

**FORMATIVE RESEARCH FOR DEVELOPING A
COMPREHENSIVE COMMUNICATION STRATEGY AND PLAN
FOR INVOLVEMENT OF MALE DURING PREGNANCY**

- Report-

Submitted to

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Abbreviations

ANC	Ante Natal Care
ANM	Auxiliary Nurse Midwife (Health worker-female)
ASHA	Accredited Social Health Activist
AWW	Anganwadi Worker
DFID	Dept. for International Development
DIL	Daughter in law
HDI	Health and development Initiatives
IEC	Information Education Communication
IPE	Infrastructure Professionals Enterprise
JSY	Janani Surakhya Yojana
TMST	Technical and Management Support Team
OHSP	Orissa Health Sector Plan
GoO	Govt. of Orissa
MIL	Mother in law
MoHFW	Ministry of Health and Family Welfare
UNICEF	United Nations Children's Fund

EXECUTIVE SUMMARY

Background of the study: In the process of finding a solution to the high level of maternal mortality in Orissa, among others, a study was conducted focusing on the reasons for death taking as sample all maternal death cases in the 8 districts comprising the backward KBK region of Orissa (MAPEDIR). One of the major factors identified in the study is that about 66% of the deaths could be attributed to delay in taking decision by the husband of the pregnant woman about accessing formal care at health institutions when her condition worsened due to complications (first level delay). The delay in decision making is further attributed to the inability of the husband to assess the severity of the symptoms. Subsequently the authorities in the Dept. of Health and Family Welfare of the Govt. of Orissa and the DFID supported Orissa Health Sector Plan decided that a focused intervention was required to promote involvement of men in pregnancy and child delivery. Towards this, it was decided to launch a comprehensive communication campaign to promote the involvement of men in the pregnancy and delivery of their wife. To inform this campaign, the need for a formative study was felt and an integrated project was commissioned to carry out a formative study and then formulate a communication strategy and develop prototypes of communication materials. The project is being implemented by Health and Development Initiatives (HDI), a leading health research organization based in Bhubaneswar in collaboration with the Mumbai based The Communication Hub (TCH). The formative research has been completed and this report presents the findings of the study.

Method and sample: A rich mix of methods were used to obtain information required for this study, including a quantitative survey, qualitative methods such as Focus Group Discussions and In-depth interviews, and the Peer Research method. The survey was done among married men and women in the rural areas. Those were divided into three categories; those who are currently pregnant, those who had a pregnancy in the last three years, and those who were never pregnant or had a pregnancy more than three years ago. 4 districts were sampled purposively for the study, representing socio-culturally and economically different regions in Orissa, and 8 villages were selected for the survey in each district. 8 men and 8 women (not married to each other) were covered in each village, and a total sample of 256 men and 256 women was covered in 32 villages. Qualitative research was carried out in 2 villages in each district, and 1 Focus group Discussion (FGD) with married men and one with married women was conducted in each village. Besides, 1 In-depth interview (IDI) with mothers-in-law, 1 or 2 IDIs were conducted with health outreach workers. The peer research method was also used in 2 villages, one with men and one with women. 5/6 men/women with at least one child were selected in the villages, and trained to collect data from their peers through repeated interviews spread over a couple of days. These peers were then interviewed to get an in-depth and rich story about the conditions governing involvement of men in pregnancy. The information collected through all the methods is summarized here in different sections.

Existing literature review: Published and unpublished reports and documents, and materials found on the internet, including studies and interventions conducted in the country and abroad, were reviewed. On the basis of the review, the following gaps emerged as important factors affecting involvement of men:

- Lack of sufficient information and knowledge related to wife's pregnancy and delivery
- Home delivery v/s institutional delivery
- Gender inequalities
- Existing cultural norms in the society

It was concluded on the basis of the reports that men can play a role in reducing maternal and infant mortality by providing transportation to clinics, recognizing symptoms that require medical attention, and by assuring that women get proper nutrition and rest. The most important finding from the review was summarized as “Improved awareness of obstetric complications among members of a pregnant women's immediate and wider social network including their partners, are a factor in reducing maternal and child mortality and morbidity”.

Knowledge: Overall, only about 29% of women and 25% of men know that 3 check-ups are done during pregnancy. Regarding the do's and don'ts during pregnancy, large majorities of men and women know about taking IFA tablets (88% of women and 75% of men), green leafy vegetables (87% of women and 84% of men), and protein rich diet (75% of women and 73% of men). Only a minority mentioned regular check-up, avoiding hard work, and taking medicines. Neither men nor women have knowledge regarding complications during pregnancy as important signs of complications are not mentioned by anyone, and majority mention signs such as vomiting (93% of women and 69% of men), abdominal pain 47% of women and 67% of men), head reeling (14% of women and 35% of men), and cold and fever (24% of women and 37% of men). Similarly both men and women do not have any knowledge about complications during delivery, and bleeding (21% of women and 25% of men) and abdominal pain (31% of women and 27% of men) are mentioned as signs of risks during delivery. For post partum complications, a minority have correct knowledge. Men and women recognize bleeding (27% of women and 24% of men) and cold and fever (28% of women and 32% of men) as signs for post partum complications. Knowledge on complications is incomplete and inadequate. There is a strong need to create awareness on these issues.

Knowledge about MCH related services was assessed. Large majorities of both men and women know about the pregnancy and delivery related services available in different health centres in their area. 84% of men and 61% of women also know about the 24x7 health facilities. However, people do not have specific knowledge about blood bank, health providers or vehicle owners/drivers who can be contacted in an emergency. It appears that majority of people are not ready with knowledge to deal with any emergency related to pregnancy or delivery.

Attitudes: Men have very positive attitudes towards their own involvement in care of wife during pregnancy, and care of both wife and newborn after birth. A large majority of men and women

(over 90%) agree that men should carry out tasks at home and also outside the house during this period. They agree that men should take wife for check up, ascertain whether wife has taken sufficient food and rest, and also ensure that she is taking medicine regularly. On post partum care, they agree that men should take wife and kid for immunization. On newborn care, men and women agree that men should ensure that the new born has been breastfed; that it has taken all the immunization shots, proper sanitation and hygiene is maintained at home, and that hygiene and cleanliness of the newborn is maintained. Majority of women (70%) report that their husbands will get the doctor home, and if it is necessary then the husband will take them to the hospital, if medical care is required during pregnancy. Thus, both men and women have positive attitudes about involvement of men in providing care to pregnant wife and newborn both in activities within the house and outside the house.

Practice: Regarding decision making at home, majority of the decisions are made jointly by the couple. The husband makes decisions by himself in a minority of cases, whereas the wife makes decisions by herself rarely. During last delivery when it was decided to have home delivery, while majority of men report that they made the decision, majority of women report that the decision was joint.

Regarding involvement of men in last pregnancy, 79% of men and 76% of women report that the husband took wife for ante-natal checkup. Further, the husband also got involved in different activities within the household such as ensuring proper diet (70% of men and 80% of women; ensuring adequate rest (54% of men and 75% of women), and ensuring regular intake of medicine (61% of men and 80% of women).

In case of complication during last pregnancy which required medical attention, 93% of men and 72% of women reported that the husband had carried out the activity (bringing medicine or doctor to the pregnant woman or taking pregnant woman to the hospital).

Regarding involvement in post partum care after last delivery, more men and women report that men took care of newborn at home (75% of men and 87% of women), and less took out wife and newborn to health center for immunization (52% of women and 69% of men).

Similarly majority of men and women report that after last childbirth, men were involved in activities outside the house such as taking to health center for immunization, and also in activities within the house such as ensuring breast feeding, cleaning the baby and cleaning the house. Men also play the major role in getting medicine, arranging transportation, and in going to the health center during delivery and also during post natal complications.

If wife had to be taken to medical after post natal complication, in majority of cases the husband took her there (83% of women and 100% of men).

Perceptions of mothers-in-law: Mothers-in-law are not aware about the appropriate practices during pregnancy and delivery. Though they take DILs for check-ups and also give nutritious food and do not force for heavy work, they are not convinced about the modern practices and do not usually follow the advice of the doctors or the health workers. It is observed that most of the MILs do not take major precautions during pregnancy like health check up, immunization, proper diet and rest seriously. They are also not aware of the signs of risk during pregnancy, delivery or post-partum period.

Though few mothers-in-law said that they would not mind their son helping his wife, most of the MILs are not open to the fact of a man helping or taking care of his wife inside the house during her pregnancy and delivery as for them it is completely a women's domain and they think men neither have any understanding nor should they be required to have any knowledge in this matter. MILs expect men to take care of all the outside activities during pregnancy and delivery of their wives.

In coastal areas mostly the mothers in law make decisions in pregnancy and delivery related matters, but in western areas the decision is made by the couple mostly. In tribal areas the mother in law stays aloof from the affairs of the couple and the decision is mostly made by the husband.

Health providers' perspective: There is no deliberate effort by any of the health workers to counsel men on pregnancy or delivery related issues either in the health center or during home visits.

Health workers rarely get a chance to counsel men, and it is purely incidental. Many men accompany their wives to Mamata Divas for ante-natal care and there they get a chance to learn a few things about pregnancy and delivery related care. Few men seek knowledge or clarifications on their own from the health workers.

Men do not get involved in ante-natal care but their presence is seen in hospitals and during complications and referrals.

Health workers feel that men are currently involved in hospitalization during delivery. They should get involved in providing care at home also. *The most important role of men is to save and arrange funds to meet pregnancy and delivery related expenses.*

To motivate men for involvement during pregnancy and delivery, TV is a good medium and small advertisements should be placed in TV. Mamata divas should be utilized to counsel men, and senior providers such as ANM, LHV and doctors should be involved here to talk to men. Repeated group discussions should be organized in villages and men should be addressed by senior providers.

Media and messages: Access to different media (at least once in the last one week) was observed. Access to IPCs is the maximum (33% of men and 23% of women) followed by TV (31% of men and 17% of women). Newspaper is accessed by 24% of men and 3% of women, whereas Radio does not seem to be popular any more with only 18% of men and 9% of women listening to it in 7 days, whereas cinema was accessed by 9% of men and 3% of women. Proportion attending exhibition and street theatre/folk performance within a week was very less.

If they had any question on MCH issues, men reported that they will contact ASHA (44%), then doctor (42%); whereas women mentioned ASHA (44%), Anganwadi worker (30%), and ANM (35%).

About 69% of men and women were exposed to messages on mother and child health in some media. ASHA is the major source of such messages (53% of men and 56% of women) followed by TV (37% of men and 33% of women). Other mass media (radio, wall writing) and other health workers (ANM, AWW) come next. Women also receive information from neighbours and relatives.

People were asked about the preferred source if they wanted more information on MCH issues. Men preferred ASHA (26%) the most, followed by TV (22%), then Anganwadi worker (13%) and ANM (11%). Women preferred ANM (27%) the most, followed by ASHA (24%), TV (10%), and Anganwadi worker (10%).

After men and women were asked certain questions to assess their knowledge on different issues, they were asked the source of their knowledge. Compiling data on the source of knowledge on different issues, it is seen that men gained knowledge mainly from ASHA (and other health workers) and their wife. Women had learned mainly from the different health workers (ASHA, ANM, AWW, doctors) and their neighbours. The role of mass media (only TV) was very marginal in creating such knowledge.

Conclusions: The study concludes that knowledge level of men is very inadequate about the complications during pregnancy and delivery. Strong positive attitudes exist among young couples regarding involvement of men in providing care both within and outside the house, though the older generation and family members in the coastal area do not appreciate this. In practice, men are found to provide care during ante-natal and post-partum period. There is scope for involvement of men in seeking appropriate care during complications if they are made aware about the signs for which medical attention should be sought. There are opportunities for informing and motivating men to take responsibility of care of wife and newborn during ante-natal and post-partum period through TV and outreach activities. Health workers have scope for addressing men with suitable messages. A number of actions are suggested for promoting involvement of men in mother and child health care:

- Men need to be given detailed knowledge regarding different aspects of ante-natal care and post-natal care

- Men have very inadequate knowledge about the signs of complications during pregnancy and delivery and there is an urgent need to build this knowledge.
- There is a need to promote the preparedness of men with arrangement of funds to meet the delivery related expenditure, knowledge of health centers with blood facility, and knowledge of cell number of the Janani Express or any other suitable transport.
- There is a need on the part of the health workers to address men with necessary information and to promote a sense of responsibility for care of the wife during pregnancy, delivery, and post-partum period.
- There is a need for a comprehensive communication campaign using appropriate media to address men with necessary information and also to motivate them to take all responsibility of their wife during pregnancy, delivery, and post-partum period.
- There is a need to address the negative attitude of the older generation through appropriate communication so that a favourable environment and public acceptance is created for the involvement of men.

1. BACKGROUND AND INTRODUCTION

1.1 Project background

The Government of Orissa (GoO) has developed a comprehensive Orissa Health Sector Plan (OHSP) 2005-2010. DFID provides Health Sector Budget Support to the GoO channelled through the Departments of Health and Family Welfare (DH&FW) and Women and Child Development (DWCD). GoO has established an Orissa State Health Mission (OSHM) for OHSP oversight. The Mission Directorate, headed by the Director National Rural Health Mission (NRHM), provides technical and implementation support for NRHM and OHSP. The responsibility for delivery of health services lies with the Directorates of Health Services and Family Welfare. The OHSP aims to achieve equity in health outcomes and has a key focus on access and utilization of services by vulnerable and marginal groups including women, scheduled caste (SC) and scheduled tribe (ST) populations. It aims at delivering accountable and responsive health care to reduce maternal mortality; infant and child mortality; reduce the burden from infectious diseases; under-nutrition and nutrition-related diseases and disorders.

In the context of maternal mortality, a situation analysis conducted through Maternal and Perinatal Death inquiry in 8 districts of Orissa in the KBK region reported that out of 800 maternal deaths:

- 49.5 % mothers died at home
- The maximum (57.1%) deaths occurred within 6 weeks of delivery
- The 2nd highest deaths (29.88%) occurred during pregnancy
- 44.2% of deaths occurred within 24 hours of delivery
- 65% deaths are of BPL mothers, of which 92.4% do not know about BPL health benefits
- Out of the total deaths, 64.7% had their delivery conducted by untrained personnel at home
- **Male Responsibility for Delay (Husband – 68.8%)**

The results of this study led to the conclusion that male involvement during pregnancy is very low in the state which has led to levels 1 and 2 delays (child birth preparedness and referral transport) causing maternal deaths.

About MaPeDIR

Maternal and Perinatal Death Inquiry and Response (MAPEDIR) is a new innovative technique launched jointly by UNICEF and Govt. of Orissa with a view to raise community awareness, streamline reporting system of maternal deaths, and inquire into the social factors and biological causes that contribute to the high level of maternal mortality rate in the state. White Ribbon Alliance(WRA) has been entrusted to carry out the MaPeDIR process in 8 KBK districts of Orissa since it has partner organizations in every block of Orissa.

MAPEDIR was implemented in eight Navajyoti Districts selecting four districts each from the Western and Southern regions focusing on KBK areas. The districts include Bolangir, Kalahandi, Nuapada, Sonepur, Koraput, Nowrangpur, Raygada, and Malkangiri.

The study also looked at the influencing persons who make decision in seeking care during obstetric complications. It was found that the husband plays a dominant role as the decision maker and about 69% of the cases where decision was made for seeking care were the husband's, while her mother-in-law took decision in case of 5.19% of the cases. It was also seen that in 34 cases, the woman herself took decision to seek care. If husband is the main decision maker in the family during this crucial period, it is important to trace out how long after and in which stage he is making decision to seek the formal care and how appropriate is the decision so far as addressing the complication of PW is concerned. Data further reveals that formal health care was sought in case of 50.5% of the total maternal deaths while informal health care was sought in case of 49.6% which is nearly half of the total maternal deaths. The MAPEDIR tried to know what prevents the maternal death cases to access formal health care, which culminated in severe complication and death. There might be lack of knowledge, or non-availability of transport or poor economic standard, or cultural beliefs and so on. It was found that 66.2% did not think that she was sick enough while 7.6% thought she needs traditional care and there are 4.2% of the cases who could not pay for the care at facility.

Need for the formative study

In response to the above, the expert review committee on maternal and child health led by the Commissioner-cum-Secretary recommended the development of a communication strategy for the involvement of men during pregnancy. A consultative process and a team approach was adopted in strategizing for IEC/ BCC on involvement of men during pregnancy in respect to addressing the level 1 and 2 delays, by the SIHFW. A series of meetings were held to discuss choice of media and messages, and to strategize in terms of audience segmentation, identification of barriers or triggers to change, positioning etc. The consultative process begun with stakeholders in reviewing communication materials for standardization and a concept note was developed for designing an integrated BCC strategy.

The IEC/BCC strategy will specifically focus on:

- Creating awareness on RCH services among the target group
- Improving practices of involvement of men during pregnancy
- Information dissemination of health care needs, especially for children (0-6 age), and women in child birth preparedness, referral transport arrangement and post natal care through involvement of men in the decision making process

With the above background, a research project was commissioned with the objective of developing a comprehensive communication strategy and plan for involvement of men during pregnancy which will include the development of messages, media mix and prototypes of materials. The project is being implemented by the **Health and Development initiatives (HDI)**, a research agency based in Bhubaneswar, in collaboration with **The Communication Hub**, a communication agency based in Mumbai.

1.2 Formative Research

The task of developing the communication strategy has four main sub-tasks:

- A. Review of information and further discussion to understand the existing knowledge, attitude and practices
- B. Finalise Key Issues that can be addressed through an IEC/BCC strategy
- C. Pre-test and finalise a package of communication messages and implementation strategy
- D. Ensure effective implementation strategy

Of the 4 sub-tasks, the first one relates to collecting information, using both secondary and primary data sources, regarding the knowledge, attitudes and practices of the target population. This includes a desk review of evaluation reports and best practices of state, national and international strategies adopted in involvement of men during pregnancy. Besides, the research will also review the existing information on current practices and dialogue with the community to identify facilitating factors and barriers to desired practices. The findings of the formative research and the KAP study should help to identify key issues on public health awareness, cultural practices and health care information for specific target groups that can be effectively addressed through an IEC/BCC strategy. Based on this report, the communication strategy will be formulated and later the communication materials will also be developed.

The formative research component of the entire project was implemented first, and this report presents the findings of this study. The objectives, methodology, and the specific research areas for this study are described in the subsequent sections.

Research Objectives

The major objective of this study was **to identify the knowledge, attitude and current practices adopted by husbands/male and other key family members during pregnancy of a woman in the family.**

The specific objectives of this study included the following:

- To review the existing information on current practices through a desk review of evaluation reports and best practices with regards to strategies adopted in involvement of men during pregnancy
- To carry out dialogue with the community to identify facilitating factors and barriers to desired practices
- Identify key issues on public health awareness, cultural practices and health care information for specific target groups that can be effectively addressed through an IEC/BCC strategy

1.3 Areas of enquiry

To respond to the diverse above-mentioned objectives of the study, specific areas of enquiry were listed. The enquiry areas pertain to the knowledge, attitudes and practices of the target group pertaining to the issue of involvement of males in the pregnancy and delivery of their wives. Besides, the perceptions and beliefs of the mothers-in-laws and the health service providers, particularly outreach workers in the village, were also included. The specific areas are as follows:

Knowledge: The knowledge indicators included not only the awareness levels but also sources of knowledge, exposure to the various aspects of reproductive health care and preferred sources for the primary audience to learn about these issues. Specifically, some of the questions for which answers were elicited are

- What is known in the community with regard to maternal and child health services?
- Exposure to antenatal and postpartum care services provided at the health centres/PHC/CHC
- Source of knowledge (for each, and separate for different groups in the village)
- How is this knowledge disseminated (IPC, mass-media, group meetings, etc)
- How easy is it to access MCH related information in the community and if known, would they access it?

Attitude: This was be a key area of enquiry and involved answering questions such as

- What are the perceptions of a wife in terms of involvement of her husband during her pregnancy?
- Which areas would she like more involvement from him?
- Is there a willingness among the husbands to get more involved? If so, in which aspects of the wife's pregnancy do they envisage a role for themselves, and why?
- What are the basic barriers for the husband to getting involved? Assess the barriers, both qualitatively and quantitatively with respect to
 - i. Time
 - ii. Attention
 - iii. Cultural practices
 - iv. Attitude/ Self image
 - v. Economic condition
 - vi. Knowledge of services
 - vii. Any other

Practice: Current practices with respect to male involvement constituted the area of enquiry on this topic. Some of the answers that were sought are

- Who influences decision-making in a family during the pregnancy of a woman in a family? What happened during the last pregnancy in the household?
- If there is an evidence of husband's involvement, what are the primary triggers for such practices?
- What are the current practices adopted by husbands and young men with regard to their involvement during pregnancy of their wives?
- What role do the family members play in encouraging greater involvement of men during the pregnancy of a woman in a family?

Areas for mothers-in-law:

- Knowledge of vulnerabilities during pregnancy; ante-natal period and delivery
- Awareness on care for woman and child during post natal period
- Source of her knowledge
- Awareness about services available
- Attitude towards male involvement in safe delivery
- Barriers to male involvement
- Perceptions regarding advantages and disadvantages of male involvement
- Decision making with regards to woman and child's health
- During last pregnancy of daughter-in-law

Areas for Health care providers

- Years of service in providing ante/post natal care
- Usual accompaniment with pregnant women/women and child to the health centre
- Experienced husbands accompanying their wives
- Any kind of discussion with the man and issues discussed on
- Attitude of men towards knowledge/information gained
- General attitudes of men in the area
- Attitudes of men with regard to reproductive and child health issues
- Support that can be given to men to actively participate in women's well-being during pregnancy and beyond
- Barriers to male involvement during ante-post natal period
- Distance, cost, social and cultural barriers, limited awareness, and perceived efficacy of treatment
- Problems that couples face while accessing services –(transportation, medication, repeat visits, waiting time at clinic)
- Suggestions to improve male involvement in the community

1.4 Methodology and Sampling

Following methods were used in this project for collecting the required information:

Secondary research: Existing information on the subject in terms of research reports, documents, papers or articles were collected and analyzed to learn useful lessons. This includes research and studies on this subject done in any other country, those done in South Asian countries, and those in India. Effort was also made for collecting any relevant material for Orissa or that pertaining to the behavior of Oriya men vis a vis women in a conjugal relationship. In this context, information pertaining to the picturization of men in Oriya literature and in Oriya movies have also been collected. All the secondary information collected are summarized and documented. The lessons learnt from the literature review are highlighted in the next chapter.

Primary Research: Both quantitative and qualitative methods of data collection were used for this study. Details of both the exercises are given below:

Quantitative survey: A household survey using structured questionnaires and face to face interviews was conducted to collect primary data on relevant topics from the target group of rural men and women in sample villages in the state. For this purpose, a total of 512 respondents, including equal number of men and women, were selected from across 32 sample villages. The survey covered a total of 4 sample districts. 8 villages were covered in each district.

District selection: To get a representative sample, the survey covered a total of 4 districts from different socio-economic-cultural regions of Orissa. Of these, 2 districts (Koraput and Nuapada) were selected from among the 8 KBK districts. This selection was done randomly, keeping the insurgency affected areas in mind. One more district was selected (Deogarh) from among the 7 districts in Western Orissa where MaPEDI will be conducted in the near future. This was selected randomly. Then one more district (Jagatsinghpur) was selected from among the coastal districts of Orissa.

Thus the 4 study districts are

Sl. NO.	Type of District	District selected
1	KBK	Nuapada
2	KBK	Koraput
3	Western new MAPEDIR	Deogarh
4	Coastal	Jagatinghpur

Village selection and sample: Two blocks were selected randomly in each district for selecting the sample villages. 8 villages were selected in each district, 4 in each selected block, for conducting the survey. Of the 8 villages where survey was conducted, 4 were in remote areas. The survey sample in each village included 16 respondents; 8 men and 8 women. Men and women from the same household were not included in the survey. Thus the survey covered a sample of 512 respondents in 8 districts, including 256 men and 256 women.

Two separate questionnaires, 1 for men and 1 for women, were developed and revised following inputs from TMST and the Govt. and the same were used in the survey.

Qualitative study: Qualitative methods of data collection, such as Focus Group Discussion (FGD) and In-depth Interview (IDI), and the Peer Research method were used in this study to delve into the complex interplay of beliefs, perceptions and convictions of diverse players in the family and in the society.

Overall, the qualitative study covered 8 villages, including 2 in each district. In each sample village for qualitative study, there were 2 FGDs; 1 with men and 1 with women. Besides, there were IDIs with 2 Mothers-in-law and 2 health outreach workers in each village. The guidelines for FGDs and IDIs were developed and revised incorporating inputs from all quarters.

Peer research: This was carried out in 2 villages in total, 1 for men and 1 for women. The study was conducted over a period of 5 days in each of the 2 villages. In each village, 5 peers were selected, and each peer interviewed 2 men/women in turn. The peer research with women was conducted in Jagatsinghpur district and that with men was conducted in Koraput district.

The total sample for data collection using different methods can be summarized as:

Method of enquiry	No. of districts	No. of villages	Sample in each district	Sample in each village	Total sample
Quantitative survey	4	32	128	16	512
Qualitative-FGD	4	8	4	2	16
Qualitative-IDI	4	8	8	4	32
Peer Research	2	2	Overall 2		2

1.5 Survey Sample Profile: The study sample that was covered through the survey method is described here in terms of its demographic and socio-economic profile. A total sample of 512 respondents was covered, including 256 married men and 256 married women.

Age distribution: Overall the age distribution shows that the male sample was more aged than the women sample. While almost half of the women sample (49%) was within 25 years of age; only 17% of the male sample was within this age. About 49% of women in the sample were in the age range of 26 to 35 year, compared to about 69% of the male sample. A high 14% of the male sample was more than 35 years in age compared to only 2% of women.

Years of marriage: The time since marriage was observed for all the respondents. 17% of women compared to 10% of men respondents were married since one year. About 24 to 29% were married between 2 to 4 years. 36% of female respondents and 45% of male respondents were married between 5 to 10 years. About 19% were married for more than 10 years.

Type of family: More of female respondents belonged to nuclear family. About 53% of male respondents and 71% of female respondents belonged to nuclear family, whereas only 28% of female respondents belonged to joint family compared to 45% of male respondents.

Family size: A large majority of 73% of male respondents had less than 6 members in the family compared to 57% of female respondents. 39% of female respondents compared to 23% of male respondents had between 6 to 10 members.

Schooling and education level: Men in the sample were more educated generally compared to the women. 85% of men had ever gone to school compared to only 61% of women. More than a third of the women were illiterate (36%) compared to only about 16% of men. About two-thirds of the men (64%) have completed different levels of school from primary to secondary, compared to only 50% of women. Similarly, about 17% of men had gone above school level, compared to only 5% of women. Across districts, the coastal district of Jagatsinghpur has best literacy, followed by Deogarh and Nuapada which have similar profile, but Koraput is way behind. About 64% of female respondents in Koraput are illiterate.

Social group: Close to 99% of respondents belong to Hindu religion (including tribes). Very small proportion belongs to Christian and Muslim community.

Considering castes and tribes, more than one-third of men and women belong to scheduled tribes category, whereas those belonging to scheduled castes range between 14 to 18%. The upper castes and the other backward castes each constitute about 20 to 22% of total sample.

Livelihood and work: The occupations of the respondents were noted. Cultivation was found to be the most common occupation reported by maximum proportion of respondents. The other major occupations reported include casual labour and services (both govt. and private). Small business was reported by about a tenth of male respondents.

Availability of assets: The assets owned by a household were noted to assess the socio-economic status of the respondents. Household assets including farm assets, electronic goods, household durables, means of transport and conveyance, etc., were noted. Among furniture, bed and mattress are common, but chair or table are not owned by many. Durables such as radio, TV or fan are owned by only a fifth. Among conveyance, cycle is common, but motor cycle or other vehicles are rare. Mobile phone was reported by more than a fifth. Watch was also found to be very common.

Monthly family income: The monthly income of the family was also noted for all the respondents. 13% of women compared to 18% of men reported income less than Rs.1000/- per month. 56% of men reported income between Rs.1000 to Rs.2000, compared to 39% of women,

but 40% women reported income in the 2000 to 5000 range compared to 19% of men. Only about 6 to 7% of respondents had family income of more than Rs.5000 per month.

Pregnancy and children

For the purpose of this study only married respondents were included as sample. Their status with respect to number of children and pregnancy was ascertained.

Number of children: 14% of men and 17% of women did not have child yet. The rest had between 1 to 7 children. Most men (61%) and women (57%) had between 1 to 2 children. 14% of men and 15% of women had 3 children. 10% of men and 11% of women had more than 3 children.

Currently pregnant: 22% of men said that their wives were currently pregnant, whereas 26% of women were currently pregnant. Pregnancy ranged from the 3rd to the 9th month. Among men, about 53% were between 5th to 7th month of pregnancy, whereas as reported by women, 55% were between 7th to 9th month.

Duration since last pregnancy: For the purpose of the survey, it was necessary to take respondents who are either currently pregnant or were pregnant in the last three years. This is because to collect information on practices during pregnancy and delivery we need respondents who have gone through pregnancy and delivery in the last three years or are currently pregnant. This is also because many of the schemes and health provisions around pregnancy and delivery are of recent origin. Therefore, the respondents were divided into three categories, those who (or their wife) are currently pregnant, those were pregnant in the last three years, and those who were pregnant more than 3 years ago.

While 22% of men (their wives) and 26% of women were currently pregnant, 53% of men (their wives) and 50% of women were pregnant in the last three years, and 19% of men (their wives) and 21% of women were pregnant more than three years ago.

2. REIVEW OF LITERATURE

2.1 Background

Both published and unpublished literature on the subject of male involvement in pregnancy and delivery was collected and compiled. Recognizing that the subject is too specific, a broader topic of involvement of men in maternal and child health was included. A lot of work done on the international level was reviewed. There is less literature on the national level and those were included in the review. Effort was also made to search for any available work at the state level, but hardly anything could be located. The available literature and their contents are discussed in this chapter.

2.2 Literature on involvement of men

Research has addressed different aspects of involvement of males in the area of reproductive health. Different programmes and projects have also explored different ways for promoting the involvement of males. Literature also includes evidence from evaluations of different programmes promoting the role of men. This chapter reviews the existing literature on various aspects of involvement of men. Major landmarks in the area are described here with reference to the researchers. The learnings from the existing literature and the work carried out till date are listed here. The abstracts of the different papers are given in Annexure.

Gender perspective in male involvement: Initial work in the area pertained to describing male involvement with a gender perspective. One of the obstacles that was recognized was that the notion of gender was rooted in feminist activism and thus was falsely understood to pertain to women only. The concept of gender suggests that differences between men and women are socially constructed, changeable over time and vary widely within and between cultures (UNFPA, 2000). Post ICPD 1994, there was a spurt in programmes that involved men. Men were considered as obstacles to family planning and were taken as allies to enhance the contraceptive prevalence rate. The frameworks of male involvement in reproductive health was developed by Greene (1999) and provides the most upto-date definition of gender-equitable reproductive health programs that involve men by tracing their evolution. Considering high levels of maternal morbidity and mortality, it was recognized by Bloom et. al. that men lack understanding of risks of pregnancy and need to be taken in as solution to reduce maternal mortality. High level of maternal mortality was considered to reflect societal gender inequity and low value placed on women's lives.

Role of men: Many papers in the initial period (Adewuyi et.al.,1999; Carter, 2002; Galloway, 2000; Misra et.al., 2002, Ntabona, 2001; Population Council/Horizons, 2001; Raju and Leonard, 2000; Ransom, 2000) described that increased involvement of men aims to improve men's understanding of pre and postnatal care. They were of the view that programs reflecting male involvement in MCH underline the role men can play in reducing maternal and infant mortality by providing transportation to health centers/hospitals, recognizing symptoms that require medical attention and assuring that women get proper nutrition and rest.

In an important paper Roth and Mbizvo (2001) stated clearly that programs improving *“awareness of obstetric complications among members of a pregnant women’s immediate and wider social network,” including their partners, factor in reducing maternal and child mortality and morbidity.* In another paper Ngom (2000) and Ntaboma (2001) emphasized advocating for increased investment in health care by community members and policy makers, and increased awareness by men that they can do more to support their partners.

With regards to programs within the country, the SEWA program in rural India has been successful in increasing pregnant women’s use of health facilities by working with men and extended family members to begin preparing them for childbirth as soon as pregnancy is acknowledged (Raju and Leonard, 2000). Similarly in China, male participation in reproductive health included sharing responsibility with women in childbearing and childrearing (Liu and Xie, 2002).

A very important program in India was on involving men in maternity care – India 2004 (PC/Frontiers). This investigated the feasibility, acceptability, and cost of a model that encouraged husbands’ participation in their wives’ antenatal and postpartum care. The basic hypothesis was that men are primary decision makers in the family but are insufficiently informed with reference to women’s health. The strategies included **experimental clinics (3)**, and face to face training was provided to 12 ANMs and 12 doctors in skills in offering couple and individual counseling. Consenting men and women received couple, individual or same sex group counseling on pregnancy care and danger signs, family planning, postpartum infant care, breastfeeding and lactational amenorrhea method, and symptoms and prevention of STIs. Couples were seen during pregnancy and at 6 weeks postpartum. The experimental design also included **control clinics (3)** wherein pregnant women received standard care but very little counseling. The outcomes of the program were:

- Intervention during prenatal consultations found to improve knowledge about pregnancy and family planning
- Increase couples’ discussion and use of contraception and correct condom use
- High level acceptance and universal interest among men and women to involve men in antenatal and postnatal care
- Improvement in RH and greater couple communication in service delivery settings in India

The National Family Health Survey (NFHS) is being conducted once in 5 years. The last survey yielded the following findings which reflect on involvement of men in maternal and child health:

- Two-thirds of men with a child under age 3 reported that the mother received antenatal care
- Half of men with a child under 3 present for at least one of the mother’s antenatal care visits
- Slightly more than one-third of men were informed what do to in case of pregnancy complications
- Half of men were informed about proper nutrition, and about 2 in 5 men were informed about the importance of delivery in a health facility and family planning

- Men in the South and in Gujarat, Punjab, Delhi, Sikkim, and Mizoram are more likely to be informed about the importance of delivery at a health facility
- Main reason men with a child under three years give for their child's mother not getting ANC - not necessary or they do not allow it
- Main reason men with a child under 3 years for their child's mother not delivering in a health facility - not customary

It was concluded on the basis of NFHS results that men's participation in maternal health care needs to be strengthened; and information provided to men who participate in ANC visits is inadequate and needs to be more comprehensive

Ahmednagar study: Another important study was conducted in rural Ahmednagar in 2009 (Abhishek Singh, F.Ram) on male involvement in pregnancy and childbirth. Primary data was collected from men aged 15 to 54 years. The 3 important indicators of involvement of men were:

- Presence of men during antenatal visits and child birth
- Type of assistance provided during pregnancy
- Men's involvement in deciding place of delivery, person to conduct delivery

Gender roles and social network were found to be important predictors of men's involvement during pregnancy and child birth.

2.3 Conclusions

On the basis of the review of the existing literature, the following gaps emerge as important factors affecting involvement of men:

- Lack of sufficient information and knowledge related to wife's pregnancy and delivery
- Home delivery v/s institutional delivery
- Gender inequalities
- Existing cultural norms in the society

It is concluded that men can play a role in reducing maternal and infant mortality by

- providing transportation to clinics,
- recognizing symptoms that require medical attention
- assuring that women get the proper nutrition and rest

The main finding from the review can be summarized as **“Improved awareness of obstetric complications among members of a pregnant women's immediate and wider social network including their partners, are a factor in reducing maternal and child mortality and morbidity”**.

2.4 Challenges to be addressed

On the basis of the findings of the studies, the following challenges need to be addressed in order to promote involvement of men in maternal and child health:

- Undertake wider community outreach so that more men can be persuaded to participate in their partners' maternity care.
- Develop ways to disseminate information that are acceptable and appropriate for the target group, both men and women.
- Reorganize public services to be friendly and flexible to both men and women
- Strengthen monitoring and supportive supervision for all health services.
- Train more health provider to serve couples and to conduct couple counseling.

3. COMMUNICATION AND MEDIA

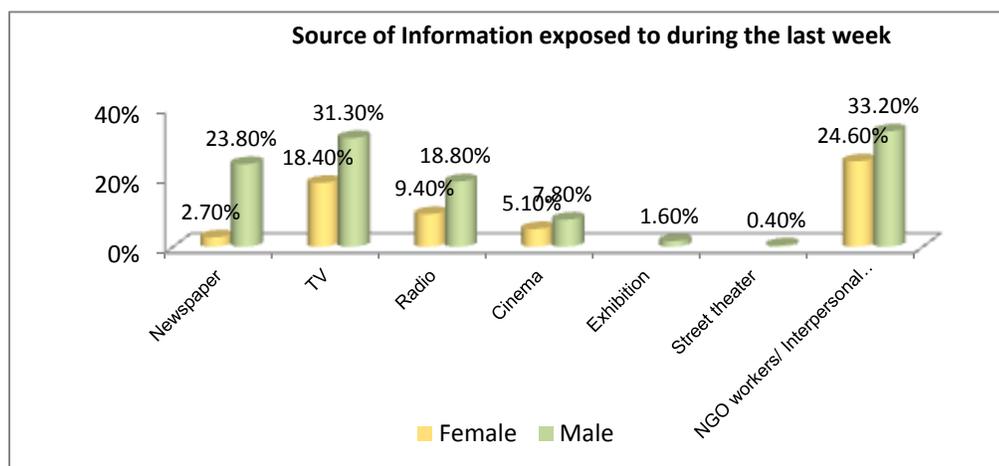
3.1 Introduction

Besides studying the knowledge, attitudes and practices of the target group, the study also looked into different aspects of media and communication related issues such as exposure to different media, media habits, access, exposure to communication in different media and channels and comprehension of messages, etc. The source of information and knowledge about mother and child health related issues, the way information and knowledge is disseminated, and the ways to access MCH related information in the community were also looked into. The findings related to media and communications are presented in this section.

3.2 Exposure to different media in the last 7 days

All respondents were asked about the different media which they had the opportunity to attend in the last one week. Considering both men and women;

- Interpersonal communicators emerge as the media/source of information to which 33% of men and 25% of women were exposed to in the last week.
- TV emerges as the second most popular media, and 31% of men and 18% of women were exposed to it in the last week.
- Radio is at the third place as 19% of men and 9% of women listened to it in the last week.
- Newspapers appears more popular with the men only as 24% of men read it in the last week, compared to only 3% of women.
- Cinema is also being attended regularly, as 8% of men and 5% of women has seen it last week.
- Exhibition and street theatre were not that popular or frequent and negligible proportion of men and women were exposed to it in the last week.



Discussion about pregnancy and delivery related matters

The pattern of communication networks among the people is important to map and in this context the persons with whom people will discuss MCH related matters were explored.

With whom do you generally discuss about pregnancy and child birth related issues?	Jagatsinghpur	Deogarh	Nuapada	Koraput	Total	Jagatsinghpur	Deogarh	Nuapada	Koraput	Total
ASHA	40.6%	32.8%	37.5%	35.9%	36.72	37.5%	51.6%	45.3%	43.8%	44.53
AWW	20.3%	39.1%	51.6%	40.6%	37.89	7.8%	51.6%	29.7%	31.3%	30.08
ANM	14.1%	21.9%	51.6%	42.2%	32.42	4.7%	29.7%	46.9%	45.3%	31.64
MIL	18.8%	21.9%	28.1%	9.4%	19.53	.0%	1.6%	.0%	.0%	0.39
Neighbours	34.4%	29.7%	9.4%	10.9%	21.09	.0%	7.8%	.0%	.0%	1.95
Relatives	20.3%	23.4%	26.6%	14.1%	21.09	6.3%	12.5%	6.3%	4.7%	7.42
Husband/wife	39.1%	29.7%	39.1%	29.7%	34.38	.0%	3.1%	1.6%	.0%	1.17
Doctors	43.8%	6.3%	15.6%	6.3%	17.97	78.1%	48.4%	21.9%	18.8%	41.80
Never discussed	6.3%	6.3%	.0%	6.3%	4.69					0.00
Mother	6.3%	.0%	4.7%	9.4%	5.08	.0%	.0%	.0%	1.6%	0.39
Wife						1.6%	15.6%	6.3%	14.1%	9.38
Total	64	64	64	64	256	64	64	64	64	256

Among men, maximum had discussed these matters with the ASHA (51%), followed by wife (44%), ANM (30%), Anganwadi worker (AWW) (28%), and then doctor (24%).

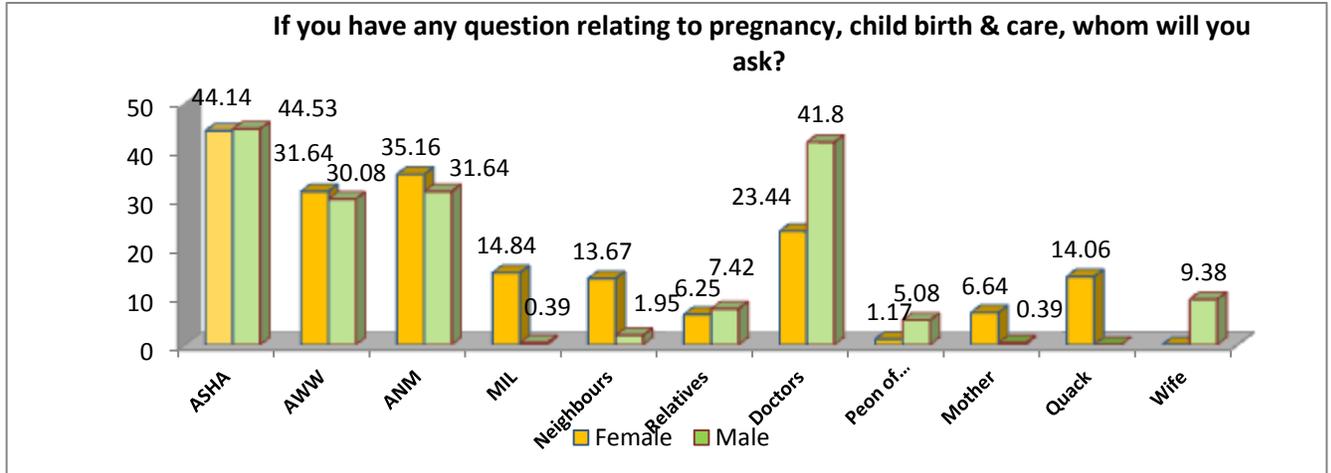
Among women, maximum had discussed with husband (38%), followed by AWW (38%), ASHA (37%), ANM (32%), and then doctor (18%). Many women had also discussed with neighbours (21%) and relatives (21%).

Thus, men tend to discuss with fewer people, but women tend to discuss with larger varieties of people. Further, men do not discuss these matters with other family members.

As men revealed during FGDs, in one way they are busy in earning a livelihood for their family and to fulfill their day to day needs. On the other hand they find it uncomfortable to discuss about different situations and complications related to pregnancy and delivery either with community people or with health workers. In most cases they assume that the general people in the community have little to do with this matter and have little knowledge or experience about it.

If there is any question about mother and child health, whom will they ask:

Among men, ASHA was mentioned by 44%, followed by doctor (42%), ANM (32%) and AWW (30%).



Women also favoured ASHA (44%) the maximum, followed by ANM (32%) and Anganwadi worker (32%). Doctor was favoured by about 23%. The MIL (15%) and neighbours (14%) were also preferred by women.

Thus it is seen that men only mention different health providers, whereas women give preference to health providers but a small proportion also favour relatives, friends and neighbours.

From which media they have received MCH messages

Whether exposed to messages on mother and child health in any media: About 69% of both men and women are found to be exposed to messages on mother and child health on some media.

Source of information	Jagatsingh pur	Deogarh	Nua pada	Koraput	Total	Jagatsingh pur	Deogarh	Nua pada	Koraput	Total
Newspaper	9.4%	2.1%	5.0%	8.3%	6.21	41.7%	12.3%	4.5%	6.9%	17.42
Television	66.0%	18.8%	30.0%	8.3%	33.33	60.4%	22.8%	40.9%	20.7%	37.08
Radio	28.3%	20.8%	5.0%	8.3%	16.95	16.7%	12.3%	11.4%	31.0%	16.29
IPC	3.8%	22.9%	25.0%	61.1%	25.42	.0%	5.3%	2.3%	.0%	2.25
ASHA	56.6%	70.8%	50.0%	41.7%	55.93	50.0%	49.1%	61.4%	51.7%	52.81
Neighbours	20.8%	25.0%	12.5%	2.8%	16.38	4.2%	5.3%	9.1%	.0%	5.06
Wall painting	1.9%	18.8%	15.0%	8.3%	10.73	27.1%	19.3%	15.9%	3.4%	17.98
Friends/relatives					0.00	2.1%	12.3%	15.9%	3.4%	8.99
Doctor	13.2%	18.8%	10.0%	2.8%	11.86	8.3%	12.3%	4.5%	3.4%	7.87
AWW	5.7%	20.8%	20.0%	22.2%	16.38	.0%	33.3%	6.8%	31.0%	17.42
ANM	7.5%	25.0%	25.0%	69.4%	28.81	.0%	17.5%	20.5%	31.0%	15.73
Total	53	48	40	36	177	48	57	44	29	178

Sources of message on mother and child health: Among men ASHA topped the list (53%), followed by TV (37%). Then the men mentioned other media such as wall painting (18%), newspaper (17%), and radio (16%).

Among the women also, ASHA is the most popular source (56%), followed by TV (33%). This is followed by ANM (29%), AWW (16%), and then radio (17%), neighbours (16%), doctors (12%), etc.

It is observed that ASHA is the major source of MCH related information for both men and women, followed by TV. Other mass media (radio, wall writing) and other health workers (ANM, AWW) come next. Women also receive information from neighbours and relatives.

Recall of media messages: Message on institutional delivery was reported by maximum men (68%) but maximum women (72%) could recall a message on giving nutritious food to pregnant women. About two-thirds of women recalled messages on institutional delivery and immunization of children (64 to 65%). Only four-fifth of men recalled messages on polio drops for children and giving nutritious food to pregnant women. Message on JSY benefits was recalled by less than a third of men (31%) compared to 39% of women. About half of women could recall messages on giving rest to pregnant women and on polio drops for children (49%). Less than a third of women (32%) could also recall messages on taking help of ASHA during delivery.

If you can recall any of the key messages that were communicated, what were those?	Jagatsi nghpur	Deo garh	Nua pada	Kora put	Total	Jagatsi nghpur	Deogarh	Nua pada	Kora put	Total
Delivery at hospital	58.5%	68.8%	62.5%	69.4%	64.41	62.5%	66.7%	81.8%	58.6%	67.98
Nutritious food to pregnant woman	69.8%	64.6%	92.5%	63.9%	72.32	35.4%	49.1%	29.5%	48.3%	40.45
Sufficient rest to pregnant woman	41.5%	43.8%	57.5%	58.3%	49.15	10.4%	14.0%	11.4%	24.1%	14.04
Rs 1400 if deliver at hospital	37.7%	47.9%	32.5%	33.3%	38.42	27.1%	28.1%	38.6%	31.0%	30.90
Help from ASHA during delivery	43.4%	25.0%	27.5%	27.8%	31.64	8.3%	5.3%	15.9%	24.1%	11.80
Timely immunize children	64.2%	64.6%	77.5%	55.6%	65.54	37.5%	33.3%	43.2%	24.1%	35.39
Give polio to 0-5 years	54.7%	47.9%	50.0%	44.4%	49.72	47.9%	33.3%	50.0%	20.7%	39.33
Not working hard during pregnancy	9.4%	4.2%	2.5%	8.3%	6.21					
Total	53	48	40	36	177	48	57	44	29	178

Preferred media for MCH messages: People were asked to state their preference for different sources if they wanted to acquire more information about pregnancy, delivery and care of the new born.

If you want more information about care of mother during pregnancy and child birth and care of the newborn child, which would be your most preferred source of information?	Jagatsinghpur	Deogarh	Nua pada	Koraput	Total	Jagatsinghpur	Deogarh	Nua pada	Koraput	Total
Television	18.8%	9.4%	9.4%	3.1%	10.16	42.2%	14.1%	21.9%	10.9%	22.27%
Radio	7.8%	6.3%	1.6%	1.6%	4.30	7.8%	7.8%	3.1%	15.6%	8.59%
ANM	4.7%	14.1%	45.3%	46.9%	27.73	1.6%	9.4%	23.4%	10.9%	11.33%
ASHA	25.0%	31.3%	15.6%	23.4%	23.83	35.9%	21.9%	23.4%	25.0%	26.56%
AWW	6.3%	15.6%	9.4%	9.4%	10.16	6.3%	25.0%	9.4%	10.9%	12.89%
MIL/Old women	3.1%	9.4%	9.4%	6.3%	7.03	.0%	4.7%	.0%	.0%	1.17%
Doctor	14.1%	9.4%	3.1%	6.3%	8.20	1.6%	6.3%	9.4%	4.7%	5.47%
Newspaper						1.60%	6.30%	6.30%	1.60%	3.90%
DK	17.2%	4.7%	6.3%	4.7%	8.20	0.00%	1.60%	7.80%	9.40%	4.69%
Total	64	64	64	64	256	64	64	64	64	256

Men preferred ASHA (26%) the most, followed by TV (22%), then Anganwadi worker (13%) and ANM (11%).

Women preferred ANM (27%) the most, followed by ASHA (24%), TV(10%), and Anganwadi worker (10%).

Reason for preference: The major reason given for preferring a health worker is that the source is trained and capable and elaborates and explains the message in a very simple way which is easy to comprehend. Another common reason is that the preferred person belongs to the village and is accessible for clarification. Those preferring TV stated that the TV is a major and common source of a variety of information on mother and child health issues.

Source of information on MCH related topics

Men and women were asked about the care related activities and about complications during pregnancy and delivery. They were also asked about the source of such information. The response reveals a lot about the actual source of information of men and women in the villages about MCH related topics.

Source of knowledge about check up during pregnancy: For men, ASHA (49%) is the main source, followed by Anganwadi worker (38%) ANM (33%), and Doctor (28%). Many men also learned this from friends/relatives or peers (23%) and about 10% learned it from their wife.

Women also mentioned the same sources; ASHA (43%), Anganwadi workers (41%) and ANM (39%). Neighbours (24%) and friends/relatives/peers (17%) were also mentioned next.

A major observation is the absence of mass media, including the TV, as a major source.

Sources of information on check-up during pregnancy	Female					Male				
	Jagat singhpur	Deo garh	Nua pada	Kora put	Total	Jagatsi nghpur	Deo garh	Nua pada	Kora put	Total
TV	10.8%	12.5%	2.9%	.0%	6.4	6.7%	.0%	2.3%	.0%	2.52
ASHA	45.9%	41.7%	28.6%	58.6%	43.2	53.3%	52.5%	47.7%	40.0%	49.06
AWW	18.9%	41.7%	51.4%	48.3%	39.2	26.7%	47.5%	29.5%	60.0%	38.99
ANM	13.5%	16.7%	65.7%	58.6%	39.2	6.7%	37.5%	40.9%	56.7%	33.33
MIL	10.8%	.0%	11.4%	.0%	6.4	.0%	2.5%	.0%	.0%	0.63
Neighbours	51.4%	25.0%	14.3%	.0%	24	15.6%	12.5%	9.1%	.0%	10.06
Relatives	29.7%	16.7%	17.1%	.0%	16.8	46.7%	20.0%	15.9%	3.3%	23.27
Husband/wife	18.9%	4.2%	8.6%	3.4%	9.6	6.7%	20.0%	9.1%	3.3%	10.06
Doctor	37.8%	8.3%	31.4%	6.9%	23.2	44.4%	22.5%	27.3%	13.3%	28.30
Own feeling	.0%	4.2%	8.6%	6.9%	4.8	4.4%	2.5%	2.3%	.0%	2.52
SIL	18.9%	.0%	2.9%	3.4%	7.2					0.00
Total	37	24	35	29	125	45	40	44	30	159

Source of knowledge on priority activities during pregnancy: For men, ASHA (42%) topped the list, followed by doctor (36%), Anganwadi worker (35%), ANM (34%). This is followed by relatives (24%) and then wife (10%).

Women, however, gave first position to ANM (45%), followed by AWW (41%), then ASHA (36%) and doctor (32%). Women mentioned neighbours (32%) as a major source.

Both men and women hardly mentioned TV as a source. It is observed that people are learning about pregnancy related activities more from health providers and peers and very less from mass media.

Source of knowledge about symptoms of pregnancy: The men reported that they knew these mainly from wife (43%), followed by health workers such as ASHA (32%), ANM (30%) and AWW (25%).

The women reported the neighbours (50%) as the major source of information, followed by ANM (34%), AWW (28%), relatives (25%) and ASHA (21%).

Sources of information on effects and symptoms during pregnancy	Female					Male				
	Jagat singhpur	Deo garh	Nua pada	Kora put	Total	Jagatsi nghpur	Deo garh	Nua pada	Kora put	Total
TV	14.3%	4.7%	.0%	1.6%	5.08	12.5%	4.7%	1.6%	.0%	4.69
ASHA	28.6%	17.2%	25.0%	14.1%	21.09	20.3%	39.1%	43.8%	25.0%	32.03
AWW	20.6%	28.1%	43.8%	20.3%	28.13	10.9%	39.1%	20.3%	29.7%	25.00
ANM	11.1%	31.3%	48.4%	43.8%	33.59	9.4%	34.4%	40.6%	37.5%	30.47
MIL	17.5%	6.3%	21.9%	12.5%	14.45	.0%	1.6%	.0%	.0%	0.39
Neighbours	49.2%	70.3%	37.5%	45.3%	50.39	14.1%	7.8%	3.1%	10.9%	8.98
Relatives	42.9%	14.1%	23.4%	20.3%	25.00	35.9%	28.1%	10.9%	15.6%	22.66
Wife	7.9%	3.1%	1.6%	4.7%	4.30	62.5%	45.3%	32.8%	32.8%	43.36
Doctor	23.8%	21.9%	21.9%	4.7%	17.97	28.1%	23.4%	26.6%	4.7%	20.70
Own feeling	25.4%	20.3%	25.0%	26.6%	24.22	.0%	6.3%	.0%	1.6%	1.95
Total	64	64	64	64	256	64	64	64	64	256

Source of knowledge on complications during pregnancy, delivery, and post partum period: The men reported two major sources, ASHA (36%) and their wife (35%), followed by ANM (28%) and then doctor (27%).

The women mentioned neighbours (44%), followed by ANM (31%), doctor (21%), friends/relatives/peers (21%), and ASHA (21%).

It appears that men learn about these issues from their wife, but the wives in turn learn from other women or peers from among neighbours, friends or relatives. The health providers also play a major role for both.

Sources of information on danger signs and complications during pregnancy, delivery and post partum period.	Female					Male				
	Jagat singhpur	Deo garh	Nua pada	Kora put	Total	Jagatsi nghpur	Deo garh	Nua pada	Kora put	Total
TV	14.1%	6.3%	1.6%	3.1%	6.25	10.9%	3.1%	.0%	3.1%	4.30
ASHA	29.7%	25.0%	17.2%	10.9%	20.70	29.7%	45.3%	46.9%	23.4%	36.33
AWW	15.6%	31.3%	34.4%	15.6%	24.22	7.8%	35.9%	18.8%	32.8%	23.83
ANM	6.3%	23.4%	48.4%	43.8%	30.47	3.1%	31.3%	45.3%	34.4%	28.52
MIL	12.5%	4.7%	15.6%	7.8%	10.16	.0%	1.6%	.0%	.0%	0.39
Neighbours	56.3%	53.1%	35.9%	25.0%	42.58	9.4%	7.8%	3.1%	7.8%	7.03
Relatives	23.4%	23.4%	21.9%	14.1%	20.70	42.2%	23.4%	15.6%	1.6%	20.70
Wife	6.3%	4.7%	.0%	1.6%	3.13	45.3%	32.8%	28.1%	31.3%	34.38
Doctor	25.0%	23.4%	28.1%	6.3%	20.70	42.2%	31.3%	28.1%	9.4%	27.73
Own feeling	32.8%	23.4%	25.0%	26.6%	26.95	1.6%	6.3%	3.1%	.0%	2.73
DK	1.6%	4.7%	.0%	6.3%	3.13	.0%	1.6%	1.6%	9.4%	3.13
Total	64	64	64	64	256	64	64	64	64	256

Source of knowledge about doctor who was called home:

Source of knowledge: Maximum proportion of men report that they knew about the doctor mainly from ASHA (41%) and then through their relatives (35%). About a quarter (25%) knew about the doctor through the ANM.

Source of knowledge about blood bank: The source of this knowledge about the blood bank was asked and maximum had known through relatives (33%), followed by doctor (28%), and neighbours (20%). About 22% of men had learned through wall painting.

Feedback On Popular Person/Character In Orissa

The perceptions and opinions of men and women regarding the male person liked the most was assessed in order to find out a suitable person/character who can endorse messages on male involvement.

Preferred character/person among men and women in Orissa: Respondents were asked to state the person they like most and whose activities they would like to emulate. They were asked to select a person who may be a real person or a character from fiction, movie, TV serial, etc. The result is shown in the table below:

Person/character	Men's preference (%)	Women's preference (%)
Mahatma Gandhi	14	7
Naveen Patnaik	11	2
Sidhant Mohapatra		3
Rajiv Gandhi	3	
Atal Behari Bajpayee	2	
Sachin Tendulkar	2	

Among men, the maximum preference was for Mahatma Gandhi (14%), followed by Nabin Patnaik (11%). The next preferences were for Rajiv Gandhi (3%) and Atal Bihari Bajpayee (2%). Next was Sachin Tendulkar (2%).

Among women also, Mahatma Gandhi was found to be most popular (7%). This was followed by Sidhant Mohapatra (Oriya movie actor and MP)(3%) and then Nabin Pattnaik (2%).

Preferred Oriya male: The most liked or appreciated Oriya male person/character was also studied. Nearly half of the men did not mention anyone. Among women, about 65% did not mention anyone. The result is given below: Maximum men preferred Nabin Pattnaik (28%). Next to him, other men were mentioned by few only; Gopabandhu Das (3%) and Sidhant Mohapatra (3%). Biju Patnaik was mentioned by only 2.3%. The women in general did not like any one particular person and small proportions mentioned each name. Nabin Patnaik was mentioned by only 8% and Sidhant Mohapatra by 5%.. Next Gopabandhu Das was liked by 3% and Uttam Mohanty by 2% only. No other person was mentioned by more than 2%.

Person/character	Men's preference (%)	Women's preference (%)
Naveen Patnaik	28.0	8.0
Sidhant Mohapatra	3	5.0
Gopabandhu Das	3	3.0
Biju Patnaik	2.3	2.0

Oriya movie and popular character: Respondents were asked about watching Oriya movies and the character they liked. 41% of men and only 26% of women reported that they watch Oriya movies. The male actor liked most was mentioned as given below:

Person/character	Men's preference (%)	Women's preference (%)
Sidhant Mohapatra	46	45
Bijoy Mohanty	17	
Mihir Das	11	9
Uttam Mohanty	7	15
Anubhav Mohanty	6	13

Maximum men liked Sidhant Mohapatra (46%), followed by BijayMohanty (17%) and Mihir Das (11%). Next were Uttam Mohanty (7%) and Anubhav Mohanty (6%). Sidhant Mohapatra was also mentioned by maximum women (45%). Next were Uttam Mohanty (15%) and Anubhav Mohanty (13%). Mihir Das was liked by 9%.

Oriya TV serial and popular character: About 14% of men and 15% of women are watching Oriya serials. The result on most popular male TV characters is as follows:

Person/character	Men's preference (%)	Women's preference (%)
Debu Bose	14	
Pradyumna Lenka	11	
Bijoy Mohnaty	8	
Ashrumochan	8	
Mihir das	8	24
Uttam mohanty		8
Pappu		5

Men liked Debu Bose (14%) and Pradyumna Lenka (11%). Next Bijay Mohanty, Ashrumochan and Mihir Das were liked by 8% each. However, Mihir Das (24%) was mentioned by maximum women. Next were Uttam Mohanty (8%) and Papu (5%).

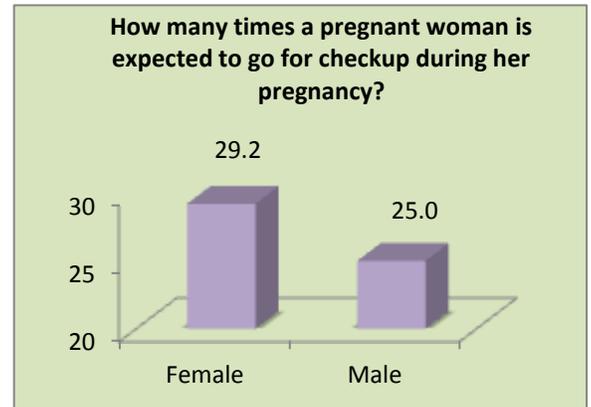
4. KNOWLEDGE ABOUT MOTHER AND CHILD HEALTH ISSUES AND SERVICES

The formative research has major focus on exploring the knowledge, attitudes and practices of the men and women in the community about different issues pertaining to mother and child health issues and services. The information regarding this was collected using the survey and also through Focus Group Discussions conducted with groups of men and women in the villages. The results from the survey and the qualitative research are presented together. This section presents the findings of the study on knowledge of the community about MCH issues and services.

4.1 Knowledge on number of check-ups during pregnancy

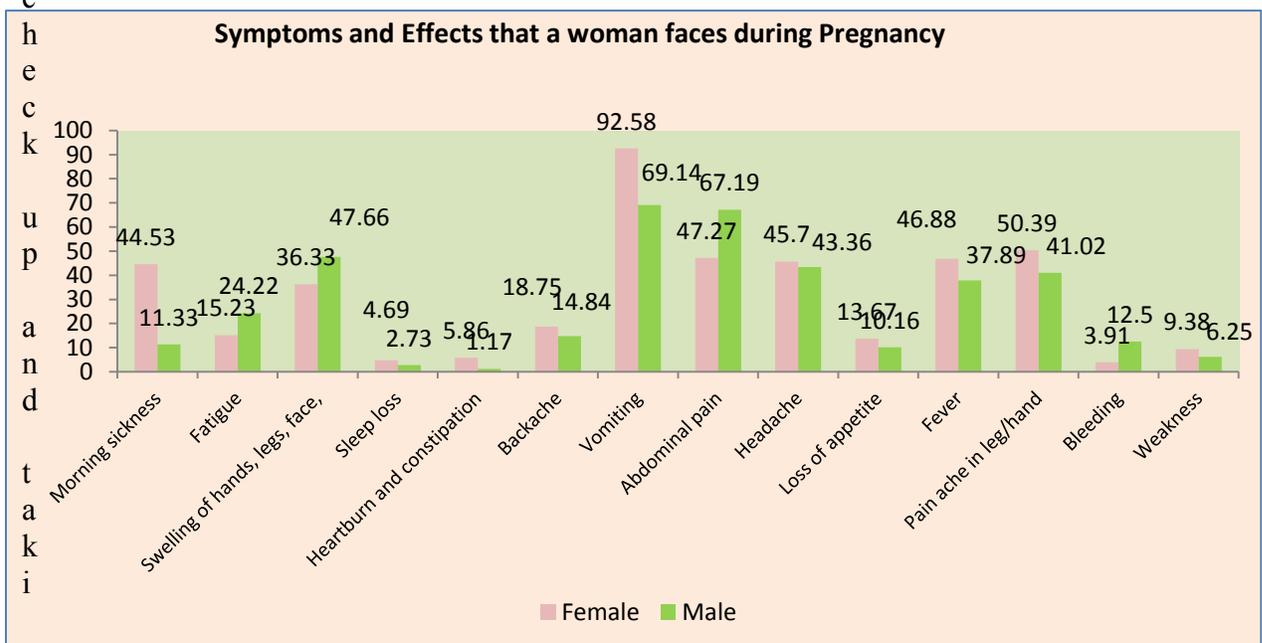
How many check ups during pregnancy:

Knowledge regarding number of check ups during pregnancy was assessed. Overall, 25% of men and 29% of women answered 3 times. While 17% of men and 36% of women said that they did not know about this, others gave incorrect answers, ranging from twice to 10 times.



4.2 Knowledge about things/activities to take/do during pregnancy

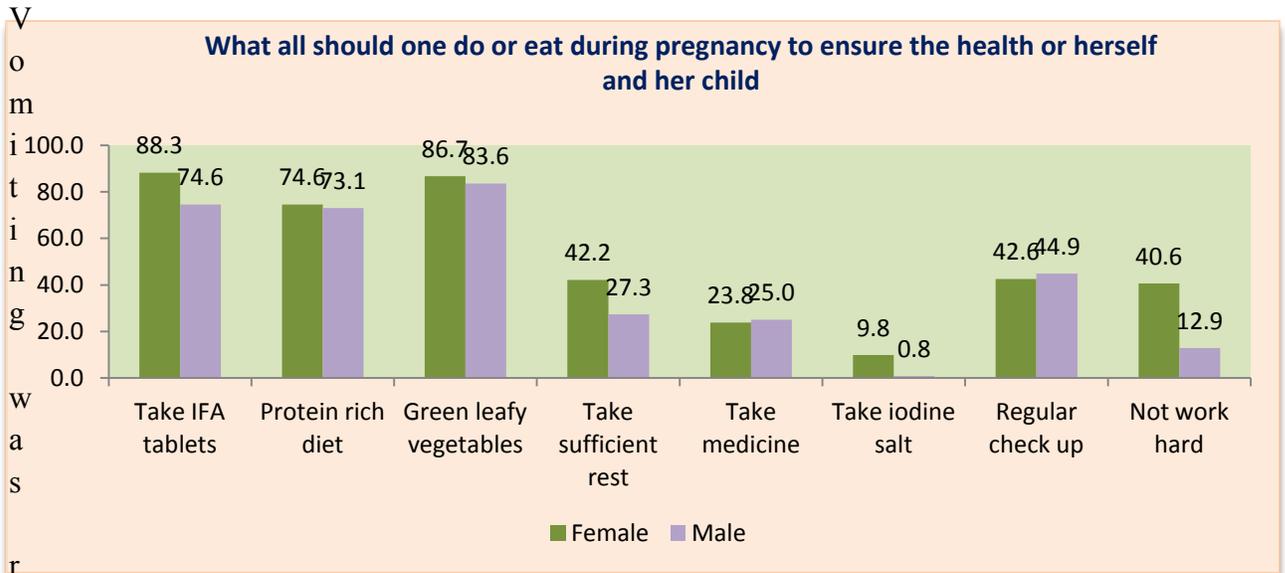
Food and priorities during pregnancy: Knowledge of people regarding the appropriate food to be taken or other tasks to be performed by the pregnant women for the health of herself and her child was assessed. Majority of men mentioned green leafy vegetables (84%), protein rich diet (73%), and IFA tablets (75%). Regular checkup (45%) and taking medicines (25%) was also mentioned by many. Similar pattern of responses was given by the women with majority mentioning IFA tablets (89%), protein rich diet (75%) and green leafy vegetables (87%). Regular



ng sufficient rest were mentioned by 43% each. Avoiding hard work (41%) was also mentioned by many women.

4.3 Knowledge of Symptoms and effects during pregnancy

Symptoms and effects during pregnancy: Both men and women were asked regarding the symptoms and problems that women face during pregnancy. A large number of conditions were reported by both. Large majorities of men reported vomiting (69%) and abdominal pain (67%).



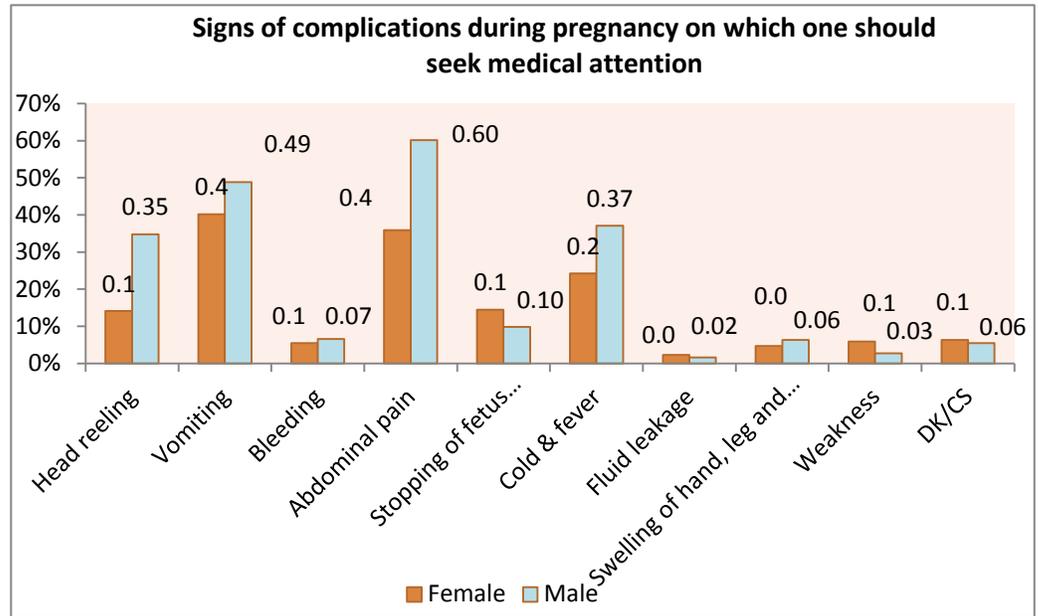
reported by a larger proportion of women (93%), but abdominal pain was reported by only 47%. Pain in limbs and swelling of limbs (49%) and pain in limbs (41%) were also mentioned by majority of men, whereas pain in limbs was also reported by majority of women (50%) along with morning sickness (44%). While headache was reported by 46% of women and 43% of men, 47% of women also reported fever.

4.4 Knowledge of Complications during pregnancy, delivery and post partum period

Knowledge about the complications; the conditions or symptoms due to which a woman has to go to a health center during pregnancy and delivery was assessed.

Pregnancy related complications, among men, abdominal pain was reported as a complication by maximum (60%) proportion, followed by vomiting (49%), head reeling (35%) and fever and cold (37%). Women also mostly reported abdominal pain (36%), followed by vomiting (41%), stopping of movement of foetus (14%), and cold and fever (24%). Only 17% of women considered head reeling as a complication.

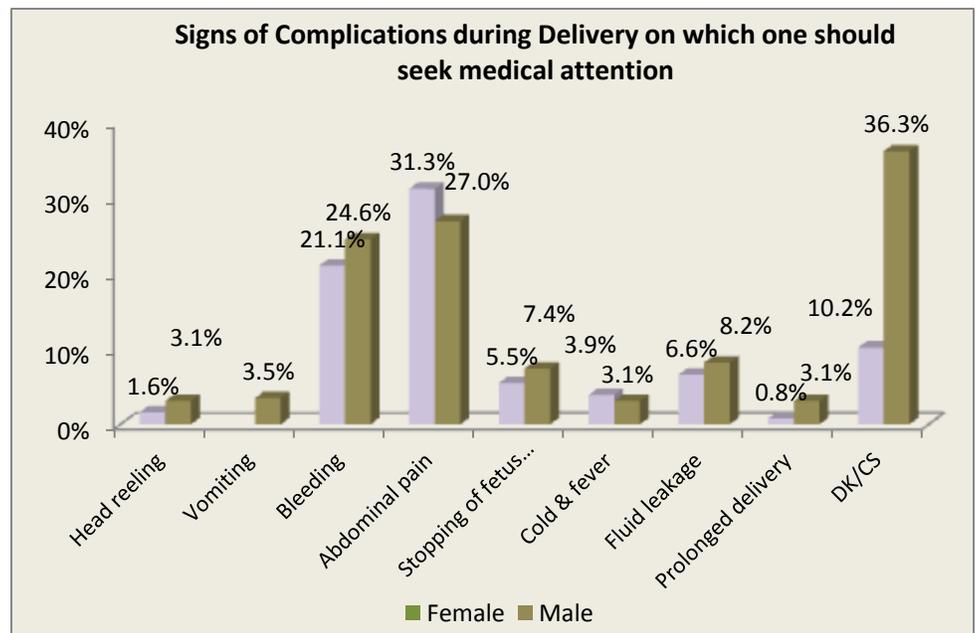
It is observed that important complications such as high blood pressure, anemia, swelling of foot, are not mentioned by anyone, whereas some other important symptoms such as stopping of movement of foetus is



known to only 10% of men and 15% of women. Bleeding, another important symptom of complication is also mentioned by very less proportion. Overall, both men and women in the community have very less knowledge about the important symptoms of complications during pregnancy.

Delivery related complications,

more than a third of men did not know symptoms (36%), compared to 10% of women. Men mostly reported abdominal pain (27%) and bleeding (25%). Women reported in the same pattern; 32% reported abdominal pain, followed by bleeding (21%). It is

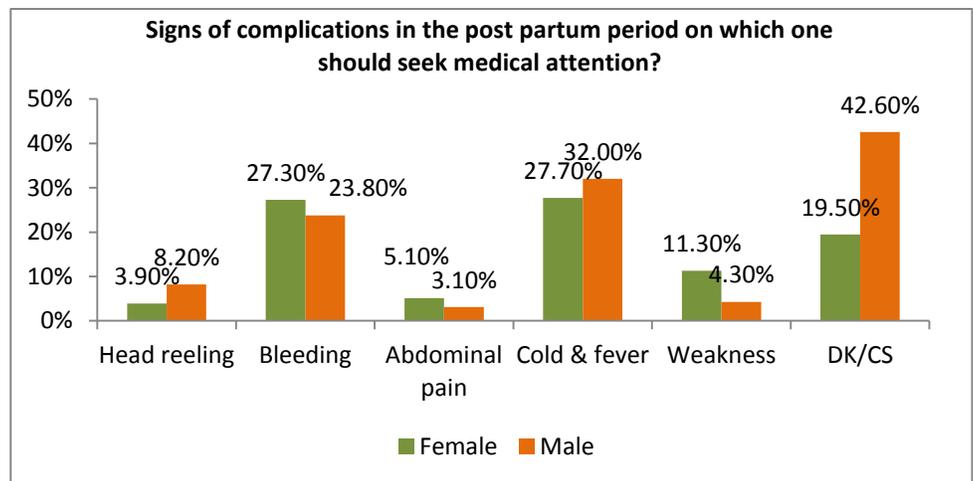


observed that important symptoms of complications during delivery such as fluid leakage and stopping of movement of foetus are known to very few (less than 10%) men and women. Other important symptoms such as absence of uterine contractions and abnormal presentation of child

are not mentioned by anyone. Prolonged labour is however perceived as abnormal and taken as a sign to seek medical attention, as mentioned in many group discussions. Overall, the knowledge of the community about the important signs of complications during delivery is very low.

Post partum complications, 43% of men and even 19% of women did not know about the complications. Among men, cold and fever (32%) was reported by maximum, followed closely by bleeding (24%). Among women, 27% reported bleeding, and 28% reported cold and fever as major symptoms. It is observed that only few symptoms are known to about a quarter of men and women. Overall, the knowledge of the community about the complications in the post partum period is low.

Overall, there is no clear or adequate knowledge among men and women regarding the complications or danger signs during pregnancy, delivery or post partum period. Large proportion of men admitted not knowing about the issues and could not answer anything. Knowledge of women is also not elaborate or adequate.



4.5 Knowledge about delivery related services

Delivery related services: Knowledge about different aspects of services available during delivery was studied.

Knowledge of suitable place of delivery: Regarding a suitable place for delivery near their house, 100% of men reported about govt. health institution, whereas in case of women, 91% mentioned govt. institutions and the rest 9% mentioned private institutions.

Knowledge about 24x7health center: Knowledge regarding the institution where delivery services are available all 24 hours (24 x 7) was assessed. A majority of 84% of men knew about this. Among women, 61% knew about the facility. 16% of men and 39% of women did not know about this.

4.6 Knowledge of men about services during delivery and ante- natal period

The knowledge of men about the different types of ante-natal and delivery related services were studied.

Whom to call for seeking medical care: Only 47% of men knew whom to call in case a doctor or health worker had to be consulted or the wife had to be taken to one.

4.7 Knowledge of men about health center and related services if wife has to be seek medical attention in an emergency.

- A large majority of 98% of men reported that they know which health center to go if the wife has to be taken to a health enter in an emergency;
- 98% of men also knew how to go there;
- 89% knew about which vehicle is available to go there;
- Only 36% had the contact number of the vehicle owner or the driver,
- 96% knew how much time it takes to go to the health center.
- Only 42% knew about the location of the nearest blood bank.

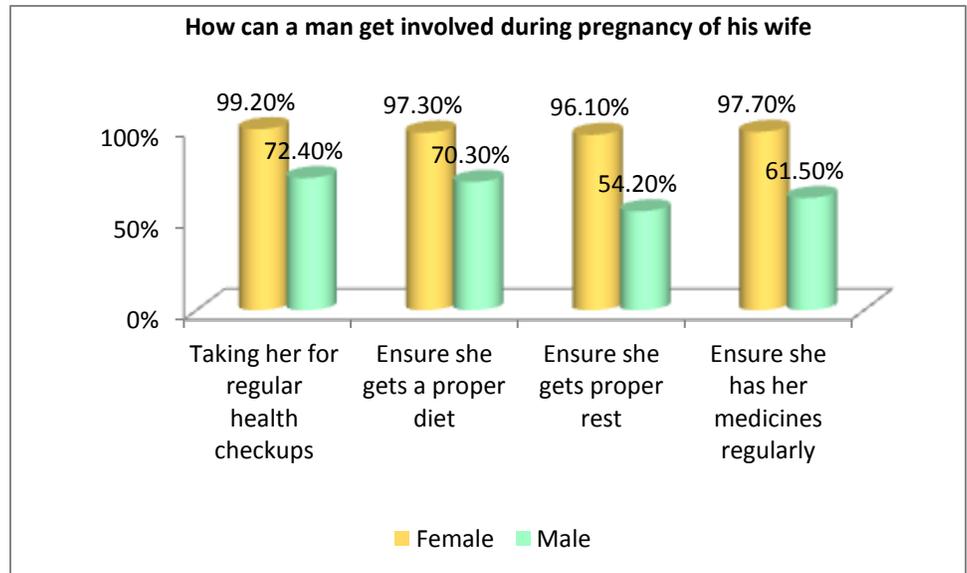
Overall, it is observed that large majorities of both men and women know about the pregnancy and delivery related services available in different health centres in their area. However, they do not have specific knowledge about blood bank, health providers or vehicle owners/drivers who can be contacted in an emergency. Majority of people are not ready with knowledge to deal with any emergency related to pregnancy or delivery.

5. ATTITUDES TOWARDS INVOLVEMENT OF MEN IN MCH ACTIVITIES

The attitudes of both men and women towards different tasks and priorities during pregnancy and delivery and in the post partum period were assessed.

5.1 In which activities men can get involved during pregnancy: The different ways through which a man should take care of his wife during pregnancy was discussed and specific tasks were asked.

Large majorities of men reported that during pregnancy men should take wife for regular checkups (99.6%); they should ensure that she gets proper diet (1000%), proper rest (98%), and ensure that she takes her medicines regularly (99%). Therefore, men have

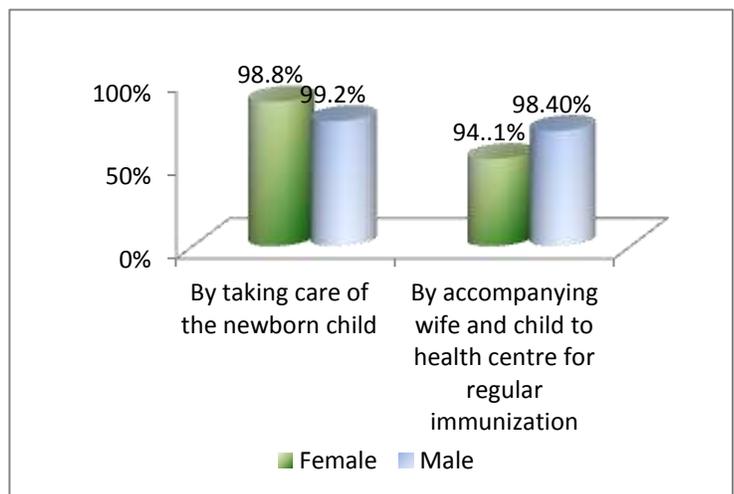


a very positive attitude towards involvement of men in different activities during pregnancy.

Women also have a similar attitude towards involvement of men in different activities during their pregnancy. Very large majorities of women reported that men should take women for checkups, should ensure she gets proper diet and proper rest, and take her medicines regularly.

5.2 In which activities men can get involved for post partum care:

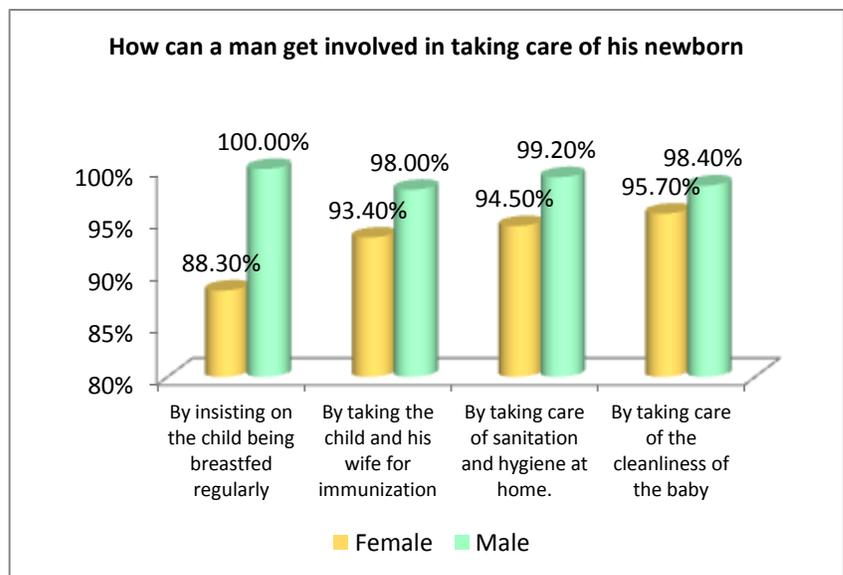
Attitudes towards role of men during post-partum period was also discussed with both men and women. Very large majorities of men reported that during post partum period men should accompany wife and child to health center for immunization (98%) and should take care of the newborn (99%).



Large majorities of women also reported that during post partum period, men should take care of the newborn child (99%) and should take wife and child to health center for immunization (94%).

- 5.3 What all activities can men do for care of the newborn: the role of men in taking care of the newborn child at home was discussed. Large majorities of men reported that men can take care of the newborn child by taking it for immunization (98%), by taking care of sanitation and hygiene at home (99%), taking care of baby’s cleanliness (98%), and by insisting that the baby is breastfed (100%). *Thus it is observed that the men approve of a role for men not only in doing outside work like taking to health center but also in taking care of food and hygiene, etc. at home also.*

The women also reported in large majorities that men should get involved in different activities at home and outside for taking care of the newborn. They reported that men should take care of the cleanliness of the baby (96%), maintain sanitation and hygiene at home for the baby (94%), should take baby to the health center for immunization (93%), and should see to it that the baby is breastfed (88%).



- 5.4 Role of men in calling a doctor home during pregnancy: Women were asked who would help them if a doctor had to be called home. 70% of women reported that their husband will help. 24% reported that the health worker would help. Among others, 11% each reported father-in-law and neighbor.

Role of men in taking wife to hospital during delivery: 70% % reported that husband will help. About 24% reported that the health worker will help in taking to hospital. Among others, mother in law and neighbor were reported by 10% each.

It is observed that majority of women (70%) report that their husband will take responsibility for seeking medical care, if required, during pregnancy. Involvement of men in seeking medical attention during pregnancy is desired by majority of women.

5.5 Attitudes of men towards involvement in pregnancy and delivery related matters of wife

Scope of involvement of men: Husbands in all areas felt that there is a need for them to be more active during pregnancy and delivery of wife, but due to illiteracy and lack of sources of information, they are neither aware of the different things to be done during pregnancy and are also not aware of the complications and risk factors during pregnancy or delivery. They also reported that since health workers do not talk to them about these issues their knowledge is also very limited and they are unable to perform a larger role. They also seemed to lack clarification about what all they should do during this period. They expressed the need for information and awareness about the dos and don'ts during delivery and their role in the process. Pregnancy and delivery related knowledge should be provided to husbands to enable them to identify the complications and danger signs and seek timely medical care.

The areas in which a husband should get involved and participate for the well being of his wife and to get a healthy child were discussed. In the coastal area the males reported that a husband should get involved in 3 things: giving proper rest to his wife during pregnancy, giving nutritious food, and ensuring appropriate ante-natal care. They also pointed out that a wife should share any complication she faces during pregnancy so that the husband can take appropriate action and provide her treatment services. In the non-coastal areas, the males reported that they are already helping their wives to some extent in 2 aspects: sharing household work and in providing ante-natal care. They wished to be more active in 2 things: catering to the nutritional needs of the wives and allowing them sufficient rest.

Willingness for more involvement: Men in all regions expressed willingness to get involved in a larger way in pregnancy and delivery related care of their wife. In most areas men reported that due to the pressure of work involved in earning their livelihood, they are not able to afford time for the care of their wife during this crucial period.

How to facilitate involvement of men: Disseminating knowledge on maternal health care, including an audio-visual programme describing in detail the different aspects of care will facilitate male involvement. This was reported in all regions. Information should be given on requirements of care and other needs in different stages of pregnancy and delivery. Promoting group or community action in pregnancy and delivery care was also suggested.

5.7 Barriers in involvement of men

Lack of knowledge about nutritious food: Most of the husbands both in rural and tribal areas do not have enough understanding and clear knowledge about nutritious diet that a pregnant woman should take even though they have been into agriculture or collection of forest produce since childhood. They are not aware clearly about the value of local diet and food habits that support

good nutrition for women in pregnancy. More often they know about converting vegetable from kitchen garden to money rather than utilizing it as a nutritional support for a pregnant woman. Due to low, very low and irregular income status, they are not capable enough to purchase nutritious food also. Actual involvement in providing nutritious diet to PW is difficult for them

Inadequate time to listen to wife during pregnancy: Time available to listening to their wife is very limited as most of the husbands are away from home and are busy in different means of earning an income. The time they devote at home is mostly utilized in fulfillment of household needs and in informal discussions either with peers or elderly members. For them involvement means just talking to wife, listening the problems of wife and shifting responsibility to other members like elderly members, neighbours or relatives. For instance they arrange transportation to reach hospital for seeking medical care but are not able to accompany, apprehending wage loss. In some cases if there is complication and they happen to reach the hospital with wife, but they prefer to stay outside and look after physical arrangements like medicine, food and treatment of relatives who have accompanied him rather than being present at the time of check up or treatment by the doctor.

Pregnancy care is women's domain: Many men reported that care during pregnancy and the do's and don'ts during delivery are too technical and women specific and since they do not have much knowledge about the issues they should stay away from it. In this context, they are ready to do whatever they are asked to do but they refrain from taking any decision in these matters. Due to this they do not give much attention towards the care of their wife during this period. They assume that the other women members in the family like grand mother, MIL, sister and also neighbours are more experienced to understand the pregnancy related problems and know how to manage the complications better than him. During such situation husbands think that they have no role to play other than providing financial support and bringing essential commodities like food, medicines, clothing, etc. They are more driven by the advice and suggestions of other experienced members in the family or in the neighbourhood.

Self-abnegation tendency of women: Another reason why the husbands are less involved during this period is due to the widely prevalent gender inequality in all the areas. The women's status in the house and the community is very low. This in turn gives rise to a situation where women behave as silent sufferers. In coastal region, the divide is larger and there is family support and social support for respecting the husband like God. Women perceive that they are there to worship their husbands and are not supposed to order them to do something for them. Women who cannot do the household work and require the help of the husband are not considered good. They are considered to be lazy and showy. Additionally, women who voice their needs to the husband and make him spend money on her needs is also not regarded good. Due to this, women never share their problems, difficulties, or even the symptoms during pregnancy. Rather they try to suppress and marginalize their problems and symptoms, apprehending expenditure by the

husband on their health needs. Without any expressed need or demand for any action or any care, men do not perceive any opportunity to get involved during pregnancy.

Defying mother and other elders: Both in tribal and costal districts it has been observed that men are quite attached to their mothers. In most cases, the mother being the most elder and experienced person in the family, takes all sorts of decisions regarding pregnancy and delivery related issues. Under such a situation, men keep themselves aloof from the decision making process as otherwise they may contradict the decision taken by the mother and ultimately it may hurt the sentiment and respectful position of mother in the family. Getting more involved or trying to take some initiative in the matters of pregnancy may be perceived as a sign of defiance to mother and other elderly women in the family. In such a situation, they encourage their wives to share their symptoms and problems with their mother. The social structure and prevalent norms do not offer scope for discussion on these issues between the mother and the son. For that matter, any joint discussion involving both men and women members in a family on issues related to pregnancy or child birth is not the norm in the present Oriya family or society. This further reduces the involvement of men in all types of decision making during pregnancy or delivery.

Pressure of Social norms and customs: In tribal areas, home delivery is preferred as a traditional and cultural practice although there is no influence of MIL or elderly persons in the family. Still they rely much upon the role of local healers (Dishari) and traditional birth attendants whom they treat as magic doers. Preference for traditional care and treatment systems is not limited to pregnancy and delivery but cuts across all health seeking behavior. Resorting to local healers and traditional methods is culturally approved and there is an implicit social pressure to not seek modern services unless it is necessary and unless traditional systems have failed. The community, mostly the family members and the neighbours offer support when traditional services are utilized. When modern services are sought in far off hospitals the community is not able to offer much help or moral support.

Lack of community support: Sometimes addressing any complication noticed during pregnancy, delivery or post partum period involves many activities to be conducted at the same time and this may be beyond the capacity of a husband operating alone. At that time, he requires community support in activities such as accompanying to hospital, giving financial and moral support, taking timely and appropriate decision in tackling the situation, etc. In such a situation, due to lack of capacity in dealing with multiple tasks the husband remains passive and his involvement in taking care of his wife lower than what is barely expected. For instance, when at the time of complication husband rushes to arrange a vehicle but the transportation charge is beyond his capacity, he stays back instead of seeking care at a hospital which is not at all safe for the forthcoming delivery. Here in this case a little support from community is required in terms of providing finance or sensitizing the vehicle owner that this is a situation of complication and maximum relaxation should be allowed for the family at this crucial time. May be in future he would compensate the loss incurred by the vehicle owner. Different situations like this leading

to complication may affect performance of activities such as calling a doctor, getting life saving drug from a distant place, etc.

In remote and inaccessible villages where there is no road and the pregnant woman has to be taken to the hospital, it is not possible on the part of a single husband to perform this task without the help of the community. In communities which are deprived in terms of physical infrastructure, communication facilities, or poverty, the dependence on the community is more in performing difficult tasks. It also requires community support for illiterate villagers to negotiate their way through the hospital staff for accessing quality care in the hospitals.

Poor financial capacity: A major reason why husbands are not fully involved in their wife's pregnancy is due to lack of financial capacity to access proper health care for their wives. This holds good for both husband and wife. In many cases different basic requirements and aspects of care are not fulfilled properly. In such a situation the husband cannot think of seeking proper medical care and fulfilling all the appropriate needs of wives during pregnancy quite rationally.

Poor economic condition makes the people around the pregnant woman helpless and frustrated and consequently they rely upon the traditional healing system which is less costly and has fair evidence of success. This also strengthens their beliefs upon God who can help them during such a critical situation. In such circumstances, they compromise with the situation and think it better to act upon the advice of MIL or any other elderly relatives who can suggest any traditional or reasonable option for ensuring safe delivery and that is the main reason why home delivery is preferred in tribal regions and in parts of coastal Orissa. The people of Sargiguda village in Koraput presented this nicely and said, "Previously we had no source of income here and never had any cash with us. Now after the opening of the stone quarry and a crusher unit near the village we are getting work regularly and have some cash with us. Now we can think of going to the hospital and taking medicines. Earlier we were totally dependent on traditional treatment in the village and did not have confidence to go to the hospital even in any emergency as we had no funds with us to buy medicines or to pay to the doctor or any other staff."

Concern for minimizing expenditure and inability to arrange money: Both in coastal and tribal areas, many husbands or family members of the PW stress upon minimum expenses to be incurred during delivery instead of safe delivery at a health centre. When probed, some husbands in Koraput district expressed, "we are told that in hospital treatment is available free of cost and JSY benefit of Rs. 1400/- is available. But actually it is not like that. We have to spend excess amount both for medicine, transportation, food and some other expenses like fee to health personnel, etc." The hidden expenses add to the inconveniences and put modern care out of the reach of the common people. Also JSY money is disbursed only after delivery. Sometimes they have to arrange money before getting the JSY money by selling of their household assets and sometimes they borrow money from others which is not practical at the time of need. The need for excess money and the inability to arrange it beforehand constrain the selection of modern care as the first choice of common people.

Inadequate knowledge of health care provisions: Men in general do not have complete idea about different health care provisions related to mother and child health which are available at different levels, like at village or panchayat or block level. They do not know what all services are available during pregnancy at different levels and what all they should access. They perceive only the services available at sub-divisional or district level as good modern health care services. They do not have clear knowledge about the services available at ASHA, Anganwadi or sub-center level, and the need for these services during pregnancy, and the appropriateness and quality of these services. Thus they undermine all the outreach services. Due to this tendency of equating appropriate services with those available at higher levels, they perceive that pregnancy and delivery related health care is not within their reach and the expenses involved are beyond their capacity. This also discourages them from getting involved and taking any appropriate initiative.

Lack of information or counseling: Since husbands do not present themselves at the time of ANC care, they cannot know in detail about the procedure of ANC care and precaution required to be taken during pregnancy. In the house, since there is no discussion on these matters in his presence, they also get sidelined from the information. The outreach workers also do not target them in any way for counseling and what ever counseling they get is purely incidental. Hence they become casual and agree upon the wish of their wives. They do not realize the importance of each activity or their relevance to the health of the wife or the baby. For instance, if some wife does not show willingness to consume IFA tablets, the husband does not insist on her to take the full course. During this situation, it is noted that involvement of husband is there but cannot be termed as appropriate involvement.

Communication between ASHA, AWW and ANM and husband does not happen at all. If at all ASHA comes to house for counseling, she either talks to MIL, PW or any women present in the house but not with male members like husband or FIL. On the other hand husband perceives ASHA as a recent introduction and not of any use during the situation of complication. Many husbands also have to come to believe that service of ANM, LHV etc. has become rare in the village. On very limited occasion, the doctor interacts with husband and counsel him to take proper care of wife as a consequence husband feels apprehensive and shy while accompanying wife to hospital. They try to shift the responsibility to others just by giving expenses to be made at hospital.

Unfriendly services at health centers: The attitude of the care givers and the delay in providing care or treatment services at health centers experienced by those husbands who have accompanied their wives during ANC period usually discourages them from going back to those centers again. Other men in the community also learn about these experiences from their peers

as the bad experiences of people are generally discussed among the peer groups in the village. This constrains the husbands from accessing appropriate services for their wives during pregnancy.

Practical difficulties in accessing appropriate care: Inaccessibility to health centre in difficult terrains and interior pockets, combined with lack of appropriate transport facilities, make it difficult for a family to seek modern services in hospitals, even though the family is willing to and has the financial capacity to go there. Since one does not go alone for such a work, taking family members poses additional difficulties for transport, and back home the absence of some family members makes it difficult for the remaining ones for managing the home. These factors together work against the decision to access appropriate care during pregnancy and delivery.

Opportunities for involvement of men

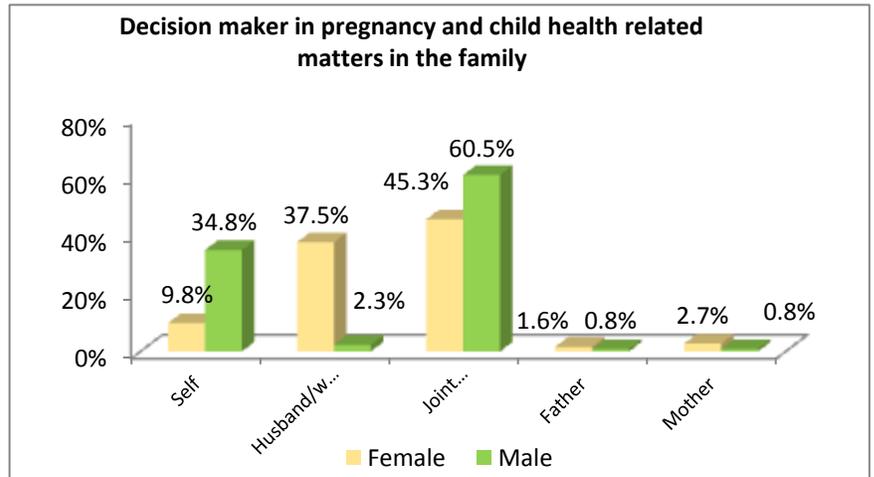
- A wife who has experienced a pregnancy earlier and has encountered any complication or still birth during her previous pregnancy, insists her husband to seek proper medical care for the current pregnancy. In such a situation, usually husband arranges money by selling assets to save the life of his wife and to ensure safety of newborns. Here due to pressure from wife, the situation compels the husband to take his wife to a health centre to have a safe delivery.
- Where wife is more educated or has exposure to earlier cases or examples where she has observed the husbands being more cooperative and supportive during pregnancy, usually she motivates her husband to be more involved in taking care of her during such periods.
- In tribal areas husbands are culturally more involved and attached to their wives with full social support. For instance at the beginning of pregnancy, they call the traditional healer and arrange for rituals, and they also accompany their wives to the work place like forest or nearby worksites so that in case any problems arises they can assist.. Even there are instances where wife delivered the baby at work place and husband had to call for local TBA to do the necessary task.
- There is more involvement in areas where the society holds the husband accountable for everything concerning his wife. In tribal areas the wife is more like an individual responsibility but in coastal areas she is more of a household responsibility. In tribal areas husbands are vigilant and stay present in the house while the woman is in labour. But in coastal areas, the husband usually shifts the responsibility to the elderly women or mother and goes to work place while his wife is in labour.
- In tribal areas, most of the families live in a nuclear family and have limited scope for getting family support during pregnancy or later period. Under such circumstance, husband is the only hope who can give support to his wife otherwise he has to face problems in future. So there is more involvement even though the health seeking behaviour is not observed.

- In some joint families, where MIL and co-sisters-in-law are jealous and do not cooperate with the wife, husband's involvement goes up and he feels bound to support his wife as she might encounter any complication and ultimately he would bear the loss.
- Earlier experience of husband in handling sick cases or dealing with pregnant women make him more involved. Where complication has arisen and husband was present during the complication stage and he had to take her to a higher facility, during such period the situation compels the husband to be more involved otherwise she may lose her life. In such situation husband is usually more involved in future.
- Husbands are found to more involved in those areas where ASHAs and health workers are very much proactive and dynamic. For instance, ASHA belongs to the same village and the concerned health worker (F) is stationed in the village, then husbands are more sensitized, counseled and more responsive on different aspects of pregnancy care. Health workers motivate husband to accompany his wife and listen to their advice so that they can know the exact complication of their wives and adopt necessary precautionary measures to overcome such problems in future.
- Where the size of the family is very small, in that situation the involvement of husband is more, whereas in larger families the responsibility gets divided and the husband does not feel individually accountable.

6. MOTHER AND CHILD HEALTH RELATED PRACTICES OF MEN AND WOMEN

6.1 Decision-making: Previous studies indicate that one of the major causes of maternal death is the delay in decision making when complications occur during pregnancy. In this context, the trends in decision making was studied.

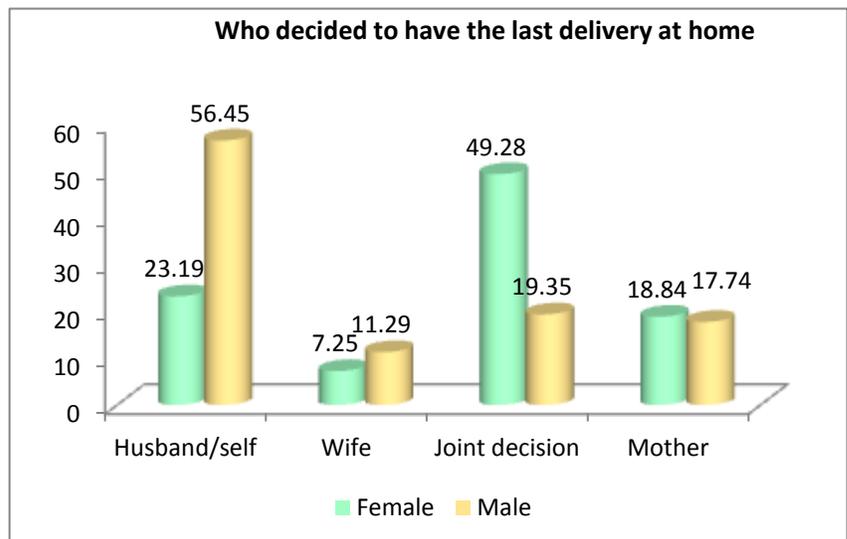
Who usually makes decision at home: Men and women were asked who usually makes decision at home in matters related to mother and child health. Most men reported that decision is made jointly by husband and wife (60%), and another 35% reported that the husband makes the decision. Only 2% of men said that the wife makes the decision.

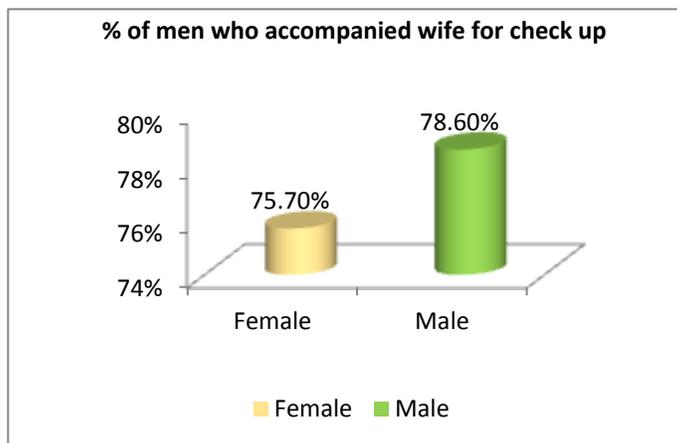


Most women also reported that decision making is joint (45%), whereas 37% reported that the husband makes the decision, and 10% of women reported that the wife makes the decision.

Thus it is observed that usually in matters related to mother and child health, in most cases it is joint decision. In more than a third of cases, the husband makes decision, whereas the role of wife is very limited.

Decision making about home delivery in last pregnancy: In those cases where delivery has been conducted at home, the person who made the decision was studied. As reported by men, husband is the major decision maker (56%), followed by joint decision making (19%). In about 18% of cases the mother (of husband) took the decision, whereas in only 11% the decision was made by the wife.





The women report that in majority of cases it was a joint decision (50%), and the husband decided in 23% of cases. In 19% of cases it was decided by the mother in law. In only 7% of cases the wife took the decision.

In case of home delivery, decision is made jointly by the husband and the wife or the husband decided alone. The MIL also decides in a minority of cases, whereas the wife makes decision in very less cases.

For decision making within the household in general, the major decisions such as buying land, marriage in the family, major purchases, etc., are usually taken by the males, involving the elderly males or the household head. In the non-coastal areas and the tribal areas, the women also are involved in the decision. For things of household requirements, mostly the women take the decision as they are more aware of the needs of the household.

In case of making decisions relating to health related issues of women, usually the couple takes the decision, and later informs the parents to seek their blessings and also financial support. Usually the parents help by taking care of the children when the couple is away for health seeking or delivery. In non-KBK western areas, the women reported that they take the decision themselves in consultation not with the spouse but with the MIL and ASHA. Besides, distinct trends are observed in different areas, as in coastal areas formal health system is sought for all health problems; whereas in western area, minor problems are first taken to traditional health system and for major ones formal system is used; but in tribal areas, traditional system is first used even for delivery and only in case of complications the formal system is sought at the last moment.

Family members take decisions, but usually the husband is not the major decision maker. The ASHA plays a major role in these decisions to seek delivery services. Family members also consult the neighbours.

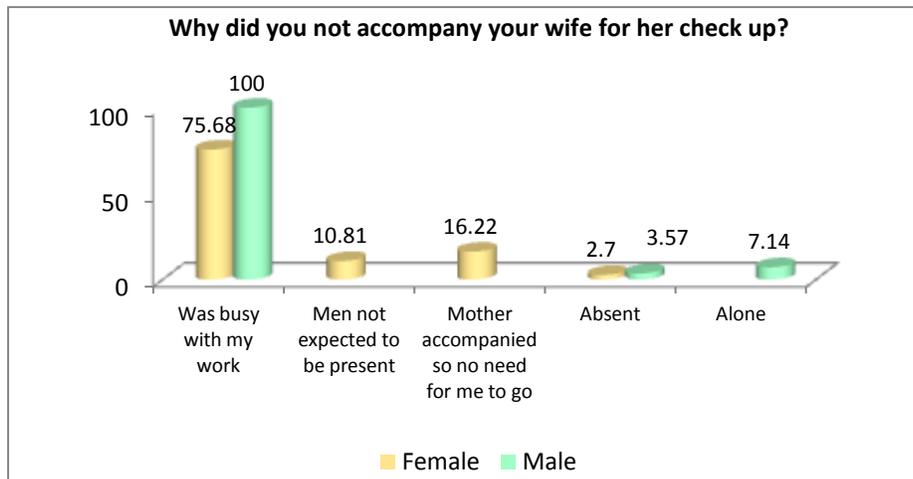
6.2 Last pregnancy episode and involvement of men

Events that took place during the last pregnancy with regards to ante-natal care, delivery, complications and health seeking, and the involvement of men in those events was studied.

Ante-natal check-up and involvement of men: Majority of men (79%) report having gone with wife during check up; and an equal majority of women (76%) also confirm this.

Reason for not taking wife for check-up: All the men who had not gone reported that they were busy with their work. Majority of women also reported this. However, 16% of women also reported that there was no need for the husband to go there as the MIL was there.

But 11% of women also reported that the husband is not expected to be there during check-up. This shows that the wives do not think that the husband should get involved in these matters.

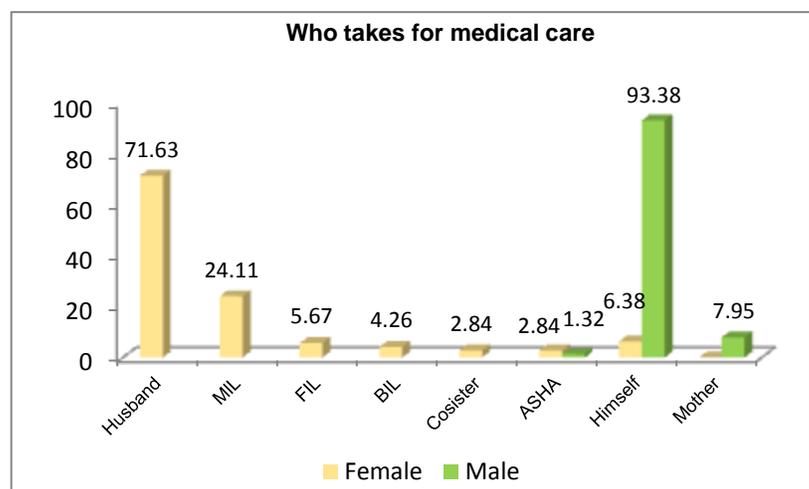


Who takes for Medical care during pregnancy: Of those who had faced complications during the last pregnancy, men reported that in 78% of cases medical intervention was required, whereas women reported that medical intervention was required in 72% of cases.

As reported by men, in 93% of cases requiring medical assistance, they had played the major role in getting medicine/taking wife to doctor, etc., whereas in another 8% of cases their mother had carried out the activity.

The women reported that the husband carried out the activity in 72% of cases, whereas the mother carried it out in 24% of cases.

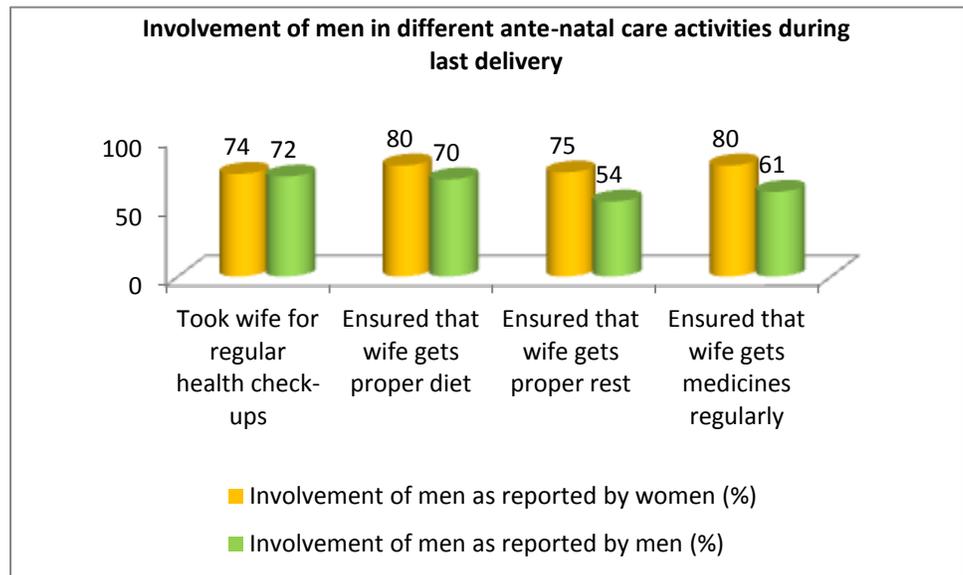
There are differences in the reports of men and women, but despite that it is clear that the men are involved in seeking medical care for their wife in a large majority of cases.



Involvement of men in ante-natal care during last pregnancy: Both men and women were asked whether the husband carried out a number of activities as part of ante-natal care during the last pregnancy.

As reported by men, during the last pregnancy of wife, 72% of men had taken their wives for checkup; 70% of men had ascertained that their wives had appropriate food during pregnancy; only 54% of men had ensured that wife took rest regularly; and 61% ensured that wife took medicine regularly.

Women also reported on the role of men during their last pregnancy. As reported by women, 74% had taken them for check-up, 80% had ensured proper diet at home; 75% had ensured sufficient rest; and 80% had ensured that wife took medicine regularly.



Women's reports indicate more involvement of men in different ante-natal care activities, compared to reports of men. Men report less involvement in ensuring rest and medicine, but women report similar involvement in all activities. There is evidence that majority of men are involved in different ante-natal activities of wife.

Involvement of men in post-partum care after last delivery: Men and women were asked about the role of men in post partum care after the last delivery.

As reported by men, 75% had taken care of the newborn child, and 69% had accompanied wife and child to the health centre.

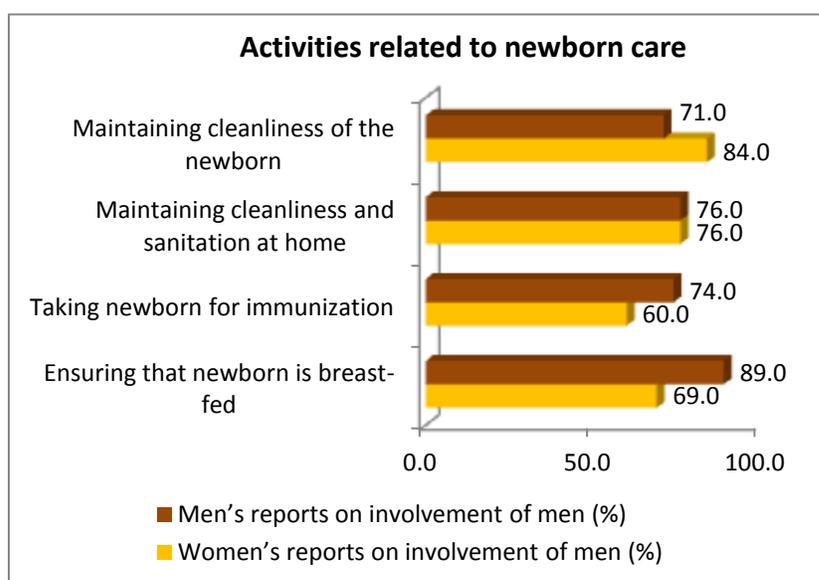
Women reported that 875 of men had taken care of the newborn child, whereas only 52% had taken wife and child for immunization.

Reports of both men and women indicate that majority of men are involved in newborn care, whereas less are involved in taking mother and child for immunization.

Care of the newborn child by husband	Female	Male
Took care of newborn child	86.7%	75.0%
Accompanied wife and child for immunization	52.3%	69.1%
Total	128	136

Involvement of men in newborn care after last delivery:

Reporting about the activities they had carried out for their last newborn, about 89% of men reported that they had ensured that their newborn had adequate breast feeding; 74% of men reported having taken the newborn for immunization, 76% of men reported that they had ensured cleanliness and sanitation at home; and 71% of men reported that they had ensured that the baby was clean.



Women also reported on involvement of men, and 69% reported that men had ensured that the newborn was breastfed; 60% reported that men had taken newborn for immunization; 76% of men had involved themselves in maintaining cleanliness and sanitation at home; and 84% had looked into cleanliness of the baby.

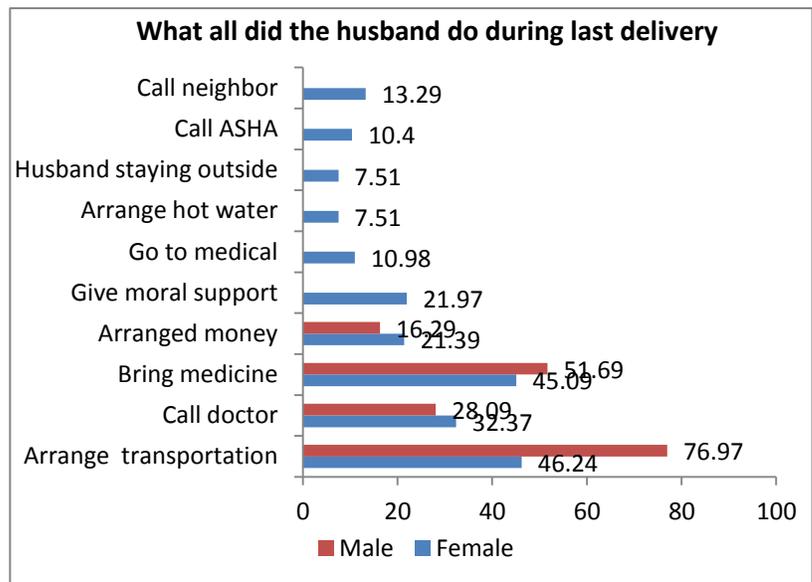
Thus, majority of men had carried out crucial activities related to care of the last newborn, even though there are differences in the reports of men and women.

Activities of husband during last delivery: Major activities reported by men are arranging transport (77%), bring medicine (52%), and call a doctor (28%).

The women described husband's role in delivery as arranging transport (46%), bringing medicine (45%), calling a doctor (32%), etc.

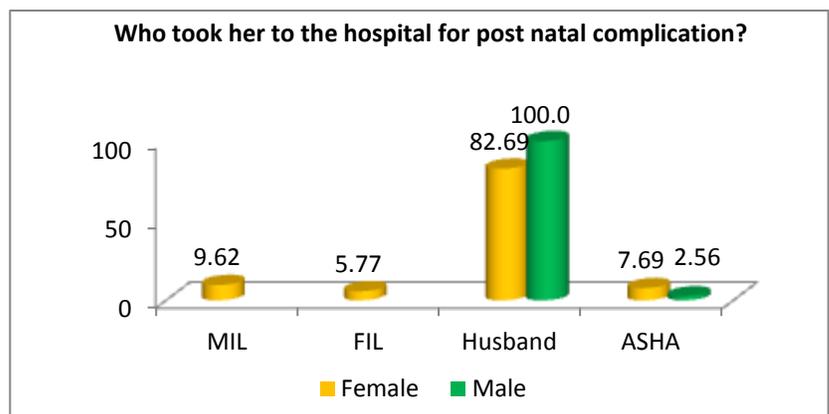
Both men and women describe same activities for men, but larger proportion of men report that they carried out those activities, compared to women's reports.

During delivery, majority of men are involved in arranging transportation and bringing medicine, and about a third are involved in calling a doctor.



Involvement of men in taking wife to hospital for post partum complication

Of those cases where wife had to be taken to hospital for post partum complications, in all cases the husbands reported that they took her there. About 83% of women reported that their husband took her there, whereas in a minority of the cases her mother or father in law, or the ASHA worker took her there.

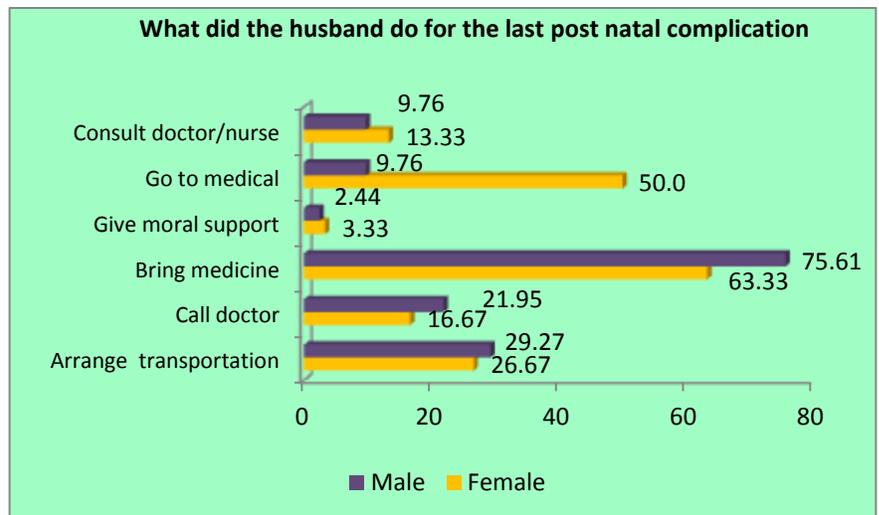


In most cases, men are involved in taking wife to the hospital in case of post partum complications.

Involvement of husband in post natal complication: Men reported their own role in bringing medicine (76%), arranging transportation (29%), calling a doctor (22%) mostly.

The women also reported similar pattern, and half of them also reported that the husband went to the hospital (50%).

Men play a major role in post natal complications by either getting medicine or doctor home or by facilitating going to the hospital for treatment.

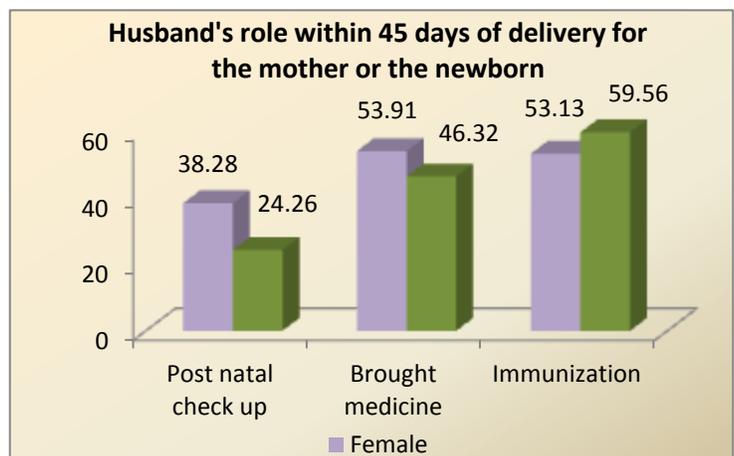


What all did husband do within 45 days of delivery for the wife or the newborn.

As per the reports of men, maximum were involved in immunization of the child (60%), bringing medicine (46%), and about a quarter in post natal check-up (24%).

Women also reported in a similar way; saying that men are involved in immunization (53%), bringing medicine (54%), and in post natal checkup (38%).

It can be concluded that men are involved in the post natal period in care of the wife and the newborn, by taking them for immunization, getting medicine home and in post natal check-up.



7. PERCEPTIONS AND ATTITUDES OF MOTHERS-IN-LAW

7.1 Introduction: In a household, matters related to pregnancy and delivery belong to the domain of “women issues” and the MIL usually acts as the gatekeeper to this domain. She is in a position to regulate the food intake, rest, magnitude of work performed by the pregnant women, seeking of ante-natal care, taking necessary pregnancy related precautions such as taking IFA, TT shots, etc., and may decide on when and where to deliver the child. She also has the potential to regulate the involvement of men in the family in pregnancy related activities. This section seeks to study the role played by the MIL in pregnancy related activities and their perceptions and priorities regarding male involvement in these activities.

7.2 Knowledge, attitudes and practices: In general, MILs have very little knowledge about the do’s and don’ts during pregnancy and delivery. During discussion with them, it was very clear that most mothers-in-law do not have basic knowledge regarding problems that might occur during pregnancy and delivery. They are not much aware of the problems that might lead to infant or maternal death. They know about check ups but are not aware about the number of check-ups and the timing. They have heard that pregnant women should be given extra food, along with green vegetables and other “nutritious” food, and they should avoid heavy work and take sufficient rest. While they are aware that nowadays doctors and health workers advice that these activities should be carried out during pregnancy, they do not understand the necessity of these activities and hence are not convinced about these practices. Some educated MILs in the coastal areas were found to be convinced about modern and medical advice and practices, but the large majority of MILs are not convinced. Their own experience with traditional practices leads them to believe that these are not important. Based on the discussions with MILs in different areas and different socio-economic and cultural groups, distinct trends in the knowledge and practices of MIL are observed:

1. Strong belief in traditional knowledge and practices: Many MILs still consider their traditional way the best and do not trust medical care or extra food or rest during pregnancy. Some MILs said that they hardly care for medical counseling. They take their daughters-in-law to the doctor for regular check-up just for the namesake, but later they act as per their own knowledge and will. While many MILs have adopted new pregnancy care practices, they do not seem to be entirely convinced of the advantages of the new ones over the old ones. They are very complacent about medical care during pregnancy and are pretty sure that the medical assistance is of no good and thus useless. On a lighter note, one MIL narrated how she gave birth to healthy children at home without any medical support and special care and how the women these days give birth to low weight child even after having all the facilities in diet, rest and institutional delivery. However, despite lack of confidence on modern care practices, wherever they can afford, MILs give nutritious food to pregnant DILs and take them for check-up, and also go for institutional delivery. Due to the general trend in following modern practices, and due to the pressure of health providers and general public opinion, many MILs resort to modern practices despite not being convinced.

Many MILs in non-coastal areas subscribe to traditional beliefs and favour traditional practices. They look after the diet and food intake of the daughter-in-law as per their knowledge and assist in home deliveries and take proper care of the timely food of their daughter-in-law. Though mothers-in-law are aware of the facilities of institutional delivery, they prefer home delivery as according to them one can get the support of entire family and kinfolk at home.

2. Alienation from young couples: Where there is a generation gap or a huge difference in educational level and socio-cultural practices among the young couple and the MIL, some MILs are alienated from the young couples. Since they are not consulted by the young generation, they also do not give their advice and do not participate in anything and carry out few activities when asked by the couple.

The divide between the MIL and the younger generation is clear in some places where modern care practices are being adopted. One MIL stated that the ASHA does not counsel her during her visit and talks only to her pregnant daughter-in-law. She does not have access to any source of information in this regard. The old woman said that she does not accompany her daughter-in-law to the health centre for check-up or immunization. She does not have any idea in this regard. Some of her daughters-in-law have had institutional deliveries and some delivered at home. In case of institutional delivery she only accompanies her daughters-in-law to the hospital and in case of home delivery she along with few other old women, assists in delivery.

3. Belief in modern and medical knowledge and practices: Many MILs are convinced about the benefits of modern medical practices and accordingly take care of their daughter in law during pregnancy and delivery and post partum period. They listen to the advice of the younger generation and the health workers and do accordingly. Many MILs have realized the value of medical care and recalling their experience, some mothers-in-law agreed that in old days, mother and child used to die due to lack of proper knowledge, care and medical assistance and they do not wish the same to happen with their daughter-in-law. A typical MIL of this type commented that she looks after her daughters-in-law properly during their pregnancy and takes extra care. She said that she had ordered extra milk for her daughter-in-law when she was pregnant. In many families in the coastal area, the men have migrated in search of a good earning and in such cases the mother-in-law also accompanies and assists the pregnant woman in accessing health care facilities.

7.3 Perceptions and attitudes towards involvement of husband: Over interviews with the MILs belonging to different geographical and socio-economical and cultural groups, a variety of statements were made about the type and extent of involvement of men in mother and child health related matters. The common theme that emerges is that *men should carry out all the activities outside the house and should leave those activities that are carried out inside the house to other women in the household*. Where there is no other female member in the family,

men can carry out different activities in the house when the wife is unwell or not in a position to do those.

There is difference among MILs regarding the activities that men should perform within the house. A MIL said that *a man should help his wife in caring for the child*. According to another MIL, men should not do women's work. She is of the opinion that *men hardly have any role to play in pregnancy and delivery other than arranging money*. Another MIL reported that *the son is there to take care of all other stuffs (other than diet and work at home), from immunization to consulting doctor and arranging money*. Another MIL said that while she took care of her daughter-in-law and the new born for 4 months after delivery, *her son used to accompany the DIL to the health care center as ASHA suggested*. The mothers-in-law in one village said that *the son brings nutritious food and fruits that she (MIL) provides to her daughter-in-law*. One MIL said that *she considers it the responsibility of a man during her wife's pregnancy is limited to take her to the hospital for regular check up* as there are other female members in the family (she has a joint family) to take care of all other matters.

In western Orissa, where the mothers-in-law are very caring and supportive towards their pregnant daughter-in-law, *some MILs even do not mind seeing their son taking proper care of his wife during her pregnancy and delivery*. Yet, they want to be on lead when it comes to pregnancy and delivery in the family and *do not accept men getting deeply involved in women's work or a husband helping his wife frequently in household works*. In the perception of most of the mothers-in-law, *expecting care from a husband is a vague and weird thought*. They do not like *men (their sons) helping women (daughter-in-laws)*. Mothers-in-law think that women can take better care of a pregnant woman much better than a man. According to one MIL, *men involvement is sufficient and there is no need for more involvement*. Another MIL drew the line more clearly by saying that *a husband should look after his wife throughout the period of pregnancy but a man has no role to play in delivery*.

However, in the tribal areas, there is no restriction on men in helping women in household matters. The MILs do not take it positively. The old ladies do not like to see their son helping his wife in household works like cooking, and bringing water when his wife remains unwell. According to them, men should not do women's work. But her opinion is hardly considered.

Mothers-in-law are open to a *husband taking care of his pregnant wife only in the absence of the mother-in-law or other female members*. Another MIL in another village said that though she helps her daughters-in-law in household works, *she does not like a husband helping or supporting a wife*. According to her, as the mother-in-law and other female members of family are there to take care of the pregnant woman, *there is no need for the husband to help his wife. He may help only in the absence of other female members*. In western parts of KBK area, a mother-in-law in one village said that *her son helps his wife in household works like cooking and bringing water when his wife remains unwell but she (the mother-in-law) does not like her son to help his wife*.

7.4 Role in decision making: In costal districts, the values associated with joint family still persist and in many families the elders are active in decision making or consulted wherever the son/husband takes a decision. The mother-in-law plays a major role in decision making.

In western Orissa both men and women are involved in the decision making process, and even women do not hesitate to decide on their own if they find their husbands not showing any interest in any matter, especially health of women and children. MILs help the daughter-in-law during her pregnancy and delivery, even though they are not the decision makers of the family. Generally men take all the house hold decisions and the family remains un-influenced by the mother-in-law.

In tribal districts there is no interference of parents in a married son's life. They prefer to work and earn their own livelihood and therefore parents are not the decision makers or head of family. Husband takes decision in every household matter. As most of the families are nuclear in nature, mother-in-law does not have a say in son's family matters. The husband and wife decide on every issue where husband's decision is considered the final one. They remain un-influenced of the involvement of mother-in-law. But as pregnancy is considered to be a feminine issue, generally the mother-in-law or other elderly women in family and neighborhood are consulted in decision making process. Not being the decision maker of the family, the mothers-in-law are least concerned about the pregnancy of their daughter-in-law. They do not accompany daughters-in-law on their visit to health centre for check up, nor do they show any interest on immunization and other activities.

Conclusions

- Mothers-in-law are not aware about the appropriate practices during pregnancy and delivery. Though they take DILs for check-ups and also give nutritious food and do not force for heavy work, they are not convinced about the modern practices and do not usually follow the advice of the doctors or the health workers. It is observed that most of the MILs do not take major precautions during pregnancy like health check up, immunization, proper diet and rest seriously. They are also not aware of the signs of risk during pregnancy, delivery or post-partum period.
- Though few mothers-in-law said that they would not mind their son helping his wife, most of the MILs women are not open to the fact of a man helping or taking care of his wife inside the house during her pregnancy and delivery as for them it is completely a women's domain and they think men neither have any understanding nor should they be required to have any knowledge in this matter. MILs expect men to take care of all the outside activities during pregnancy and delivery of their wives.
- In coastal areas mostly the mothers in law make decisions in pregnancy and delivery related matters, but in western areas the decision is made by the couple mostly. In tribal areas the mother in law stays aloof from the affairs of the couple and the decision is mostly made by the husband.

8. PERCEPTIONS AND PRIORITIES OF HEALTH WORKERS

8.1 Background: The perceptions, opinions, and priorities of health care providers on the issue of involvement of male in pregnancy and delivery related matters was also assessed using qualitative methods of research. In each of the 8 villages in-depth interviews were carried out with village or panchayat level outreach workers (ASHA, ANM, and Anganwadi Worker). The opinions and beliefs of these stakeholders are presented here.

8.2 Involvement of health providers in providing maternal and child health services:

Anganwadi workers: AWWs have received training at District Headquarters Hospital (DHH) and Block level PHC (BPHC) on different topics such as development of mother and child health, care of 0-6 years of child, community development, and counseling of pregnant and lactating women, etc. But they have not received specialized training on some issues of mother and child health such as SAB training, etc. Different fixed days are observed in a village to ensure care to mothers and children and the AWW plays a major role on such occasions. On Prusti Divas and Mamata Divas, they conduct group discussions with small groups of women and this also provides them some scope to sensitize some men, who have accompanied their wives to the occasions, on the topics of care of mother and child. The AWW was earlier involved in registering pregnancy cases, providing IFA and other medicines and in monitoring consumption of these by the pregnant women. But now these activities are carried out by ASHA but still AWW helps and supports ASHA in these and also carries these out if ASHA is absent.

Accredited Social Health Activists: Taking care of women in pregnancy, conducting counseling at home and escorting women for delivery at health facility constitute the main responsibilities of ASHA. After confirmation of pregnancy, ASHA helps the women to register her pregnancy with the concerned HW (F) at Sub centre. Then ASHA motivates the women to seek ANC and also ensures the intake of 100 IFA tablets and 2 TTs.

ANM: In the context of mother and child health, ANMs have received training on Skilled Attendance at Birth (SAB) and are hence capable of conducting deliveries. All the ANMs interviewed expressed that maternal and child health care is one of their core areas of function in the community. ANMs also interact with PW and counsel on appropriate technique of care during pregnancy but it does not happen at household level. ANMs organize Mamata Divas, where ANC is provided and services include weight check up, BP check up, Hemoglobin test, and application of TT. Prior to delivery, they also check the position of baby, hemoglobin level of PW, Hypertension, and fits.

8.3 Health providers on involvement of men:

Exposure of men to counseling: ASHAs agreed on the point that they *do not discuss with husbands frequently*. During home visit normally ASHA talks to women members in the family, particularly the PW and her mother-in-law (MIL) or any elderly co-sister –in-law. As she visits during the day time, *ASHA rarely meets husbands at home. Even husbands seldom like to be present and listen to the conversation of ASHA and other women as they assume that pregnancy is a woman related matter and the women in the home will take care. They do not take it seriously and do not make it a point to be present and keep themselves busy in their own business.*

During the Mamata Divas some *husbands come with PW and find it convenient to listen to discussion on care during pregnancy standing outside. Sometimes they clarify their doubts on specific issues at the end of the meeting.* These husbands really come from far off villages carrying their wives on a bicycle as PW cannot come walking.

As one ANM said, “*Purusa lokanku bujhaiba pain amara semiti kichhi swotantra karyakrama nahin*” (There is no such special programme to counsel males during pregnancy). ANMs briefly narrated, “*We don’t have frequent interactions with husbands. In some situations we find scope to talk to them when we come across them on the way. Some husbands who come with PW on Mamata Divas enquire about certain problems of pregnancy which we try to answer appropriately so that they take needful follow up measures at home*”

AWWs reported that they regularly *counsel men who accompany their wives to immunization points during ante-natal care so that they feel the necessity of care in consequent period of delivery.*

Observations on involvement of men, factors affecting involvement: Some ASHAs observed that some husbands are not interested in caring for their wives during pregnancy. *Men assume that it is an affair which is women specific.* They prefer to do their work instead of staying at home during delivery. Only in case of emergency situation, their presence is required. In case of complication and referral the husbands accompany the wife to the hospital. Recently the scenario is changing and it is good to see that husbands accompany their child for immunization. They are also interested to know all about pregnancy care. Usually the place of delivery is decided after discussion among the spouse.

Doctors were of the opinion that husband’s presence at the hospital at the time of delivery is 100% but very low during ANC period. Men are not fully involved in pregnancy and delivery and this is mainly due to *poverty, and lack of education and awareness.* The two main factors that affect involvement of men during pregnancy, delivery and post natal care are economic condition and education. *Addiction to alcohol* is another factor that affects the behavior and responsibility of a man towards his. Another view given by doctors was that men remain aloof of

almost everything related to maternity and show concern only at the time of delivery, this is mostly because of the Rs 1400 they get (as per JSY provisions) for institutional delivery.

AWWs were also of the opinion that *male members in the family go outside for work and do not get time to take care of their wives*. Sometimes during pregnancy, they help their wives in cooking food at home, but they cannot cook food by themselves. Even though the men listen to the counseling by health workers but most of the time they do in their own way. For instance, they say “*tumara katha manile amaku kie khaibaku deba. Ghare basile kis khaiba?*” (If we obey your advice and our wives do not go for work, then who will feed us? If we sit at home, what will we eat?). Another major factor reported by AWWs was that the *men never save money to meet the delivery cost and whatever money they earn they spend it on buying household items*.

One AWW mentioned that now-a-days husbands are found positive in taking care of their wives. They are *staying at home and watching television programme* in the evening which is a good sign, as they are becoming more aware on care, support and cooperation from pregnancy to child birth.

Attitudes to male involvement: ASHAs gave their own opinion that there is a need for husband to be more involved during pregnancy and delivery. They are not just to accompany women in the hospital. At home they have so many other responsibilities like giving good food, saving money for delivery, etc. Recently, due to the impact of counseling by ASHA and also due to other factors, there has been a positive change in the behavior of husband. They are now a little cooperative with wife during pregnancy.

In order to ensure safe delivery and appropriate post partum care, it is required that husbands are sensitized well before delivery so that they arrange money to meet with the delivery expenses. It is the duty of husband to support the PW through arrangement of food, taking wife to hospital for check up and delivery, and arrangement of money well before delivery. The ANMs believe that it is always better to counsel husband which ensures that they become responsible to the need of PW but in the current situation it is perceived that husbands have a limited role in delivery and pregnancy of his wife.

Discussing the issue of involvement of men, one ANM blamed hooch addiction as one of the major reasons that affects their involvement and care in pregnancy, delivery and post partum care. One ANM reported that only educated people take proper care of their wives. Another ANM was of the view that ASHA and the doctor have better opportunity to counsel husband on how to take better care of pregnant wife.

8.4 Suggestions to improve male involvement in the community

Best way to sensitize men: On the best way to make husbands aware and to sensitize them about care during delivery, the AWW said that it should be through *television*. Some kind of documentary in the local language will work better. Similarly *small advertisements on breast*

feeding and institutional delivery will helpful to motivate people. They also pointed out that the *doctor and ANM should jointly be present on Mamata Divas and counsel the PW and husband.* There is a need for *repeated small group discussions to be conducted by senior health personnel* like doctors and LHV where ANM, ASHA and AWW should be present so that they will follow it properly afterwards.

8.5 Conclusions: There is no deliberate effort by any of the health workers to counsel men on pregnancy or delivery related issues either in the health enter or during home visits.

Health workers rarely get a chance to counsel men, and it is purely incidental. Many men accompany their wives to Mamata Divas for ante-natal care and there they get a chance to learn a few things about pregnancy and delivery related care. Few men seek knowledge or clarifications on their own from the health workers.

Men do not get involved in ante-natal care but their presence is seen in hospitals and during complications and referrals.

Health workers feel that men are currently involved in hospitalization during delivery. They should get involved in providing care at home also. *The most important role of men is to save and arrange funds to meet pregnancy and delivery related expenses.*

Barriers to involvement of men mentioned by health workers include:

- Men feel that pregnancy and delivery are women related matters
- Poor economic condition
- Lack of education
- Alcoholism
- Lack of time due to involvement in work
- Lack of habit of savings for pregnancy or delivery related expenses

Opportunities mentioned by health workers

- More men are getting involved due to the JSY funds
- Men are staying at home and watching TV and get exposed to MCH related messages
- Educated men take proper care of their wives

To motivate men for involvement during pregnancy and delivery, TV is a good medium and small advertisements should be placed in TV. Mamata divas should be utilized to counsel men and senior providers such as ANM, LHV and doctors should be involved here to talk to men. Repeated group discussions should be organized in villages and men should be addressed by senior providers.

9. CONCLUSIONS

The previous chapters in this report have each discussed findings from different components of the study. Information collected through different methods and techniques and pertaining to different aspects of involvement of men during pregnancy have been reviewed. There is also information about the perspectives of different role players of this broad topic, including the men, women, concerned relatives, and health service providers. This chapter briefly refers to the information and evidence pertaining to different aspects of the study and draws important conclusions.

Knowledge: Knowledge is at a very broad and superficial level, with majority of men and women knowing about the important things to take care of during pregnancy (going for ante-natal check-ups, taking nutritious diet, and taking IFA tablets). But only about a quarter know about the number of check-ups. Qualitative research shows that majority do not know about which diet is nutritious diet, how much rest is adequate rest, and what type of work constitutes heavy work. Knowledge about the complications during pregnancy and delivery is inadequate and large majorities are not aware about the danger signs. Knowledge about post-partum complications is moderately good. Similarly, regarding services, majority of men and women know about the health facility in the vicinity and the doctor to be contacted, but few are ready with the number of the ambulance driver or the location of the nearest blood bank. Knowledge is at a very basic level, and is not elaborate or in-depth. Since signs of complications are not recognized and emergency contacts are not known, there is potential of appropriate health seeking being hampered in case of an emergency during pregnancy or delivery.

Attitudes: Both men and women have very positive attitudes towards the involvement of men (husband) in different activities during pregnancy of wife, post-partum care and newborn care. Both men and women report that men should carry out different activities not only outside the house, but should also ensure care of the wife (during pregnancy and post-partum period) and the newborn inside the house through ensuring good diet, adequate breast-feeding, cleaning the baby, cleaning the house, etc. With regards to the attitudes of other members in the house, the opinion of the mothers-in-law was assessed. MILs have positive attitudes towards involvement of men, but mostly in activities outside the house such as getting medicines or food and taking mother and newborn to the health center. MILs do not want men to get involved in any activity within the house. Only if there is no other member in the family and the wife is unwell then the husband can carry out certain activities within the house. Following traditional cultural norms, the community does not appreciate involvement of men in household activities, and a man engaging in such behavior is likely to be ridiculed, more so in the coastal area.

Practice: Reports of both men and women about the role of men during last pregnancy, delivery, and post-partum and newborn care shows that corresponding to the positive attitudes towards involvement of men, men actually participated in provision of care both outside the house and also inside the house. A majority of men took wife outside for check-up, and also ensured

provision of proper diet and rest and intake of medicine at home. During post-partum period men took wife/newborn for immunization and also took care of newborn at home. For care of newborn, men ensured breast-feeding by baby at home, as also cleaning of baby and cleaning of the house, besides taking baby for immunization. During complications, large majority of men also took lead in fetching medicines or doctor, or in arranging transport and taking wife to the health center.

Health providers' perspective: They do not carry out any counseling activity specifically addressing men, and advising men regarding pregnancy related practices is purely incidental. Doctors also report that men come to the health center accompanying wife only during delivery and only few come during ante-natal period. All health workers report that “Mamata divas” provides opportunities to men to seek clarification and to listen to various messages on pregnancy-care or delivery preparedness. Husbands usually accompany wife to the meeting and there they also happen to learn something. Health workers feel that men should primarily get involved in arranging funds before hand to meet delivery related expenses. They also suggest that the best way to reach men with important messages is through TV, and by organizing repeated group discussions for men in villages with involvement of senior health providers such as the LHV and the Doctor.

Types of involvement: Review of existing literature on involvement of men in mother and child health indicates three ways in which men can get involved; providing transportation to clinics, recognizing symptoms that require medical attention, and assuring that women get proper nutrition and rest. Majority of men in this study are found fully and almost solely involved in transport arrangement to clinics. Regarding the issue of recognizing symptoms that require medical attention, men do not have knowledge about the symptoms of complications and due to this they are not involved in this activity. Regarding the third issue, men are reported to be involved in assuring that women get proper nutrition and rest at home. However, in many families the mother-in-law and other members also play a more important role, particularly in joint families and in the coastal areas

Opportunities for involvement of men: The young couples have very positive attitudes in favour of involvement of men in providing care to wife and newborn inside the house and in carrying out all activities outside the house, during pregnancy, delivery and post-partum period. Despite reservations from the older generation, men are currently involved even in assuring care inside the house. In couples where either the men or the women have previous experience of complications and hospitalization, the men are more involved in pregnancy and delivery care to avoid repetition of such cases. In nuclear families or where there is no help forthcoming from other members, men are more involved. Where outreach workers are active and dynamic they convince the men to get involved in providing care and in preparing for institutional delivery. Health workers are willing to address men through counseling and they can build the knowledge

of men regarding complications that require medical attention. Men will be in a position to make decisions regarding seeking appropriate medical care in emergencies once they have the requisite knowledge regarding complications.

Barriers to involvement of men: General lack of finance and poverty constrain men from getting involved in pregnancy related activities. Lack of time due to heavy workload affects his availability at home to provide care and to accompany his wife to the health center. In unreachable areas and tribal communities social norms favour traditional care and healing; and this constrains him further from seeking modern institutional care. Lack of knowledge regarding the signs of complications also stops him from taking any step. He also perceives that the women members in the family are more knowledgeable on these issues and thus leaves all care in their hands. Due to existing gender inequalities, their wives do not inform them about their problems, and he is also cut off from the counseling provided by the outreach workers in the village. Due to these problems men do not get involved and tend to stay from the issues of care and health seeking of pregnant wives and depend upon the advice and decisions of the women members in the family.

Implications for future action

Knowledge of men regarding different aspects of ante-natal care and post-natal care needs to be enhanced. While they have very basic awareness, detailed knowledge will help them to get involved and provide vital support to the wife during pregnancy and after child birth.

Men have very inadequate knowledge about the signs of complications during pregnancy and delivery and there is an urgent need to build this knowledge. Without this, men will be unable to provide appropriate help in the most crucial periods.

There is a need to promote the preparedness of men with arrangement of funds to meet the delivery related expenditure, knowledge of health centers with blood facility, and knowledge of cell number of the Janani Express or any other suitable transport. These will enable men to provide crucial help to wife during emergency.

At present counseling by health workers do not cover men and any interaction with them is purely incidental. There is a need on the part of the health workers to address men with necessary information and to give them responsibility for care of the wife during pregnancy, delivery, and post-partum period. Vast opportunity exists in terms of Mamata Divas when men are available.

There is a need for a comprehensive communication campaign using appropriate media to address men with necessary information and also to motivate them to take al responsibility of their wife during pregnancy, delivery, and post-partum period.

As against the positive attitude of the young couple towards involvement of men, the older generation, backed by traditional social norms, does not appreciate such an involvement, and there is a need to address this negative attitude through appropriate communication so that a favourable environment and public acceptance is created for the involvement of men. This will motivate men to shed their inhibitions and provide crucial care both inside and outside the house without apprehending comments and ridicule from the household members and the public.