |
| *Husband's age at marriage* | | | | | | |
| Less than 22 years | 72.0 | 84.2 | 65.4 | 83.3 | 78.6 | 65.4 |
| 22 years or later | 81.6 | 86.3 | 72.0 | 87.3 | 86.9 | 77.0 |
| *Wife's age at marriage* | | | | | | |
| Less than 16 years | 72.9 | 83.8 | 66.0 | 83.3 | 82.4 | 68.4 |
| 16 years or later | 83.2 | 87.6 | 73.1 | 88.6 | 83.7 | 76.0 |
| *Husband's current age* | | | | | | |
| Less than 25 years | 72.3 | 78.9 | 62.1 | 81.3 | 72.9 | 62.1 |
| 25-29 years | 77.1 | 86.3 | 69.5 | 85.7 | 83.9 | 72.9 |
| 30+ years | 79.8 | 87.3 | 71.8 | 87.3 | 87.3 | 74.2 |
| *Wife's current age* | | | | | | |
| Less than 18 years | 73.6 | 79.1 | 66.4 | 77.3 | 75.5 | 62.7 |
| 18-19 years | 79.8 | 83.6 | 65.0 | 86.8 | 83.6 | 70.0 |
| 20+ years | 76.0 | 87.5 | 71.6 | 86.2 | 84.0 | 73.9 |
| Total (N) | 972 | 972 | 972 | 972 | 972 | 972 |
| Total per cent aware | 77.0 | 85.3 | 68.8 | 85.4 | 82.9 | 71.4 |

(20). Respondents were part of a convenience sample: those who were responsive, available, and willing to be interviewed.

Based on the formative research, an intervention programme to improve adolescent reproductive health was started in 2001. Before the intervention, a census was conducted in 2001 of all married women under 22 years old, in 22 villages covering four PHCs in Ahmednagar and Parner blocks. The data used in this paper come from a follow-up survey conducted from May-July 2001 among the husbands of 972 (roughly half) of these women. Six male field investigators who were trained on-site collected data.

The survey of husbands was based on a questionnaire that was designed with inputs from the previous qualitative research study, and the young women's survey. The questions focused on husbands' awareness about their wives' reproductive and other health needs, use of available services by the wife, husbands' attitudes towards own participation, and actual participation in her use of these services.

This paper focuses on husbands' knowledge of and involvement in maternal care. We use the qualitative data to set the socio-cultural context and to provide a richer interpretation of the quantitative data on husbands' involvement. Though the qualitative data collection was done in an earlier period than the quantitative survey, the cultural, social, and other factors that affect health-seeking and men's involvement in their wives' reproductive health in this area are unlikely to have changed substantially in the intervening period. Therefore we use the two data sources together and present results of descriptive and bivariate analyses.[2]

A majority of the households were Hindus (92 per cent), and more than a quarter (29 per cent) belonged to the socially disadvantaged scheduled castes and tribes. Of these young couples, 86 per cent lived in joint or extended families that comprised, in addition to the couple, the husband's parents and other family members. The average family size was six members per household. About 28 per cent came from poor households (owning none or one of the assets asked about in the survey), 40 per cent from medium-wealth, and the remainder from households that owned four or more of the assets included in the survey.

On average, men had nine years of education and their wives seven years of education. Wives were much younger than husbands, (mean current age 20 years vs 27 years). Mean age at marriage was 23 for the men and 16 for the women, indicating that, while men married past adolescence, women tended to marry early in this population. Childbearing was early, with 86 per cent women reporting at least one pregnancy by the age of 22 years, almost a third with two or more surviving children at the time of the survey, and only slightly less than one-third with no surviving children. About 8 per cent reported at least one stillbirth or spontaenous abortion.

The qualitative data provided information on the context in which these young couples negotiated pregnancy and childbearing. Marriage was early and nearly universal. Early marriage was accompanied by pressure for early childbearing, usually to prove the young couple's fertility. With joint families being almost a norm, this pressure arose most often from the older generation in the family. Pressure from the joint family meant that a newly-wed young woman's preferences about the timing of the first child were overruled: "I do not feel any pleasure about this pregnancy. I did not expect to conceive this early as I think I am too young to bear children. This will increase my responsibilities. I will have to look after the children at such a young age. But my in-laws wanted me to have a child" (wife, age 17). The family is not, however, the only one to apply pressure; even friends in the same age-group expect young couples to have children soon after marriage: "I wanted to have the first child three years after marriage. We were using pills and Nirodh for this spacing. We used these for one year, then we stopped. My friends used to comment, you have been married for more than a year, how come your wife has not yet conceived?" (husband, age 24). In some cases, the wife and/or husband themselves wanted to have a child. To quote one of the husbands: "In villages it is almost a norm to have a child as soon after marriage as possible. If the woman does not conceive people think that there is some problem" (husband, age 25).

The qualitative data also showed that young wives' access to health services was dependent on the awareness of other family members, particularly husbands, about the need for care. If the care was not free, there was the added issue of cost which the husband or in-laws usually had to bear. Young women had very little mobility and had to depend on husbands or other family members to take them to a health centre, even if the care itself was free. This entailed time spent by husbands, who did not accompany their wives unless they perceived it necessary. If my wife is unwell she first tell me and I ask her to go to the centre. Her illness affects our routine as I have to stop my work and go with her. My mother's work also increases" (husband, age 22).

Overall, the household delayed seeking care for a young woman's illness unless it interfered with the woman's responsibilities

**Table 2: Husbands' Obstetric Knowledge and Experience and Current Levels of Awareness**

| | Knowledge of Need for Care | | | Knowledge of Problems | | |
|---|---|---|---|---|---|---|
| | ANC | Delivery | PNC | ANC | Delivery | PNC |
| Pregnancy and parenthood | | | | | | |
| *Wife's pregnancy* | | | | | | |
| Never pregnant | 49.1 | 66.7 | 44.7 | 56.0 | 62.9 | 49.7 |
| Pregnant at least once | 82.4 | 88.9 | 73.6 | 91.1 | 86.8 | 75.7 |
| *No of living children* | | | | | | |
| None | 80.1 | 82.2 | 65.0 | 81.8 | 78.3 | 66.1 |
| One only | 77.3 | 86.9 | 70.6 | 88.2 | 83.2 | 76.7 |
| Two or more | 73.7 | 86.2 | 70.2 | 85.3 | 86.9 | 69.9 |
| Knowledge and experience: previous pregnancy phase | | | | | | |
| *Antenatal care* | | | | | | |
| Aware of need for antenatal care | - | 91.0 | 74.5 | 90.9 | 87.8 | 76.2 |
| Not aware of need for antenatal care | - | 66.1 | 50.0 | 67.0 | 66.5 | 55.4 |
| *Delivery precautions* | | | | | | |
| Aware of delivery precautions | - | - | 74.3 | - | 89.5 | 78.7 |
| Not aware of delivery precautions | - | - | 37.1 | - | 44.8 | 29.4 |
| *Postnatal care* | | | | | | |
| Aware of need for postnatal care | - | - | - | - | - | 82.2 |
| Not aware of need for postnatal care | - | - | - | - | - | 47.5 |
| *Antenatal problems* | | | | | | |
| Wife had problems in antenatal period | - | 91.0 | 76.5 | - | 91.3 | 81.2 |
| Wife had no problems in antenatal period | - | 87.9 | 72.0 | - | 84.5 | 72.8 |
| *Problems during delivery* | | | | | | |
| Wife had problems during delivery | - | - | 83.8 | - | - | 79.6 |
| Wife had no problems during delivery | - | - | 71.8 | - | - | 75.3 |
| Total (N) | 972 | 972 | 972 | 972 | 972 | 972 |
| Total per cent aware | 77.0 | 85.3 | 68.8 | 85.4 | 82.9 | 71.4 |

*Note*: N=813 for antenatal care problems and N=802 for delivery problems

[Barua and Kurz 2001]. However, the qualitative data suggested that, given the high value placed on proving fertility early in the marriage, pregnancy-related care was promptly sought, especially for the first child. Given this context, husbands' awareness of aspects of maternal care, perceptions of their responsibility for maternal care, and ability to participate in getting this care for their wives are likely to be key determinants of the extent to which young pregnant women seek care. The rest of this paper explores type of knowledge, sense of responsibility, and participation in care-seeking for antenatal, delivery and postnatal care among husbands with young or adolescent wives.

## Participation in Maternal Care

More than three quarters of the husbands were aware of the need to seek routine antenatal care, the antenatal problems and the need to treat these problems. An even higher proportion was aware of the need for hygienic precautions during delivery, problems during delivery and that such problems require care. The extent of basic awareness was lowest for the postnatal period, still more than two-thirds of the husbands interviewed had some awareness of postnatal care.

Husbands seemed well-informed about specifics of antenatal care. The provision of iron tablets and tetanus-toxoid injections are the most common antenatal care services of the Indian government health system, while other services are less frequently available. Husbands' knowledge followed this pattern, with over three-quarters being aware of iron tablets and tetanus-toxoid injections provision, and fewer of other services such as physical, abdominal examination, blood pressure, weight, and height measurement and urine test. Only a third of husbands were aware of all the antenatal care services that are to be provided.

Husbands knew little about the details of care during delivery. Their perceptions of 'care' in this period usually entailed arranging for the delivery at a medical institution. Less than 47 per cent knew any of the five cleans (clean place, hands, blade, thread, cloth and disposable delivery kits) to be observed during delivery at home. Similarly, while a large majority of husbands was aware that problems can occur in the antenatal, delivery and postnatal periods, knowledge about specific serious problems like excessive bleeding, convulsions, abnormal presentation, puerperal sepsis was reported by less than half the men. The most dramatic was the case of antenatal care where 85 per cent husbands are aware of antenatal problems , but only 48 per cent of them were aware of swelling, and 20 per cent or fewer knew about other serious problems.

The qualitative data suggested a more nuanced picture of husbands' knowledge. Husbands were clear about the need for nutritious diet and precautions in lifting heavy objects or working hard. "I would make sure that her work load is less during pregnancy and that she has proper nutritious diet, medicines and checkups. All this care benefits both the mother and the child and is therefore necessary" (husband, age 25). Even husbands who did not know the tablets and injections their pregnant wives were given were willing to follow doctor's orders. "I know nothing about medicines given during pregnancy and have no views on the subject. However, if the doctor recommends some for my wife during her pregnancy, I would get them for her" (husband, age 25).

The poorer knowledge about delivery and the postnatal period was probably related to the local custom whereby women go for delivery to the mother's house and the mother takes all the responsibility and necessary care during delivery and a postnatal period of six weeks. In the few cases where the delivery did take place at the marital house, the husbands did not know the details as it is not expected of them and their mothers took complete charge. Even talking about wives' delivery was not deemed necessary by men, as these are considered a 'woman's affair'. "I sent her to her mother's house for delivery. This is the custom in our area, specially for the first deliver. I was told that she delivered at home and the local sister conducted the delivery. I am not sure. I did not ask" (husband, age 23). "I do not know the details because I wasn't there and I did not ask about such things. These are women's affairs" (husband, age 26).

On the whole, husbands were well-informed, even though their knowledge of specific details was limited. Given this knowledge and the traditional values which consider pregnancy, delivery and postnatal care as exclusive female responsibilities, to what extent did husbands feel responsible for their wives' maternal care-seeking, and how much did they actually participate in this process?

For both routine care and treatment of problems, most husbands professed a sense of responsibility to accompany and pay for care. In fact, for treatment of problems, the sense of responsibility was stronger than the degree of awareness that there could be problems. The qualitative data also suggested that men seemed to want to participate. "I want to take her for check up. I think I will take her to private doctor as the care is better. I have advised her to be more careful about her work and diet" (husband, age 22).

**Table 3: Husbands' Socio-Economic Characteristics Associated with Participation in Routine Maternal Care**

| | Accompanied for Routine Care | | |
|---|---|---|---|
| | ANC | Delivery | PNC |
| Background characteristics | | | |
| *Husband's education:* | | | |
| None/primary | 34.9 | 23.0 | 47.6 |
| Secondary (5-8 grade) | 41.8 | 21.7 | 40.0 |
| High school+ | 60.8 | 31.8 | 54.6 |
| *Wife's education:* | | | |
| None | 30.5 | 25.0 | 40.4 |
| Till middle school (8 grade) | 47.7 | 23.7 | 42.9 |
| High school+ | 67.2 | 34.8 | 60.7 |
| *Husband's profession:* | | | |
| Farmer/labourer | 48.6 | 25.0 | 49.5 |
| Service/business | 61.8 | 34.3 | 53.0 |
| *Household structure* | | | |
| Joint/extended | 54.3 | 26.4 | 50.1 |
| Nuclear | 50.4 | 40.5 | 56.0 |
| *Household possessions:* | | | |
| 0-1 | 51.3 | 29.0 | 49.7 |
| 2-3 | 50.8 | 26.4 | 50.0 |
| 4+ | 59.2 | 30.9 | 53.2 |
| *Husband's age at marriage* | | | |
| Less than 22 years | 46.7 | 26.7 | 47.2 |
| 22 years or later | 60.1 | 30.2 | 54.0 |
| *Wife's age at marriage* | | | |
| Less than 16 years | 48.2 | 25.2 | 49.0 |
| 16 years or later | 62.0 | 33.8 | 53.6 |
| *Husband's current age* | | | |
| Less than 25 years | 56.6 | 27.3 | 48.1 |
| 25-29 years | 52.2 | 29.2 | 51.2 |
| 30+ years | 55.3 | 27.9 | 52.1 |
| *Wife's current age* | | | |
| Less than 18 years | 54.7 | 18.9 | 51.0 |
| 18-19 years | 56.2 | 28.6 | 49.1 |
| 20+ years | 52.2 | 30.1 | 52.0 |
| Total (N) | 795 | 795 | 520 |
| Total per cent accompanied | 53.7 | 28.6 | 51.0 |

The degree of knowledge and the perceived sense of responsibility rarely, however, translated into husbands actually accompanying or paying for their wives' routine care, particularly for delivery. They were more likely to accompany their wives and pay for treatment for problems.

In both routine care and treatment of problems, their participation was more likely to take the form of paying for care than accompanying their wives. Husband's absence from the actual process of care was a result of the traditional and medical systems that discourage their participation. Traditional role expectation in this community dissuaded them from taking an active responsibility since these periods are seen as exclusively 'woman's affair'. In addition, there is evidence that the health system itself does not accommodate husbands accompanying their wives for care. Husbands who did go with their wives were made to sit outside, and were not given any explanations about the care their wives received, "She had registered at the local government centre. I had gone with her but I was made to wait outside…I don't know about the advice given to her as I was outside" (husband, age 25).

Thus, a large number of men were aware of maternal care and problems, and an even larger number perceived it their responsibility to participate in and pay for their wives' maternal care. However, a much lower proportion of men actually accompanied wives for care . The rest of this paper explores the association of some key factors with a husband's accompanying his wife for care. We limit our analysis to factors associated with accompaniment rather than paying for care. Since fewer men accompanied their wives than paid for care, this seems to be the more stringent measure of participation.

## Characteristics of Knowledgeable Husbands

Awareness of care and problems during all three periods was higher in men who were better educated, and whose wives had higher education. Interestingly, husbands and wives who married later than the average age at marriage for this community were more likely to be knowledgeable about maternity care (Table 1). Men whose wives had at least one pregnancy were also more likely to be aware of care and problems. Similarly, men whose wives had problems in one maternity phase were more likely to know about care that may be needed as well as problems that may occur in subsequent phases (Table 2). Knowledge of one aspect was found to be related to knowledge of other aspects (Table 2). For example, men aware of care during pregnancy were more likely to be aware about care during delivery and postnatal periods. Moreover, knowledge of delivery precautions and the need for postnatal care was strongly associated with knowledge of problems that could arise in these periods. Over three-quarters of men who knew of delivery precautions were aware of problems in delivery and postpartum periods, compared to less than half the men who did not know that delivery precautions are necessary.

The basic socio-demographic characteristics of men who accompanied their wives for routine care[3] were similar to those who knew about care. Thus, participation in care during all three periods was higher among men who were better educated, and whose wives were educated. There is a jump in the degree of husbands' participation between middle school and higher levels of education for both husband and wife (Table 3). This pattern may reflect the wife's ability to express a desire for her husband to accompany her if she is more educated and possibly more confident of herself. Literature does suggest that women with higher education have stronger conjugal bonds [Nagawa 1994], and this could play a role in this observed pattern of higher husbands' participation in maternal care when their wives are better educated. A similar phenomenon may be the reason why age at marriage of both husband and wife is positively associated with greater husbands' awareness of and participation in their young wives' maternal care.

Except in the case of antenatal care, men who lived in a nuclear family were more likely to accompany their wives in seeking care. This is particularly true of care for delivery, where 41 per cent of men in nuclear families accompanied their wives compared to 26 per cent in joint families. One possible reason could be that a woman at this stage is incapable of going on her own to seek care and her husband must accompany her when no one else is available. When living in a joint family, on the other hand,

**Table 4: Husbands' Obstetric Knowledge and Experience and Participation in Routine Care**

| | Accompanied for Routine Care | | |
|---|---|---|---|
| | ANC | Delivery | PNC |
| Pregnancy and parenthood | | | |
| *No of living children* | | | |
| None | 65.6 | 31.5 | 53.8 |
| One only | 55.8 | 26.1 | 51.3 |
| Two or more | 43.0 | 29.6 | 48.5 |
| Knowledge and experience: previous pregnancy phase | | | |
| *Antenatal care* | | | |
| Aware of need for antenatal care | 56.9 | 30.4 | 53.0 |
| Not aware of need for antenatal care | 38.9 | 19.9 | 38.4 |
| *Delivery precautions* | | | |
| Aware of delivery precautions | | 29.1 | 52.7 |
| Not aware of delivery precautions | | 23.9 | 31.8 |
| *Postnatal care* | | | |
| Aware of need for postnatal care | | | 53.7 |
| Not aware of need for postnatal care | | | 29.3 |
| *Perceived responsibility for routine care* | | | |
| Husband should accompany wife for routine care | 53.8 | 29.4 | 53.4 |
| Husband need not accompany wife for routine care | 50.0 | 12.2 | 3.9 |
| *Participation in routine ANC* | | | |
| Accompanied wife for routine care | | 35.8 | 68.7 |
| Did not accompany wife for routine care | | 20.6 | 28.4 |
| *Participation in delivery* | | | |
| Accompanied/present for wife's delivery | | | 73.3 |
| Did not accompany/not present for wife's delivery | | | 41.3 |
| *Antenatal problems* | | | |
| Wife had problems in antenatal period | | 30.2 | 53.9 |
| Wife had no problems in antenatal period | | 27.7 | 49.2 |
| *Problems during delivery* | | | |
| Wife had problems during delivery | | | 67.0 |
| Wife had no problems during delivery | | | 46.7 |
| Total (N) | 795 | 795 | 520 |
| Total per cent accompanied | 53.7 | 28.6 | 51.0 |

**Table 5: Husbands' Obstetric Knowledge and Experience and Participation in Treatment**

| | Accompanied Wife for Treatment | | |
|---|---|---|---|
| | ANC | Delivery | PNC |
| *Awareness of need for routine care* | | | |
| Aware of need for care | 73.3 | 77.6 | 81.5 |
| Not aware of need for care | 65.5 | 76.9 | 70.0 |
| *Participation in routine care* | | | |
| Accompanied wife for routine care | 90.3 | 94.8 | 94.7 |
| Did not accompany wife for routine care | 51.7 | 64.6 | 65.3 |
| *Perceived responsibility for treatment of problems* | | | |
| Husband should accompany wife for treatment | 73.8 | 78.1 | 81.5 |
| Husband need not accompany wife for treatment | 16.7 | 0.0 | 25.0 |
| Total (N) | 250 | 138 | 150 |
| Total per cent who accompanied wife | 72.4 | 77.5 | 80.0 |

husbands may participate less because other female members of the household are there to accompany the wife, which, as the qualitative data suggest, may be more socially acceptable than the husband's participation.

There is a positive relationship between awareness about care and actual participation (Table 4). Men who responded that they are aware of the need for maternal care are more likely to accompany their wives for care (or delivery) than men who are not aware. This association holds both for knowledge and participation for the same phase of maternity, as well as for knowledge of one phase and participation in subsequent phases. For instance, men who are aware of the need for antenatal care are more likely to accompany their wives for all three phases of care compared to men who are not aware, and men who are aware of precautions during delivery are more likely to accompany their wives for delivery as well as for postnatal care.

Most husbands professed responsibility, however, participation was limited: only half the men who said that husbands should accompany their wives actually accompanied their wives for antenatal or postnatal care, and a third were present at delivery. This gap is consistent with the gap that the qualitative data illustrated between men's desire to participate and their ability to do so because of attitudes about maternal care being 'women's domain', as well as constraints within the health system.

In addition to being limited, husbands' participation in routine care during the three phases was linked such that men who accompanied their wives for one phase of care were more likely to also accompany them for subsequent phases of care. Thus, husbands who accompanied their wives for routine antenatal care were more likely to be present at delivery and to accompany their wives for routine postnatal care than husbands who did not go with their wives for routine antenatal check-ups.

Experiences of problems in one phase influenced husbands' participation in care-seeking for subsequent phases. Men whose wives had problems in the antenatal period were more likely to be present at delivery and to accompany their wives for routine postnatal care, and men whose wives had problems during delivery were more likely to accompany their wives for postnatal check-ups than the men whose wives did not report any problems during these period. Given the emphasis on early childbearing in this population, it is not surprising that husbands were more anxious to participate if their wives had problems.[4]

Husbands' greater willingness to participate in seeking treatment for problems was evident. Table 5 further shows that greater participation for treatment-seeking was associated with knowledge about routine maternal care. Men who were aware of routine care in any one phase were more likely to accompany their wives when seeking treatment for problems experienced in that phase. Almost all the husbands who accompanied their wives for routine care also accompanied them for treatment if the wives experienced problems, compared to half to two-thirds of husbands who had not accompanied their wives for routine care. A larger proportion of husbands who thought they should be responsible actually participated in their wives' seeking treatment for problems (three-quarters or more) as compared to participation in routine care.

## Conclusions

Analysis showed that a majority of husbands in the study area were knowledgeable about prenatal, delivery and postnatal care, and were aware that problems could occur during these periods. The qualitative data suggested that much of men's knowledge centred on the need for a nutritious diet and precautions for hard work, rather than on details of care, and specific problems. Data also suggested that it is the same subset of husbands who know about all phases of maternal care. Most husbands – regardless of knowledge – voiced a sense of responsibility when it came to paying for care or accompanying their wives to clinics.

Despite high awareness and a professed sense of responsibility, the extent to which husbands were present at routine antenatal or postnatal care, or at delivery, was limited. We found that knowledge was important in the extent to which men accompanied their wives. Thus, the husbands who were likely to participate in routine care were those who were aware of the need for care. Moreover, the same sub-group of men were likely to accompany their wives for antenatal, delivery, and postnatal care. In addition, husbands of educated wives were more likely to accompany them as compared to illiterate wives, and this effect was stronger for higher levels of the wife's education, possibly indicating the wife's ability to express a desire for her husband to accompany her.

The qualitative data suggested that men were often excluded from participating in routine care because the medical system does not accommodate them and the community considers maternal care as exclusively women's domains. The patterns of participation by family structure bears this out: husbands from joint families were much less likely to be present during delivery than those in nuclear households, probably because in the former other women in the family take the responsibility.

Even though there are deterrents to men being present while their wives seek care, data showed that men were eager to be involved when there were problems, and in fact they did participate more than for routine care. At the same time, the pattern of who participated remained the same in that it was the same sub-group of men who were active: those who accompanied their wives for routine care were more likely to participate in seeking care when problems arose.

These composite patterns of husbands' participation in care-seeking for routine care and treatment of problems, combined with attitudes about the extent to which men should be present, raised important policy and programmatic questions. First, in terms of immediate implications for the intervention research currently ongoing in the study area, it is clear that programmes no longer need to focus on awareness building for need for maternal care but on imparting detailed information about available care and specific problems during these periods. Similarly, the intervention does not need to have a primary focus on increasing men's perceptions of their responsibility in their wives' maternity care. Despite – or perhaps because of – being young and under pressure to have children early, these husbands are conscious of the need for men to participate in their wives' maternal care. The gap, then, lies in the bridge between knowledge and responsibility on the one hand, and participation on the other. This begs a larger programmatic and policy question: how should men's participation be defined and what kind of participation should be encouraged?

Our in-depth interviews suggest that young, newly-married women experience pregnancy and childbearing in an environment where they have little or no autonomy in decision-making, finances, or mobility to seek care. Thus, it may be crucial to get husbands involved, since husbands are often the decision-makers,

the ones who have to accompany the young woman to a clinic, and the ones who pay for care. However, the same interviews also suggest that women themselves may not want their husbands to be present; and the health system makes it hard for husbands to be present. Other literature cautions that increasing male involvement could potentially encroach on women's empowerment by allowing men to intrude on concerns that have traditionally been managed by women [Helzner 1996; Ransom 2000].

Our analysis and ongoing community research suggests that it is important to involve men, but that we need to redefine 'involvement' to include ways that strengthen men's potential supportive roles in the home when their wives are pregnant. The quantitative data that we have is limited by the narrow definition of participation that we used – accompanying or paying for care. These measures provide little information about how else a husband may be involved in his wife's pregnancy experience, nor about how engaged a husband may or may not be when he accompanies his wife for care.

The qualitative research suggested a broader definition of husbands' role which includes encouragement to the wife to rest and reduce workloads, to have a nutritious diet, and to follow-up on care as prescribed. Also, given the enormous pressure faced by her to have a child soon after marriage, and the dominance of parents-in-law, a husband can be a positive mediator between his parents and spouse, and support her in taking care of herself during pregnancy and postpartum. Finally, our research points to an urgent need to improve the health system in rural India – both in terms of facilities and attitudes of health staff – so that among young couples who wish to be together when accessing care, husbands can truly participate in and be knowledgeable of the medical care received.

Young and adolescent married women in large parts of rural India face experiences similar to those described here for the women in rural Maharashtra. Given the realities of the constraints and reproductive pressures faced by these women, and the large role played by husbands, it is imperative to define husbands' involvement in maternal care more broadly than has often been the case. The definition has to be contextually valid and should recognise the role of the household and family, while at the same time taking into account the desires and needs of the young woman, her husband, and the two as a couple who will jointly share the responsibility of bringing up their children. EPW

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## Notes

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1 According to the present Indian health system's infrastructure, there is one PHC for every 20-30,000 population and one subcentre for every 3-5,000 population (International Institute for Population Sciences (IIPS) 1995).

2 Multivariate analysis to examine the independent role in participation of knowledge, and of participation in previous maternity phases (e g, influence of participation in ANC on participation in delivery) was problematic because of possible endogeneity between knowledge and participation, as well as unobserved heterogeneity in the influence of past pregnancy experiences on both knowledge and participation. Future rounds of data collection will allow us to control for these problems to some extent, and multivariate analysis is planned at that stage.

3 In the case of delivery, 'accompanying for routine care' should be understood as accompanying for or being present at delivery.

4 The samples for husbands' participation, in both routine care and treatment for problems, comprise women who sought care, and, in the case of problems, women who had problems and who sought treatment for those problems. The qualitative data suggests that this may be a select sample, given the constraints to care-seeking for young or adolescent married women, and thus these results may not be generalisable to all young married women.

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