Men in Women’s Health Care in India:
How far man’s supportive stance makes a difference

Abstract:

Men’s supportive stance is an essential component for making women’s world better. There have been growing debates among policy makers and researchers on the role of involving male in maternal health program. Male involvement in maternal health is a big challenge in a country like India where the society is male driven. The paper aims to look into the variations and determinants of maternal care utilization in India and three demographically and socio-economically disparate states namely Uttar Pradesh, West Bengal and Maharashtra by husband’s knowledge, attitude, behavior and gender violence culling data from couple’s information provided by the National Family Health Survey III (2004-05). Women’s ANC visit, Institutional delivery and freedom in health care decision are looked into by applying descriptive statistics and multivariate models. Husband’s presence in ANC markedly increases the chance of wife’s Institutional delivery in India. Men's knowledge and positive gender attitude definitely enhances maternal care and women’s health care decision making.

Introduction:

The commitment to include men in reproductive and sexual health has never been so clearly reaffirmed since Cairo, Beijing and their follow-up plan of actions. The actions adopted by consensus at the 1994 International Conference on Population and development (ICPD), Cairo shifted from a purely demographic approach to a more holistic reproductive health framework that links health to gender equality and sustainable development. The ICPD also makes a clearer connection between reproduction, power relation and sexuality and is a strong advocate for gender equality and women's empowerment as means of achieving the goals of sustainable development.

Male involvement in maternal and child health (MCH) is one of the burning issues in the reproductive and child health program (RCH). Tradition, norms, values are some of the important pillars of the Indian society. It has been seen that reproductive and child health are the very personal matter of Indian women for ages. Male are less involved in it (WHO, 1998). In the boundary of in-house work women have restricted her in cooking, taking care of the family members, rearing child and thus male involvement in maternal health is a big challenge in India. Although studies of men's reproductive attitude and behavior have grown in number, they are dominated by a problem oriented approach. In spite of the sizable increase in the interest in male involvement in RCH, Indian studies have mainly focused on the basic measurement of fertility, contraceptive use and reproductive preferences. The knowledge is still scanty with regard to predictors in MCH by husband's perceptions, attitudes, behaviors and communication. Whereas, the process of reproduction entails mutual responsibilities, men's participation in reproductive and maternal health is mostly negligible and neglected in many developing countries.

Ever since it has been established that the attitude and level of involvement of the husbands towards their wife's health and morbidity plays a very prominent role in their wife's treatment seeking process, there have been efforts to involve men actively in the maternal health care. Women are often unable to access pre-natal and natal health services for a variety of reasons

including lack of control over household financial or transportation resources. Reasons apart from financial often ranges from “because their spouse could not take time off from work” to “because she could not leave her children and other dependents to travel to the nearest clinic or hospital”. These reasons prove the urgency of the need to include men in the MCH and RCH care.

Need for the study:

Men’s supportive stance is an essential component for making women’s world better, be it during pregnancy, child caring and rearing and household chores. In a patriarchal society like India, to improve the appalling state of women’s health, men must share the responsibility to break down the social barriers that prevent the realization of becoming a healthy mother and healthy women. There has been a growing debate among policy makers and researchers alike on the role of involving male in reproductive health programs. This is especially important in communities like India where men play many roles (as sexual partners, husbands, fathers, and often gatekeepers for their families to the outside world) that influence and determine not just their own reproductive health but also that of their wives and families. Importance of men’s role in improvement of women’s health is now well accepted. Formulation of policies related to these issues is still at the infancy for poor data and research. In Indian context, whatever studies carried out till date are mainly area specific and based on small sample. Thus, the present study is an attempt to use the recently published large scale national data, NFHS for understanding men’s views and practices regarding maternal health care.

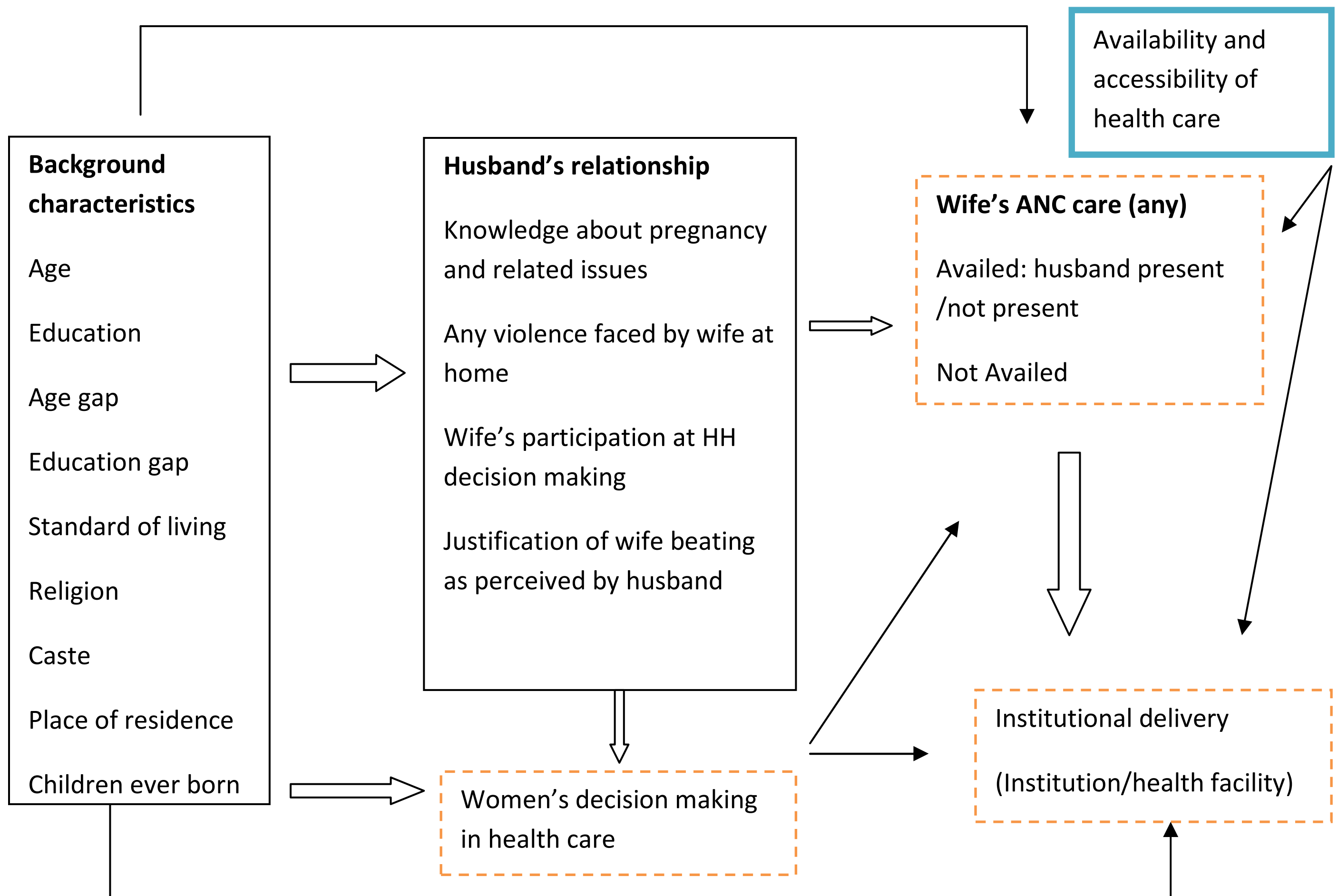
Based on the ICPD Cairo (1994) recommendations, the current RCH and MCH programs in India have included men in the programs with modules prepared specifically for men, in an attempt to increase their knowledge on MCH and its requirements. Guidelines are also laid down on the specific responsibilities of husbands towards their wives during pregnancy, during and after delivery. However, formulation of necessary policies is still at its nascent stage due to unavailability of adequate and reliable research data, which explored into men’s knowledge

and attitude regarding women's reproductive health. The current study seeks to understand how far men's attitude, behavior etc explains reproductive health care and decision making of wife , based on the data available from NFHS-III, where a wide range of questions have been asked to married men to bring to light their knowledge and attitude towards their (his and his wife's) reproductive health.

Conceptual framework:

To predict behavior in family planning from attitude and intentions, Ajzen and Fishbein (1980) proposed a framework. According to them background variables affect beliefs about the behavious being studied, which in turn influence attitudes towards the behavior, which influence intentions, which, in large part determine whether the behavour occurs or not (Becker, 1996).

Husband's role in maternal care:



ANC care and Institutional delivery of women is a complex effect of four set of variables, as indicated in the above framework. As the paper explores husband's role in maternal care, the above conceptual framework indicates the possible effect of husband's explanatory variables on ANC and Institutional delivery, besides availability and accessibility of care. Socio economic and demographic variables of husband and/or wife (age, education, religion, caste) or couple (standard of living, place of residence, Children ever born) directly and indirectly affects maternal care and decision making in maternal care. At the intermediate level husband's role and the husband–wife relation come into picture. Husband's better knowledge about pregnancy and related matters received during wife's pregnancy, a non violent conjugal life, wife's ability to take household decision, husband's disapproval towards justification of wife beating portray positive relation of Husband- wife. These set of intermediate variables enhances the chance of maternal health care utilization.   Wife's ability to take her own health care decision which is affected by husband- wife relation, are also acting as a positive factor in maternal health care use. Besides the above three sets of factors, availability and accessibility of health care is an important determinant in this regard.

Objectives:

The paper aims to understand husband's role in maternal health care in India and in three selected states (Uttar Pradesh, West Bengal and Maharashtra). Specific objectives are: (i) to examine husband's role in availing any ante natal care and Institutional delivery (institution or health facility) and (ii) to explore women's decision making in health care in the context of her relation with husband.

Hypotheses:

The hypotheses of the study are as follows-

- Husband's presence at the time of any ANC visit has positive effect on women's Institutional delivery.
- A positive husband-wife relationship (husband's better knowledge about pregnancy and related matters received during wife's pregnancy, a non violent conjugal life, wife's ability to

take household decision, husband's disapproval towards justification of wife beating) enhances women's ANC visit, Institutional delivery and women's decision making in own health care.

Data and methodology:

For the first time, NFHS III (2005-06) provides couples' information. This large scale survey, collected data from husbands on varying aspects of women's health and welfare. The weighted sample size (in couple file) in India is 43105 (husband and wife). Three states are chosen for the study based on their varying developmental stage (table 1). The weighted sample for Uttar Pradesh, West Bengal and Maharashtra in the couple file are 9155, 2335 and 6216 respectively. Descriptive statistics and binary logistic regressions are applied for the analysis. NFHS III asked several questions on health and related issues to men and women aged 15-49 years.

The information collected in NFHS III pertaining to our objectives is as follows:

Husband's socio-economic background, husband's knowledge about pregnancy complications, nutrition during pregnancy (reported by husband); Institutional delivery; non violent husband-wife relationship (reported by wife), wife's practice of taking decision in household and in own health care (reported by wife), attitude of husband towards justification of wife beating (reported by husband), husband's presence in ANC (reported by husband); his report on non utilization of ANC and non-Institutional delivery. Women's ANC care and delivery in health facility are looked through husband's background and intermediate variables. Women who have given birth in the last five years are considered in the analysis. As women's background factors are having a cofounding effect with husband's background, only the latter is considered in the multivariate models.

Questions asked to husband regarding ANC care are as follows:

When wife was pregnant did she have any antenatal checkup? Where you ever present during any check-up? What was the main reason why she did not have any antenatal check up?

Questions put forth to husband regarding pregnancy and related care are as follows:

At any time when wife was pregnant, did any health provider or health worker ever tell you about the signs of pregnancy complications like vaginal bleeding, convulsions, prolonged labour? At any time during pregnancy did any health provider or health worker speak to you about- importance of delivering the baby in a hospital or health facility and importance of proper nutrition of the mother during pregnancy? Besides considering the above variables in calculating 'husband's knowledge about pregnancy and delivery', the other variables taken into account for summative index are: whether any health provider or health worker speak to you about family planning or delaying the next child, whether anyone explained husband the importance of : breastfeeding the baby immediately after delivery, keeping baby warm immediately after birth, cleanliness at the time of delivery and use of new /unused blade to cut the cord. So the index of 'husband's knowledge about pregnancy and delivery' includes seven questions and the score ranges from 0 to 7.

In NFHS III ever married women were asked about seven type of physical violence, two of sexual violence and three of emotional violence by their current or most recent husband. In non violent husband-wife relationship, we assume that women should not face any type of violence. Here physical violence includes, pushing, slapping, twisting arm, punching, kicking, chocking or burning, attacking with weapon; sexual violence includes sexual coercion in sexual intercourse or any sexual act and emotional violence incorporates husband's humiliation or insult in front of others, threatening to hurt or herm.

NFHS III also asked married men about his opinion of justification of wife beating. The question put forth is: Sometimes a husband is annoyed or angered by things that his wife does. In your opinion is a husband justified in hitting or beating his wife in the following situations- if she goes out without telling him, neglects the house or children, argues with him, refuses to have sex with him, does not cook food properly, disrespect in-laws or he suspects her of being unfaithful. A summative score is computed to understand husband's justification of wife beating. The score is 0 if in any of the above statements the husband is not justifying beating of

wife. Higher the score, stronger is the husband's justification in this regard. The score is kept as 0 for not justifying wife beating and 1 (more than 0) otherwise in the multiple regression.

Regarding women's health care decision in NFHS III, the question asked to women is, who usually makes the health care decision of yourself? And the answer codes are mainly you, mainly husband, you and your husband jointly and someone else. In this analysis first and the third response is considered as 1 i.e. respondent own or jointly with husband and the rest is 0 i.e. someone else.

Regression analysis is used to understand the determinants of the following outcome indicators: ANC visit of women, Institutional delivery and health care decision making. At India level analysis, two regression models are constructed. In the first model only background variables are considered. While in the second model all variables are used and level of significance of Husband-Wife relation variables or intermediate variables is seen after controlling background components.

To mention here some of the drawbacks of the data, NFHS III does not provide information on availability and accessibility of health care components. Although the approach of NFHS III in measuring violence is optimal, the possibility of underreporting of violence, particularly of sexual violence cannot be entirely ruled out (IIPS, Macro, 2005-06). After inclusion of husband-wife relationship variables, the sample size at state level reduces sharply. So whether the result at state level can be generalized poses doubt. Also, in the couple file of NFHS III many of the questions that have been asked to both husband and wife are not included (like in availing ANC only husband's report is given) and thus application of Kuppa index is out of reach of the researcher. Again, though studies like Ezeh (1993), Miller (1991), Stolley (1995) Thomson (1995) etc. showed that in couple analysis husband and wife's characteristics do have separate and significant effect on the outcome variables (especially family planning, birth interval) here only husband's variables are given more importance because of co-linearity of husband-wife

individual variables and as the emphasis of the study is to see the women health care use/decision from husband's perspective.

Findings:

Bivariate Analysis:

During pregnancy a woman is advised to have at least three antenatal care (ANC) checkups. Figure 1 shows that one third women as reported by husband have not received any ANC in India and such proportion rises to 59 percent in Uttar Pradesh while it is 16 percent for Maharashtra and 22 percent for West Bengal. More than half of the husbands of the expectant women were reported to be present in at least one of the ANC checkups except Uttar Pradesh where husband's presence is only 27 percent. In India out of the total expectant women, 50 percent husbands were present in ANC check up, baring 17 percent who were absent when their wife availed ANC. Out of the total husband reported about ANC, in Uttar Pradesh, only 27 percent were present in ANC while this proportion goes up to 55 percent in West Bengal and 68 percent in Maharashtra.

Among those women who have not received any ANC, the husband was asked for plausible reasons. In majority of the cases their husband feels that it was not necessary at all, as shown in Table 2. Such response is 42 percent for India, 48 percent for Maharashtra, 42 percent in West Bengal and 44 percent in Uttar Pradesh. In Uttar Pradesh, while 17 percent mothers (wife) did not think its requisite while 13 percent husband's family believes that ANC is not required. In West Bengal who has not received ANC, 22 percent families pay no attention to the need for ANC and 17 percent believe that the cost is too high, though ANC check up in government and municipal hospitals are free of cost. In Maharashtra, one out of every five family ignores the requirement of ANC among those who failed to avail ANC and almost half of the husbands did not allow their wife to take benefit of ANC as they feel that it is not required. So, those women who did not avail ANC, familial reasons are the main hindrance for three fourth cases.

As shown in figure 2, 45 percent deliveries are Institutional in India. It ranges from merely 23 percent in Uttar Pradesh to 40 percent in West Bengal and 59 percent in Maharashtra. As reported by husbands, 55 percent wife experienced non- Institutional delivery of their last child in India. Thirty one percent husbands in India believe that it is not necessary to deliver in the hospital or in health centers under the supervision of trained health personnel. Such proportion goes up to 48 percent in Uttar Pradesh while in West Bengal one out of every four husband believes so. Among the three states, non- Institutional delivery is the lowest (34 percent) in Maharashtra where 15 percent husband believes that it is not necessary.

Among those children who were born in a non- Institutional set up, 26 percent fathers, 13 percent mothers and 17 percent family members believe that delivery in a health facility is unnecessary (table 3). After familial reasons, high cost of delivery is coming out to be the second most important reasons for non- Institutional delivery. Information received by husbands from a health care provider regarding delivery and breastfeeding is far from universal as shown in figure 3. Only three to five in every ten husband in India are aware of such maternal and child care practices with a wide state level variation. For instance, in Uttar Pradesh, less than one fourth husband know about necessity of delivering in hospitals, about family planning during pregnancy and about breast feeding. The knowledge of breast feeding is low among husbands even in Maharashtra and West Bengal. So the need to cater knowledge and awareness of maternal health among husbands is very much necessary.

Table 4 indicates a positive association of ANC (irrespective of husband's presence) and Institutional delivery. It also shows that the maximum percentage of women experienced Institutional delivery whose husband was present at the time of any ANC check up. To elaborate, among those women whose husband was present at any ANC, 65 percent of them experienced Institutional delivery in India. Such percentage is 77 percent in Maharashtra, 60 percent in West Bengal and 39 percent in Uttar Pradesh. While those women who took ANC in absence of their husband, 48 percent experienced Institutional delivery in India. This percentage ranges from 67 percent in Maharashtra, 34 percent in West Bengal and 30 percent

in Uttar Pradesh. While in India, only one out of ten women availed Institutional delivery who did not take ANC check up.

Table 5 shows whether ANC and Institutional delivery vary with the knowledge received (not received) by husband from a health worker during wife's pregnancy. Those husbands who have knowledge about Institutional delivery, among them 88 percent wives received ANC and 64 percent experienced Institutional delivery. While, among those who do not have this knowledge, 70 percent experienced non- Institutional delivery. Similarly, 87 percent women received ANC and 62 percent had Institutional delivery among those who have the knowledge of proper nutrition during wife's pregnancy. While those who did not receive the knowledge of proper nutrition, only 13 percent availed ANC and 28 percent experienced Institutional delivery.

Figure 4 explains whether the decision on health care is taken by wife alone, jointly or by someone else. In India, 62 percent women said that the health care decision is taken by them alone or jointly. Out of the three selected states, the lowest percentage where wife takes the decision is observed in West Bengal (60.5 percent). State wise variation is not seen much in this regard.

Table 6 points out the association of ANC care, Institutional delivery and health care decision making by justification of wife beating. Among those who say that wife beating is justified, a lower proportion of wife is availing ANC, Institutional delivery and health care decision than those who rejects the justification of wife beating. For example, 27 percent women in West Bengal avails Institutional delivery among those husbands who justifies wife beating , while it is for 52 percent who rejects the justification of wife beating. The difference of percentages between two groups (i.e. who justifies and who rejects justification of wife beating) is minimal in Uttar Pradesh.

Multivariate Analysis:

Table 7 looked into the determinants of availing any ANC by husband's background and relationship variables. Model 1 shows the coefficients of husband's background characteristics with ANC care. Model 2 shows the association of husband's role in ANC care controlling husband's background. Almost all the background characteristics of husband i.e. age, place of residence, education, caste, wealth index and children ever borne are coming out to be significant both in model 1 and 2. With increasing age, urban residence, more education, more wealth and lower number of births the chances of having ANC care increases. The strongest association is observed in case of wealth index as the chance of availing ANC increases 5 times for the richest against the poorest group. However, being an OBC, the chance for ANC care goes down significantly compared to SC/ST. When background variables are controlled (model2), justification of wife beating by husband decreases the odds of availing ANC, while husband's knowledge about pregnancy and related matters increases the probability of availing ANC 1.27 times. However, none of the violence variables and household decision making by wife are showing any significance in this regard.

Table 8 explores the determinants of husband- wife relation with ANC checkups in three selected states controlling all the background characteristics of husband as far as the data allows. Knowledge of husband about pregnancy and delivery is a very important positive determinant of ANC in all the three selected states. In Maharashtra and West Bengal physical violence comes out to be an important determinant of ANC care as with increasing experience of violence by wife the chances of availing ANC care reduces significantly. While emotional violence plays an important role in this regard in Uttar Pradesh as the probability of availing ANC decreases by 20 percent. Husband's approval regarding wife beating turns out to be a negative predictor of ANC in Maharashtra where the odds of availing ANC decreases by 60 percent.

Table 9 indicates the determinants of Institutional delivery in India. As expected, of the individual factors of husband, education, urban residence and wealth promotes Institutional

delivery while number of children decreases this chance. All the background characteristics of husband in model 1 are remaining significant predictor for Institutional delivery in model 2 where the relationship variables are incorporated. Like ANC care, here also wealth index is playing a marked role as the richest cohort is having 12.5 times more chances of availing Institutional delivery against the poorest. Model 2 also supports the bivariate finding of the association of Husband's presence (absecce) in ANC and Institutional delivery (non Institutional delivery). Husband's presence in ANC increases the odds of availing Institutional delivery by 35 percent and thus it supports our first hypotheses that Husband's presence at the time of any ANC visit has positive effect on women's Institutional delivery. Again, husband's knowledge about Institutional delivery during pregnancy has a statistically significant positive effect on Institutional delivery. However, none of the violence variables or justification of wife beating have an important effect on Institutional delivery at India level.

Looking into the determinants of relationship variables at state level in table 10, it is seen that the impact of husband's presence is most noteworthy in West Bengal where husband's presence enhances the odds of availing Institutional delivery by 2.37 times. While in the two other states, ANC care as a whole imparts an impact on Institutional delivery; where as husband's presence (absence) does not make any difference. Knowledge of safe delivery markedly increases the probability of availing Institutional delivery in West Bengal and Uttar Pradesh. However, violence variables are not indicating much significance even at state level except for one variable in Uttar Pradesh and Maharashtra each. In Uttar Pradesh, physical violence (less severe) decreases the chance of Institutional delivery by 33 percent. While in Maharashtra, emotional violence reduces the same chance by 42 percent. Full participation in decision making enhances the likelihood of Institutional delivery 4 times in West Bengal.

Table 11 explores the determinants of wife's health care decision where two regression modes are constructed. When husband- wife relations are not controlled, almost all background characteristics are having some significant role in this respect. Higher education, not being a Muslim and OBC, better wealth index have a positive effect on own health care decision making

along with urban residence and higher age. However education and wealth index loses its significance when husband- wife relationship variables are controlled in model 2 which means that it is not wealth per se but some important relationship factor/s that are playing determining role. Of the relationship variables, experience of emotional violence is having detrimental effect on women's own health care decision making.

At state level (Table 12), in Maharashtra when knowledge about pregnancy and related matters are coming out to be an important positive predictor of wife's decision making on own health care, it is the other way round in Uttar Pradesh where husband's better knowledge decreased the wife's decision making probability. Experience of physical violence and wife beating justification by husband are having negative impact in this regard in Maharashtra while in Uttar Pradesh severe physical violence and emotional violence come out to be negative predictors.

Discussions:

After ICPD Cairo, more attention has been focusing on the issue of male involvement in reproductive health, and as its importance is acknowledged, more programmes are trying to incorporate it as one of their components. However, existing programmes tend to share potentially problematic aspects: first, male components are usually limited to male methods of family planning, only one element of reproductive health. Second, they tend to address men only, in a similar way as the old programmes addressed women only without taking into account their gender relations. A focus on men only is as inadequate as a focus on women only because it fails to take into account the way in which many decisions are made and the context that influences them (Bankole A and Westoff CF, 1998). Third, they tend to be grounded on men's responsibility, rather than an encouraging one of promotion of men's rights. Fourth, by viewing men as a route for women's well-being they instrumentalize men and fail to address men's needs.

The way in which programmes are traditionally Institutionalized, through the maternal and child health (MCH) facility of the Ministry of Health, focused on women (and children, in the

traditional dyed) and barred men from access to services and from exercising a number of responsibilities in the area of reproductive health of their wives and health of their children. The surveys most relied upon for reproductive health (RH) programmes usually ask questions only to women, assuming that they are the ones who make the decisions regarding reproduction and that the men are either not involved or marginally involved (Chatterjee N, N.E.Riley, 2001). Hence the need for an inclusive policy has come up.

The issue of lack of data to understand male perspectives and the extent of their involvement in reproductive health is now solved to some extent with the availability of the NFHS III. Significant facts that came out of the study are: in most cases where the pregnant women are deprived of ANC, the most prominent reason was that either the husband or other family members thought that it was unnecessary as evident in this study. In cases where the women did get ANC, they were in most cases accompanied by their husbands. Very few people have stated “Had children earlier” as a reason for no ANC, which is a good sign as it indicates that people have understood that ANC is equally important to all expectant mothers irrespective of parity.

The proportion of wife’s who are going for Institutional delivery in Uttar Pradesh is too low and the major reason is reluctance of family, husband and the mother. Though majority of the wives said that they alone or jointly take the health care decision, it is basically husband’s education, wealth, non violent physical and emotional relation, knowledge that determines wife’s Institutional Delivery. Husband’s knowledge about ANC and Institutional delivery needs lot of improvement especially in less developed state like Uttar Pradesh. In India husband does play an important role in Institutional delivery as presence of husband in ANC check up markedly improves the chance of availing Institutional delivery.

Emotional violence, physical violence and justification of wife beating are coming out to be a deterrent factor of wife’s ANC, Institutional delivery and wife’s health care decision making at varying level of significance in selected states. However, unlike knowledge variable of husband,

the violence factor are not showing much consistency at state level indicating variation in culture within India. Though husband' knowledge about pregnancy and delivery has a positive effect on ANC and delivery, it has a contradictory role in health care decision in Uttar Pradesh and it needs further research.

Conclusion:

There is no doubt that ignorant, indifference and unconcerned men are hindrances in fulfilling MCH goals. Household dynamics of power relations are critical in this respect. Empowering women and giving equal importance to men are necessary along with proper dissemination of knowledge to men for a healthy mother and a child. Thus men's support in every respect is necessary prerequisite for a sound maternal health care.

As a good proportion of husbands are accompanying wife in ANC check up and husband's presence enhances the chance of Institutional delivery, it can be made mandatory to counsel the husband too along with wife in ANC for better maternal health. Level of knowledge received during wife's pregnancy by husband is another vital determinant of ANC and safe delivery. Emphasis can also be put forth for more serious effort in health education to the male counterpart. Thus programmes should be implemented based on the understanding of gender dynamics, on how decisions are made and implemented, on the changing needs of both genders and their interaction. Much more needs to be known about the relations between men and women in the particular contexts where programmes will be set up in order to make an effective change. The forthcoming programmes under the umbrella of RCH and MCH must focus on mobilization of men on maternal care, encouraging a sound husband- wife relation for catering a hospitable environment of maternal concern at household level.

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Fig:1 Percentage of women received any ANC care in last birth and Husband's presence in any ANC

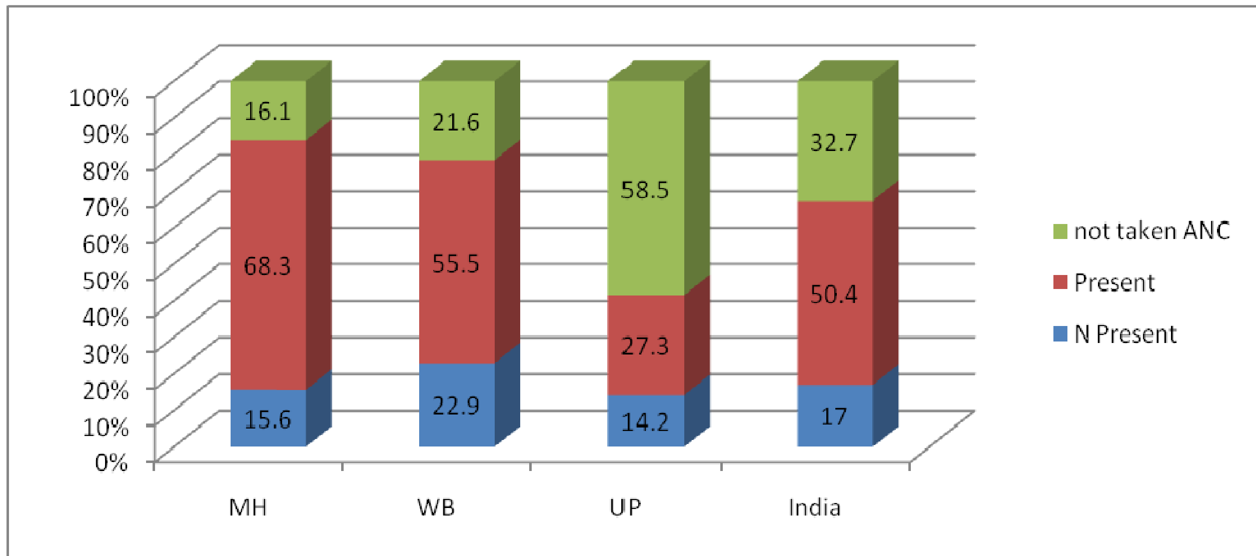


Fig:2 Percentage of women availed (not availed) Institutional delivery for the last birth and reasons for Non Institutional Delivery as opined by Husband

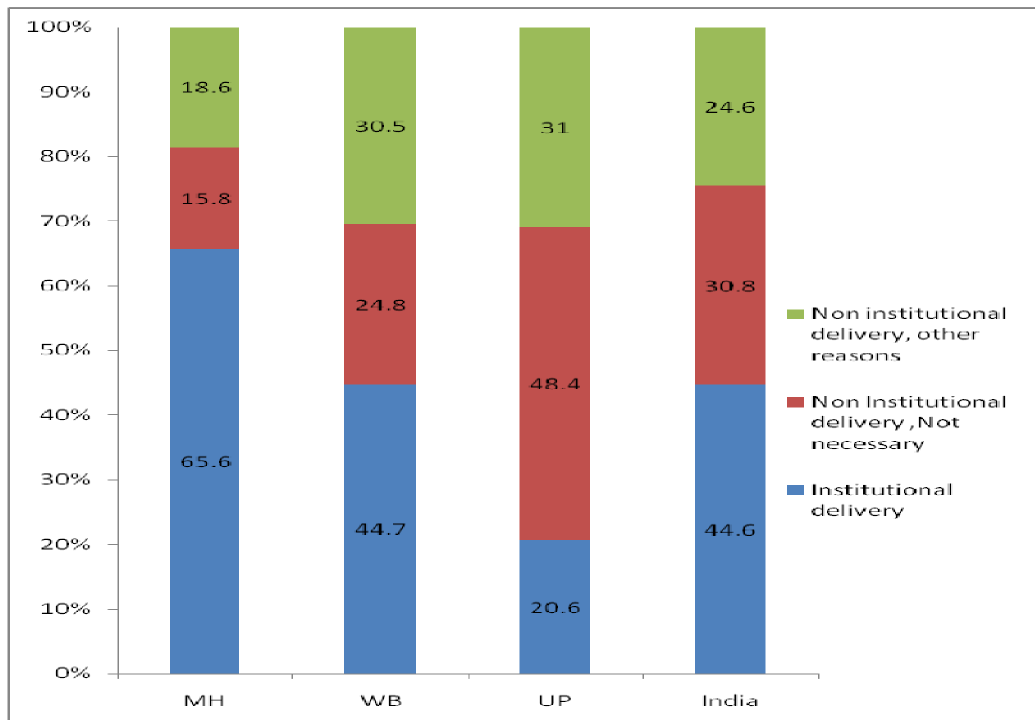


Fig: 3 Percentage of Husband having knowledge and awareness about pregnancy and related care

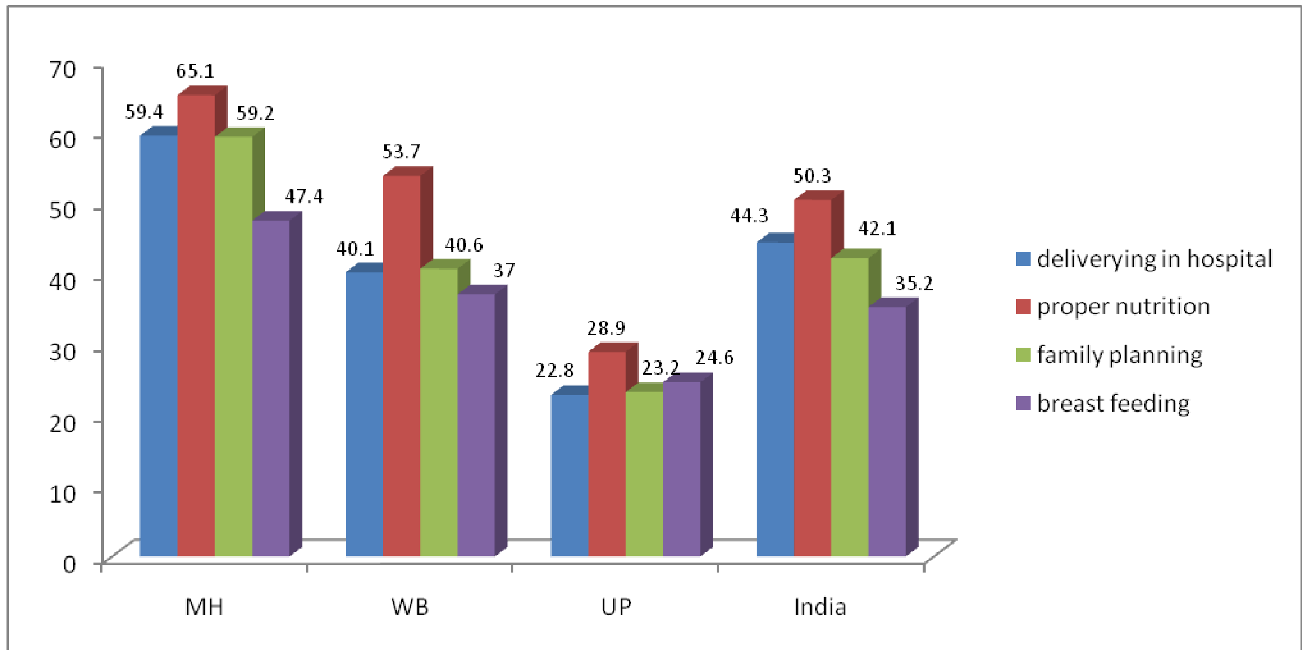
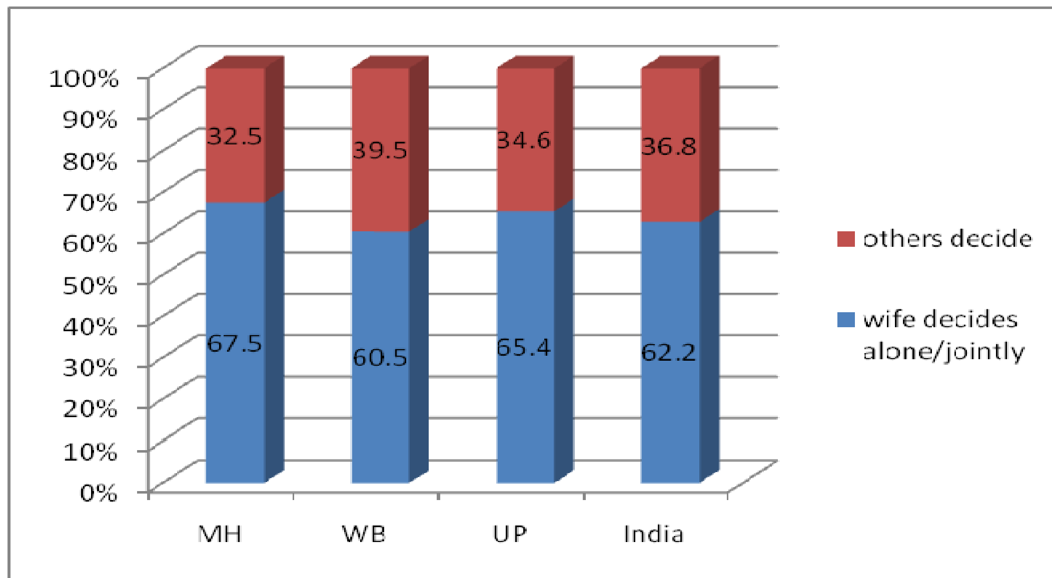


Fig: 4 Percentage of women by decisions on own Health Care



Note: jointly means wife with husband/parents/in-laws/others

Table: 1 Socio- Economic and Health Indicators of India and three selected states

	India	Maharashtra	West Bengal	Uttar Pradesh
Percentage of household with electricity	67.9	83.5	52.5	42.8
Percentage of household live in a *pucca* house	41.4	47.3	39.0	27.3
Percent women of reproductive age literate	55.1	70.3	58.8	44.8
Percent women of reproductive age not regularly exposed to any mass media	34.6	23.6	36.0	47.5
Total Fertility Rate	2.68	2.11	2.27	3.82
Mothers who had at least three antenatal visits of their last birth (%)	50.7	75.3	62.4	26.3
Institutional Births (%) *	40.7	70.7	43.1	22.0
Infant Mortality (for the last five year period)	57.0	37.5	48.0	72.7

*based on the last two births in the three years before the survey

Source: NFHS 2005-06

Table: 2 Reasons for not receiving any ANC among those whose wife did not have ANC Check Up: Husband's report, India

	India		[UP] Uttar Pradesh		[WB] West Bengal		[MH] Maharashtra	
	N	%	N	%	N	%	N	%
He did not think it necessary/did not allow	20320	42.48	10522	44.05	684	42.96	1410	48.11
Family did not think it necessary/did not allow	7488	15.65	3190	13.35	352	22.11	603	20.57
Child's mother did not want check-up	5928	12.39	4036	16.89	46	2.89	319	10.88
Has had children before	945	1.98	523	2.19	0	0.00	45	1.54
Cost too much	9513	19.89	4537	18.99	276	17.34	340	11.60
Too far/no transportation	1676	3.50	481	2.01	116	7.29	90	3.07
No female provider at facility	672	1.40	161	0.67	72	4.52	77	2.63
Other	822	1.72	318	1.33	23	1.44	1	0.03
DK	469	0.98	121	0.51	23	1.44	46	1.57
	47833	100.00	23889	100.00	1592	100.00	2931	100.00

Table: 3 Reasons for not delivering in hospital or health care centre among those who did not have Institutional delivery for last birth: Hisband's report, India

	India		MH		WB		UP	
	N	%	N	%	N	%	N	%
Cost too much	19317	23.63	1004	16.66	937	22.51	8554	25.84
Facility closed	1300	1.59	202	3.35	184	4.42	259	0.78
Too far/no transportation	5802	7.10	702	11.65	550	13.21	982	2.97
Don't trust facility/poor quality service	948	1.16	70	1.16	302	7.25	219	0.66
No female provider	438	0.54	32	0.53	0	0.00	60	0.18
Not the first child	3946	4.83	338	5.61	90	2.16	2040	6.16
Mother did not think necessary	10965	13.41	1022	16.96	160	3.84	6077	18.36
Respondent did not think necessary	21462	26.25	1215	20.16	653	15.69	9372	28.31
Family did not think necessary	14080	17.22	818	13.57	1054	25.32	4947	14.94
Other	2928	3.58	579	9.61	210	5.04	458	1.38
DK	573	0.70	45	0.75	23	0.55	140	0.42
	81759	100	6027	100	4163	100	33108	100

Table: 4 Percentage Women Experience institutional delivery by Husband's presence (non presence) in ANC, India and selected states

	India	**Maharashtra**	**West Bengal**	**Uttar Pradesh**
	Percent experience institutional delivery			
Husband Present in ANC	65.0 (7396)	76.6 (12652)	60.4 (408)	39.5 (1117)
Received ANC but husband was absent	47.6 (2488)	66.8 (289)	34.3 (168)	29.7 (581)
Not received ANC	14.2 (4789)	32.5 (297)	18.6 (159)	9.9 (2390)

Table: 5 Percent Women received ANC and safe delivery by Husband's knowledge on Nutrition and Institutional delivery during pregnancy

	Received Knowledge of delivery in Hospital during wife's pregnancy		Received knowledge of proper nutrition during wife's pregnancy	
	Yes	No	Yes	No
Received ANC	88.4	50.2	86.7	13.3
Not Received ANC	11.6	49.8	47.3	52.7
	(6583)	(8097)	(7464)	(7215)
Experienced Institutional delivery (last child)	64.2	29.9	61.6	28.4
Experienced non Institutional delivery (last child)	35.8	70.1	38.4	71.6
	(6610)	(8297)	(7498)	(7408)

Table 6: Percent Women who availed ANC, Safe Delivery and Takes Health Care Decision by Husband's Justification of Wife Beating

		Wife Beating Justified	Wife Beating Not justified
India	Received ANC	62.6	71.2
	Safe Delivery	39.7	48.6
	Takes health care decision	60.5	65.3
Maharashtra	Received ANC	75.0	90.4
	Institutional Delivery	51.9	73.8
	Takes health care decision	64.7	69.0
West Bengal	Received ANC	74.1	80.2
	Institutional Delivery	26.8	51.9
	Takes health care decision	63.3	59.4
Uttar Pradesh	Received ANC	41.9	47.8
	Institutional Delivery	13.8	25.0
	Takes health care decision	65.6	65.4

Table :7 Determinants of any ANC care in India: Binary Logistic regressions

Variables	Exp (b)	Exp (b)
Background variables	***model1***	***model 2***
Age©	1.034**	1.021**
Place of residence		
Urban #		
Rural	.631**	.714**
Husband's education		
No education #		
Primary	1.718**	1.521**
Secondary	1.857**	1.499**
Higher	2.417**	1.435*
Religion		
Hindu#		
Muslim	.951	1.001
Others	.926	.865
Caste		
Sc/St #		
OBC	.892*	.846*
Others	1.316**	1.360**
Wealth index		
Poorest#		
Poorer	16387**	1.490**
Middle	2.788**	2.371**
Richer	4.042**	2.526**
Richest	8.661**	5.206**
Children Ever born ©	.777**	.841**
Husband's role		
Knowledge about pregnancy and delivery©		1.271**
Wife experienced less severe violence		
No#		
Yes		.938
Wife experienced severe violence		
No#		
Yes		.879
Wife experienced sexual violence		
No#		
Yes		1.170
Emotional violence experienced by wife		
No#		
yes		.936
Participate in hh decision making by wife		
No #		
Somewhat		1.113
Fully		1.090
Wife beating justified as reported by husband		
No #		
Yes		.872*
Constant	.728	.329
R2	.376	.306
N	13195	5359

Region is controlled; ANC Care 0=no 1= yes level of significance ** 1%, * 5 %

Table :8 Determinants of any ANC care in three states: Binary Logistic regressions

Variables	Exp (b)	Exp (b)	Exp (b)
	MH	**WB**	**UP**
Knowledge about pregnancy and delivery of husband©	1.620**	1.387**	1.160**
wife experienced less severe violence			
No#			
Yes	.381*	.520	1.107
Wife experienced severe violence			
No#			
Yes	1.160	.124~	1.114
Wife experienced sexual violence			
No#			
Yes	8.424	1.298	1.232
Wife experienced Emotional violence			
No#			
yes	.847	1.401	.801~
Participate in HH decision making by wife			
No #			
Somewhat	.944	.777	2.485
Fully	1.178	.733	2.682
Wife beating justified as stated by husband			
No #			
Yes	.419*	2.742	.809
R2	.551	.582	.232
N	257	124	1469

Husband's age, education, place of residence, wealth index, caste, religion, CEB are controlled.

ANC Care 0=no 1= yes; Level of significance ** 1%, * 5 %, ~ 10%

Table: 9 Determinants of Institutional delivery in India: Binary Logistic regressions

Variables	Exp (b)	Exp (b)
Age©	1.045**	1.038**
Place of residence		
Urban #		
Rural	.576**	.620**
Husband's education		
No education #		
Primary	1.378**	1.183**
Secondary	1.450**	1.203**
Higher	2.147**	1.698**
Religion		
Hindu#		
Muslim	.817*	.825*
Others	.826**	.738**
Caste		
Sc/St		
OBC	1.333**	1.387**
Others	1.655**	1.558**
Wealth index		
Poorest#		
Poorer	1.894**	1.804**
Middle	3.329**	2.980**
Richer	5.595**	4.606**
Richest	16.4.4**	12.570**
Children Ever born ©	.726**	.755**
Husband's role		
Not present, received ANC #		
Present and received ANC		1.350**
Not received ANC		.436**
Received knowledge about Institutional delivery		
No #		
Yes		1.589**
Experience less severe violence by wife		
No#		
Yes		.958
Wife experienced less severe violence		
No#		
Yes		1.209
Wife experienced severe violence		
No#		
Yes		1.024
Wife experienced sexual violence		
No#		
Yes		.946
Participate in hh decision making by wife		
No #		
Somewhat		1.065
Fully		.992
Wife beating justified as stated by husband		
No #		
Yes		1.007
Constant	.099	.119
R2	.510	.550
n	13361	10639

0= non-Institutional delivery 1= Institutional delivery level of significance ** 1%, * 5 %

Table: 10 Determinants of Institutional delivery in three states: Binary Logistic regressions

Variables	Exp (b)	Exp (b)	Exp (b)
	MH	WB	UP
Husband's role			
Husband's presence in ANC			
Not present, received ANC#			
Present and received ANC	1.138	2.370*	1.097
Not received ANC	.531~	.753	.448**
Received knowledge about Institutional delivery			
No #			
Yes	1.106	2.192*	1.813**
Wife experienced less severe violence			
No#			
Yes	.872	.670	.672*
Wife experienced severe violence			
No#			
Yes	1.575	.642	.674
Wife experienced sexual violence			
No#			
Yes	1.604	.975	1.037
Wife experienced emotional violence			
No#			
yes	.589**	.926	1.195
Participate in HH decision making by wife			
No #			
Somewhat	.651	2.227	.323
Fully	.775	4.019**	.344
Wife beating justified as stated by husband			
No #			
Yes	1.100	.549	.912
constant	*1.338*	*1.792*	*.184*
R2	*.436*	*.598*	*.432*
n	*1009*	*306*	*1965*

0= Non-Institutional delivery 1= Institutional delivery, level of significance ** 1%, * 5 %, ~ 10%

Controlled: Age, Place of Residence, religion, Caste, SLI, Education, CEB.

Level of significance ** 1%, * 5 %, ~ 10%

Table: 11 Determinants of Own health care decision in India: Binary Logistic regressions

Variables	Exp (b)	Exp (b)
Age©	1.028**	1.024**
Place of residence		
Urban #		
Rural	.652**	.689**
Husband's education		
No education #		
Primary	.990	1.045
Secondary	.996	.965
Higher	1.204**	1.014
Religion		
Hindu#		
Muslim	.878**	1.051
Others	1.166**	3.097**
Caste		
Sc/St#		
OBC	.876**	.807**
Others	.948	1.030
Wealth index		
Poorest#		
Poorer	1.010	.912
Middle	1.121**	1.008
Richer	1.146**	.912
Richest	1.1.188**	1.147
Children Ever born ©	1.018*	1.017
Husband's Role		
Knowledge about pregnancy and delivery©		1.008
Wife experienced less severe violence		
No#		
Yes		1.008
Wife experienced severe violence		
No#		
Yes		.831
Wife experienced sexual violence		
No#		
Yes		.916
Wife experienced Emotional violence		
No#		
yes		.725**
Participate in HH decision making by wife		
No #		
Somewhat		1.020
Fully		1.156
Wife beating justified		
No #		
Yes		1.035
Constant	1.097	1.435
R2	.061	.092
N	37952	5445

Others taking decision=0 Decision taken by own or jointly=1 level of significance ** 1%, * 5 %

Table : 12 Determinants of own health care decision by states: Binary Logistic regressions

Variables	Exp (b)	Exp (b)	Exp (b)
	MH	WB	UP
Husband's Role			
Knowledge about pregnancy and delivery of husband©	1.107~	1.040	.933**
Experience less severe violence by wife			
No#			
Yes	.557~	.475	1.189
Experience severe violence by wife			
No#			
Yes	.960	1.405	.744~
Experienced sexual violence by wife			
No#			
Yes	.402	.696	1.140
Emotional violence experienced by wife			
No#			
yes	1.131	.942	.522**
Participate in HH decision making by wife			
No #			
Somewhat	.801	.472	.676
Fully	.760	.932	.790
Wife beating justified as stated by husband			
No #			
Yes	.443**	1.996	1.163
R2	.129	.217	.085
N	262	129	1501

Others taking decision=0 Decision taken by own or jointly=1

Level of significance ** 1%, * 5 %, ~ 10%

Controlled: Age, Place of Residence, religion, Caste, SLI, Education, CEB.