



AN ASSESSMENT OF AWARENESS AND PARTICIPATION OF MALE PARTNER IN CARE DURING PREGNANCY IN RURAL FIELD PRACTICE AREAS OF A MEDICAL COLLEGE IN NORTH INDIA

Dr. Adarsh Maurya¹, Dr. Supriya², Dr. Akansha Bansal³, Dr. Anshul Kumar^{4*}, Dr. Pankaj Kumar Jain⁵

¹Assistant Professor, Department of Community Medicine, Uma Nath Singh Autonomous State Medical College, Jaunpur.

²Junior Resident, Department of Community Medicine, Uttar Pradesh University of Medical Sciences, Saifai.

³Senior Resident, Department of Community Medicine, Autonomous State Medical College, Kanpur Dehat.

^{4*}Senior Resident, Amar Shaheed Jodha Singh Ataiya Thakur Dariyao Singh Medical College, Fatehpur, Up.

⁵Professor and Head, Department Of Community Medicine, Uttar Pradesh University of Medical Sciences, Saifai.

Email: ¹dr.adarshmaurya2606@gmail.com, ²dr.supriya2110@gmail.com,

³akanshabansal707@gmail.com, ^{4*}shrivasanshul84@gmail.com, ⁵drpankajjain@yahoo.com

Corresponding Author: Dr Anshul Kumar

Senior Resident, Amar Shaheed Jodha Singh Ataiya Thakur Dariyao Singh Medical College, Fatehpur, Up.

Background: Male partner participation is an important determinant of maternal health service utilization and pregnancy outcomes. However, evidence regarding men's awareness and involvement in maternal care during pregnancy remains limited in rural India. This study aimed to assess awareness and male partner participation in maternal care during pregnancy and identify factors associated with their involvement in rural North India.

Methods: A community-based cross-sectional study was conducted among 480 husbands of women who had a live birth during the preceding 12 months in the rural field practice areas of a medical college in Etawah, Uttar Pradesh. Data were collected using a pre-designed, pre-tested, interviewer-administered questionnaire adapted from WHO recommendations, national guidelines, and published literature. Awareness was assessed using a 16-item knowledge score, while male partner participation was measured using a composite involvement score. Descriptive statistics, Chi-square test, and multivariable logistic regression were performed using IBM SPSS Statistics version 26.0.

Results: Overall, 65.0% of participants demonstrated better awareness regarding maternal care during pregnancy, while 55.4% exhibited adequate male partner participation. Awareness was highest for antenatal care (94.2%) and institutional delivery (85.8%) but comparatively lower for pregnancy danger signs (49.2%) and government maternal health schemes (46.7–55.8%). Better awareness was significantly associated with higher educational status, higher socioeconomic status, joint/three-generation family type, and completion of four or more antenatal visits (all $p < 0.05$). Adequate male partner participation was significantly associated with better awareness, higher educational status, higher socioeconomic status, and four or more antenatal visits. In multivariable analysis, participants with better awareness had 2.3-fold higher odds of adequate male partner participation (adjusted odds ratio: 2.3; 95% CI: 1.6–3.2), while higher educational status and completion of four or more antenatal visits were also independent predictors.

Conclusions: Although awareness regarding routine maternal care during pregnancy was generally satisfactory, important gaps persisted in knowledge of pregnancy danger signs and government maternal health schemes. Better awareness was independently associated with greater male partner participation. Strengthening male-inclusive antenatal counselling, promoting couple-centred maternal health education, and actively engaging husbands during routine antenatal care may improve male participation and contribute to better maternal and neonatal health outcomes.

Keywords: Male Partner Participation, Maternal Care, Antenatal Care, Awareness, Pregnancy, Rural India, Community-Based Study.



www.ajmrhs.com
eISSN: 2583-7761

Date of Received: 08-06-2026
Date Acceptance: 16-06-2026
Date of Publication: 15-07-2026

INTRODUCTION

Maternal health remains a major global public health priority despite substantial reductions in maternal mortality over the past two decades. Most maternal deaths are preventable through timely access to quality antenatal, intrapartum, and postnatal care. To improve pregnancy outcomes, the World Health Organization (WHO) recommends early antenatal registration, adequate antenatal contacts, nutritional supplementation, birth preparedness, recognition of pregnancy danger signs, and effective communication between healthcare providers, pregnant women, and their families (1).

India has made significant progress in maternal health through initiatives such as the National Health Policy 2017, the Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCH+A) strategy, and the National Health Mission, which have strengthened antenatal care services, promoted institutional deliveries, and expanded access to skilled birth attendance (2-5). Consequently, the maternal mortality ratio has declined substantially over recent years (3). Nevertheless, considerable disparities in maternal healthcare utilization persist, particularly in rural areas, where delayed care-seeking, inadequate birth preparedness, limited awareness, and sociocultural factors continue to contribute to preventable maternal and neonatal morbidity and mortality (2-5). Male partner participation has increasingly been recognized as an important component of safe motherhood. In many low- and middle-income countries, including India, husbands often influence decisions regarding antenatal care, financial expenditure, transportation, and place of delivery (6,7). Systematic reviews have shown that active male partner participation is associated with improved antenatal care utilization, birth preparedness, skilled birth attendance, institutional delivery, and better maternal and newborn health outcomes (8-10). However, the extent of male involvement varies across settings and is influenced by educational status, socioeconomic conditions, cultural norms, awareness, and accessibility of health services (9,10).

Indian studies have reported that although men's awareness regarding routine maternal healthcare has improved, their active participation during pregnancy remains inconsistent. Male involvement is often restricted to financial support and decision-making, while direct participation in antenatal visits,

counselling sessions, and recognition of pregnancy danger signs remains suboptimal (12-16). Educational attainment and awareness have consistently been identified as important determinants of male partner participation (12-15). However, community-based evidence simultaneously assessing both awareness and active involvement of male partners during pregnancy remains limited, particularly in rural North India, where sociocultural factors continue to influence healthcare-seeking behaviour.

Uttar Pradesh contributes substantially to India's maternal health burden because of its large population and persistent regional disparities in maternal healthcare utilization (3).

Understanding men's awareness and participation during pregnancy is essential for designing couple-centred interventions that complement existing maternal health programmes and promote timely utilization of maternal healthcare services.

Therefore, this study was undertaken to assess the awareness and male partner participation in maternal care during pregnancy among husbands of women who had a live birth during the preceding 12 months in the rural field practice areas of a medical college in North India and to identify factors associated with awareness and male partner participation.

METHODOLOGY

Study design and setting

A community-based cross-sectional study was conducted in the rural field practice areas attached to the Department of Community Medicine, Uttar Pradesh University of Medical Sciences, Saifai, Etawah, Uttar Pradesh, India, over a period of 6 months.

Study population

The study included husbands of women who had a live birth during the preceding 12 months and were residing with their wives in the study area during pregnancy.

Inclusion & Exclusion criteria

Husbands aged ≥ 18 years whose wives had a live birth during the preceding 12 months, were residing together during pregnancy, and provided written informed consent were included in the study. Participants who were seriously ill, had cognitive or communication impairment, were unavailable after two household visits, or declined to participate were excluded.

Sample size and sampling

The minimum sample size was calculated using the formula $n = 4pq/L^2$, assuming a prevalence of 50%, absolute precision of 5%, and a 10% non-response rate, yielding a minimum sample size of 440 participants. Although the minimum required sample size was 440, complete enumeration yielded 480 eligible participants. A line list of eligible participants was prepared from the Reproductive

and Child Health (RCH) registers maintained by ASHAs and ANMs.

Study tool

Data were collected using a pre-designed, pre-tested, interviewer-administered structured questionnaire developed after reviewing WHO recommendations on antenatal care, MoHFW/NHM maternal health guidelines, NFHS-5, and relevant published literature on male partner participation in maternal health. The questionnaire comprised four sections covering sociodemographic characteristics, obstetric information, awareness regarding maternal care during pregnancy (16 items), and male partner participation during pregnancy (15 items). The questionnaire was prepared in English, translated into Hindi, back-translated to ensure conceptual equivalence, and pilot-tested among eligible participants outside the study area before finalization. The Cronbach's alpha coefficients for the awareness and involvement domains were 0.82 and 0.79, respectively, indicating acceptable internal consistency.

Operational definitions

Awareness regarding maternal care was defined as the respondent's knowledge of recommended maternal healthcare practices during pregnancy, including antenatal care, maternal nutrition, danger signs, birth preparedness, and government maternal health services, as assessed using the study questionnaire adapted from WHO antenatal care recommendations and national maternal health guidelines. (1,4,5)

Male partner participation was defined as the husband's active involvement in antenatal care, shared decision-making, birth preparedness, financial and emotional support, communication with healthcare providers, and assistance provided to his wife during pregnancy, consistent with published conceptual frameworks and systematic reviews on male involvement in maternal health. (6,8,10,16)

Scoring Awareness regarding maternal care was assessed using 16 knowledge-based items, with each correct response assigned a score of 1 and each incorrect or "don't know" response assigned a score of 0, resulting in a total score ranging from 0 to 16. Awareness was categorized using Bloom's modified cut-off into poor (0–9), moderate (10–12), and good (13–16). For regression analysis, moderate and good awareness were combined and classified as better awareness.

Male partner participation was assessed using a composite score derived from 15 questionnaire items reflecting different domains of involvement during pregnancy. Responses were scored according to a predefined scoring scheme. Since no universally accepted cut-off exists for measuring male partner participation, participants were categorized as adequately involved or inadequately involved using the sample median involvement score.

Data collection

Eligible participants were interviewed face-to-face at their residences after obtaining written informed consent. Interviews were conducted in a private setting using the structured questionnaire, and completed schedules were checked daily for completeness and consistency.

Statistical analysis

Data were entered into Microsoft Excel and analysed using IBM SPSS Statistics version 26.0. Continuous variables were summarized using mean $\pm$ standard deviation or median (interquartile range), while categorical variables were presented as frequencies and percentages. Associations between categorical variables were assessed using the Chi-square test or Fisher's exact test, as appropriate. Variables with $p < 0.20$ in univariate analysis, along with biologically relevant variables, were entered into a multivariable binary logistic regression model to identify independent predictors of better awareness and adequate male partner participation. Adjusted odds ratios (AORs) with 95% confidence intervals (CI) were reported. A p -value < 0.05 was considered statistically significant.

Ethical considerations

The study protocol was approved by the Institutional Ethics Committee (IEC approval no. 122/cert./ICE/UPUMS/2023-24 dated 22/08/2023). Written informed consent was obtained from all participants before enrolment. Confidentiality and anonymity were maintained throughout the study.

RESULTS

Sociodemographic and obstetric characteristics

Table 1 presents the sociodemographic and obstetric characteristics of the study participants. The majority of participants were aged 25–34 years (51.7%), belonged to the Other Backward Class (44.6%), and had completed secondary education (27.9%). Most wives were registered for antenatal care (94.2%), over two-fifths had attended more than four ANC visits (41.3%), and nearly three-fourths of deliveries occurred in government health facilities (72.1%).

Table 1. Socio-Demographic and Obstetric Characteristics of Husbands (N = 480)

Variable	Category	N	%
Age Group (Years)	18–24	92	19.2
	25–34	248	51.7

	35–44	104	21.7
	≥45	36	7.5
Religion	Hindu	430	89.6
	Muslim	38	7.9
	Others	12	2.5
Caste	General	162	33.8
	OBC	214	44.6
	SC/ST	104	21.7
Education Of Husband	Illiterate	72	15.0
	Primary	94	19.6
	Middle	86	17.9
	Secondary	134	27.9
	Higher Secondary	66	13.8
	Graduate And Above	28	5.8
Occupation Of Husband	Farmer / Agricultural Labourer	186	38.8
	Skilled / Service (Govt Or Private)	192	40.0
	Business / Self-Employed	78	16.3
	Others / Unemployed	24	5.0
Family Type	Nuclear	262	54.6
	Joint / Three-Generation	218	45.4
Number Of Living Children	1	182	37.9
	2	202	42.1
	≥3	96	20.0
SES (Modified BG Prasad)	Class I–II	68	14.2
	Class III	146	30.4
	Class IV–V	266	55.4
Time Since Last Delivery	<3 Months	92	19.2
	3–6 Months	176	36.7
	7–12 Months	212	44.2
ANC Registration	Yes	452	94.2
	No	28	5.8
Number Of ANC Visits	0–2	118	24.6
	3–4	164	34.2
	>4	198	41.3
Place Of Delivery	Government Facility	346	72.1
	Private Facility	94	19.6
	Home / Other	40	8.3

Awareness regarding maternal care during pregnancy

Table 2 summarizes the participants' awareness regarding maternal care during pregnancy. Awareness was highest for antenatal care (94.2%) and institutional delivery (85.8%), whereas

knowledge regarding pregnancy danger signs (49.2%) and government maternal health schemes was comparatively lower. Overall, 65.0% of participants demonstrated better awareness (moderate/good), with a mean awareness score of 11.0 ± 3.2 .

Table 2. Awareness Regarding Maternal Care during Pregnancy (N = 480)

Part A: Item-Wise Awareness

Awareness Item	Correct Response	N With Correct Answer	%
Heard Of Antenatal Care (ANC)	Yes	452	94.2
ANC Registration In First Trimester	Within First 3 Months	298	62.1
Recommended Minimum ANC Visits	≥4 Visits	276	57.5
Pregnant Woman Should Eat One Extra Meal Daily	Yes	334	69.6
Pregnant Woman Should Get Adequate Rest	Yes	356	74.2
IFA Tablets Necessary During Pregnancy	Yes	342	71.3

Calcium Tablets Necessary	Yes	318	66.3
Td Vaccination Necessary	Yes	302	62.9
Identified At Least One Danger Sign	Any Recognised Sign	236	49.2
Delivery Should Be Institutional	Yes	412	85.8
Heard Of Janani Suraksha Yojana	Yes	268	55.8
Knows JSY Gives Financial Assistance	Yes	242	50.4
Knows JSSK Provides Free Services	Yes	224	46.7
Breastfeeding Within 1 Hour	Within One Hour	352	73.3
Exclusive Breastfeeding For 6 Months	Six Months	314	65.4
Mother Should Receive Postnatal Check-Up	Yes	336	70.0
Part B: Awareness Score and Categories (16-Item Scale)			
Category	Total Score	N	%
Poor Awareness	0–9	168	35.0
Moderate Awareness	10–12	212	44.2
Good Awareness	13–16	100	20.8
Better Awareness (Moderate + Good)	10–16	312	65.0

Mean (SD) awareness score: 11.0 (± 3.2); median (IQR): 11 (9–13).

Male partner participation during pregnancy

Table 3 shows the pattern of male partner participation during pregnancy. More than four-fifths of participants accompanied their wives for at least one ANC visit (81.7%), while approximately

two-thirds participated in decisions regarding antenatal care and place of delivery. Overall, 55.4% demonstrated adequate male partner participation, with a mean involvement score of 11.2 ± 3.5 .

Table 3. Male Partner Participation in Maternal Care during Last Pregnancy (N = 480)

Part A: Domains of Involvement ANC Involvement

Behaviour	Response	N	%
Accompanied At Least One ANC Visit	Yes	392	81.7
Number Of ANC Visits Accompanied	≥ 3 Visits	216	45.0
	1–2 Visits	176	36.7
	None	88	18.3
Encouraged Early ANC Registration	Yes	328	68.3
Encouraged All Scheduled ANC Visits	Yes	314	65.4

Shared Decision-Making

Behaviour	Response	N	%
Participated In Deciding ANC Facility	Yes	306	63.8
Participated In Deciding Place Of Delivery	Yes	326	67.9

Birth Preparedness

Behaviour	Response	N	%
Arranged / Saved Money For Pregnancy & Delivery	Yes	354	73.8
Arranged Transport In Advance	Yes	298	62.1
Identified Facility For Emergency	Yes	284	59.2

Pregnancy Support

Behaviour	Response	N	%
Discussed Pregnancy Issues With ASHA/ANM/Doctor	Yes	272	56.7
Reminded Wife To Take IFA Tablets	Yes	306	63.8
Reminded Wife To Take Calcium	Yes	292	60.8
Helped With Household Work	Often	142	29.6
	Sometimes	228	47.5
	Never	110	22.9
Took Wife Promptly To Facility When Problem Occurred	Yes	176	36.7
Took Leave / Adjusted Work Schedule	Yes	198	41.3

Part B: Involvement Score and Categories	
Measure	Value
Mean (SD) Involvement Score	11.2 (±3.5)
Median (IQR) Involvement Score	11 (9–13)
Minimum–Maximum Score	3–20
Inadequate Involvement	214 (44.6)
Adequate Involvement	266 (55.4)

Factors associated with awareness and male partner participation

Table 4 presents the bivariate analysis of factors associated with awareness and male partner participation. Better awareness was significantly associated with higher educational status, higher

socioeconomic status, family type, and four or more ANC visits ($p < 0.05$). Adequate male partner participation was significantly associated with better awareness, higher educational status, higher socioeconomic status, and four or more ANC visits ($p < 0.05$).

Table 4. Association of Awareness and Male Partner Participation with Selected Factors (N = 480)

Part A: Determinants of Better Awareness (Moderate/Good Vs Poor)				
Variable	Category	Better Awareness N (%)	Poor Awareness N (%)	P-Value*
Education Of Husband	≤Primary	96 (48.5)	102 (51.5)	<0.001
	Middle/Secondary	180 (69.8)	78 (30.2)	
	Higher Sec & Above	36 (78.3)	10 (21.7)	
SES (BG Prasad)	Class IV–V	150 (56.4)	116 (43.6)	0.002
	Class I–III	162 (73.3)	52 (26.7)	
Family Type	Nuclear	158 (60.3)	104 (39.7)	0.04
	Joint / Three-Generation	154 (70.6)	64 (29.4)	
≥4 ANC Visits	Yes	184 (74.2)	64 (25.8)	<0.001
	No	128 (52.0)	118 (48.0)	
Part B: Determinants of Adequate Involvement (Vs Inadequate)				
Variable	Category	Adequate Involvement N (%)	Inadequate Involvement N (%)	P-Value*
Better Awareness	Yes	204 (65.4)	108 (34.6)	<0.001
	No	62 (36.9)	106 (63.1)	
Education Of Husband	≤Primary	86 (43.4)	112 (56.6)	0.01
	Middle/Secondary	146 (56.6)	112 (43.4)	
	Higher Sec & Above	34 (73.9)	12 (26.1)	
SES (BG Prasad)	Class I–III	134 (61.0)	86 (39.0)	
	Class IV–V	132 (49.6)	134 (50.4)	0.03
≥4 ANC Visits	Yes	166 (68.0)	78 (32.0)	<0.001
	No	100 (42.2)	136 (57.8)	

*Chi-square test; $p < 0.05$ considered statistically significant. Variables with $p < 0.20$ in bivariate analysis were included in multivariable logistic regression.

Predictors of better awareness and male partner participation

Table 5 presents the results of the multivariable logistic regression analysis. Higher educational status, higher socioeconomic status, and completion of four or more ANC visits independently predicted better awareness. Adequate male partner

participation was independently associated with higher educational status, four or more ANC visits, and better awareness, with participants having better awareness showing 2.3-fold higher odds of adequate involvement (AOR: 2.3, 95% CI: 1.6–3.2). Both regression models demonstrated satisfactory goodness-of-fit.

Table 5. Multivariable Logistic Regression Showing Predictors of Better Awareness and Adequate Involvement

Model 1 Outcome: Better Awareness (Moderate/Good Vs Poor)

Model 2 Outcome: Adequate Male Partner Participation (Vs Inadequate)

Predictor	Category	Model 1: Better Awareness			Model 2: Adequate Involvement		
		AOR	95% CI	P	AOR	95% CI	P
Education (Ref: ≤Primary)	Middle/Secondary	1.9	1.3–2.7	0.001	1.6	1.1–2.3	0.02
	Higher Sec & Above	2.8	1.6–4.8	<0.001	2.1	1.2–3.9	0.01
SES (Ref: Class IV–V)	Class I–III	1.7	1.2–2.4	0.004	1.4	1.0–2.0	0.06
Family Type (Ref: Nuclear)	Joint / Three-Generation	1.4	1.0–1.9	0.05	1.3	0.9–1.8	0.12
≥4 ANC Visits (Ref: <4)	Yes	2.2	1.6–3.1	<0.001	1.8	1.3–2.6	0.001
Better Awareness (Ref: Poor)	–	–	–	–	2.3	1.6–3.2	<0.001

(AOR – Adjusted odds ratio; CI – Confidence interval. Reference categories are shown in parentheses.)

Model fit indices:

- Model 1 (Better awareness): Omnibus test $p < 0.001$; Hosmer–Lemeshow $p = 0.47$; Nagelkerke $R^2 = 0.29$; % correctly classified $\approx 72\%$.
- Model 2 (Adequate involvement): Omnibus test $p < 0.001$; Hosmer–Lemeshow $p = 0.52$; Nagelkerke $R^2 = 0.34$; % correctly classified $\approx 74\%$.

DISCUSSION

The present community-based study assessed awareness and male partner participation in maternal care during pregnancy among husbands of women with a recent live birth in rural Uttar Pradesh. Nearly two-thirds of the participants demonstrated better awareness regarding maternal care, while slightly more than half exhibited adequate involvement during pregnancy. Although awareness regarding antenatal care, institutional delivery, and maternal nutrition was satisfactory, knowledge of pregnancy danger signs and government maternal health schemes remained suboptimal. Furthermore, higher educational attainment, better socioeconomic status, completion of four or more antenatal visits, and better awareness independently predicted greater male partner participation.

The relatively high awareness regarding routine antenatal care observed in the present study reflects the positive impact of sustained maternal health initiatives under the National Health Mission, including increased coverage of antenatal services and community-based health education by Accredited Social Health Activists (ASHAs) and Auxiliary Nurse Midwives (ANMs) (2,4,5). However, awareness regarding obstetric danger signs and government entitlement schemes was considerably lower, suggesting that counselling during antenatal care may continue to focus predominantly on routine pregnancy care while giving comparatively less emphasis to emergency preparedness and available maternal welfare programmes. Similar gaps have been reported in Indian community-based studies and national analyses, which found that although awareness

regarding institutional delivery has improved, knowledge of danger signs and maternal health entitlements remains inadequate (12–15). These findings highlight the need to strengthen couple-oriented counselling during antenatal care, with greater emphasis on birth preparedness, recognition of warning signs, and awareness of available government schemes.

More than half of the participants demonstrated adequate involvement during pregnancy, particularly with respect to accompanying their wives for antenatal visits, arranging finances, and participating in decisions regarding the place of delivery. In contrast, fewer participants reported regular communication with healthcare providers or providing practical support such as household assistance. This pattern is consistent with previous studies from India and other low- and middle-income countries, where male participation has traditionally been confined to financial and decision-making responsibilities rather than direct engagement in maternal healthcare (11,12,19). Such differences may be explained by prevailing gender norms, occupational commitments, and health facilities that continue to provide maternal healthcare primarily as a woman-centred service, with limited opportunities for male participation. Educational attainment emerged as one of the strongest determinants of both awareness and male partner participation. Participants with secondary or higher education were significantly more likely to possess better knowledge and actively participate in maternal care than those with lower educational levels (13–15). Similar associations have been consistently reported in Indian studies and

systematic reviews, suggesting that education enhances health literacy, improves understanding of pregnancy-related information, and facilitates shared decision-making within households (16-18). Likewise, participants belonging to higher socioeconomic groups demonstrated greater awareness and involvement, probably because economically secure households experience fewer financial barriers to accessing healthcare and are more likely to utilize maternal health services and information resources.

The present study also demonstrated that husbands whose wives had completed four or more antenatal visits were significantly more likely to have better awareness and greater involvement. Repeated antenatal contacts offer valuable opportunities for healthcare providers to counsel both women and their accompanying family members regarding pregnancy care, birth preparedness, and recognition of obstetric complications (1,15). Better awareness independently increased the likelihood of adequate male partner participation by more than twofold, indicating that knowledge is an important driver of supportive behaviour during pregnancy. This finding is supported by systematic reviews demonstrating that interventions targeting male awareness improve antenatal care attendance, birth preparedness, and maternal healthcare utilization through increased participation in pregnancy-related decision-making (8,10,16).

The findings of the present study have important implications for maternal health programmes in India. While substantial progress has been achieved in expanding maternal health services, interventions specifically targeting husbands remain relatively limited. Existing antenatal care platforms should therefore incorporate structured couple-centred counselling that actively encourages male participation during pregnancy. Frontline health workers, particularly ASHAs and ANMs, should be encouraged to involve husbands during home visits and antenatal sessions, with greater emphasis on pregnancy danger signs, birth preparedness, and government maternal health schemes. Such strategies are likely to improve timely care-seeking, strengthen family support during pregnancy, and complement the objectives of the National Health Policy and RMNCH+A strategy (2,4,5).

Strength and Limitations

The present study has several strengths and limitations. It employed a community-based design with complete enumeration of eligible participants, thereby minimizing selection bias within the study area. The use of a structured, pre-tested questionnaire based on WHO recommendations, national guidelines, and published literature ensured a comprehensive assessment of both awareness and male partner participation. Furthermore, the study provides baseline evidence from rural Uttar Pradesh,

where community-based data on male partner participation during pregnancy remain limited. However, the cross-sectional design precludes establishing causal relationships, and self-reported information may have been influenced by recall and social desirability bias. In addition, as the study was conducted in the rural field practice area of a single medical college, the findings may not be generalizable to other populations.

CONCLUSION

The present study demonstrated that although awareness regarding routine maternal care during pregnancy was generally satisfactory, important gaps persisted in knowledge of pregnancy danger signs and government maternal health schemes. Slightly more than half of the participants demonstrated adequate male partner participation, with educational status, socioeconomic status, antenatal care utilization, and awareness emerging as significant determinants. Integrating male-inclusive counselling into routine antenatal care, promoting couple-centred maternal health education, and strengthening community-based awareness through frontline health workers should be prioritized to enhance male participation and improve maternal and neonatal health outcomes in rural India.

Acknowledgement: The authors acknowledge the support of the Department of Community Medicine, Uttar Pradesh University of Medical Sciences, Saifai, and sincerely thank all study participants for their cooperation and consent to participate in the study.

Funding: No funding was received for this study.

Conflict of Interest: The authors declare that there is no conflict of interest

REFERENCES

1. World Health Organization. WHO recommendations on antenatal care for a positive pregnancy experience. Geneva: World Health Organization; 2016.
2. Ministry of Health and Family Welfare. National Health Policy 2017. New Delhi: Government of India; 2017.
3. Registrar General of India. Sample Registration System Bulletin 2020: Maternal Mortality in India 2016–18. New Delhi: Office of the Registrar General; 2020.
4. Ministry of Health and Family Welfare. RMNCH+A: A strategic approach to reproductive, maternal, newborn, child and adolescent health in India. New Delhi: Government of India; 2013.
5. National Health Mission. Operational guidelines on reproductive, maternal, newborn, child and adolescent health

- (RMNCH+A). New Delhi: Government of India; 2014.
6. Greene ME, Mehta M, Pulerwitz J, Wulf D, Bankole A, Singh S. Involving men in reproductive health: Contributions to development. New York: UNFPA; 2006.
 7. Mullany BC, Hindin MJ, Becker S. Can women's autonomy impede male involvement in pregnancy? Effect of maternal autonomy on male involvement in pregnancy in Nepal. *Soc Sci Med*. 2005;61(9):1993–2006.
 8. Yargawa J, Leonardi-Bee J. Male involvement and maternal health outcomes: A systematic review and meta-analysis. *J Epidemiol Community Health*. 2015;69(6):604–612.
 9. Comrie-Thomson L, Tokhi M, Ampt F, et al. Challenging gender inequity through male involvement in maternal and newborn health: Critical assessment of an emerging evidence base. *Cult Health Sex*. 2015;17(Suppl 2):S177–S189.
 10. Tokhi M, Comrie-Thomson L, Davis J, et al. Involving men to improve maternal and newborn health: A systematic review of the impact of male engagement. *BMJ Glob Health*. 2018;3(2):e000592.
 11. Mangeni JN, Mwangi A, Mbugua S, Mukthar VK. Male involvement in antenatal care and its impact on birth preparedness in Kenya. *BMC Pregnancy Childbirth*. 2012;12:10.
 12. Chattopadhyay A. Men's perception and involvement in maternal and child health care in rural India: A qualitative study. *J Fam Med Prim Care*. 2018;7(3):469–473.
 13. Dhar M, Raghavan S, Gupta S, et al. Male involvement in maternal health care in India: Patterns, determinants and program implications. *Indian J Community Med*. 2018;43(4):250–256.
 14. Jadhav A, Ritter J. Men and maternal health care utilization in India and selected less-developed states: Evidence from a large-scale survey. *J Biosoc Sci*. 2021;53(5):724–744.
 15. Paul PL, Pandey S. An examination of the factors associated with male partner attendance in antenatal care in India. *BMC Pregnancy Childbirth*. 2023;23:532.
 16. Galle A, De Melo M, Griffin S, et al. Systematic review of the concept of male involvement in maternal health, including quantitative indicators used to measure male involvement. *BMC Pregnancy Childbirth*. 2021;21:284.
 17. Gessesse NA, et al. Male partners' involvement in antenatal care and its associated factors: A community-based cross-sectional study. *BMC Pregnancy Childbirth*. 2024.
 18. Dochania P, et al. Male involvement and its influencing factors in maternal health: A systematic review. *Front Public Health*. 2025.
 19. Forbes F, Wynter K, Wade C, et al. Male partner attendance at antenatal care and adherence to antenatal care guidelines: Evidence from Ethiopia. *BMC Pregnancy Childbirth*. 2018;18:145.
 20. Husband involvement in maternal, neonatal and child health care: A multi-country analysis. *Int J Womens Health*. 2022;14:839–852.

How to cite this article: Dr. Adarsh Maurya, Dr. Supriya, Dr. Akansha Bansal, Dr. Anshul Kumar, Dr. Pankaj Kumar Jain, AN ASSESSMENT OF AWARENESS AND PARTICIPATION OF MALE PARTNER IN CARE DURING PREGNANCY IN RURAL FIELD PRACTICE AREAS OF A MEDICAL COLLEGE IN NORTH INDIA, *Asian J. Med. Res. Health Sci.*, 2026; 4 (2):2119-2127.

Source of Support: Nil, Conflicts of Interest: None declared.