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Advices on RCH during Ante-natal Care and its Association on Utilizations and Practices of RCH Services in India

Priyanka Yadav

Abstract

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. Purpose of this disquisition is to analyse the extent of advice and discussion given to husband and wife during Ante-natal care and its utilization and practices in India. The method of working is quantitative. Study is emanate from National family health survey-3 data with the methodology used bivariate analysis to present the data and Phi and Cramer v tests for measured the association between independent and dependent variables. Evaluation of this paper where both husband and wife adviced for ANCs, both husband and wife advised for the institutional delivery is 3.4 times more likely to go for institutional delivery and the level of using modern method of family planning is 2.3 times more likely where both husband and wife advised. Thus, it may be get crucial to get husbands involved, since they are often the decision-makers, the ones who have the accompany the women to a clinic and the one who pay for care.

Introduction

Historically most of the RCH and family planning programs had focussed only on women with the basic assumptions that women are the ones who are bestowed with the noble job of bearing a child. However, childbearing is never an easy unidirectional wisdom as it happens to be the outcome of a participation of both the partners in a conjugal union and men together with women play equally if not more crucial role in major decision-making including family planning and RCH related issues. The idea of increasing men's participation in family planning has receive periodic attention for the past 20 years, but there is no generally accepted understanding of what men's involvement means. Routine antenatal care (ANC) is defined as the care provided by health practitioners (or others) to all pregnant women to ensure the best health conditions for the women and their foetuses during pregnancy. The basic components of the ANC include risk identification, prevention and management of pregnancy-specific or concomitant diseases, education and health promotion. The goal-oriented approach with reduced number of visits, currently recommended by the World Health Organization (WHO), was incorporated into WHO's Integrated Management of Pregnancy and Childbirth guidelines. However, even though the number and content of antenatal visits have been appraised and summarised in systematic reviews during recent years an evaluation of the evidence is needed because recommendations may have changed over time in light of new and compelling evidence. Family planning allows people to attain their desired number of children and determine the spacing of pregnancies. It is achieved through use of contraceptive methods and the treatment of infertility. Promotion of family planning – and ensuring access to preferred contraceptive methods for women and couples – is essential to securing the well-being and autonomy of women, while supporting the health and development of communities. A woman's ability to choose if and when to become pregnant has a direct impact on her health and well-being.

Family planning allows spacing of pregnancies and can delay pregnancies in young women at increased risk of health problems and death from early childbearing. It prevents unintended pregnancies, including those of older women who face increased risks related to pregnancy. Family planning enables women who wish to limit the size of their families to do so. Evidence suggests that women who have more than 4 children are at increased risk of maternal mortality. By reducing rates of unintended pregnancies, family planning also reduces the need for unsafe abortion. Family planning can prevent closely spaced and ill-timed pregnancies and births, which contribute to some of the world's highest infant mortality rates. Infants of mothers who die as a result of giving birth also have a greater risk of death and poor health. Family planningreduces the risk of unintended pregnancies among women living with HIV, resulting in fewer infected babies and orphans. In addition, male and female condoms provide dual protection against unintended pregnancies and against STIs including HIV. Family planning enables people to make

informed choices about their sexual and reproductive health. Family planning represents an opportunity for women to pursue additional education and participate in public life, including paid employment in non-family organizations. Additionally, having smaller families allows parents to invest more in each child. Children with fewer siblings tend to stay in school longer than those with many siblings Pregnant adolescents are more likely to have preterm or low birth-weight babies. Babies born to adolescents have higher rates of neonatal mortality. Many adolescent girls who become pregnant have to leave school. This has long-term implications for them as individuals, their families and communities. Family planning is key to slowing unsustainable population growth and theresulting negative impacts on the economy, environment, and national and regional development efforts. It isimportant that family planning is widely available and easily accessible through midwives and other trained health workers to anyone who is sexually active, including adolescents.

Midwives are trained to provide (where authorised) locally available and culturally acceptable contraceptive methods. Other trained health workers, for example community health workers, also provide counselling and some family planning methods, for example pills and condoms. For methods such as sterilization, women and men need to be referred to a clinician. Contraceptive use has increased in many parts of the world, especially in Asia and Latin America, but continues to be low in sub-Saharan Africa. Globally, use of modern contraception has risen slightly, from 54% in 1990 to 57.4% in 2015. Regionally, the proportion of women aged 15–49 reporting use of a modern contraceptive method has risen minimally or plateaued between 2008 and 2015. In Africa it went from 23.6% to 28.5%, in Asia it has risen slightly from 60.9% to 61.8%, and in Latin America and the Caribbean it has remained stable at 66.7%. The unmet need for contraception remains too high. This inequity is fuelled by both a growing population, and a shortage of family planning services. In Africa, 24.2% of women of reproductive age have an unmet need for modern contraception. In Asia, and Latin America and the Caribbean – regions with relatively high contraceptive prevalence – the levels of unmet need are 10.2 % and 10.7%, respectively (Trends in Contraception Worldwide 2015, UNDESA). WHO is working to promote family planning by producing evidence-based guidelines on safety and service delivery of contraceptive methods, developing quality standards and providing pre-qualification of contraceptive commodities, and helping countries introduce, adapt and implement these tools to meet their needs.

Healthcare sector has been experiencing a regular increase in shift from non-institutional to institutional deliveries over the years. Institutional delivery refers to the childbirth at technology-equipped medical facility under supervision of skilled medical staff. In an institutional delivery, various medical tools and technologies are used to ascertain that health of neonate or mother is not compromised. Non-institutional delivery still accounts for a major proportion of childbirths across the globe. Reason for people not accepting modern medical facilities for childbirth is either the cost involved in it or the perception that home delivery is completely safe. According to many of them, home deliveries are common cultural practice and there is no need to visit a health facility for the natural phenomenon.

Advantages of Institutional Childbirths

- Antenatal care is a perquisite for a healthy delivery. Medical facility with trained staff and advanced facilities provides all services related to antenatal check-ups and counselling.
- In a medical institution, trained healthcare professionals provide specific care and attention to newborn babies with special needs in order to improve their survival chances and reducing the risk of maternal mortality.
- Women seeking assistance of medical institution for delivery are the ones given ample support to conceive at the right maternal age without delaying childbearing.
- Mothers are regularly assisted for post-pregnancy care, with medical staff discussing various aspects such as care for umbilical cord stump, nutrition, breastfeeding and bathing.
- Improper care during pregnancy term can also affect overall maternal health, specifically the reproductive health of the woman besides the health of the newborn baby.
- Hygienic conditions and surroundings are also important for safe delivery, which are mostly ignored in non-institutional setting for a delivery.

- Immunisation chart can be easily adhered to in an institutional medical facility. Following immunisation schedule ascertains that baby as well as mother is safe from various maladies and health complications.
- Institutional settings provide aid to hasten labour like intravenous (IV) drips and intramuscular injections during labour.
- Institutional medical facilities aim for safe delivery by labour monitoring, active management of the third stage of delivery, immediate attention of the newborn, postpartum monitoring, addressing complications of mother and infant post-delivery.
- Quality of care is all-important, which is provided by institutional medical setting.
- Institutional medical facility also provides personnel and equipments to handle emergency circumstances which necessitate immediate medical attention.
- Round-the-clock supervision ensures comfort for mother with medical staff looking after nutrition and diaper changes of her baby.

Studies conducted in India and globally recognise the contribution of the antenatal care (ANC) in not only sustaining better maternal health but also in reducing maternal mortality and morbidity. In an effort to reduce maternal mortality, the Reproductive and Child Health (RCH) Programme under National Health Mission, Government of India is aimed at providing at least three antenatal check-ups which include a weight and blood pressure check, abdominal examination, immunization against tetanus, iron and folic acid prophylaxis, as well as anaemia management. Antenatal care utilization is associated with a number of socio-demographic and economic factors such as age of the woman, education, work status, parity, media exposure, household income, awareness and knowledge regarding antenatal care services, cultural beliefs, woman's autonomy, availability and access to health care, prior experience of delivery complications and motivation by either health care provider or family. In India, according to National Family Health Survey (NFHS-3), more than three-quarters of pregnant women received at least some antenatal care, but only half of the women had received at least three ANC visits as prescribed mandatory by the government norms of ANC in India. Further analysis indicated that the likelihood of receiving any antenatal care and specifically care from a doctor was lowest among Scheduled Tribes women. Even among the tribal population, there was regional disparity in the health indicators and utilization of health care.

Realization of the need to focus on men had resulted at the 1994 International & Conference on Population & Development (ICPD) in Cairo as well as at the 1995 World Conference in Beijing. The program of action endorsed at the Cairo conference calls for the need to recognize men as equal partners with women in all matters relating to reproductive health & family planning. Taking cue from the ICPD, the National Population policy of India, 2000 recognizes men as the under-served population. It sees the exclusion of the men from the family planning program as a patriarchal society like India men play the critical role in all matters relating to the family. Therefore, it aims at focussing attention on men in the information and education campaigns and to promote the small family norms. It also aims at re-popularizing male contraception especially no-scalpel vasectomy as a simple and painless procedure more convenient and acceptable to men (MoHFW, 2000). Reproductive health program and services are commonly targeted to women's reproductive health and offered their services exclusively to women, especially conduct with family planning, prevention of unwanted pregnancy, maternal care during the pregnancy period, risky abortion, and the improvement of safe motherhood. But the role of men in reproductive health and family planning programs and most contraceptive methods are designed for women only (Dewi,2009).Moreover, this is traditional practice that men always want to avoid taking the equal responsibility un their conjugal life on fertility related issues, especially on contraceptive usage though they support to their wife on contraception (Mosiur, 2008).Most of men's have little knowledge on reproductive health especially they have no proper knowledge of symptoms, transmutations, and prevention of Reproductive Tract Infections (RTIs) and Sexually Tract Infections (STIs). So, there are huge number of male sufferings from reproductive health problem (Dunn et al, 2006). The ICPD held in Cairo 1994 emphasis on men's involvement in this area "special efforts" should be made to emphasize men's shared responsibility and promote their active involvement in responsible parenthood, sexual and reproductive behaviour, including family planning: prenatal, maternal and child health; preventing of STIs; including HIV; prevention of unwanted and high risk pregnancies; shared control and contribution to family income, children's education, health and nutrition; and recognition and

promotion of the equal value of children from the earliest ages (UNFA,1994:5).The World Health Organization (WHO) gives a clear outline of the reproductive health it declared that HEALTH means as a state of total physical, psychological, and social well-being and just not the absence of disease or illness (UNFA, 1995).This Organization considers the all aspects of reproductive life such as "people are able to have a responsible, satisfying and safe sexual life and that they have the capability to reproduce and the freedom to decide if when and how often to do so" (UNFA,1995:6).They emphasis on that men and women have equal right to get information about reproductive health and access to safe and satisfactory methods of fertility control and the ability to access to appropriate health care services (UNFA, 1995).

Male's involvement in family planning and reproductive health may improve equality in gender relation, promoting better relationship between men and women through which they can take decision regarding family planning jointly and equal responsibilities of sexual behaviour (Hossain,2003).Male involvement in family planning and reproductive health is an umbrella term which includes three aspects such as reproductive health problems and programmes, reproductive rights and reproductive behaviour (UNFA,1995).Male involvement in family planning and reproductive health regards men's knowledge of reproductive health and family planning attitudes about the use of contraception, communication with partners about Family Planning, choices about appropriate contraceptive methods, gives emotional and behavioural support to their partner's contraception use. There is also been a shift in objective of male participation and concerns, from increasing contraceptive use and achieving demographic goals to achieving gender equality and fulfilling various reproductive responsibilities.

Male involvement in family planning and reproductive health is most important for maternal and neonatal care in Bangladesh. Nasreen (2012) showed that male was involved with BRAC health programme named 'Improving Maternal, Neonatal and Child Survival' (IMNCS) were more likely to take care maternal health, more knowledge on Neonatal danger signs, new-born care and birth responsiveness compared with not involved in this project. So, male involvement in family planning enables them to take care of reproductive issues. But the rate of male involvement in family planning is low in Bangladesh. On the other hand, the adolescent has no proper knowledge on their reproductive health. Due to religious and cultural norms, in the time of adolescent, they are not getting the proper knowledge on their reproductive health. The role of men in fertility and family planning in sub-Saharan Africa is becoming increasingly important in the context of raising contraceptive prevalence and reducing level of fertility. Fertility studies in the recent past, however, have been dominated by findings almost exclusively from women (Mbizvo and Basset, 1995; Bankole, 1995; Ottenbarg, 1995; Danforth and Jezowski, 1994; Raimi, 1994; Orubuloye, 1993; Adamchak and Adebayo, 1987).

Regrettably, policies and programs based on such findings have not had expected success in increasing contraceptive prevalence and simultaneously reducing overall fertility in sub-Saharan Africa. Men's involvement could assume an essentially prominent role in the individual couple's family planning effort. It is assumed in the African context that women do not have control over their own reproductive behaviour. Most studies carried out in Nigeria and other African countries (Lasee and Becker, 1997; Donovan, 1995; Isiugo-Abanihe, 1994; Roudi and Asford, 1994; Mbizvo and Adamchalk, 1991; Oni and MacCarthy, 1991) have all asserted the domineering position of men on reproductive health matters. According to the results of these studies, men are dominant decision makers within the family. They also gain socially and economically from having large numbers of children, and that men reproductive preferences and motivation influence their wife's reproductive outcome. These assertions are also corroborated by Fapohunda and Todaro (1988) when they concluded in their study that men's negative attitude is a major reason their wives fail to practice family planning, even when the latter are motivated to do so etc. Studies also show that male involvement enhances both the use of ante-natal care and contraception. A study conducted in rural Uttar Pradesh, India, revealed that majority of men were not aware of their wives' pregnancy, including ante-natal care received by them and pre-and post-natal complications experienced by them. This was due to limited inter-spousal communication and involvement of men in matters to women is also either little or limited. A four-day workshop organized by SIDH, an NGO, brought out certain problems faced by men such as alienation, isolation, and ridicule. The workshop suggested that providing more opportunities for men to articulate their problems can lead them to become more

sensitive to women's problems. Furthermore, in recognition of the role of the couple in family planning, one of the goals set at the 1990 World Summit for Children was to make 'Family planning education and services' 'available to all couples to empower them to prevent unwanted pregnancies and births which are too many and too close, and to women who are too young or too old' In Africa, men are the decision makers and therefore, studies have documented improvement in family planning acceptance and reduction in total fertility rates in areas where males have been involved in the family planning. Research has shown that women would like their partners to be more involved in maternal and child health care and that, in many cases, men are interested in being involved (Population Council, 2005). Increased male participation could yield health benefits for men, women, and children by ensuring the use of antenatal care (ANC), healthy practices during pregnancy, institutional delivery and child care (Singh 1998; Caleb Varkey, 2001; Caleb Varkey et al. 2004; Barua et al. 2004; Walston, 2005; Singh & Ram, 2007). There have been several 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).

This brief includes four in-depth case studies of interventions using gender-transformative approaches to engage men in family planning programs. A review of recent initiatives informed the brief to engage men in sexual and reproductive health programs and a technical consultation aimed at defining and discussing male engagement practices, the evaluation of male engagement programs, and the feasibility of scaling-up successful approaches. Only a small number of those programs focused on family planning, though not all set out to be gender transformative. What follows here are short descriptions of those illustrative programs that highlight successful elements in engaging men in family planning efforts. These are a sampling of programs drawn from the larger review that have well-documented evaluations related to family planning outcomes and had program managers available to provide additional information. Some of these programs did not significantly impact family planning use, but remain valuable examples because they were successful short-term interventions that addressed issues related to family planning uptake such as couple communication and joint decision-making. USAIDA recent baseline survey on reproductive health activities implemented or planned by USAID missions or cooperating agencies [Pillsbury, 1994, PD-ABJ-873] revealed that increased male involvement in both pregnancy and STD prevention is a *high priority*.

Following are examples extracted from the survey of how some missions view the issue: Expand the focus from women and children to include men (they are the primary decision makers and are in economic control over reproductive behaviour (USAID/El Salvador). We must increase our efforts to include men in reproductive health initiatives. The reason is obvious: For both genders to enjoy healthy sexual relations, and health reproductive lives, both genders need not only to be aware of but also to act on their reproductive health responsibilities. (USAID/Honduras)"Men have a direct, major role in contraceptive decision-making, but also an indirect role as a dominant factor in women's calculations concerning their own economic, social, and family needs. Men's sexual behaviour has direct impact not only on their own health, but also that of their wives, partners, and offspring, especially in the context of STDs/HIV. Thus, men are a major determinant of contraceptive use by women and couples and, in fact, of women's health in general. A successful approach to reproductive health calls for their full participation and commitment (Pillsbury, 1994)."

Definition of keywords

Institutional delivery- The World Health Organization (WHO) defines a skilled attendant as *"an accredited health professional-such as a midwife, doctor or nurse-who has been educated and trained to proficiency in the skills needed to manage normal (uncomplicated) pregnancies, childbirth, and the immediate postnatal period, and in the identification, management and referral of complications in women and new-borns".*

Family planning (using modern method)- Increasing access to modern contraception among adolescent girls is a crucial starting point for improving their long-term health. It is also essential for improving maternal and new-born health. In low- and middle- income countries, complications from pregnancy and childbirth are leading killers of adolescent girls (ages 15-19). Their babies also face a

higher risk of dying than the babies of older women. Yet adolescents face enormous barriers to accessing reproductive health information and services.

Methodology

Study Design

This study has been carried out by National Family Health Survey Data (NFHS-3 2005-06). In NFHS data women and men files has been used for the study.

Statistical Analysis

Bivariate analyses such as cross tabulation was used to present the data and Phi and Cramer v tests were measured to check the association between independent variables and dependent variable. The variables that found significant in the bivariate analysis were only included in the logistic regression analysis. Phi is a chi-square based measure of association. The chi-square coefficient depends on the strength of the relationship and sample size. Logistic regression model is appropriate when the dependent variable is nominal dichotomous (Sufain, 2009). The dependent variable are dichotomous whether institutional delivery and using modern method of Family Planning ("1" for Yes; "0" for No). So, the logit transformation of the model is:

$$\text{Logit}(P)=\ln(P/(1-P))=\beta 0+ \beta 1X1 + \beta 2X2+ \beta 3X3\ldots+\beta kXk+ e$$

here the p is the probability of using the modern method family planning and reproductive health is high, X1; X2; X3….Xk, are the explanatory variable,β0the intercept and *e* is an error term. The regression coefficients βi shows the change in log odds for on unit change in xi. Exponent of β are called odd ratios.

Description of Variable

Dependent Variables: The analysis confines to the advice given to both husband and wife for a like, importance of Institutional delivery and importance of using modern method of family planning.

Independent Variable: predictor variables are used in this study are: this is independent variable age group (under 24, 25-34, and 35+), women education (no education, primary, secondary and higher), caste (SC, ST, OBC and General), religion (Hindu, Muslim and others), wealth quintile (poorest, poorer, middle, richer and richest) and place of residence (rural and urban).Logistic regression has been carried out to understand the association between institutional delivery, and using modern method of family planning various socio-economic and demographic variables.

Results

Table 1 shows the advice on exclusive breastfeeding by selected background characteristics among age, caste, religion, education, wealth quintile and place of residence, in this, in age group between 25 to 34 the percentage is high only husband advised for this is 30%. Only the wife is advised on institutional delivery and the percentage is 22%. In place of residence, the percentage is high among in urban areas. The percentage for both husband and wife advised, only wife advised, only husband advised and none of them advised 25.1%, 31.2%, 22.2% and 21.5% respectively. The difference of women and only wives who advised for the institutional delivery is 54.5% up and the difference of men and husband is 65.6%In education level, where only advised is given to husband is high in all category of education and it is 40.5 % and both who has not advised neither the husband nor the wives is 37.7%. But difference in between only wife advised and women advised is considerably high in secondary and higher education with 78.7% and 95.5% and the same for men and husband with 64.4% and 91.6% respectively. There are variations also seen in the table in types of caste and religion. In caste, the percentage is low among all three categories such as both husband and wife advised, only wife advised and husband only advised on institutional delivery.

Table 2: the age structure 25-34 the only husband and both not advised percentage is high with 30.7% and 34% respectively and in the age group above 35 only husband who advised on it. Both not advised on family planning are 39.1% and 41.6% respectively. In place of residence, variation is here in rural where only husband who advised and used modern family panning method is 31.1% and this number is more than the urban users where only husband is advised with 26.5%. Rest of the results are not so different across the categories; the percentage is as usual high in none of them advised. Same in all the other background characteristic, residence, wealth quintile, education level. In

wealth quintile, the percentage is again high in only husband advised on family planning through the poorest to middle category for poorest, poorer, and middle, the percentage are 35.8%,34.3%, and 30.5% respectively. In both husband and wife are not advised for using modern method of family planning by health workers the percentage is also high.

Table 3: Level of institutional delivery by respondents who have been advised for institutional delivery with the model of phi and Cramer, and the prevalence of the institutional delivery, age of women is associated with husband and wife involvement in going for institutional delivery. About 55.9% went for institutional delivery where both advised for the institutional delivery in the age group 15-24. Only wife is advised is 60.8%, only husband is advised is 24.2%. The phi and Cramer v test also shows the association of age of women who are advised for institutional delivery is highly significant. This percent are only went for institutional delivery who have been advised on the importance of institutional delivery. The difference of women irrespective of their husband either they advised or not is 9.1% up with the only wives advised. In the age group 25 to 34, the proportion for only husband advised is high with 79.1% and they went for institutional delivery, again, it is highly significant. In place of residence, urban is higher than rural in both advised only wife advised and only husband advised with the proportion of 83.9%, 80% and 42.5% respectively and test is also significant. In wealth index, richest category proportion is comparatively in between good. The percentage for both husband and wife are advised is 87.5%, 84.5% for only wife advised and 9.5% for men who advised and went for institutional delivery. In education level, secondary and higher level, the value is good here participation is much among the involvement of both husband and wife and wives. In secondary, both advised is 68.1% and only wife is 66.9%. In higher, both advised is 98.7% this value is highly considerable and again ideally in where only wife advised for institutional delivery with 90.4%In caste, in SC the more participating is where both advised is 60.4% and only wife is 49.8%. in OBC, both advised is 54.9% and only wife is 60.2%. They went for institutional delivery. In background characteristics, religion, the percentage is moderately high among Hindu and Muslim who went for institutional delivery who have been advised for the importance of institutional delivery in the category of both husband and wife are advised and the percentage are 65.9% and 42.6% respectively.

Table 4: Level of modern family planning method use women who have been advised for family planning with the model of phi and Cramer v. For wife's husband where high proportion among both advised in 62.8%, only wife advised is 55.5%, only husband advised is 35.0% in the age group below 24 yrs., in age group, 25-34, both advised for using modern family planning method that 71.9% and only wife advised for this is 72%.In place of residence, urban area where only wife advised for using modern method of family planning is 74.4% it shows the higher use of the modern method and in rural high for both advised with 68.5%. In wealth quintile, in richer category where both advised the use of modern method is high in 78.1%, and it is low when both advised in poorest category and only wife advised is 82.2%. In education level, in secondary education, both advised is 74.8% and in higher, both not advised and this 78.7%. In religion, in Hindu religion 65.7% in both advised has as slightly lower level of modern method used and in Muslim it is higher both advised for using modern method of family planning is 70.2%. The level of utilization of the advices of using modern method of family planning is high among all the background characteristics in the category of where both husband and wife are both advised like in age group of below 25 the proportion is 62.8% who using modern method of family planning, in rural area proportion is 68.9% both husband and wife are agree with using modern method of family planning, in OBC caste, the percentage is very interesting that 81.8% where both husband and wife are advised for using modern method of family planning.

Table 5: the results from the logistic regression while using the institutional delivery as a dependent variable. The women who belongs to the Scheduled castes is 38% less likely to went for delivery than those other caste and other independent variables remain fixed. Other ST and OBC cases 0.515 and 0.974 times respectively lower than who belongs the general category and the other independent variables remain fixed. In where only wife advised for the institutional delivery is 3.2 times more likely to went for institutional delivery it is more than the reference category where both not advised for the institutional delivery. Where only husband advised for the institutional delivery is 3.6% more likely than both not advised for the institutional delivery. In which, both husband and wife advised for

the institutional delivery is 3.4 times more likely to go for institutional delivery than where none of them is advised.

Table 6: The results from the logistic regression while using the modern method of family planning as a dependent variable. The level of using modern method of family planning is 2.3 times more likely where both husband and wife advised for the using modern method of family planning than none of them was advised. It is interesting to see when only husband is advised that odds remain as high as when both were advised on family planning as compared to when none of them advised after controlling all the available background characteristics.

Discussion

Since the International Conference on Population and Development (ICPD) in Cairo in 1994, there has been increased attention on the issue of male involvement in reproductive health and family planning, and as its importance is acknowledged, more programmes are trying to incorporate it as one of their components. Men were and always often excluded from participating in routine care because the medical system does not accommodate them and the community consider maternal care as exclusively women's domain. Findings from the study indicated in table 1and 2 where the percentage distribution of women who have been advised on institutional delivery and using modern method of family planning by health workers where we see that the percentage is high in where both husband and wife together not advised for these ANCs. In table 4 and 5 shows the level of institutional delivery, using modern method of family planning and exclusive breastfeeding by the state of husband and wife advised by background characteristics and we see in these tables the percentage is very interesting in where both husband and wife are advised they utilized these ANCs services. These findings reinforce studies documenting the need to promote the utilization of ANC among women belonging to tribal population. Consistent with prior research, findings demonstrate a strong causal relationship between the timing of contact of a pregnant woman with the health system and her compliance to availing complete ANC services offered by the health facility. Early contact with the health system not only provides better opportunity to pregnant women to receive information at the right time regarding importance of complete ANC services and pregnancy carebut also motivates her to utilize these services. This study considered the motivation for complete utilization of the ANC services by other husband. Motivation by the husbands has come up as another significant causal factor for the utilization of ANC among women.

There are many emerging body of knowledge in respect to male involvement in reproductive health is due to contribution from the family planning program. A focus on men only is as inadequate as a focus on women only because it fails to consider the way in which many decisions are made and the context that influences them (Bankole&Westoff, 1998). Programmes have traditionally been institutionalized through the MCH facility of the Ministry of Health, with a dominant focus on women and children, keeping men outside the purview of services and scrutinizing their extent of responsibility sharing around reproductive health of their wives and the health of their children. The surveys most relied upon for reproductive health programmes usually pose the questions only to the women, if they are the ones who make the decisions regarding reproduction and that men are either not involved, or only marginally involved (Chatterjee & Riley, 2001) – hence the need for an inclusive policy. The issue of lack of men's data to understand male perspectives and the extent of their involvement in reproductive health is now solved to some extent with the availability of the NFHS-III (2007) data for the first time in India, which has been used for the present analysis. This study aims to understand whether the husband's positive knowledge about the family planning, institutional delivery and breastfeeding. Using modern family planning method is not only the part of women or wives it is the mutual concern with in the husband and wives both.

Again, though various studies (Miller et al., 1991; Ezeh, 1993; Stolley, 1995; Thomson, 1995) have shown that in couple analysis, husband's and wife's characteristics do have a separate and significant effect on the outcome variables (especially family planning and birth interval), here only the husband's variables are given more importance because of co-linearity of husband–wife individual variables. This is because the study views women's health care use/decision-making from the husband's perspective. In this study, this is clearly shown that in every category whether it is Using modern method of family planning, importance of breastfeeding and importance of institutional delivery the higher percentage is where both husband and wife is advised for using modern method of

family planning, going for institutional delivery and and for breastfeeding. The numbers is more high in background characteristics where exposure is more likely to be high, for instance, in urban area wife are more advised than the rural area, in wealth quintile rich category is more likely to be understand and seeking advised for these three important pillars for the betterment of family which are institutional delivery, breastfeeding and using modern method of family planning. In education level, husband and wives are more interested in the secondary and higher category where understanding is ore and they are knowing the importance of these things of using modern method of family planning, institutional delivery, and breastfeeding. They are knowing the importance of breastfeeding for new-born' growth. Husbands playing very important and crucial role for their wives, husbands should able to understand the importance of exclusive breastfeeding, using modern method of family planning and institutional delivery. Husband tell their wife to the practice of breastfeeding that how important is that for new-borns that colostrum is very important for new-borns growth.

Conclusions

There is a growing debate among policymakers and researchers on the role of involving males in reproductive health programmes. 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 get husbands involved, since they are often the decision-makers, the ones who have to accompany the women to a clinic and the one who pay for care. Formulation of policies related to these issues is still in its infancy, because of the poor quality of data and lack of research. This study, based on data from a national-level, large-scale survey, tries to assess the efficacy of the husband's role ANCs, whether it helps Indian women avail themselves of health services, and the extent to which women can make independent decisions regarding their health care. Very less number of studies fined that husbands are relatively knowledgeable and engaged in the maternal care of their wives. 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 prerequisite for sound ante-natal care and reproductive and child health acre. As a good proportion of husbands accompany their wives to ANC check-ups and the husband's presence in ANC enhances the chances of institutional delivery, it could be made mandatory to counsel husbands along with their wives during ANC visits.

Level of knowledge received during wife's pregnancy by the husband is another vital determinant of ANC and safe delivery using modern family planning method and knowing the importance of institutional delivery and breastfeeding. 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 women contexts where programmes will be set up to make Men in maternal care in India 149 an effective change. The forthcoming programmes under the umbrella of RCH and MCH must focus on the mobilization of men on maternal care, encouraging sound husband–wife relationships and creating a hospitable environment of maternal concern at the household level.

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Table 1: Percentage distribution of women who have been advised on Institutional Delivery by health worker

B.C.	Both	Only Wife	Hus Only	Both Not	Case (N)	Men (N)	Men (%)	Women (N)	Women (%)	F	M
Age											
Below 25	20.9	19.4	32.3	27.5	16200	21966	76.1	41760	66.4	47	43.8
25-34	18.7	22.3	30	29	17793	12713	60.3	61391	74	51.7	30.3
35+	10.6	14.6	35.8	29.1	2837	19241	89	6845	69.2	54.6	53.2
Residence											
Urban	25.1	31.2	22.2	21.5	9435	16809	87.8	58096	86.1	54.9	65.6
Rural	16.9	16.7	34.2	31.7	27394	37112	69.9	559011	59.3	42.63	35.7
Wealth Quintile											
Poorest	9.8	9.5	44.2	36.5	7077	8855	57.9	5674	33.7	24.2	13.7
Poorer	15.4	10.4	41.7	32.5	8172	10726	66.5	11249	49.3	38.9	24.8
Middle	18.4	15.6	32.2	33.5	7551	10718	74.6	20841	64.6	49	42.4
Richer	20.9	27.8	24.8	26.3	7467	11237	83.8	30791	76.5	48.7	59
Richest	32.1	41.7	11.4	14.7	6564	12385	94.9	45442	91.5	49.8	83.5
Education										0	0
No Education	11	10.7	40.5	37.7	17197	22252	63.9	17622	45.4	34.7	23.4
Primary	22.5	16.1	37.3	24.1	4837	7747	77.2	14037	62.2	46.1	39.9
Secondary	26.3	29.9	21.2	22.6	12447	19945	85.6	63444	78.7	48.8	64.4
Higher	32.4	50.2	6.8	10.6	2347	3970	98.4	18894	95.5	45.3	91.6
Caste/T											
Sc	15.9	16.6	36	31.5	7916	10699	71.5	17741	64.1	47.5	35.5
St	20.2	11.7	37.6	30.5	2045	3042	70.3	4426	41.2	29.5	32.7
OBC	14.5	17.2	35.2	33.1	13393	17923	70	44128	71.3	54.1	34.8
None	25.2	28	22.8	24	11920	19869	82.1	44464	79.1	51.1	59.3
Religion											
Hindu	19.2	20.3	31.2	29.2	28199	42853	76.3	91383	70.6	50.3	45.1
Muslim	18.5	16	35.6	29.9	6757	8262	65.2	14691	66	50	29.6
Christian	31.4	20.9	34.2	13.5	392	769	72.4	3594	78.7	57.8	38.2
Sikh	15	43.5	11.3	30.2	1186	1537	93.4	2323	80	36.5	82.1

Others	11.3	12.8	48.9	27	141	207	93.3	106	71.4	58.6	44.4
Total	19.1	20.4	31.4	29.1	36808	107638	74.4	151568	51.1	30.7	43

F= Female, M= Male

Table 2: Percentage distribution of women who have been advised on family planning by health worker

B.C.	Both	Wife Only	Hus only	Both Not	Case (N)	Men (N)	Men (%)	Women (N)	Women (%)	F	M
Age											
Below 25	11.3	15.4	28.5	44.8	7811	4210	16.2	11273	53.3	37.9	-12.3
25-34	13.7	16.5	30.7	39.1	8561	9726	52.7	19203	69.8	53.3	22
35+	9.1	17.3	34.1	41.6	1440	10800	58.4	2098	59.1	41.8	24.3
Residence											
Urban	12.6	20.5	26.5	40.4	4193	7710	46.3	10138	70.2	49.7	19.8
Rural	12.2	14.7	31.1	42	13618	17026	36.8	22436	59.2	44.5	5.7
Wealth Quintile											
Poorest	10	10	35.8	43.7	3782	3965	28.6	4762	50.1	40.1	-7.2
Poorer	10.4	13.2	34.3	42.1	4167	4909	47.3	5761	55.6	42.4	13
Middle	11.8	16	30.3	41.9	3848	4797	39.3	7734	63	47	9
Richer	16.2	18.1	25	39.9	3177	5516	47.3	7175	68.5	50.4	22.3
Richest	14.3	25.5	20.4	39.8	2838	5549	47.7	7142	74.5	49	27.3
Education											
No Education	7.9	11.8	34.7	45.6	9042	11486	38.3	9228	55.3	43.5	3.6
Primary	13.9	21.8	29.9	34.4	2120	3922	46.3	5446	62.4	40.6	16.4
Secondary	18.4	19	24.1	38.5	5484	7768	37.3	14850	65.6	46.6	13.2
Higher	14.7	25	21.7	38.7	1166	1560	42.2	3051	73.4	48.4	20.5
Caste/T											
SC	11.7	14.7	31.4	42.2	4110	4615	36.2	7085	61.4	46.7	4.8
ST	15.3	16.1	33.7	35	1146	1286	32.5	2505	48.6	32.5	-1.2
OBC	8.5	13.5	31.9	46	7302	8106	36.8	11913	61.9	48.4	4.9
None	15.2	20.4	25.7	38.8	4721	9676	45.5	9638	67.8	47.4	19.8
Religion											
Hindu	12.6	14.4	30.4	42.7	14046	19721	40.6	26270	62.1	47.7	10.2
Muslim	11	21.3	29.2	38.5	3034	3590	32.3	4651	65.5	44.2	3.1
Christian	25.2	4.7	52.8	17.3	127	259	26.5	817	64.9	60.2	-26.3
Sikh	10.3	26.8	12.9	50	388	957	58.8	376	70.3	43.5	45.9
Others	12.3	16.1	29.9	41.7	17789	51	15	20	10.5	-5.6	-14.9
Total	12.3	16.1	30	41.6	17812	23714	39.5	32543	62.4	46.3	9.5

F= Female , M= male

Table 3: The level of institutional delivery by the state of husband and wife advised by background characteristics, 2005-06

B.C.	Both	Wife Only	Hus Only	Both Not	Phi & Cramer	Men (N)	Men (%)	Women (N)	Women n (%)
Age									
Below 25	55.9	60.8	24.2	24.7	0.344***	21966	47.5	45760	69.9
25-34	31.3	35.2	79.1	73.6	0.433***	12713	49.1	61391	76.2
35+	59.1	53.6	22.7	19.1	0.337***	19241	49.7	6845	70.7
Residence									
Urban	83.9	80	42.5	39.7	0.420***	16809	47.1	58096	79.6
Rural	51.1	51.3	18.1	21.5	0.325***	37112	49.1	55901	67.6

Wealth Quintile									
Poorest	27	34	12.6	16.2	0.180***	8855	50	5674	53.6
Poorer	52	25.8	15.7	11	0.343***	10726	53.4	11249	60.2
Middle	53.7	49.2	21.3	25.4	0.289***	10718	50	20841	70.2
Richer	40.6	34.6	61.4	67	0.277***	11237	48.6	30791	73.3
Richest	87.4	84.5	59.5	68.6	0.242***	12385	42.7	45442	83.1
Education									
No Education	33.4	42.2	16.4	16.4	0.222***	22252	48.2	17622	56.4
Primary	68.5	47.8	21.5	23.4	0.402***	7747	54.3	14037	68.4
Secondary	68.1	66.9	36.5	40.4	0.290***	19945	48.4	63444	77.4
Higher	98.7	90.4	73.8	79.1	0.255***	3970	43.3	18894	86.4
Caste/T									
Sc	60.4	49.8	21.4	21.6	0.342***	10699	49.6	17741	68.2
St	47.8	39.3	22.5	5.6	0.365***	3042	54.4	4426	66.7
OBC	54.9	60.2	21.4	22.9	0.353***	17923	46.5	44128	73.5
None	70.7	72.6	26.1	35.8	0.412***	19869	47.6	44464	76.5
Religion									
Hindu	65.9	63.9	23.7	25	0.404***	42853	48.7	91383	73.8
Muslim	42.6	44	17.4	22.1	0.256***	8262	51.9	14691	67.4
Christian	52.5	64.6	19.3	18.5	0.402***	769	55	3594	79.1
Sikh	90.5	82.9	50	41.9	0.437***	1537	30.8	2323	74.8
Others	25	33.3	7.1	10.5	0.274***	207	47.7	106	65
Total	62.1	62.5	22.5	24.1	0.388***	51629	48	111342	73.5

*Note: ®= reference category, Level of significance: ***p<0.001, **p<0.01, *p<0.05*

Table 4: The level of family planning by the state of husband and wife advised by background characteristics, 2005-06

B.C.	**Both**	**Wife Only**	**Hus Only**	**Both Not**	**Phi & Cramer**	**Men (N)**	**Men (%)**	**Women (N)**	**Women (%)**
Age									
Below 25	62.8	55.5	35	32	0.234***	4210	48.3	11273	47.7
25-34	71.9	72	45.7	52	0.216***	9726	41	19203	48.7
35+	44.3	44.6	42.4	48.9	0.058	10800	42.5	2098	40.3
Residence									
Urban	60.1	74.8	52.3	63.2	0.160***	7710	41	10138	49.7
Rural	68.5	57.5	38	35.9	0.237***	17026	43.6	22436	46.9
Wealth Quintile									
Poorest	38.6	44.8	26.5	19.4	0.192***	3965	48.3	4762	41.7
Poorer	77.7	29.9	39.2	28.5	0.300***	4909	45.5	5761	45.5
Middle	69.1	72.9	40.7	47.7	0.246***	4797	43.6	7734	51.5
Richer	78.1	71.1	49.8	56.8	0.211***	5516	43.6	7175	47.8
Richest	62.8	82.2	66.8	73.3	0.149***	5549	36.4	7142	50.3
Education									
No Education	54.1	59.2	30.1	31.5	0.219***	11486	41.6	9228	39.7
Primary	71.9	66.2	53	42.7	0.220***	3922	46.8	5446	48.7
Secondary	74.8	62	54	55.5	0.154***	7768	43.6	14850	52.7
Higher	60.2	73.2	77.4	78.7	0.143***	1560	38.1	3051	53.7
Caste/T									
Sc	62.2	61.7	33.8	37.1	0.235***	4615	39.4	7087	50
St	38.1	16.8	26.2	40.4	0.191***	1286	55.7	2505	44.8
OBC	81.8	62.1	38.4	35.2	0.293***	8106	42.5	11913	45.8
None	64	70.9	56.8	60.2	0.102***	9676	42.5	9638	48.2
Religion									
Hindu	65.7	62.2	41.6	42.1	0.196***	19721	42.4	26270	47.7
Muslim	70.2	66	40.2	38.4	0.266***	3590	46.8	4651	45.8
Christian	61.3	50	20.9	26.1	0.365***	269	64.5	817	67.5

Sikh	100	92.2	50	65.3	0.376***	957	34.9	376	38.6
Others	0	0	0	76.2	0.847***	51	32.3	20	15.4
Total	66.5	62.7	41.1	42.3	0.203***	23714	42.4	31382	47.5

*Note: ®= Reference category, Level of significance: ***p<0.001, **p<0.01, *p<0.05*

Table 5: Results from the logistic regression while using institutional delivery as dependent variable

B.C.	B	S.E.	Exp(B)
Caste/ Tribes			
General ®			
Schedule caste	-.450	.115	.638***
Schedule tribe	-.605	.155	.546***
Other Backward Class	-.023	.010	.977**
Institutional delivery			
Both not advice ®			
Only wife	1.145	.111	3.141***
Only husband	.019	.111	1.019
Both	1.178	.114	3.248***
Age group			
Below 25®			
25-34	-.001	.087	.999
35+	.288	.172	1.334*
Religion			
Hindu®			
Muslim	-.165	.115	.848
Other	.121	.139	1.128
Wealth quintile			
Poorest ®			
Poor	-.060	.171	.941
Middle	.261	.161	1.298
Rich	.737	.163	2.090***
Places of residence			
Rural ®			
Urban	.673	.087	1.960***
Level of education			
No education®			
Primary	.282	.123	1.326**
Secondary	.700	.100	2.013***
Higher	1.660	.196	5.260***
Constant	-1.230	.200	.292***

*Note: ®= reference category, Level of significance: ***p<0.001, **p<0.01, *p<0.05*
B.C.- Background Characteristics

Table 6: Results from the logistic regression while using family planning as dependent variable

B. C	B	S.E.	Exp(B)
Age group			
Below 25®			
25-34	-.667	.035	.513***
35+	-.444	.063	.641***
Religion			
Hindu®			
Muslim	.002	.047	1.002
Other	.140	.087	1.151
Wealth quintile			
Poorest ®			
Poor	-.383	.051	.682***
Middle	-.876	.053	.416***

Rich	-1.225	.057	.294***
Places of residence			
Rural ®			
Urban	-.027	.045	.973
Level of education			
No education®			
Primary	-.515	.053	.598***
Secondary	-.458	.043	.632***
Higher	-.680	.083	.507***
Caste/ Tribes			
General ®			
Schedule caste	.185	.051	1.203***
Schedule tribe	.569	.079	1.767***
Other Backward Class	.029	.004	1.029***
Family planning			
Both not advice ®			
Only wife	.835	.055	2.304***
Only husband	.192	.064	1.212***
Both	.837	.057	2.310***
Constant	.549	.076	1.731***

*Note: ®= reference category, Level of significance: ***p<0.001, **p<0.01, *p<0.05*
B. C.- Background characteristics

Priyanka Yadav
M.Phil, IIPS, Mumbai
Email: yadav.priyankyadav@gmail.com