

A Cross Sectional Study on the Pattern of Male Participation in Utilization of Reproductive Healthcare in Kamalapur Primary Health Centre Area of Gulbarga District, Karnataka

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ABSTRACT

Introduction: One of the important barriers to seeking an appropriate treatment by women for their illness is the lack of support by their husbands and family members.

Research Question: What are the health seeking behaviours of women about their reproductive health and the extent of participation of their spouses ?

Aims and Objectives: 1. To know the health seeking behavior of women about reproductive health. 2. To study the male participation and factors influencing the utilization of RCH services by their wives.

Materials and Methods: A cross sectional study was done in 2013 among 300 currently married women of age 15 to 49 years, residing at Kamalapur PHC area, Gulbarga district using pre-designed and pre-test questionnaire. Statistical analysis was done by using percentages and chi square test.

Results: 40% of women did not seek any treatment for their gynaecological problems, 30% visited PHC, 16.7% visited private clinics 10% of them had taken home care and 3.3% of them got medicines from medical stores. 20% of the husbands accompanied women for ANC visits and in 80% of cases mother or mother in law accompanied her. Only in 6% of the couples decision about family planning was taken by both partners. Decision maker of woman's health expenditure was her husband in 76.7% of the cases, 8.3% of cases her mother and in 10% of the cases her mother in law and in 5% of the cases women alone took decision.

Conclusion: Participation in reproductive health of woman is very less in rural India. Poverty, illiteracy and gender roles are the main influencing factors for the utilization of reproductive health services by the women.

Key words: Reproductive Health, Male participation, Health expenditure, Health seeking behaviour.

INTRODUCTION

Traditionally health care providers and researchers in the field of reproductive health have focused almost exclusively on women when planning programs and services, especially with regard to family planning, prevention of unwanted pregnancy

and of unsafe abortion, and promotion of safe motherhood. In recent years, efforts have been made in many countries to broaden men's responsibility for their own reproductive health as well as that of their partners. Measures are also being taken to improve gender relations by promoting

men's understanding of their familial and social roles in family planning and sexual and reproductive health issues. ^[1]

The International Conference on Population and Development (ICPD, 1994) and the Fourth World Conference on Women at Beijing (1995) emphasized the importance of reproductive rights and reproductive health both for men and women and the greater involvement of men in reproductive health. In post-ICPD era the world has seen a paradigm-shift away from focused family planning programs towards more general reproductive and sexual health. Specifically, the focus is on key concepts and programmatic implications for locating men's involvement within a reproductive health framework. During the ICPD, the program of action endorsed emphasized the need for equity in gender relations with a special focus on men's shared responsibility and active involvement to promote reproductive and sexual health. ^[2]

Need for Men's Involvement: The two above mentioned international conferences and a dozen survey studies clearly emphasized the central role of men in sharing reproductive responsibility, promoting responsible parent-hood and safe sexual behavior in the advent of the AIDS epidemic. Studies have shown that a supportive male spouse facilitates women's contraceptive use, reduces risks of spiraling rates of sexually transmitted diseases (STDs) and reduces sexual violence directed towards female partners (UNFPA, 1995; Verma and Ray, 1997). ^[2]

In a patriarchal society where men have an all encompassing involvement in decisions pertaining to family and society, it is most important to involve men in reproductive health decisions in order to achieve small family norm, observance of safe sex, contraception use, provide support for women during antenatal and postnatal period, healthy abortion management,

prevention of STD/AIDS, gynecological and other health complications and establishing stronger bonds between men and their off springs. Survey data have shown that failure to involve men in family planning programs can have serious implications. Even when contraceptive technologies are available for women, even when they are educated and motivated to practice contraception, they may not practice at all, have little say and control over fertility decisions because negative attitudes of their husbands inhibit their wives from taking action. ^[2]

Male Responsibility for Reproductive Health: "The objective is to promote gender equality in all spheres of life, including family and community life, and to encourage and enable men to take responsibility for their sexual and reproductive behavior and their social and family roles."

-- Programme of Action, UN International Conference on Population and Development, 1994 Reproductive Health was defined during the International Conference on Population and Development (ICPD) in Cairo in 1994 as "A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. It also includes sexual health, the purpose of which is the enhancement of life and personal relations". ^[3]

Decision Making: Married women were asked who makes decisions about their own health care, making large household purchases, making household purchases for daily household needs, and visiting their own family or relatives. Although half or more of currently married women (51-56%)

in Karnataka participated in each of these decisions, only 35 percent participated in making all four of these decisions. [4]

Women in nuclear households were more likely than women in non-nuclear households to participate in these decisions; similarly, women who were employed for cash are more likely than women who did not earn cash or were not employed. Other women who were more likely to participate in all four decisions were women in urban areas, women with 10 or more years of education, Christian women, and women in the highest wealth quintile. [4]

Gender-Role Attitudes: Two-thirds of women in Karnataka believed that it is justifiable for a husband to beat his wife under some circumstances. Women were most likely to say that wife-beating is justified if a woman shows disrespect for her in-laws (52%) or if she neglects the house or children (49%), goes out without telling her husband (41%), and argues with husband (35%). A similar proportion of men in Karnataka (63%) agreed that wife-beating is justified in some circumstances, including 47 percent who believe that disrespect for in-laws and 45 percent who believe neglecting the house or children were justifications for wife-beating. Even among women and men who had completed at least 10 years of schooling, about half (48-51%) agreed that a husband is justified in beating his wife for one or more specified reasons. [4]

Two-thirds of women and men (67-68%) in Karnataka believed a woman is justified in refusing to have sex with her husband, if she knows he has a sexually transmitted disease, if she knows he has intercourse with other women, or if she is tired or not in the mood. However, more than one in ten women and men (12-16%) did not agree that a woman is justified in refusing her husband sex for all three of these reasons. [4]

Men's Attitudes: Most men in Karnataka rejected the idea that contraception is a woman's business and a man should not have to worry about it (83%) and rejected the idea that women using contraception may become promiscuous (90%). However, 32 percent of men incorrectly believed that women who are breastfeeding cannot become pregnant. Only 62 percent of men knew that a condom, if used correctly, protects against pregnancy most of the time. [4]

Antenatal Care: Among women who gave birth in the five years preceding the survey, 89 percent received antenatal care from a health professional, including 79 percent from a doctor. About one in ten women (5% in urban areas and 13% in rural areas) received no antenatal care at all. Although antenatal care coverage in Karnataka was among the highest in the country, it was the lowest among all the four southern states. [4]

Male Involvement in Maternal Care (Karnataka): About two-thirds (65%) of men with a child under three years said they were present during at least one antenatal check-up received by the child's mother; and 60 percent were ever told by a health provider or health worker what to do if the mother had a major complication of pregnancy. Fathers in rural areas were less likely to have been present at an antenatal care visit than fathers in urban areas. [4]

The majority of fathers in Karnataka with a child less than three years of age were provided information related to delivery care by a health provider or worker. About three-fourths (73%) were told about the importance of proper nutrition for the mother during pregnancy and 70 percent were told about the importance of delivering the baby in a health facility. [4]

Among fathers whose child was not delivered in a health facility, 51 percent were told about the importance of using a new or unused blade to cut the umbilical

cord, 55 percent were told about the importance of cleanliness at the time of delivery, 56 percent were told about the importance of breastfeeding the baby immediately after the birth and about keeping the baby warm immediately after birth. Urban and rural fathers were about equally likely to be provided this information. [4] Present study will explore the Male participation in reproductive and child health.

Objectives

1. To study the male participation in availing reproductive Health services as perceived by their wives.
2. To know the health seeking behavior of women about reproductive & child health.
3. To study the factors influencing the utilization of reproductive Health services by women.

MATERIALS & METHODS

Study Design: A Community based Cross Sectional Study was undertaken to study the pattern of male participation in utilization of reproductive health care & factors influencing utilization of reproductive health care services.

Place of Study: Kamalapur PHC area of Gulbarga district, Karnataka was selected. Population of Kamalapur was 6,900. Currently married women residing in this area were the study subjects.

Sample Size Calculation

Sample $n = 4pq/d^2$
 Where $n =$ sample size
 $p =$ prevalence of RCH morbidity ($p= 25\%$)
 $q = 100-p$ ($q= 75\%$)
 $d =$ error in the estimation of p (5%)
 $n = \frac{4 \times 25 \times 75}{5 \times 5}$
 $= 300$

So the sample size was 300 currently married women of age 15 to 49 years.

Total number of women aged 15-49 years old living in Kamalapur PHC area was 1100 as per the data of 2012 household survey.

Duration of Study: The present Cross Sectional study was conducted for a period of 8 months from April 2013 to November 2013. 300 women were selected randomly for the study.

Inclusion Criteria

- a. Currently married women of age 15 to 45 years and
- b. Residing in study area for at least one year preceding the date of survey

Exclusion Criteria

- a. Married women who were divorced or separated or widowed
- b. Unmarried women in the reproductive age group

Method of Data Collection: A pre-designed pre-tested questionnaire was used to collect information on socio-demographic variables, self reported symptoms by the subjects and treatment seeking behavior of subjects for same problems and participation of husbands' about Reproductive and Child Health as perceived by the women. Ethical Clearance was taken from District Health Officer (DHO), District Health and Family Welfare office, Gulbarga. Questionnaire was administered to eligible women by house to house visit by the investigator after obtaining informed consent (Annexure I). Assent of woman and consent of adult family member was taken when woman's age was below 18 years.

Data Analysis: Data entry was done in Microsoft Excel and analysis was carried out by SPSS software. Statistical analysis was done by using rates, proportions and chi square test.

Measurement of Study Variables:

1. Age - Age was recorded to the nearest completed year.
2. Type of Family

- Nuclear family – Married couple and their children while they were still regarded as dependents.
 - Joint family – A number of married couples and their children who were living together in same house.
 - Extended family – It consisted three generations related to each other by their direct descent living together.
3. *Religion* - was recorded as reported by the head of the family
4. *Education*
- Illiterate – a person who could neither read or write
 - Primary – a person who had studied till or less than VII std
 - Secondary – a person who had studied between VII to X std
- Degree – a person who had completed graduation
 - PUC/Diploma - a person who had attended college
5. *Occupation*
- Agriculture – one who was employed in large scale cultivation of land
 - Self employed– one who was employed in commercial establishment
 - Labourer – one who earned his daily wages
 - Government employee – one who worked for employer in govt sector
 - Private employee– one who worked for employer in private sector
6. *Socio economic* status as per Per capita income in Rs. / Month was classified using modified Prasad’s classification.

Social class	Prasad classification in 1961 as per Per Capita Income in Rs / month	Modified Prasad’s classification in 2009 as per Per Capita Income in Rs./ month
Class I	100 and above	2500 & above
Class II	50-99	1250 - 2499
Class III	30-49	750 - 1249
Class IV	15-29	375 - 749
Class V	Below 15	Below 375

Modification was done with aid of multiplication factor, which was obtained as follows
 Multiplication factor = (Value of All India Consumer Price Index 2009 X 4.93)/ 100
 = 450/100 X 4.93
 = 22.185

RESULTS

Socio Demographic Characteristics Of Study Subjects

Table 1: Distribution of Study Subjects & Their Husbands According to their Age (N=300).

Age in years	Women’s age		Their Husbands’ age	
	Number	Percentage	Number	Percentage
< 18	8	2.7	0	0
18-20	60	20	46	15.3
21-25	52	17.3	60	20
26-30	62	20.7	46	15.3
31-39	68	22.7	59	19.7
41-49	49	16.7	59	19.7
55-60	NA	NA	30	10
Total	300	100	300	100

In the present study among 300 couples, highest range was 22.7% in age group of 31-39 years and least was the 2.7% in age group of <18 years in women.

Table 2: Distribution of Study Subjects And Their Husbands According to Their Education Status (N=300).

Educational status	Women		Their Husbands	
	Number	Percentage	Number	Percentage
Illiterate	200	66.7	150	50.0
Primary School	60	20	80	26.7
Secondary School	30	10	52	17.3
PUC / Diploma	10	3.3	12	4.0
Graduation	0	0	4	2.0
Total	300	100	300	100

Among the study participants, 66.7% of the women were illiterate, 20% subjects were educated up to primary level, and no one had completed Graduation. Among husbands of the study subjects 50% were illiterate and only 2% had completed graduation.

of them reported depression, 8% of them reported vomiting, 3.3% of them reported body ache, 0.3% reported head ache, 3.3% of them reported diarrhea, 3.3% of them reported abdominal pain, 3.3% of them reported acidity, 3.3% of them reported general weakness and 0.3% of them reported Urticaria.

Table-3: Distribution of Study Subjects & their Husbands According To Their Occupation (N=300).

Occupation	Women		Their husbands	
	Number	Percentage	Number	Percentage
Agriculture	100	33.3	140	46.7
Self employed	14	4.7	20	6.7
Private job	8	2.7	23	7.7
Govt. job	3	1.0	4	1.3
Labourer	70	23.3	113	37.7
House wife	105	30.0	NA	NA
Total	300	100	300	100

Among the study participants 33.3% were farmers by occupation, 30% were housewives 4.7% were self employed, and only 1% were government employees. Majority of the husbands' occupation was agriculture 46.7%.

General Health Information

Majority of the women reported fever in 33.3% of cases, 16.7% of women reported cold and cough, 10% of women reported joint pain, 2% of them reported hypertension, 1.75 reported diabetes, 1%

Table 4: Distribution Of Study Subjects According To Self Reported General Sickness By The Women (N=300).

SELF REPORTED SICKNESS BY THE WOMEN	Number	Percentage
Fever	100	33.3
Cold & Cough	50	16.7
Joint pain	30	10
Hypertension	6	2
Diabetes mellitus	4	1.7
Depression	3	1
Vomiting	24	8
Body ache	10	3.3
Headache	2	0.3
Diarrhoea	1	13
Abdominal pain	39	3.3
Acidity	10	3.3
Weakness	10	3.3
Urticaria	10	0.3
TOTAL	300	100

50% of the women had taken home care only, 20% of the women had visited private clinics, 26% of them had visited PHC, 3.3% of the women had taken

medicines directly from the medical store without consulting a doctor.

Table 5: Distribution Of Study Subjects According To Treatment Seeking Behavior Of Women For General Sickness (N=300).

TYPE OF TREATMENT TAKEN	Number	Percentage
HOME CARE	150	50.0
MEDICINE FROM PHARMACY	10	3.3
PRIMARY HELATH CENTRE	80	26.7
PRIVATE CLINIC	60	20.0
TOTAL	300	100.0

80% of the women told that they had undergone surgery. Out of 240 women who underwent surgery only 3.3% of the cases husband took care after the surgery, in the rest 96.7% of cases other persons took care of her health. In 96.75% mother in

law took care in 33.3% of the cases, in 60% of cases by woman's mother and 3.3% cases by other relatives.

Table 6: Distribution Of Study Subjects According To Women Who Underwent Any Surgery And The Person Who Took Care After The Surgery.

WOMEN WHO UNDERWENT SURGERY	Number	Percentage
YES	240	80.0
NO	60	20.0
TOTAL	300	100.0

PERSON WHO TOOK CARE AFTER SURGERY	Number	Percentage
HUSBAND	10	3.3
MOTHER IN LAW	70	33.3
MOTHER	150	60.0
OTHER RELATIVES	10	3.3
TOTAL	240	100.0

Obstetric Care and Family Planning

Table 7: Distribution Of Study Subjects According to Antenatal Care Received By the Women, Husbands Accompanied For ANC Visit and Husbands Accompanied In The Room During A.N.C. Consultation (N=180).

ANTENATAL CARE RECEIVED BY WOMEN IN LAST FIVE YEARS (N=180)	Number	Percentage
YES	36	20
NO	144	80

HUSBAND ACCOMPANIED WIFE FOR ANC VISIT (N=180)	Number	Percentage
YES	36	20
NO	144	80

HUSBAND ACCOMPANIED WIFE INSIDE ANC CONSULTATION ROOM (N=36)	Number	Percentage
YES	10	25
NO	26	75

Out of 300 women only 180 were pregnant or delivered within 5 years preceding the survey. So out of 180 women 20% of the women had received ANC for the last pregnancy. Out of 36 only 10 (20%) of the cases husbands accompanied their spouses for ANC visit during last pregnancy. Out of 36 only in 25% of the husbands accompanied wife inside the consultation room during ANC visit and no husband accompanied his wife in the examination room.

Table 8: Distribution of Study Subjects According to Decision Making Regarding Family Planning by Both the Partners (N=164).

DECISION OF FAMILY PLANNING BY BOTH PARTNERS	Number	Percentage
YES	10	6.0
NO	154	94.0
TOTAL	164	100.0

When women were asked about decision regarding the family planning decision had taken by both the partners, then only 6% of the women told that decision had been taken by both the partners and

94% of the cases decision regarding family planning had not been taken by the partners.

Gynecological Problems

Among 300 women all the women had some gynecological problems within one year preceding the survey. 32.7% of the women had dysmenorrhoea and 6.7% had scanty bleeding during menses.

Table 9: Distribution of Study Subjects According to Gynecological Problems Reported by the Women within One Year Preceding the Survey (N=300).

GYNECOLOGICAL PROBLEMS REPORTED BY THE WOMEN	Number	Percentage
DYSMENORRHOEA	98	32.7
LEUCORRHOEA	64	21.0
HAEVY MENSES	50	16.7
BURNIG MICTURATION	43	14.3
IRREGULAR MENSES	25	8.3
SCANTY BLEEDING	20	6.7
TOTAL	300	100.0

Table 10: Association between Social Category and Male Participation in M.C.H. Care.

Social category	Accompanied to ANC		Nearby during delivery		Care and help during pregnancy and delivery	
	Yes	No	Yes	No	Yes	No
General (22)	20 (90.9%)	2 (9.1%)	8 (36.4%)	14 (63.6%)	13 (59.1%)	9 (40.9%)
OBC (6)	4 (66.7%)	2 (33.3%)	4 (66.7%)	2 (33.3%)	4 (66.7%)	2 (33.3%)
SC (66)	6 (9.1%)	60 (90.9%)	6 (9.1%)	60 (90.9%)	2 (3%)	64 (97%)
ST (86)	6 (7%)	80 (93%)	2 (2.3%)	84 (97.7%)	1 (1.2%)	85 (98.8%)
TOTAL	36 (20%)	144 (80%)	20 (11.9%)	160 (88.9%)	20 (11.9%)	160 (88.9%)
	$\chi^2 = 122.723$, d.f = 3, p=0.000		$\chi^2 = 37.381$, d.f = 3, p=0.000		$\chi^2 = 16.847$, d.f = 3, p=0.001	

General category husbands were more participating in MCH care of their wives compared to other categories. There was significant association between social category and male participation (p=0.001).

Table 11: Association between Education of Women and Decision Making Regarding Family Planning By Both Partners.

Women's Education	Decision regarding family planning	
	Yes	No
Illiterate (91)	42 (46.2%)	49 (53.8%)
Primary (70)	68 (97.1%)	02 (2.9%)
Secondary (52)	50 (96.2%)	02 (3.8%)
PUC/ Diploma(10)	08 (80%)	02 (20%)
Degree (2)	02 (100%)	0 (0%)
TOTAL (225)	170 (75.6%)	55 (24.4%)
	$\chi^2 = 36.319$, d.f. =4, p =0.000	

Educated women were taking more decision regarding family planning with their husbands than the illiterate women. So there was a significant association between the education of the women and their decision making power regarding the family planning with their husbands (p=0.000).

DISCUSSION

The present study was conducted in 300 married women residing in primary health center area of Kamalapur, Gulbarga district, during April 2013 to November 2013.

Socio – Demographic Characteristics of study population (Tables 1-3)

In the present study there were 300 married women among them, highest range was 22.7% in age group of 31-39 years in women and least was the 2.7% in age group of <18 years in women. Among the study participants, 66.7% of the women were illiterate, 20% subjects were educated up to primary level and 10% were educated up to secondary level. Among husbands of study participants 50% of them were illiterate. Among the study participants a major proportions were farmers (33.3%) by occupation and 30% of them were housewives. Majority of the husbands' occupation was agriculture 46.7% and 37.7% of them were laborers.

In a study done in Chandigarh 19 wives were aged 15-24 yrs, 46 were 25-34 yrs and 35 were above 35 yrs. Literacy rate of husbands was 79% and of wives was 59%. Most of the women (87%) were housewives. Almost half of the husbands (49%) were laborers or farmers.

Discussion regarding General health status of women (Tables 4-6)

In present study majority of the women reported fever in 33.3% of cases, 2% of them reported hypertension, 1.75 reported diabetes, 1% of them reported depression, 3.3% of them reported abdominal pain and 3.3% of them reported general weakness. 50% of the women had taken home care only, 20% of the women had visited private clinics, and 26% of them had visited PHC.

When women were asked about their husbands' opinion regarding their health seeking behaviour, women told 16.7% of the husbands were ignorant about the health of their wife, 20% of them told to take home care, 13.3% of husbands told to take medicines from the medical store, 34% of husbands told to visit PHC, 16% of the husbands told to visit private clinics. 80% of the women told that they had undergone

surgery. Only 3.3% of the cases husbands took care of woman after the surgery.

Similar study done in Chandigarh results showed that, some of the symptoms were reported more by wives as compared to their husbands' perception about illness of wives. Symptoms like tension and irritability/anger were reported more by the husbands for their wives who reported these less frequently.

Similar study done in Gujarat in 1997 reported considerable inconsistency between husbands' and wives' responses on reporting of pregnancy in preceding 24 months. They also reported that at least half of the men were not aware of their wives' health status or the prenatal care services received by them during last pregnancy. Weakness, diet, heat and stress were told by many of husbands as the cause of their wives' illness.

Discussion regarding the Antenatal Care (Tables 7)

Out of 300 women only 180 were recently pregnant or delivered within 5 years (preceding the interview). So out of 180 women 20% of the women had taken the antenatal care for the last pregnancy and 80% of them did not receive antenatal care during their pregnancy. 80% of the cases husbands did not accompany for the ANC visit with their wives for the last pregnancy and only 20% of the cases husbands accompanied their wives for ANC visit during last pregnancy. 75% the husbands did not accompany in the room during ANC consultation with their wife.

In a similar study conducted in Ahmed Nagar district in Maharashtra state revealed that young women had limited mobility and depended on husbands or other family members to take them to a health centre. While 77% said that women should seek antenatal care, only one third knew about all the antenatal care services that can be provided. A high 85%

said care was needed during delivery, but for most reported the need for institutional deliveries (72%) rather than care during home deliveries. Most husbands felt responsible for routine care and treatment of problems. [5]

Discussion regarding Family planning practices (Tables 8)

Out of 180 women only 92.7% of the women were using family planning practices and of the 7.3% women were not using any family planning methods. Out of 164 women who were using family planning practices, only 8.6% of them had accompanied for the family planning consultation room with their wife and 91.4% of the cases husbands had not accompanied for family planning consultation room with their wife. When women were asked about decision regarding the family planning decision had taken by both the partners, then only 6% of the women told that decision had taken by both the partners.

In a study done among women in Nigeria in 1997 revealed that women were increasingly taking active decisions on matters affecting their daily lives. More women than ever before believed that they can take decisions on family size, when to have a baby and choice of spacing period. The cultural barriers against short postpartum abstinence seem to have diminished while sex during lactation is not considered a major cultural and religious taboo. Knowledge of contraception had also become universal in recent years and the majority of women taken decisions on method and timing of family planning. When husbands were infected, nearly all women would refuse to have unprotected sexual relations with them. Nevertheless, 45 percent of urban women compared to 50 percent of rural women would ask their infected partners to use

condoms, while 30 percent urban and 35 percent rural were undecided. [6]

A multicentric Study done in all over India in 2002 based on focus group discussion results showed that all the participants agreed on need for family planning, most participants endorsed the idea that FP should be a joint responsibility. A majority of men preferred that their wives should consult them before making decisions about FP. And almost all preferred that their wives should undergo sterilization. Higher number of participants from the north old age group and non users of FP believed that the use of contraceptives by males would create problems including loss of strength, and libido. [7]

Discussion regarding Gynecological problems reported (Table 9)

In the present study among 300 women all the women had some gynecological problems within one year preceding the survey. 32.7% of the women had dysmenorrhoea, 21% of women reported leucorrhoea, 16.7% of them reported heavy menses, 14.3% of them reported burning micturition, and 8.3% of them reported irregular menses and 6.7% had scanty bleeding during menses. Out of 300 women 40% of them did not taken any treatment for their gynecological problems. 10% of them had taken home care, 30% of them had visited PHC, 16.6% of them had visited private clinics and 3.3% of them had taken medicines from the medical store without doctor's consultation.

Similar study done in Chandigarh reported that when asked 'what were common health problems of women in general' there was reasonable concordance in responses of husbands and wives. However, there were some diseases which were enumerated more by wives e.g. menstrual problem, pain in abdomen,

vaginal discharge, uterine prolapse, backache and abortion. Some diseases were, however, enumerated more frequently by husbands as compared to their wives viz. mass in uterus, anemia, AIDS, cancer of uterus. [8]

Similar study done in Mumbai in 1994 reported that husbands often did not allow their wives to go for gynecological check up. Women often become frustrated and depressed due to lack of concern shown by husbands for their health and gradually become used to not to show any interest in seeking health care. They summarized their respondents' views that men folk often felt that women's health needs should be limited to care during pregnancy, childbirth and Puerperium. There was no concept of preventive care for general illnesses or gynecological problems in particular. [9]

Factors influencing on utilization of RH services (Tables 10-11)

In the present study there was an association between social category and male participation. General category families' husbands were more participating in MCH care of their wives compared to other categories. Among study participants there was an association between social category and male participation which was statistically significant ($p=0.000$). [10]

Care during pregnancy and delivery of husbands was good in OBC's and it was very less in ST category which was statistically significant ($p=0.001$).

Decision making regarding family planning by both the partners was seen in educated husbands as compared to illiterates. A strong association was seen between the education of husband and decision regarding family planning by both the partners, which was statistically significant ($p=0.000$). Educated women were taking more decision regarding family planning with their husbands than

the illiterate women. There was a good association between the education of the women and their decision regarding the family planning with their husbands which was statistically significant ($p= 0.000$).

Similar study done in Baroda district in Gujarat revealed that, half of the men were not aware of their wives' health status and prenatal services which their wives had received during their last pregnancy. It reflected the social segregation of the roles and responsibilities of men in which reproductive processes such as ANC and ensuring safe delivery are considered to be women's affairs in which men have only a limited role to play. [11]

A similar study done among slum dwellers in Andhra Pradesh showed that the overall observation of men's participation in different aspects of on reproductive health was still not good. Only less than 30 percent of the males were actively participating in promotion of reproductive health and 23 percent were found to have moderately participated. It was disheartening to notice that nearly half of the males were not involving in the promotion of reproductive health. [12]

In a similar study done in 10 locations of India showed that about half of them expressed concern for not having knowledge about women's health care needs during pregnancy, sickness and child birth. Majority of men did not have much exposure to male and female anatomy, physiology and reproductive system, nor were they aware of their SRH needs, as well as the role sexuality plays in making the marital life satisfying and happy. [7]

In a study carried out in Andhra Pradesh revealed that many women assumed that they had no control over their bodies, whereas men thought that they had control over their wife's body. More than half of the couples had communication related to planning of their family.

Nearly one-fifth of the women reported suffering from illness after sterilization. One-fourth of the women never sought treatment because of demanding household work and lack of support from husband/family members. ^[13]

CONCLUSION

Married women in rural areas show poorer health seeking behavior possibly due to reduced decision making authority and their illiteracy. The role of partners and their family members appear crucial in the access and use of reproductive health services by women. Partner involvement appears crucial to health seeking among married women.

Half of the women had not taken any treatment, one fifth of the women visited private clinics, one fourth of them had visited PHC, and few women had purchased medicines directly from medical stores without consulting a doctor.

Men who were better educated, married later, and whose wives were educated and were older when they married knew more about and were more likely to participate in all round health care of women.

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ABBREVIATIONS

ANC	: Antenatal Care
ANM	: Auxiliary Nurse Midwifery
DHS	: Demographic Health Survey
EAG	: Empowered Action Group states
FP	: Family Planning
ICPD	: International Conference on Population and Development
IEC	: Information, Education and Communication
KAP	: Knowledge, Attitude and Practices
MTP	: Medical Termination of Pregnancy
NFHS	: National Family Health Survey
PHC	: Primary Health Centre
RCH	: Reproductive and Child Health
RH	: Reproductive Health
SRH	: Sexual and Reproductive Health
STDs	: Sexually Transmitted Diseases
STI	: Sexually Transmitted Infections
UNFPA	: United Nations Population Fund
USAID	: United States Agency for International Development

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