PATRIARCHAL DOMINATION ON NATAL CARE (NC)

PARTHSARATHI DEHURY, ANIL KUMAR

Abstarct: Male control over women's sexuality and reproduction is seen as denying women self-determination and equality. On the other hand, men's lack of involvement in their spouses' natal care (NC) which is typically focused on women and exclude men is seen as a major obstacle for the women's health status. The main objective of the study is to measure the roles and responsibilities played by male in various stages of their spouse's delivery. Primary data from male workers in Jindal Steel Power and Limited (JSPL), Odisha has been collected to assess various factors affecting the health care delivery. The data was collected by using a semi-structured interview schedule from 280 male workers. Cross tabulation, chi-square, percentiles were analyzed by SPSS software to justify the objectives. Almost them 89% (251 out of 280) male migrant workers don't have any knowledge regarding natal care amongst them 52.2% respondents were perceived that NC is women's business. Education and income are the most influencing factors which are highly signifying (level of significance .0001) with their accompanies during spouses delivery, mental and physical support at the time of their labour pain. Male partner are in the role of developing intervention to achieve a safe institutional delivery. This study reveals that education and availability of services regarding natal care are significant factors to increasing the male knowledge and future implication on the importance of men's involvement is central to improved maternal health in India.

Key words: Patriarchal, Natal care and Equality, Migrant Workers, Reproductive Health

Introduction: Reproductive health researchers generally focus on women's health. Lesser importance is given to male involvement in reproductive health. Several determinates like female sex ratio, sexual transmitted infection, HIV/ADIS, unwanted pregnancy including unsafe abortion, high MMR and IMR indicate women carry extra burden of reproductive health. . Men's role in Natal Care (NC) is a neglected issue in many developing countries. Many statistics defined that the low literacy rate and financial dependency of women on men signify that men were not playing leadership role for reducing their family reproductive health related issues. This ignorance determines men's patriarchal nature which permits to neglect women's health issues. Knowledge gap about sexual and reproductive health leads domestic violence, sexually abuse, murder, rape, sexual harassment and sex selective abortion etc. There are various role played by male on women's health, at macro level male as a policy maker, male health care administrator and service provider which also influence women reproductive health. On micro level male partner also affect the women's reproductive health as a partner and father of children on child health (Dudgeon and Marica 2004).
Cairo conference (1994) gives much more importance to men's participation in reproductive health. It introduces the concept of men's participation in family planning, knowledge and prevention of HIV/AIDS and STDs, maternal and child health. Men's participation in reproductive health policy, plan and strategy were approved by ICPD and governments after the conference. A large number of social research on masculinity promote to rapid change for equal rights through women's movement. Female labor participation in home norms of family size, develop varieties methods of contraception and changing married life within family still exit which is defining the roles and responsibilities of male (Allen and Webster 2001 & Goldscheider and Wait 1991). Women's condition in developing countries has not fully improved due to domination of male over female is seen in many society. The women are known as the mother and wife of particular person, daughter of particular kinship so she is less recognized through her identity and capacity. They are perceived to be incapable for work except domestic work in house, child rearing and bearing. Male getting more wages in work place than women's for same work (Mathur 2008, Olawoye et al 2001). Decision making power of men influences to desire number of children that wives will have. Socio-cultural patriarchal role do not accept the advantage and opportunities of women autonomy. So, men influence the health outcome of women and access to their health seeking behaviors.

Patriarchal domination on the context of health: Patriarchy has to be situated within a social framework of the class, work education and age. It has multiple dimensions without uniform cultural product. Culturally it is believed that male counterpart is less vulnerable and more powerful than women on the basis of body structure. It perceives that male body is stronger than women's which is encouraging them to do risky health activities. Ideology of masculinity is a major barrier of

positive health belief and behavior of men (Courtenay 2000). Social construction theory argue that the concept of masculinity has developed after 1970 when the feminist movement was demanding for equal right in private and public sphere of the life. Social norms, beliefs and values are defined by patriarch system in every society. Men's roles and responsibilities in their family, community and society are socially constructed and it passed from one generation to another generation by the process of socialization. Men's activity, duty, rights and obligation is different from one community to another community hence it's not universal (McMahon, 1993).

There are different viewpoints of many societies regarding rejection of feminine ideal constructs to masculinities. Idealized femininity argues that the positive health beliefs and health care utilization both are social construct. The way of health care utilization is taken by masculinity but disadvantages are seen for inappropriate way which threats to man's as well as woman's health (Kumar 2014). According to feminist perceptive masculinity varies to social structure and access to resources and power. The masculine role play by different men in different way and its totally depends on age, social class, ethnicity and sexuality. Men neglect to health care utilization is one kind of masculinity which directly affects to his own health and further its influence to women's health. Men also exercise the degree of power to men, the dominate masculinities suppress to marginal masculinities. In many society the dangerous and life threatening works is given to the particular group. Masculinity involves with grater health risk and poorest health behavior towards their lower counter parts contribute to show dominate masculinity (Courtenay 2000).

Men's roles in natal care: Men cannot involve in more intimate and nurturing activity with his children and spouses due to cultural definition of patriarchy ideology. He never shows his love and affection to his child like women but he has the same emotional relations to their new born as well as mother have (McMohan 1993). A study from Ahamdanagar shows that more than three quarters of husband were known about needs of hygienic precaution and problem during delivery. Nearly 46 percent men know about five cleanses (clean place, blade, cloth, thread and disposal delivery kit) during the home delivery. Less than half of men reports about major problems like excessive bleeding, abnormal presentation, convulsion, puerperal sepsis during delivery. Two-third of them has lowest awareness regarding basic post-natal care. Qualitative analysis also found the local custom is associated with delivery care especially during first delivery of the wife goes to her parents' house and delivery were conducted by local sister. Husbands don't have any roles and responsibilities during delivery which is totally female dominated (Barua et al 2004). Two hundred and seven (207) in-deft interviews with young husband from rural Maharashtra indicate Delivery and post delivery period are exclusively women's affair and men's participation is associates with demographic and socio-economic factors (Raju 2001).

Abortion and child birth both are life threatening event for women, which affect them physically and psychologically. It is prohibited without the permission of husband. The husband has the authority to decide financial support to women. Studies from Latin America estimate one third to one half of international abortion are decided by men rather than women (Browner 1986 & 2000). Maternal health care is one of the important areas of women's reproductive health which is influenced by men. Food, sleep and workload during pregnancy affect the reproductive outcomes. Study from US shows men have the strong control to desire the time of pregnancy irrespective of women's desire. More responsibility regarding utilization of prenatal, delivery and post natal service is associated with male. Those husbands' help in breast feeding their child are feed longer than those don't help their spouses (Casper and Hogan 1990).

Research design

Study area: Quantitative research methodology was used to collect and analyze the data in this study. The study was carried out in the Jindal Steel and power Limited (JSPL) Industries which is situated at Angul district in Odisha. The district also has sufficient natural resources, which ultimately help the district to contribute maximum amount of revenues to the state government and attract to multinational industry. JSPL is one of the major industries which came up with capital investment of Rs. 20,000.00 crores for setting a steel producing facility and a 1500 MW power generation unit. JSPL plans to commission the first phase of its 6 million tons per annum (MTPA) steel plant in Angul district by mid-2014. JSPL acquired 6,400 acres land in Banarpal and Chhendipada block of Angul district and began construction work in 2006. The industry attracts thousands of workers from all over India. So, study was done in this industry's male migrant workers to know their roles and responsibilities during their wives Natal Care.

Sampling: The purpose of the study was explained to the respondents first and their consent was taken before data collection. The sample for the study is based on purposive sampling techniques. At the first stage purposive sampling was used for the selection of JSPL industry followed by the same techniques labour camp and the villages are chosen. Male

migrant workers were taken to conduct interview at the same procedure. After conducted some interview the study took some convenient sample from migrant workers. There are 5500 male migrant workers which include both with and without families currently working in JSPL industry. Amongst them 553 migrant workers families were staying in different laborer camps within industry. Apart from that nearly 1000 workers families were living in nearest villages by rental and approximately 150 workers families were staying in their won huts which is on government land in surrounding villages (Dept. Labour & welfare JSPL, 2015). Approximately 15 respondents refused to participate and interview was incomplete for another 10 workers. Only 280 male migrant workers were interview successfully to analyze the data. The distribution of sample size is 72 (16 from labour camp, 27 from labour colony JSPL, 10 from labour colony simplix and 19 from Sramik Bihar) from different labour colony those workers are staying within industry. 46 interviews have taken from labour huts and rest of sample was chosen from nearest 24 villages and city.

Data: Data were obtained through face to face interviews by a semi-structured interview schedule in their place of residence. Data collected include the socio-demographic characteristics of workers including their religion, caste, type of housing, level of education, current residence place, age, household income, occupation, name of the contract site, nature of work and age at the time of marriage. The patriarch male domination on natal care was measured by collecting information on men's knowledge on natal care, their perception on safe delivery and place of their spouse's delivery. The study also collected information regarding men's roles and responsibilities at the time of their wive's labour pain.

Data analysis

Data collected from the male migrant workers was subject to verification, quantification and coding by referring a coding key. The coded data was entered in computer for data processing and analysis. The statistical package for social sciences (SPSS 20.0) used to calculate percentile, frequency distribution table. The cross tabulation tables were also drawn in order to compare selected variables. It helped in comparing the similarities and differences between the selected dependent and independent variables. Chi-square and correlation were used to know the level of significant and association between workers roles and responsibilities in delivery care by socio-demographic character.

Results: Characteristics of the study participants shows that nearly 38 per cent of respondents were from the age group 26-30 years. Majority of respondents about 236 (93.9%) are Hindus and on the basis of social class there are 116 (41.4%) belongs to schedule tribe and 103 (36.8%) were from other backward classes. Almost 64 (22.9%) respondents don't received any formal education and only 105 (37.5%) men received secondary education with a majority group up to 10th class of schooling. One third 206 (74.6%) of the respondents were staying in the rural area and more than half of them about 146 (52.1%) of respondents occupation were contract labour. The majority of them about 114 (40.7) reported to earn in between 4000-7000 which is consider as lower level of income. The details of the socio-demographic profile is described in the Table no.1.

Table no. 1: Demographic characteristic of respondents

Variable	Cording category	Frequency	Percentage	Total
Age	20-25 years	42	15.0	280
	26-30 years	106	37.9	
	31-35 years	105	37.5	
	36-40 years	20	7.1	
	41 and above	7	2.5	
Religion	Hindu	263	93.9	280
	Muslim	11	3.9	
	Christian	6	2.1	
Social class	SC	32	11.4	280
	ST	116	41.4	
	OBC	103	36.8	
	General	21	7.5	
	Don't know	8	2.9	
Education	Illiterate (Don't received any formal education)	64	22.9	280
	Primary (1-5th)	89	31.8	
	Secondary (6-10th)	105	37.5	
	Higher secondary (above 11th)	22	7.9	

Spouses education	Illiterate (Don't received any formal education)	167	59.6	280
	Primary (1-5th)	46	16.4	
	Secondary (6-10th)	65	23.2	
	Higher secondary (above 11th)	2	0.7	
Current place	Rural	206	74.6	280
	Urban	71	25.4	
Occupation	Labour	146	52.1	280
	Reger	47	16.8	
	Fitter	22	7.9	
	Holder	4	1.4	
	Helper	5	1.8	
	Sweeper	4	1.4	
	Civil worker	18	6.4	
	Carpenter	3	1.1	
	Mesen	21	7.5	
	Supervisor	10	3.6	
Nature of the work	Over time	170	91.9	185
	Night shift	15	8.1	
Total household monthly income, Median (range)	Low income level (Rs. 4000-7000) Mean=6140.35	114	40.7	280
	Middle income level (Rs. 7001-10000) Mean=8730.77	104	37.1	
	High income level (Rs. 10001-20000) Mean =13177.42	62	22.1	
Age at the time of marriage	> 18 years	28	10.0	280
	18 - 24 years	169	60.4	
	<24 years	83	29.6	
Spouses age time of marriage	> 18 years	147	52.5	280
	18 - 24 years	127	45.4	
	<24 years	6	2.1	

Man's knowledge regarding Natal Care by education: Table no.2 shows man's knowledge towards natal care with respect to their educational statues. Majority of respondents 251 (89.6 per cent) don't have any knowledge regarding natal care. Above 95 per cent men's are illiterate and primary level educated men don't have any knowledge regarding their spouse's delivery care. Education is a dominate factors with highly significant contribution (level of significant .0001) in influencing the knowledge towards NC. Education and knowledge about natal care both are having positive relationship (Pearson's correlation: .261, p-value .0001).

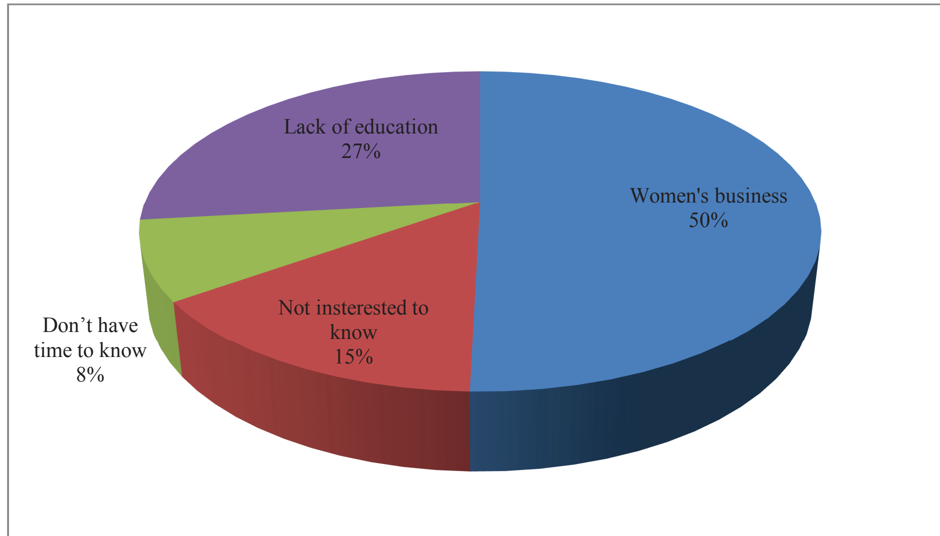
Table no. 2: Man's knowledge regarding Natal Care by education (n=280)

Education	Knowledge regarding NC		Total
	Yes	No	
Illiterate	3 4.7%	61 95.3%	64 100%
Primary	4 4.5%	85 95.5%	89 100%
Secondary	12 11.4%	93 88.6%	105 100%
Higher secondary	10 45.5%	12 54.5%	22 100%
Total	29 10.4%	251 89.6%	280 100%
Chi square Significance level: .001, Karl Pearson's correlation : .261 (p- value .0001)			

Cause for don't have any knowledge regarding delivery care

Figure no.1 shows that 50 per cent respondents perceive knowledge regarding NC is none of men's business and it's totally comes under female domain. Almost 15 per cent men do not interested to know about it and 27 per cent has lacking the knowledge because of less education. Here the male dominate patriarch system influence to their knowledge towards NC.

Figure no. 1: Cause for don't have any knowledge regarding delivery care (n=251)



Men's perception regarding safe delivery

Majority of workers 79.6 per cent (223 out of 280) were perceived that institutional delivery is safe and effective delivery. Amongst them 31.8 per cent respondent has perception that institutional delivery acts as protection for infant as well as mother's health at the time delivery. Almost 27.4 per cent respondents reported government incentive is one of the driving factors to promote institutional delivery. There are 20.4 per cent (57 out of 280) respondents perceive home delivery is promoted for effective delivery. The two major factors influencing for home delivery are the less expensive (52.6 percent) nature and fear to caesarian delivery (nearly 44 per cent).

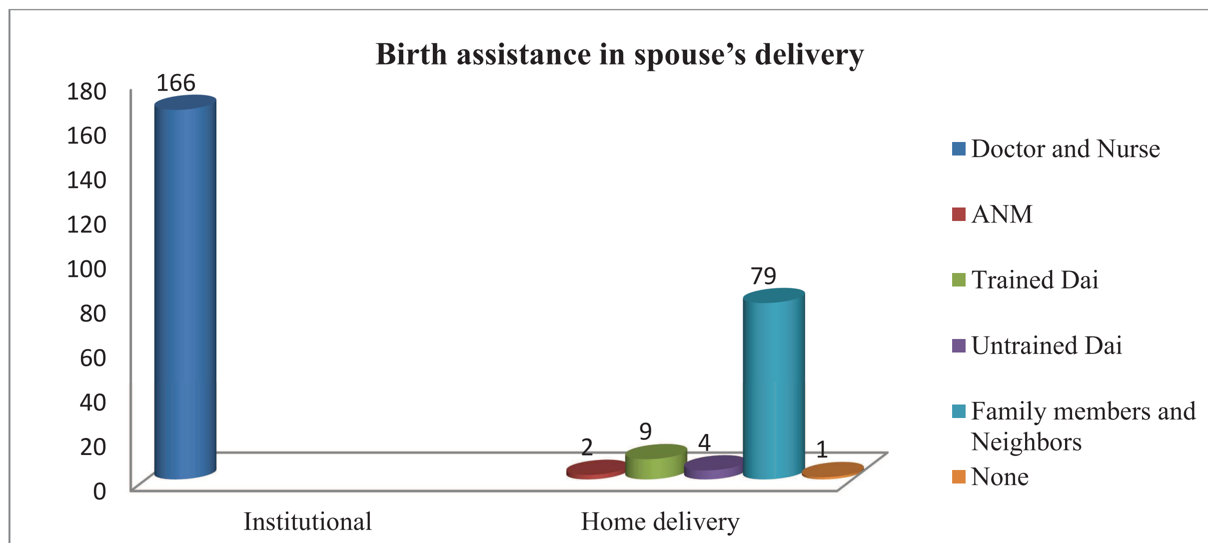
Table no. 3: Men's perception regarding safe delivery

Variable	Cording category	Frequency	Percentage	Total
Safe delivery	Institutional	223	79.6	280
	Non-Institutional	57	20.4	
institutional	It is low risk	43	19.3	223
	Performed by doctor	43	19.3	
	Low labour pain	5	2.2	
	Safety for infant and mother	71	31.8	
	Government incentive	61	27.4	
Non-Institutional	Less expensive	30	52.6	57
	Fear to C-section	25	43.9	
	Delivery is private matter	2	3.5	

Birth assistant in spouses delivery (n=261)

Figure no. 2 shows the place of delivery and assist by birth assistance. There are 166 respondent reported their wives delivery take place in various government health institution and the delivery is assist by doctor and nurses. In home delivery there are 79 family members and neighbors playing the role of birth assistance. Only 9 respondents replayed their wives delivery has assist by trained birth assistance Dai. ANM has very insignificant role to assist home delivery.

Figure no. 2: Birth assistant in spouses' delivery (n=261)



Place of delivery by household income: Table no 4 shows the place of delivery is associated with house hold income in different places. Out of 261 deliveries 40 (15.3%) respondents are reported their wives delivery take place in their parent's home whereas 55 (21.1%) respondents reported delivery take place in laws/husband's house. Majority of delivery 135 (51.7%) were take place in government hospital and 31(11.9%) were in private hospital. With regard to household income level the distribution shows that 107 respondents were living with low level of income. Amongst them majority 61(57.0%) of delivery was taken place in government hospital. Almost 18 (16.8%) and 26 (24.3%) respondents wives delivery happened in parent's home and husband's home respectively.

Table no. 4: Place of delivery by household income

Level of household income	Place of wives last delivery				Total
	Parent's home of wife	laws/husband's house	Government hospital	Private hospital	
Low level	18 16.8%	26 24.3%	61 57.0%	2 1.9%	107 100%
Average level	15 15.6%	20 20.8%	55 57.3%	6 6.2%	96 100%
High level	7 12.1%	9 15.5%	19 32.8%	23 39.7%	58 100%
Total	40 15.3%	55 21.1%	135 51.7%	31 11.9%	261 100%

Chi square Significance level: .0001, Karl Pearson's correlation: .227 (p- value: .0001)

There are 96 respondents were from average level of income reported regarding their wives place of delivery. Amongst them majority of delivery 55 (57.3%) was take place in government hospital and 20 (20.8%) delivery happen in respondents home. The respondents from high level of income groups are pReferences to institutional delivery 23 (39.7%) and 19 (32.8%) delivery happen in private hospital and government hospital respectively. Total household income level is highly significant (level of significant: .001) with place of delivery and it's having positive relationship (Pearson's correlation: .227, p: .001) with each other.

Male roles and responsibilities towards their spouses labour pain: Table no. 4 shows the role and responsibility of male during their spouse's labour pain at the time of delivery. Out of 261 respondents only 46 (17.6%) were physically helped their wives to take them to hospitals or birth attendances. Majority of respondents 215 (82.0%) don't support the spouses, amongst them about 101 (47.2%) perceived the care is an exclusive business of women. Almost 59 (27.4%) respondents reported their family members supported their spouses at the time of labour pain. Another influencing factor was engagement with their work which curtails time to help their spouses. With regard to moral support only 3 (1.1%) respondents supported their wives at the time of labour pain. Almost 99 percent respondent doesn't have any roles and responsibility to morally support

at the time of fear and anxiety during labour pain of their spouses. Amongst them 97 (37.6%) respondents were perceived it is women's business and 55 (21.1%) respondents doesn't play any role because other family members are support. There are 45 (17.4%) and 55 (21.1%) men reported that they don't have time to assist their spouses in labour room at time of labour pain.

Table no. 5: Male roles and responsibilities towards their spouses labour pain

Variables	Cording category	Frequency	Percentage	Total
Physical support	Yes	46	17.6	261
	No	215	82.0	
Causes for don't support	Women's business	101	47.0	215
	Family members support her	59	27.4	
	Don't have time	52	24.2	
	Workload	2	0.9	
	Any other	1	0.5	
Morally support	Yes	3	1.1	261
	No	258	98.9	
Cause for don't support	Women's business	97	37.6	258
	Family member support her	55	21.1	
	Don't have time	45	17.4	
	She was in labour room	55	22.5	
	Workload	1	0.4	
	Any other	2	0.8	
Knowledge towards used any disposal delivery kit (eg.blade, threads and cloths etc)	Yes	22	23.2	95
	No	3	3.2	
	Don't know	70	73.7	
Buy it from market	Yes	14	14.7	95
	No	81	85.3	
Help in domestic task	Yes	191	73.2	261
	No	70	26.8	
Cause for don't help	Women's business	19	27.1	70
	Family members help her	45	64.3	
	Don't have time	6	8.6	

In case of home delivery (n=95) about 70 (73.7%) respondents don't know the use of disposal kit. Only 22 (23.2%) men's reported that delivery kit was used during their spouse's delivery. The data define that majority of respondents 81 (85.3%) don't purchase it from market where as only 14 (14.7%) men purchased it from market. Men's roles toward domestic task just after child birth were shows that 191 (73.2%) respondents are helping their wives in domestic household work. Rest of the respondents 70 (26.8%) don't help their wives after child birth. Amongst them 45 (64.3%) respondents don't play any roles because their other family members helping, and 19 (27.1%) perceived household work is totally women's business.

Discussion: Findings in this study prevailing patriarchal norms among men's migrant workers determine the gender norms and the invisible male involvement in natal care. The study provides evidence that majority (89.6%) of the respondents doesn't have any knowledge regarding NC and half of them perceive that it is not men's business. Although the findings are same those of other studies found the various gender norms can affect to men's knowledge regarding the same issues (White et al 2003). Antenatal care clinic and labour room are women's space and it is run by women as well as attended by a woman which is perceived by men. Men may visit the clinic or labour room unwieldy and uncomfortable as it challenges gender norms and the notion of masculinity (Myburgh 2011 & Kululanga 2012). Education, mass media exposure, income and spousal communication are significant factors to knowledge regarding NC and the place of delivery (Kumar 2014). Here the data define education and income also significant (level of significant .0001) factors with knowledge and place of child birth as well as having positive relationship to each other. Majority of the pregnant women in Nepal on home delivery using the service of family members and untrained birth attendants and 9.0 percent women's are going to health institution for delivery, 31.0 percent women's

were assisted by health professional workers. Attendance of husband at the time of delivery is more sensitive than other health needs by 88.3 percent men (Kumar 2014). This study is shows that 51.7 per cent women's are going to government hospital, 11.1 percent are going to private hospitals for delivery which is assisted by doctors and nurses. Almost 21.1 percent delivered in husbands home and 15.3 per cent delivered in parent's home of wife by birth attendant Dai (trained and untrained) and neighbors and family members.

Compare to Kumar (2014) this study visualize the neglected men's role in NC. Only 17.6 percent of respondent physically and 1.1per cent respondents were morally supporting their wives at the time of labour pain. Here the male dominated patriarchy nature permit to neglect women's health at the time of delivery. Some religion and societies prohibited to men participate in women delivery even men have interest to accompany his partner. Cultural ethos, gender norms and administrative factors are the major barrier for them (Carter 2002). This study define 24.7 percent men's don't have shown their interest to physically help in spouses delivery.

Conclusion: Natal care is one of the important essential components of maternal and child health which can reduce maternal as well as infant deaths. Institutional delivery is not practiced in many societies so mothers are delivering their babies by unskilled birth attendant or family members. Husband can accompany their spouse's regularly in case of home delivery he can also provide support morally and physically. Men can encourage and advice to women at the time of complication during child birth. Many factors cultural beliefs, place of delivery, practices during child birth, birth attendance, problems reorganization and decisions making of male all these components are influencing to safe delivery. The safe and effective delivery is achieved by institutional and skilled birth attendance, treatment and management at the time of complication and men's participation in natal care specially husband's accompaniment at the time of child birth.

References

1. Barua A, Rohini P. Pande, Kerry MacQuarrie and Sunayana Walia. 2004. Caring Men? Husbands' Involvement in Maternal Care of Young Wives, *Economic and Political Weekly*, Vol. 39, No. 52, pp. 5661-5668
2. Dudgeon M.R and Marcia C Inhorn. 2004. Men's influences on women's reproductive health: medical anthropological perceptive, *Social Science & Medicine*, Vol.59, No.7, pp.1379.1395.
3. Kanchan Mathur. 2008. Gender hierarchies and inequalities: Taking stock of women's sexual and reproductive health, *Economic and Political Weekly*, Vol. 43, No. 49, pp. 54-61
4. Lucy I Kululanga, Johanne Sundby, Address Malata and Ellen Chirwa. 2012. Male Involvement in Maternity Health Care in Malawi, *African Journal of Reproductive Health/La Revue Africaine de la Sante Reproductive*, Vol. 16, No. 1, pp. 145-157
5. *Lynne M. Casper & Dennis P. Hogan. 1990. Family networks in prenatal and postnatal health, Social Biology,Volume 37, Issue 1-2,pp. 48-101.*
6. Myburgh H. The clinic as a gendered space: Masculinities, health seeking behavior and HIV & AIDS. 2011. Consultancy Africa Intelligence. Retrieved from http://www.consultancyafrica.com.
7. Saraswati Raju. 2001. Negotiating with Patriarchy: Addressing Men in Reproductive and Child Health, *Economic and Political Weekly*, Vol. 36, No. 49, pp. 4589-4592
8. Susan M. Allen and Pamela S. Webster.2001. When Wives Get Sick: Gender Role Attitudes, Marital Happiness, and Husbands' Contribution to Household Labor, *Gender and society*, Vol. 15, No. 6, pp. 898-916
9. Vikash Kc. Kumar. 2014. Men's participation in women's reproductive and child health care: a study of Western hill region, Nepal, Available on http://shodhganga.inflibnet.ac.in/handle/10603/184702.
10. White V, Greene M. Murphy E. The Synergy Project. Men and reproductive health programs: Influencing gender norms, 2003. Available on: http://www.synergyaids.com/SynergyPublications/Gender_Norms.pdf.
11. Will H. Courtenay. 2000. Constructions of masculinity and their influence on men's well-being: a theory of gender and health, *Social Science & Medicine*, Volume 50, Issue 10, pp.1385–1401

***

Parthsarathi Dehury/M.Phil Scholar/Tata Institute of Social Sciences/Mumbai/
Anil Kumar/Professor/ Center for Health and Social Sciences/School of Health System Studies/TISS