Male Involvement for the Improved Acceptance and Adoption of Reproductive and Child Health (RCH) Services in Rural Uttar Pradesh, India: An Analytical Study

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ABSTRACT

Male partner's involvement in decisions regarding the acceptance, adoption and use of various reproductive and child health services was recognized long back. However, efforts to seek their active participation was not made till early 21st century and even after the launch of RCH programme phase-I in India. Majorly the programme remained focused around the eligible women of reproductive ages (15-45 years). Also, it was a difficult task to convince males due to male dominated patriarchal set up of larger Indian society barring few exceptions. Therefore, the current analytical study was undertaken with the major objective- "To analyze and understand the status of level of participation and role of male partners of eligible women as source and tool (activities) of Information, Education and Communication (IEC) for sharing information and taking decision on availing and adopting Reproductive and Child Health (RCH) Services provided by the government under RCH programme". Information was obtained from 295 eligible women selected using random sampling from 08 villages of 02 development blocks of Lucknow district of Uttar Pradesh. Tools used for quantitative and qualitative data collection were interview schedule and 08 FGDs (Focus Group Discussions) for eligible women and another 08 FGDs for their male partners. Findings revealed an extremely critical role of male partners of eligible women from rural Uttar Pradesh as a source and tool (activities) of Information, Education and Communication (IEC) for sharing information and in taking decision about availing and adopting Reproductive and Child Health (RCH) Services provided by the government under RCH programme and calls for the need to tap this invaluable resource for better outcomes.

Key words : Male Involvement; RCH Services; Rural Uttar Pradesh; Gender; Male Partner;

Increasing population has always been one of the major focuses of India's development policy since independence. It got a prominent place in most policy documents and all five-year plans. Contrary to India's initial Family Planning Programme that was started in 1952, the new framework of RCH programme launched in 1997, widened its spectrum and incorporated new unaddressed or under-addressed areas related to Reproductive Health (RH) as its programme elements. These areas included Reproductive Rights of women and gender issues, screening and treatment of Reproductive Tract Infections (RTIs), Sexually Transmitted Diseases (STDs),[1]HIV/AIDS and other gynaecological problems, ensuring reproductive health education to adolescents considering them future eligible couples, providing a greater range, and quality of services and efficient delivery of services, etc. Service delivery related interventions were introduced in all existing and regular Child Survival and Safe Motherhood (CSSM) Programme components such as ante-natal care, natal care (delivery), post-natal care, contraception, safe abortion along with family planning. Besides above components, referral and follow up services that were found week in prior programmes, were strengthened and expanded. In a way this was an indirect approach towards motivation of the target audience towards going for family planning. The idea was that once the issue of quality and behavioural aspect of service delivery and the staff with increased access to and out- reach of services focusing on life cycle approach is provided, it will have direct impact on the acceptance and adoption of family planning methods leading to population control.

Greater emphasis was laid on use of multiple media and audio- visual aids. The situation, however, remained grim even after the launch of NRHM (National Rural Health Mission) in 2005. If we talk about reproductive health, nutrition, maternal and child health or gender discrimination with a girl child, India's' performance is even poor than many Asian countries that got independence around the same time as we got. Country has world's greatest burden of maternal, newborn, and child deaths. In 2008, 1.8 million children (age<5 year), including 1 million neonates, died, and 68,000 mothers died. (M.C., Hogan, K.J. Foreman, M. Naghavi, et. al. (2010).[6] India also has the greatest number of undernourished children, with about 52 million stunted children (age< 5years). (IIPS and Macro International, 2007).[7] Care seeking bias against girls has been clearly seen as for every two male neonates, only one female neonate is admitted to a healthy facility. Most of the girl neonates are not taken to such facilities. The situation in Uttar Pradesh is even bad. State of Uttar Pradesh in India is the most populous state of the country. One sixth of India's population resides in Uttar Pradesh and is still growing at a rapid speed. Addressing reproductive and child health and family planning issues, therefore, has always remained a big challenge for the government and non- government system. In nutshell, if one has to address the problem of population explosion in the country, it is Uttar Pradesh from where one has to begin addressing the problem to curb the increasing population.

Male involvement in reproductive health is a practice wherein fathers or male community members actively participate in caring for their wives, other women members of the family and support their family to access better health services. They also cooperate and participate in acceptance and adoption of suitable family planning methods. There is positive association between male involvement and better reproductive health, maternal health and child health outcomes. The Action Plan of Cairo International Conference on Population and Development (ICPD), 1994 and Beijing Conference, (1995) brought forth the fact that there is a necessity to involve male partner emphasizing their role in shared responsibilities for reproductive and sexual health of both eligible women and her spouse. (Promundo, UNFPA, 2011),[12] India government could not bring this component into reality at ground level in RCH – I as per the current study.

Indian women's reproductive and marital choices are particularly circumscribed by their social and economic circumstances. In particular, women's choices are severely curtailed by the absence of socially acceptable alternatives to marriage and a high degree of reliance on sons for old-age support.[3] Spousal communication, husband's approval and desire for a future child, decrease intention not to use contraception in future (Ghosh, R., 2001).[5]

Thus, across globe, male involvement in RCH care services remains a challenge to effective reproductive health care services, their accessibility and utilization. So is in case of India due to its age-old patriarchal norms and social structures. For instance, traditionally, maternal health issues have predominantly been seen and treated as a purely feminine matter. Erroneous notion that pregnancy and the processes leading to childbirth are completely a female domain. However, the fact remains that decision to opt for what type and where of almost all the RCH services always rest with the male member of the family. Previous studies show very few cases of male involvement especially in North Indian scenario (Alka Barua et.al, 2003).[2] Therefore, the current study was undertaken with the following objectives-

1. To identify the status of level and type of participation of male partners of eligible women as source and tool (activities) of Information, Education and Communication (IEC) for sharing information and taking decision on availing and adopting Reproductive and Child Health (RCH) Services provided by the government under RCH programme.
2. To analyses and understand the role of male partners of eligible women as source and tool (activities) of Information, Education and Communication (IEC) for sharing information and taking decision on availing and adopting Reproductive and Child Health (RCH) Services provided by the government under RCH programme keeping all dimensions in mind.

METHODOLOGY

The present study is analytical research where 295 eligible women (15 to 45 years of age) were chosen as sample from eight villages of two development blocks (Sarojini Nagar and Mohanlal Ganj) of Lucknow districts following random sampling technique. Quantitative data was collected with the help of pre- tested structured interview schedule. Qualitative information was also gathered from the eligible women and their male counterparts (spouse or partners) through 16 (one from each group in each village) Focus Group Discussions

(FGDs) on identified key points and their views were jotted down with their permission. Efforts were made to extract information from all possible sources on every important and determining factors so far Inter-spousal communication and role of male partners in availing services and decision making towards RCH services by the eligible women was concerned. The quantitative data was then tabulated and numbers, percentile, as well as rank orders were taken out. Qualitive information was consolidated, analyzed against pre- defined key issues and major outcomes were laid down. Inferences were drawn accordingly.

Data obtained was organised and analyzed under results and discussion section divided in following heads-

1. General Profile of the Spouse of the Respondents (Eligible Women)
2. List of IEC Sources Selected for the Study
3. Rank Order of Male Partner as the most Important Sources of Information, Education and Communication (IEC) with Regards to identified RCH Components
4. Levels of Exposure of Respondents (Eligible Women) to Communication with IEC Sources and Tools (Activities) on RCH Service Components
5. Reasons given by the Respondents for not Adopting Services Leading to Family Planning and Spacing between two Children
6. Response of Respondents on Why their Male partner who were Suffering from any of the Reproductive Health Problem (Abnormal Discharge, RTI, STD), did not go to the Doctor for the Treatment to Protect Respondents (Eligible Women) from Getting Infected with any of the Reproductive Health Problem

7. Focus group discussion (FGDs) were carried out on the following key points-

a. Reproductive Rights (i.e., The Size of Family, Timings of having Children, Number of Children to be born)

b. Choice of Contraception and Contraceptive Methods

RESULTS AND DISCUSSION

Results of analysis of data revealed extremely interesting findings. Tables as well as discussions and the final findings are given as follows-

General Profile of the Spouse of the Respondents (Eligible Women) : It was observed that about half i.e., 142 (48.1 percent) of the of the husbands of eligible women interviewed for the purpose of the study, were between 25-34 years of age which is considered as most potential years for fertility. However, their socio-economic status was quite low with either owning their own small piece of land (36.3 percent) with very low income or were labourer (21.4 percent) out of 295. It was also observed that a good number of spouse of respondents were either illiterate, functionally literate, or educated up to fifth or middle standard making a total of 59.7 percent. Only 3.7 percent of them got some engagement during the lean period. This whole scenario shows an extremely poor socio- economic condition of majority of families and hence lack of the communication and other facilities too. This also reflects that most of them are engaged in such occupation where they are not even able to earn their bread and butter properly

Table 1. General Profile of the Spouse of the Respondents (Eligible Women) (N=295)

Characteristics of the Spouse	No.	%
Age (in years)		
15-19	2	0.7
20-24	32	10.8
25-29	82	27.8
30-34	60	20.3
35-39	52	17.6
40-45	67	22.7
TOTAL	295	100
Educational level of the spouse		
Illiterate	46	15.6
Read and write name	2	0.7
Functionally literate	10	3.4
Up to primary level	49	16.6
Up to middle level	69	23.4
Up to High school	47	15.9
Up to intermediate	36	12.2
Graduate and above	36	12.2
Occupation of the spouse		
Engaged in any occupation		
Nil (not employed)	9	3.1
Labourer	63	21.4
Caste occupation	6	2.0
Cultivation (farming on other's land)	2	0.7
Business (including small shop)	16	5.4
Independent profession	37	12.5
Cultivation (farming on own land)	107	36.3
Service	55	18.6
Occupation during lean period	11	3.7

Table 2-A. List of IEC sources selected for the study

Types of IEC Sources and Tools (Activities)
Inter-group communication level iec sources
Inter-spousal communication
Home visit by ANM/ health worker
Communication with any of the family members
Communication with any of the member of society, community and functionaries responsible for providing RCH related information
Closest neighbour
Friends
Influential female member of cluster
Opinion leader (male/ female)
Gram Pradhan (male/ female)
Member of Gram Swasthya Samiti
Member of Z.S.S.
Trained Birth Attendants (TBA)
Untrained Birth Attendants (TBA)
Anganwadi worker
ANM at anganwadi centre/ sub centre
Doctor of PHC /CHC
PHC /CHC nurse
Doctor of district hospital
District / Block level Health Information Education Officer/ personnel
Private doctor /private nurse/ private nursing home or maternity home
Quake/ NGO worker
Group Meetings

Table-2. B. List of IEC sources selected for the study

Types of IEC Sources and Tools (Activities)
Mass communication level iec sources
Audio-visual media; Radio; Television
Film shows and cinema spots
Exhibitions
Posters/ hoardings/ wall paintings
Folk media; Puppet show
Nautanki; Alha
Katha–Varta
Bhajan–Keertan
Local folk songs
Mela
Nukkar Natak
Rally, Jattha
Magic show, etc.
Print media; Newspaper/ Magazines
Pamphlet/ Leaflet
Flash cards/ Flip charts

Table 3-A. Rank Order of Male Partner as the most Important Sources of Information, Education and Communication (IEC) with Regards to RCH Components

RCH Components	Inter- Spousal Communication		Rank Orders
	No.	%	
Age at Marriage	30	10.2	II
Prevention and Management of Unwanted Pregnancies	41	13.9	I
Safe Abortion			
Medical termination of pregnancies	7	2.4	II
Place and person for seeking services for safe abortion	7	2.4	II
Small Family Norms and Spacing	168	56.9	I
Contraception and Contraceptive Methods			
Permanent Methods			
Male sterilization	135	45.8	I
Female sterilizatio	124	42.0	I
Herbs and Tea	25	8.5	I
Temporary Methods			
Oral contraceptive pills	127	43.1	I
Intra-uterine device (Cu-t/ loop)	121	41.0	I
Condom	128	43.4	I
Injectable	18	6.1	I
Periodic abstinence	10	3.4	II
Withdrawal/ Abstinence	28	9.5	I
Prevention and management of RTI, STD, HIV/ AIDS			
Abnormal discharge	-	-	0
RTI 11 3.7 III			
STD/ STI and HIV/ AIDS - - 0			

(as told during FGDs). Thus, getting time to engage in conversation on any such topic was hardly a priority for many of them.

Male Partner as the most Important Sources of Information, Education and Communication (IEC) with Regards to RCH Components : An effort was made to identify the most important sources of Information, Education and Communication (IEC) for the coverage of all RCH components from the male partner of the eligible women and give them a rank (as reported by the respondents) out of all sources and tools of IEC covered in the study. Here it is not important to know that which IEC source or tool was at the previous of next rank to the male partner as IEC source when it comes to communicate or have conversation with their wives on any RCH service-related component. It was, instead an attempt to identify rank of male partner of eligible women regarding sharing messages, feelings,

Table 3-B. Rank Order of Male Partner as the most Important Sources of Information, Education and Communication (IEC) with Regards to RCH Components

RCH Components	Inter- Spousal Communication		Rank Orders
	No.	%	
Registration of pregnancies	42	14.2	II
Ante-natal check-ups	-	-	0
T.T. immunization	55	18.6	I
I.F.A. supplementation	53	18.0	III
Natal care			
Importance of institutional delivery	42	14.2	III
Complications during delivery	-	-	0
Post-natal Care			
Post-natal check-ups	-	-	0
Infections after delivery	-	-	0
Child Care			
Giving importance to take babies weight after birth	-	-	0
Understanding the importance of keeping baby warm after birth	-	-	0
Understanding the importance of giving colostrum	-	-	0
Understanding the importance of mother's milk	-	-	0
Understanding the importance of immunization	105	35.6	I
Understanding the importance of complementary feeding	-	-	0
Understanding the importance of prevention and treatment of AR	18	6.1	III
Understanding the importance of prevention & treatment of Diarrhoea	25	8.5	III
Importance of giving ORS	16	5.4	III
Importance of giving Iodine salt	-	-	0
Gender Sensitivity	22	7.8	I
Referral Services	-	-	0

views, and concerns as well as making decisions on acceptance and adoption of services related to varied components and sub- components of RCH in their own lives. These RCH components and sub- components were taken into consideration based on their inclusion under RCH Programme of government of India and the state of Uttar Pradesh. The data obtained under this section is given in table-3. A and 3. B.

Regarding taking consultation and finally making decision of age at marriage of children, inter-spousal communication was ranked as second most important source of IEC after television. The other important components where the male partners were ranked second most important source of communication was safe abortion, be it regarding taking decision on going for MTP or not or about the place and person for seeking services for safe abortion. As reported in FGDs it was told by eligible women that many times, abortion was also used as a method of family planning and information on this was hardly shared by their male partners. The number of such cases was though found to be very less with merely 2.4 percent but it is matter of concern because this may lead to long term morbidity amongst such women folk.

In case of matters related to prevention and management of unwanted pregnancies and all the practices related to choices and decisions to be taken related to contraception and contraceptive methods other than periodic abstinence, the husband was found to be the major source of IEC. For permanent contraceptive methods male partner remained the main IEC source. Though, the number of responses regarding sources of information fluctuated for different temporary contraceptive methods or spacing methods from fairly high for OCP, IUD and condom and very low for injectables, LAM, periodic abstinence and withdrawal, male partner, the most important source of IEC ranked first. Likewise, in case of small family norms inter-spousal communication ranked first most important source of communication with 168 out of 295 respondents (56.9 percent). They remained the most important source of information on spacing methods too.

Later on, when FGDs were conducted it was found that it is the male who decides on what and when to use any contraceptive method and hence is the first communication partner of wives.

The data of current study revealed that a large number of women respondents suffered or suffering from RTI (problem of white discharge), and two of them also had STDs but unfortunately, presence of spouse as source of communication as a confidant partner for sharing pain and agony caused by RTIs and STDs was minimal or nil. The sufferings caused due to these problems remained a taboo to talk to even with the husbands who were the main carriers of such problems and were never ready to go for check-ups or treatment even if they were requested by their wives.

Although the spread of HIV/ AIDS is a major

concern in India but NFHS – 2 (1998-99), data portrays that 60 percent of women in India have not heard of AIDS. Only 12 percent of women have heard of AIDS in Bihar and 20.23 percent in Uttar Pradesh, Rajasthan and Madhya Pradesh compared with 87 percent or more in Mizoram, Manipur, Tamil Nâdu and Kerala. Among women who have heard of AIDS, at least one fourth did not know of any way to avoid it in all states except Mizoram, Tamil Nâdu, Orissa and Delhi. Among women who have heard about AIDS, 79 percent learn about the disease from television. Radio is next popular media with 42.1 percent respondents obtaining information on HIV/; AIDS by Radio. (National Family Health Survey-2, 1998-99)[10]

In the present study too, where 32 percent women had heard about AIDS. Out of this 66.3 percent had correct knowledge of roots of transmission about HIV/ AIDS. This is quite encouraging. However, the source of information for this knowledge were not their male partners.

It was their male ego and fear of social defame in their community that always came into the way. These two reasons were very openly accepted by many male participants in FGDs.

Table-3. B clearly depicts extremely grim picture about the involvement of male partners as source of IEC in most decisions regarding adopting or availing services related to maternal care, child care and referral services.

Among the 80 percent of women who had registered for ante-natal care for their last pregnancy within the previous five years, less than half received "full care". (Alka Barua et.al, 2003)[2]

Spouse was absent or showed extremely low presence as potential IEC source on many most crucial matters related to maternal and child care such as importance of taking babies weight after birth, keeping baby warm after birth, importance of colostrum, importance of mother's milk, importance of complementary feeding and importance of diarrhoea management. They accepted in their FGDs that this is not their job. It is the job of purely women – their wives, elderly women member of the family or community. However, since they have to make arrangement for taking out the mother and child outside for immunization thus, they were found as the most important source of IEC on child immunization with 35.6 percent followed by *anganwadi* workers with 34.9 percent. On the contrary for post- partum checkups there was complete absence of the role of male partners showing their unawareness or indifference towards such an important matter.

The poor attitude of men towards maternal health especially in Africa has been greatly attributed to the practice of male dominance, often called "patriarchy". (J.B., Kinane, and J. Ezekiel-Hart, 2009)[9]

Other maternal care component that is crucial in reducing chances of complications and maternal mortality of pregnant women where the presence of male counterpart was seen as source of IEC though not as prominent as other sources was understanding the importance of institutional delivery and opting it for their wives. Inter-spousal communication was the major source of IEC on gender sensitivity and issues related to participation in reproductive rights and decision-making, through the number of responses was too small. This clearly depicts that this is one issue on which the male never wants to give authority solely to their women counterpart and the patriarchal mind set has not changed much.

On the whole, highest percentage of communication of rural eligible women was found with her husband as compared to any other individual of her family, society and not even with the medical attendant.

Levels of Exposure of Respondents (Eligible Women) to Communication with IEC Sources and Tools (Activities) on RCH Service Components : Exposure to any communication media also increases or reduces the chances of communication to take place between the two people. Being a closely knitted and traditional society, in rural areas there are very few chances of inter- personal communication as the traditional system, social norms and restricted movement of women do not allow them to communicate with many people. Even if they get a chance to do so it is restricted to quite formal conversation, where talking on many of such topics openly is not considered good. Thus, the data was collected from the eligible women on the levels of exposure of various IEC sources against already worked out categories based on identified parameters for the levels of exposures. It was found that 40.3 percent of the respondents (eligible women) were moderately exposed to most inter-personal communication media whereas highest levels of exposure was seen in inter-spousal communication with equal number of respondents with 40.3 percent respondents each in both,

Table-5. A to 5. D. Reasons given by the Respondents for not Adopting Selected RCH Services

Reasons Given by the Respondents	No.	%
For not Taking any Step to Prevent Unwanted Pregnancies	208	70.5
Wanted more children	40	19.2
Husband opposed	57	27.4
Never worried	45	12.0
Scared of side effect	41	10.1
Lack of knowledge/ Incomplete knowledge	30	9.6
Highest number of eligible women responded (27.4 percent) that husband did not allow them to take any step for the prevention of unwanted pregnancy		
For their Intentions towards not using any of the Contraceptive Methods in Future	120	40.7
Wanted one more child/ more children	47	39.2
Husband opposed/ did not allow	49	40.83
Want a son/	27	22.5
Here again dominance of husband's decision was visible with 40.83 percent respondents gave reason for not using and contraceptive method as opposition by their male partners		
For using Family Planning Methods (in case where only respondents, eligible women, were using contraceptive methods)	37	12.5
Consent of both	11	29.7
Male partner opposed	6	16.2
Respondents who gave no reasons	4	10.8
Male partner wanted so	4	10.8
Male partner dislikes using condom	16	43.2
Male partner considers it as wife's responsibility	12	32.4
Male partner will become week	2	5.4
Respondent is using against the wishes of male partner and family members but in his knowledge	5	13.5
Male partner stays outside and availability of condom cannot be ensured whenever he comes back home	4	10.8
Using one without the making is known to male partner (using oral pills)	6	16.2
Lack of communication with male partner so no discussion on the topic	5	13.5
In case where only women were using any of the contraceptive method again the will of husband for all related decision was found to be prominent be it choice of contraceptive method or the decision to use or not to use was concerned. Only 05 respondents reported that they were using these methods against the wish of their husbands but in their knowledge. However, a small number (06) of the respondents were using oral pill without bringing it to the knowledge of their male partners as they knew their spouse would never agree.		
For using Family Planning Methods (in case where only respondents' male partners were using contraceptive methods)	26	8.8
Consent of both	7	26.9
Male partner herself wanted to use the method	6	23.1
Male partner is scared of side effect to their female counterpart if uses temporary permanent contraception	7	26.9
Wife has to do house hold chores and she will become week after using any family planning method	2	7.7
Male partner has easy access to the method	4	15.4

There was a very small number (26 out of 295) of male partners who preferred using any of the contraceptive method themselves rather than forcing their wives. It is also encouraging that reasons show real concern of the male partners towards their wives. However, we need to work seriously on increasing the number of such cases to attain a more gender sensitive and equitable society. Several studies confirm the same stating that male sterilization accounted for only 8 percent of all sterilizations in 1989-90 (Ravindran, 1993b), and a 1988 survey by the Operations Research Group (1990) showed that only 5 percent of couples use condoms. (Desai, S., 1994)[4]

Table 6. Response of Male Partners of the Respondents Suffering from any of the Reproductive Health Problem (Abnormal Discharge, RTIs, STDs and HIV/ AIDS) (N = 6)

Particular	No.*	2.0
Financial problem (lack of money)	2	33.3
Paucity of time as labourer and earning bread is my priority	1	16.7
Did not tell due to hesitation- fear of social disapproval or humiliation	2	33.3
Feel shy to consult the doctor as they will think it is their fault	1	16.7

*Number of Male partners of the respondents suffering from any of the Reproductive Health Problem (Abnormal Discharge, RTIs, STDs and HIV/ AIDS)

Though the number of males suffering from any of the RTIs, STDs was very less (2 percent) but the trend data shows is really worrisome. It revealed that as many as 50.0 percent of the total respondent suffering from any of the reproductive health problem were more bothered about social stigma and their reputation in society rather being concerned about their own health or the health of their partner

falling under the category of moderately exposed and highly exposed category respectively.

Focus group discussion (FGDs) were carried out on the following key points-

Reproductive Rights -The Size of Family, Timings of having Children, Number of Children to be born

i. Majority of male participants in all FGDs were of the opinion that being the bread earner of the family and having hold on economic resources with higher social

status, males have the sole right to take decision about the issues related to reproductive rights.

ii. Though the female respondents wanted their participation in decision-making process related to reproductive rights but simultaneously accepted the dominant socio-economic status of their male counterparts.

Similar findings are also given by Dyson & Moore (1983) and Das Gupta (1987) who reported that women's status and autonomy are critical in promoting change in reproductive attitude and behaviour, especially in patriarchal societies.[11]

These, calls for increasing participation of women in work place or income generating activities, thereby encouraging them and helping in raising their status as far as decision making in terms of reproductive issues are concerned. A great deal of work needs to be done for boasting self-confidence of rural women.

Choice of Contraception and Contraceptive Methods :

i. Except for few males, rest never wanted to use any contraceptive method because they felt it as the responsibility of women. They were of opinion that since women have to bear the consequences, she should take the preventive measures. Female respondents on the other hand, said it as male responsibility. Male do not prefer to use condoms due to lack of feeling of sexual satisfaction and hindrance to enjoyment as reported by male respondents and few of their female counterparts as well.

ii. Most male were resistant to any type of sterilization, they were of the opinion that if at all, sterilization has to be done, should be on their female counterparts. The qualitative study indicated factors largely contributing to negative perception existed amongst the male partners towards male sterilization. First is the dominance of male chauvinism.

iii. Second was the tendency to shift the botheration to the wives on various pre texts. Most important of the pre-text was inability to do heavy work after sterilization operation. This was even supported by females. It is felt that perhaps this is the perception that unconsciously has generated the feeling of protecting male from taking any risk, as they are the bread earner in poor rural families.

iv. The second issue was related to the fear of failure of permanent contraceptive method and its consequences. Social embarrassment of a sterilized person, in case his wife conceives, was concern of both male and female groups. Two such failure cases were reported and also a heated discussion on the amount and type of embarrassment or shame these males had to face after their wives got pregnant even the husbands had got their sterilization done, took place in one of the FGDs.

v. Last factor was associated with the fear of impotency.

vi. Few of female respondents, though favoured male sterilization but their number was meager.

vii. Many of women never wanted to go for their sterilization but they were scared that their husband or in-laws would not accept it. Final decision making on contraceptive choice was found to be mainly in hands of male as reported by most female respondents.

viii. During FGDs and observations made while data collection, it was found that there is a large number of women who were willing to use contraceptive methods but either due to lack of complete information or services or non -acceptance of their partners they could not make it a reality, thus they were not using any contraceptive methods.

ix. Male Respondents also denied having any separate or special counseling meetings for them on any of the RCH components to seek their support.

CONCLUSION

Several previous research evidences and the data of the present study has shown the male involvement as significant factor in optimizing RCH services. In the current study it was also found that despite being on such key decision-making position no separate spouse counseling meetings were held. The male counterpart (spouse) is the key connecting persons helpful in increasing the outreach and access to services for these poor women. He is the most important source for almost all the information, and to make final decisions for availing or not availing most RCH services by the eligible women, therefore this particular IEC source need to be tapped properly. Reproductive health is the core priorities for any country, more so for India. Progress in reproductive health, child health and nutrition in India is not satisfactory and the country has still a long way to go.

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