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MALE PARTNER INVOLVEMENT IN MATERNAL HEALTH CARE: A STUDY IN THE NANDOM DISTRICT OF THE UPPER WEST REGION-GHANA

BY

FRANK DOMAH

(10635149)

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DECLARATION

I, Frank Domah, declare that except for references to other people's work which have been duly acknowledged, this piece of work is my own composition and neither in whole nor in part has this work been presented for the award of a degree in this university or elsewhere.

SIGNATURE..... DATE……

DOMAH FRANK

(MPH CANDIDATE)

SIGNATURE..... DATE……

DR. PRISCILLIA NORTEY

(ACADEMIC SUPERVISOR)

DEDICATION

Dedicated to my late mum,

Catherine Bedere

And to my precious and loving son,

Captain Asuadoba Macario Nuoire Domah NAAB,

And to my sweet heart,
Modesta Kafari
I truly love you

GOD IS KING AND MIGHTY

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ABSTRACT

Background: Male partners play a critical and impactful roles in Reproductive Health(RH),and are gradually being incorporated into Family Planning(FP) programs, maternal Healthcare and HIV/AIDS" prevention programs, and in the effort to achieve Ghana's SDG 3 by 2030. For the very few men who would want to be involved in maternal healthcare, existing situations (congestion in hospitals, attitude of health workers, socioeconomic restraints) militate against their full participation. This study was conducted to assess factors influencing male involvement in ANC in the Nandom district.

Methods: A cross sectional study design- mix method involving 395 male respondents who are aged 18 years and above, whose partners have ever attended or attend ANC in the Nandom district. Data was obtained via administered questionnaires and analyzed using STATA version 15.The qualitative study involved FGDS via a guide with probes. Logistic regression was ran to assess the predictors of male ANC attendance in the Nandom district. All statistical tests will be two-sided and considered significant at $p<0.05$.

Results: Majority (92.4%) of the respondents had accompanied their partners to ANC clinics, with an average attendance of 5 times. This was largely due to the CHPS concept of health, their faith and agreed deterring community norms regarding ANC. Predictors of male partner involvement in ANC in the multivariable analysis were predisposing factors (age, education level, marital status, religion, residence and parity), enabling factors (distance, means of accessing ANC, time and staff attitude at ANC, and community acceptability) and reinforcing factors (knowledge, ANC discussion with partner, men who accompany partners to ANC). Consequently, the study found a significant association between the amount spent on transportation

(p<0.001), distance to the ANC center *(p<0.001),* respondents' views about ANC services *(p<0.001)* and male partner participation in ANC.

Conclusion: The study results have greater implications for public health policy formulation and implementation due to the 92.4% ANC attendance in the Nandom District-largely as a result of the punitive or deterrent measures adopted by the community. In addition, the distance, and high transport fares to ANC and PNC were highly associated to the outcome.

ABBREVATIONS

AIDS	-	Acquired Immunodeficiency Syndrome
ANC	-	Antenatal Care
AOR	-	Adjusted Odd's Ratio
CHAG	-	Christian Health Association of Ghana
CHRPE	-	Committee on Human Research, Publication and Ethics
ENT	-	Ear Nose and Throat
GDHS	-	Ghana Demographic Health Survey
GHS	-	Ghana Health Service
GSS	-	Ghana Statistical Service
HIV	-	Human Immunodeficiency Virus
ICPD	-	International Conference on Population and Development
IPPF	-	International Planned Parenthood Federation
MCH	-	Mother and Child Hospital
MDG	-	Millennium Development Goals
MDHS	-	Malawi Demographic and Health Survey
MHS	-	Malawian Health Survey
MMR	-	Maternal Mortality Ratio
NDCH	-	Nandom District Catholic Hospital
NDHD	-	Nandom District Health Directorate
NGO	-	Non-Governmental Organization
PNC	-	Post-Natal Care
RH	-	Reproductive Health
STIs	-	Sexually Transmitted Infections
UNFPA	-	United Nations Population Fund
UNICEF	-	United Nations Children's Fund
FBO	-	Faith Based Organization
MPI	-	Male Partner Involvement
NRB	-	Nandom Rural Bank
SDGs	-	Sustainable Development Goals

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CHAPTER ONE

INTRODUCTION

1.1 Background

Men in the past years were seen as barriers and not as part of a remedy in antenatal and postnatal care services (Ntabona, 2002). Critical interventions and services to promote sexual and reproductive health, including care during pregnancy, child birth and the postpartum have been largely focused on women.

Women are often the sole recipients of Reproductive Health (RH) services such as Family Planning, Abortion, Sexually Transmitted Infections and management of infertility services among others. Pregnancy and childbirth are reproductive functions of women essential for the survival of our species but often accompanied by potential risks that women should be protected from (Nyane, 2007). This responsibility calls for a holistic involvement of the entire family notably: the husband, the community and the state.

There has been increasing recognition on a global scale that involvement of men in reproductive health policy and service delivery offers both men and women important benefits (Naomi, 2005). The International Conference on Population and Development (ICPD) in Cairo 1994 was the turning point in recognizing the critical role of men in RH. In addition, men's reproductive responsibilities received global attention at the ICPD and the Fourth Conference of Women in Beijing in 1995(WHO, 2001). Resolutions of both meetings advocated for men's shared responsibility, promotion of their active involvement in responsible parenthood, and reproductive and sexual health behavior (WHO, 2001). Family planning policies were to be more extensive- including prevention and treatment of sexually transmitted infections and to equally attend to the needs of adolescents, men and the unmarried woman (Hansen

2006). Moreover, the function or role of men in reproductive health was to be elaborated in three (3) different levels: Men seen as clients, men as partners and men as agents of positive change. Following the efforts by the ICPD, there has been a number of attempts to further help the need to actively involve men in various RH issues (Dewi 2009). Towards the end of the 1980s, women's empowerment approach became an important driving force within health promotion and, more particularly, within sexual health promotion (Stein, 1997). Greater male involvement in maternal health programmes may help to reduce unwanted pregnancies and transmissions of sexually transmitted infections (STIs), as well as improve child survivals (WHO, 2004.).

The introduction of the Safe Motherhood Initiative (SMI) which was initiated in 1987 had little effect on maternal and child mortality which remained the human development indicator showing the widest disparity between rich and poor nations, with the life time risk of a woman dying from causes related to pregnancy and child birth nearly 40 times higher in developing than in developed countries (World Health Organization and UNICEF 1996). Gender norms greatly or enormously influence access to Reproductive Health (RH) services and health seeking behavior. Many of the global reproductive health programs in developing countries involve education of women on issues concerning maternal health care and Family Planning (FP) (WHO, 2004). In many of these societies however, it is the male partner who wields decision-making power in the relationship including when to have children, when to seek health care, or whether protection will be used during sex (EH/MP, 2011). Male partners thus play a critical role in reproductive health and are gradually being incorporated into FP programs, maternal care and HIV/AID‟S prevention programs.

In Sub-Saharan Africa, male accompanying partners to attend ANC or the post-natal is rare and in many African communities it is unthinkable to find male partners accompanying the pregnant woman to the labour room (Babalola et al, 2009). The shortages of skilled health workers and equipped facilities, and the often-unequal distribution of existing health resources, also create barriers to care for large segments of the population. The situation in Ghana is similar to what pertains in other African countries. A detailed observation at ANC and post-natal attendance in any government health facility shows mostly women in attendance. Apart from male health workers who are usually present if on duty at ANC clinics, very few men normally would accompany their partners for ANC, in Ghana. The slow progress in reducing maternal mortality is partly a result of low male involvement in maternal health services and in some cases where services exist, some husbands have reportedly denied their wives to seek maternal health services. Research has showed that sometimes, men not only acted as gate keepers who restricted women and children's access to health services, but also through abuse or neglect, man's actions had direct effects on the health of their partners and their children (Gallen et al., 1986). The failure to incorporate men in maternal health promotion, prevention and care programmes by policy makers, programme planners and implementers of maternal health services in Sub-Saharan countries have had a serious impact on the health of women, and success of the programmes (Greene et al., 2004).

Some of the reasons for the high proportion of males in ANC attendance were disclosed through the focus group discussions held with participants. It was revealed that most of the communities had instituted strict, deterring and punitive measures which made ANC visits mandatory-for a man to accompany the partner to the health center when pregnant. This may have been influenced by the Twenty Ghana cedis

(Ghc20) fine paid by the household or partner to the Chief, into designated bank account. The said money when amassed was used as an emergency and revolving loan scheme to expectant mothers, especially in times of need. Again, the household was taxed if the pregnant women defaulted deliberately on her monthly ANC visits.

It is in this light that the study identified the factors that are associated with male partner involvement in maternal health services in the Nandom District.

1.2 Problem Statement

Ghana is a patriarchal country and where issues surrounding pregnancy and child birth are largely seen as a domain of women. Men to a large extent are considered as leaders and decision makers at households and policy level (WHO, 2001). Additionally, division of responsibilities are drawn on the basis of gender which favors men and eventually makes them dominant in decision making process at household level, leaving women with little or no say in matters that affect their reproductive life (WHO, 2001). The majority of reproductive health services in developing countries that promote sexual and reproductive health including care, support during pregnancy and childbirth mostly are focused on women (Ntabona, 2002).

Advocating for men's involvement in reproductive health including care and support during pregnancy, and childbirth should not only be seen as rhetoric in health policies but rather implemented (WHO, 2001). Therefore, men participation in ANC results in a more humane comprehension between husband and wife, low unwanted pregnancies, and above all low maternal and child mortalities in connection with labour(that is by being prepared in obstetric emergencies).

Long working hours and difficulty in taking time off work to attend services were also cited as reasons why many men would be unable to participate in ANC care services in the study by Bulut and Molzan (1995). Male involvement in women's decision to attend ANC had been reported in some studies from Africa. For example, according to a study conducted in Kano Nigeria, 17.2 % of women did not attend regular ANC because of husband denial (Adamu and Salihu, 2002). This fact of male's affecting utilization of ANC and delivery care is supported by the findings of the study done by Nyane (2007) in Tororo, Uganda in which she observed that some pregnant women when asked to come with their partners during the next ANC visit dropped out. Although Ghana like many other African countries has adopted international treaties on Sexual and Reproductive health, the reproductive health status of the country is far from ideal. ANC attendance of at least four visits is 78.2% whilst at least one visit is 97% (GHS, GSS and Macro International, 2009) and maternal mortality ratio (MMR) still hovers at unacceptably high levels with different authorities quoting different figures, none reassuring. For 2007, the Ghana Health Service report gave an MMR of 230/100 000 live births, WHO country statistic estimates quoted 451/100 000 live births whilst the Ghana Maternal Health Survey gave an estimate of 580/100 000 live births. Infant mortality and under five mortality rates are 50 and 74 per 1000 live births respectively. This is in sharp contrast with a country such as Egypt which recorded an MMR of 59/100 000 live births in 2006 and infant mortality and under five mortality rates as 27 and 32 per 1000 live births respectively (Hogan et al, 2010).

The issue of male partner involvement need a great deal of attention, in order to come up with effective interventions and policies, which will aid reduce maternal mortality in developing countries, notably Ghana. Again, the WHO new ANC model suggested

that pregnant women should have a minimum of 8 ANC visits in other to improve fetal and maternal outcomes (Tuncalp et al., 2017). WHO projected that Ghana recorded over 800 institutional maternal deaths in 2009, thus impeding the country's efforts at achieving its SDG 3, (notably target 1 and 2). The Upper West region alone where Nandom district is situated had an estimated MMR of 520/100,000 Live Births, from 2005-2010(Joshua et., al, 2017). Again, the Nandom District is faced with problems of inadequate and aged midwives hence registered 51% first trimester ANC attendance, resulting in a recorded MMR of 161/100,000 Live Births in 2014,among the highest in the region (out of 11 districts)(Upper West Regional Health Services Annual Report, 2014). In addition, Nandom recorded 34% FP acceptance by Districts in Wa and possessed the least number of health facilities in the region (Upper West Regional Health Services Annual Report, 2014).

It is clear there is a teething problem as result; Nandom is ranked 9th District out of a total of 11 with the highest death rate of 18.11(average of 9.2), Institutional Neonatal Mortality is pecked at 7.9, with under 5 mortality as 5.9.Again Still birth is registered as 5.9, very high per its population dynamics as stated in previous chapters (First Quarter 2018 Health Service Performance Indicators League Feedback to Districts, Upper West HD, 2018). Therefor research in other areas as captured in this study, with men as agents of change is timely: implying male involvement in ANC is definitely a major remedy to achieving ideal MMRs, Neonatal mortality ratios and better pregnancy outcomes among other benefits. This study would identify the factors, which militate against male partner involvement in ANC attendance in the Nandom District of the Upper West region.

1.3 Justifications

The behaviour of men, their beliefs and attitudes affect the maternal health outcomes of women and their babies. The exclusion of men from maternal health care services could negatively affect the number of women seeking maternal health services and as a result worsen their maternal health outcomes. Increasingly, recognition is growing on a global scale that the involvement of men in reproductive health policy and service delivery offers both men and women important benefits (Walston, 2005). The slow progress in reducing maternal mortality is as a result of a number of factors including lack of maternal health services, and in some cases where services exist some husbands have been reported to refuse their wives to seek maternal health services (Conde-Agudelo and Belizán, 2000).

Globally, research done in many countries have reported cultural, social, economic factors, policy issues and communication issues as the factors influencing male partner continuous involvement. Identifying and overcoming these obstacles require working with women, young people and men especially to better understand their needs and analyze their problems and to propose acceptable solutions (WHO, 2004).

Comprehending the factors influencing male partner involvement in ANC, delivery and PNC in the Nandom district are vital in order for health service policy makers and managers to design and implement interventions that will encourage and maintain male continuous involvement which will considerably better maternal and child health outcomes.Favourable outcomes would enable Ghana attain its Sustainable Development Goals (SDGs), especially goal number 5 by the year 2030.

1.4 Research Questions

1. What are men's perceptions regarding male partner participation in Antenatal care (ANC) in the Nandom district?

2. What are the current levels of male partner participation in ANC in the Nandom District?
3. What are the predisposing, enabling, and reinforcing factors that affect male partner participation in ANC?
4. What specific strategies can be employed to aid improve male partner involvement in ANC in the Nandom district?

1.5 General Objective

To determine factors influencing male partner participation in ANC- in the Nandom district of the Upper West region.

1.5 Specific objectives

1. To examine the community's perceptions regarding male partner involvement in ANC attendance.
2. To assess the current level of male partner participation in ANC services in the Nandom district.
3. To identify the predisposing, enabling and reinforcing factors influencing male partner participation in ANC.

1.6 Conceptual Framework

The conceptual framework was adopted and modified from the PRECEED and PROCEED model and the Safe Motherhood and Partnership Family Approach used to assess men's participation in family planning in Indonesia, 2007. This model explains that male participation in reproductive health is influenced by predisposing factors (demographic characteristics), enabling factors and reinforcing factors. Green

et.al (2005) identified factors, which influence human health behaviour. This was grouped into predisposing, enabling and reinforcing factors. These factors have been modified over the years and are used in the PRECEED and PROCEED models created as a participatory model for community health promotion and other health interventions. The PRECEED model has been adapted and modified for this project as it seeks to identify factors that influence behaviour.

Predisposing factors are those characteristics that make an individual likely to adopt a particular lifestyle or behaviour. Anderson in 1995, described them as the socio-cultural characteristics of individuals that exist prior to their illness. These he grouped into demographic characteristics, health beliefs and social structure.

Enabling factors are the logistics aspect of obtaining healthcare. They are lifestyle/ behaviour, or not. Anderson used to enable factors to describe factors that determine use of health services (Green, 2005). He grouped these factors into two groups; community enabling resources (e.g., health personnel and facilities must be available), and personal/family enabling resources (e.g., people must know how to access and use the services and have the means to get to them).

Reinforcing factors are the positive or negative influences or feedback from others that encourage or discourage health-related behaviour change (Green, 2005). These factors come from the influential people around us- family, friends, peers, service providers, politicians etc. and they can encourage or discourage certain health related behaviour.

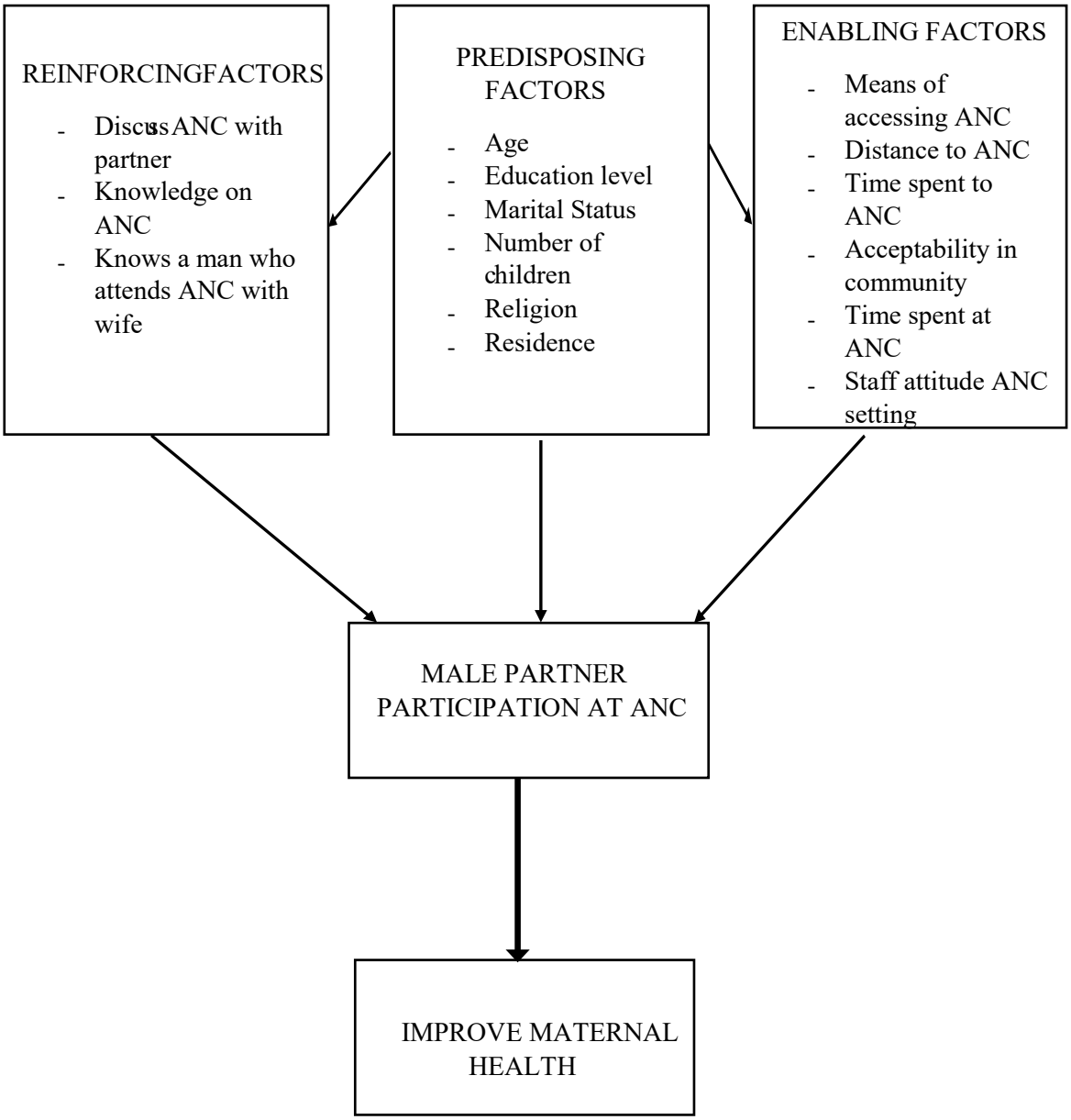

Figure 1. 1: Conceptual Framework of the study, modified from Green (2005)

1.8 Definition of terms

Antenatal Care:

Skilled care given to the pregnant woman before delivery

Delivery Care Services:

This is health care given to the pregnant or expectant mother after onset of labour until complete expulsion of the baby, placenta and membranes.

Male partner involvement in ANC:

Attendance to the ANC by male partner of the pregnant woman and exhibition of knowledge in danger signs of pregnancy, last menstrual period and postpartum contraception.

Maternal health services:

Maternal health services for purposes of this study refer to Antenatal (ANC), labour/delivery and post-natal care.

Postnatal care:

This is health care service given to the mother and the baby after childbirth or delivery up to the period of six (6) weeks

Knowledge of male spouses:

Refers to their total life experiences regarding maternal health and their involvement.

Perceptions of male partners:

Refers to their beliefs, thoughts, cognitive deductions regarding issues of maternal health and male partner involvement.

Focus Group Discussion Survey:

Refers to a qualitative type of obtaining data for possible transcription and coding for purposes of analysis and interpretation.

Focus Group Discussion Checklist:

Refers to a qualitative research tool, usually used for research.

CHAPTER TWO

LITERATURE REVIEW

2.0 Overview

The Safe Motherhood Initiative, launched in 1987 by WHO, UNICEF, UNFPA, the World Bank and other organizations placed maternal health at the forefront of international public health (Family Care International, 1997). Maternal health is the health of women during pregnancy, delivery, and the postpartum period (WHO). It entails and comprises the health care dimensions of family planning, preconception, ANC, and PNC in order to avert maternal and neonatal morbidity and mortality.

The aim of maternal health care services is to ensure that no woman or newborn dies or incurs injuries due to pregnancy and or childbirth. To achieve this aim, there was the need for maternal health service planners, service managers and providers to view maternal health services in the context that women's potential to control and improve their wealth as well as their health is more limited than men's in most parts of the world (Engender Health, 2008). This impedes women from patronizing salient health information and services and can lead to poor reproductive, maternal and child health outcomes, including unwanted infections and pregnancies. Due to men's great influence on women's health and their access to care, hence there is the need for male partner involvement in maternal health care services. This has become even more vital and critical in maternal health care delivery services. According to Adamehak and Adebayo (1997), in order to encourage improved reproductive health, emphasis need to be focused on the understanding of men's reproductive behaviour and the influence to their wives.

Although Ghana like many other African countries has adopted international treaties on Sexual and Reproductive health, the reproductive health status of the country is

far from ideal. ANC attendance of at least four visits is 78.2% whilst at least one visit is 97% (GHS, GSS and Macro International, 2009) and maternal mortality ratio (MMR) still hovers at unacceptably high levels with different authorities quoting different figures, none reassuring. For 2007, the Ghana Health

Service report gave an MMR of 230/100 000 live births, WHO country statistic estimates quoted

451/100 000 live births whilst the Ghana Maternal Health Survey gave an estimate of 580/100 000 live births. Infant mortality and under five mortality rates are 50 and 74 per 1000 live births respectively. This is in sharp contrast with a country such as Egypt which recorded an MMR of 59/100 000 live births in 2006 and infant mortality and under five mortality rates as 27 and 32 per 1000 live births respectively (Hogan et al, 2010).

In Ghana as in many other countries, programs on maternal health focus more on women than their male partners. The few programs that target men tend to focus more on use of condoms and treatment of sexually transmitted infections. However, men undoubtedly play critical and decisive roles in sexual and reproductive health. It can thus be inferred that their health seeking behaviours will either compliment or impede efforts aimed at reducing maternal mortality. Strategies geared at encouraging communities to participate in safe motherhood activities should take into account the need to involve men as well as appreciate the importance of the cultural and social aspects of making motherhood safe (Safe Motherhood Demonstration Project, 2004).

2.1 Male partner Involvement in Maternal Health Care Services

The International Conference on Population and Development 1994, defined Reproductive health as "a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and process. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when, and how often to do so. Implicit to this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health care services that will enable women to go safe through pregnancy and childbirth and provide couples with the best chance for having healthy infant" (ICPD Program of Action, Paragraph 7.2).

In relation to the above mentioned definition, it is apparent and vital that men as well as women play critical and pertinent roles in reproductive health. It is in view of this that the ICPD 1994 came out with a Plan of Action which specifically states: "Changes in both men's and women's knowledge, attitudes, and behaviour are necessary conditions for achieving a harmonious partnership of men and women. The role of men in Reproductive Health (RH) was to be expressed in three different levels:

- Men seen as clients: To extend the same range of RH services to both men and women and to employ more male Family Planning personnel.
- Men as partners: To recruit men as allies and resources in improving maternal health and

- Men as agents of positive change: To work with men as sexual partners, fathers and community leaders. It seeks to move towards gender equity by looking at the way service is delivered to serve the interest of both men and women (ICPD, 1994).

In her report on "The role of WHO in addressing inequities between women and men", the WHO Director General in 2005 stated the need "to involve the fathers and other male decision-makers as well" in attempts at Reducing child mortality and improving maternal health. Unfortunately, the role of male partners is still largely unknown and untapped in many regions around the globe (Dudgeon et al, 2004). Decades after the ICPD and the Beijing conference, the involvement of men in reproductive health exist as new concept in developing countries.

With global efforts aimed at attaining the Millennium Development Goals 4 and 5, there have been some attempts aimed at involving men on the continent in Sexual and Reproductive Health. Studies conducted in Lesotho and Uganda identified barriers such as traditional gender roles, fear of losing respect from their peers, lack of communication skills, lack of knowledge and strong perceptions about masculinity (IPPF, 2005). From these studies, it was found that purposeful or calculated attempts to reach men are very limited and still not given high priority neither by the local governments, donor agencies, NGO‟s nor researchers. Generally, men do not escort or follow their wives for ANC, postnatal care services and are not expected to be present during the delivery (of their children).

The husband is often the key and major decision maker, and wife's economic dependence on her husband gives him stronger authority or influence on major household decisions, as was reported in Nepal by Britta and others (2004) where 50%

of the women had the final decisions about their own health care made by their husbands (Nepal Demographic and Health Survey, 2001). Studies have suggested that male involvement in maternal health results into positive outcome for not only the pregnant woman but also for the unborn child. Reporting findings of their studies, Pagel et al (1990) and Mutale et al (1991) concluded that social support; especially from the husbands or family has positive effects on fetal growth. In most undeveloped and poorer countries many of which have a patriarchal society, increase in male involvement during pregnancy has been seen as a possible factor in reducing the number of children born with low birth weight (Mira and UNICEF, 2000). However, despite these benefits of male involvement in maternal health care services, the majority of interventions and services to promote SRH including care during pregnancy and childbirth in most countries have been exclusively focused on women (Ntabona, 2002). Yet it is important to assume that for all the steps leading to maternal survival there is always a man standing by to support the spouse before, during and after each pregnancy (Kainz, Eliasson and von Post, 2010).

2.1.1 Male Involvement in Antenatal Care

Decision-making by men and women per the allocation of roles by society influences utilization of ANC. It is therefore imperative for males to comprehend, accept and appreciate the importance of attendance of ANC, delivery at a health facility and PNC services. A study conducted by Britta et al (2004) in Nepal revealed that only 40% of husbands accompanied their women attending ANC for the first time and that greater decision-making power for women was associated with lower husband accompaniment to ANC and lower overall male involvement. Other reasons reported

for low male involvement in maternal health care is that many men feel marginalized and left outside in their contact with the mother and child care services (Plantin, 2007; Britta, 2004). In effect men's involvement in the maternal health care system often ends at the doors to the clinic; yet to exclude and ignore men from the information on the benefits of Antenatal care(ANC), counselling and services is to ignore the important role men's behaviours and attitudes may play in a woman's maternal health choices and decisions.

Male involvement in women's decision to attend ANC has been reported in some studies from Africa. For example, according to a study conducted in Kano Nigeria, 17.2 % of women did not attend regular ANC because of husband denial (Adamu and Salihu, 2002). This fact of male's affecting utilization of ANC and delivery care is supported by the findings of the study done by Nyane (2007) in Tororo, Uganda in which she noticed that some pregnant women or expectant mothers when asked to come with their partners during the next ANC visit dropped out.

2.1.2 Delivery care

Several studies have also depicted that the presence of husbands in the labour room shortens the labour, reduces pain, panic and exhaustion of the women (Somer-Smith, 1999, Kennel et al, 1991, WHO, 2001*)*. However, it is widely recognized that men are often marginalized by the maternal health care provided with limited access to basic information and knowledge to help them make informed choices and decisions in order to promote their own health as well as that of their families (Ntabona, 2002). Koisa (2002) reported that most men do not actually accompany their partners during labour or delivery. Part of the reason for the low male involvement have come a long way with the traditional attitude of health workers, coupled with notices in the health care premises, for example "men are not allowed into the labour ward" which

discourage men from giving support to their wives in ANC and labour (Muwa et al, 2008)

2.1.3 Postnatal care

Although RH guidelines make recommendations on women postnatal care attendance, reports from the 2008 GDHS (GHS, GSS and Macro International, 2009) shows that about three in five women (57 percent) receive a postnatal check-up within 24 hours of delivery, and about seven in ten (68 percent) are checked within the first two days. Only 7% of women receive postnatal care 3 to 41 days after delivery. If men were well sensitized and knowledgeable about PNC services and their concerns addressed, several mothers seeking and accessing PNC should rise. It is salient henceforth, for all stakeholders to realize that maternal health is not just a woman's issue or concern because a mother's health has a direct bearing on the health of her newborn, and even the entire family.

2.2 Factors affecting Male Involvement in Maternal Health Care Services

A number of factors have been suggested and reported by several researchers as being responsible for influencing male involvement in maternal health care services. Some of which are explained in the succeeding paragraphs in this segment. These factors were discussed under predisposing, enabling and reinforcing factors.

2.2.1 Predisposing Factors

Predisposing factors are those characteristics or qualities that make an individual likely to adopt a particular lifestyle or behaviour. These are antecedents in a person's life that motivates and influences behaviour; his values, knowledge, attitudes and beliefs or faith. Predisposing or Socio-demographic factors include: Age, sex, marital

status, religion, and level of education among others. In a Malawian Health Survey (MHS), some characteristics, which may be related to health seeking behaviour were identified. Although general knowledge on pregnancy related issues and available services were low among men, it was noted that knowledge increased with age, higher educational levels, and being married (MHS, 2004).

Often some males feel, it is role and task to facilitate their wives in terms of transport and if they do not have means of transport they see no point in escorting them while both are walking: men tend to feel some low esteem when they walk with their pregnant partners. Yet in many situations in Africa where the man is economically in position to provide the basic necessities of life he tends to be polygamous and it tends to affect negatively his willingness and ability to escort the wife to seek maternal healthcare. Multiple partner relationships promote different interests for the man and his partners, and these hamper possibilities for transparent decision making on maternal health service issues in addition to participation in maternal health services of all his wives when needed. Reporting his findings, Radcliffe (2001) noted that men are often involved in multiple sexual relationships that present a considerable challenge to fertility awareness and reproductive health programmes. Long working hours and difficulty in taking time off work to attend services were also cited as reasons why many men would be unable to participate in ANC services in the study by Bulut and Molzan (1995).

2.2.2 Enabling factors

Enabling factors are the logistics aspect of obtaining healthcare. They refer to conditions that are outside a person but help him to either adopt or maintain a healthy lifestyle/ behaviour, or not.

Anderson used enabling factors to describe factors that determine use of health services (Green 2005). The 2004 In Health Survey in Malawi questioned men as to what enabling factors discouraged them from attending ANC. Almost half of all fathers interviewed said the only available ANC was too far, 44% thought it was not necessary, whilst 12% said it was too costly. Not surprisingly though, 27% of men interviewed denied knowledge of ANC care and thus will not use the service (MDHS, 2004).

In Kenya, it was found that only 13% of women attending ANC were ever accompanied by their partners (Muia et al, 2000). On interview, both men and women in the study identified structural and attitudinal health service factors as well as sociocultural constraints playing a major role in „keeping men away" from ANC. Women autonomy in the relationship or family have also been reported to influence men's participation in ANC. Reporting their results from the study on women's autonomy, and male involvement in Nepal, Britta at el (2004) concluded that changed in women autonomy was associated with lower male involvement in pregnancy health.

Most of the factors relating to the health facility have also been described as playing a major role in men's" participation in ANC. In sum, research also depicts that service related predictors are more important than user related predicators in affecting and influencing male involvement in maternal health care. Salient ones pointed out

consists of long physical distances from the health unit, frustrating clinic hours, long waiting hours at the clinic, delayed operational, social skills, male unfriendly settings at the ANC center. These factors may actively frustrate and discourage men from participating in maternal healthcare services. In Turkey, it was observed that health care workers were not supporting men who wanted to join in maternal health services (Cigdem et al, 1999). The same study noted that a lot of men come to the clinic with their wives but stop at the door to avoid interactions with health staffs. The study by Kasolo and Ampaire (2000) in Uganda also argued that poor knowledge of what is done at the health facility coupled with poor communication among partners, and the low status of women in the community greatly affect men's utilization of ANC services.

2.2.3 Reinforcing factors

Reinforcing factors refer to the positive or negative influences or feedback from others that encourage or discourage health-related behaviour change (Green 2005). These factors come from the influential people around us- family, friends, peers, service providers, politicians etc. and they can encourage or discourage certain health related behaviour. Some authorities refer to this as social influence, again others call it peer influence especially in modern times and specifically youthful couples. For example, a man who wants to accompany his pregnant wife to the ANC might be discouraged from doing so if no other man in the community attends ANC

(Tweheyo, 2010). Education by health workers can also be seen as reinforcing factors. Unfortunately, a lot of the education in pregnancy tends to over-concentrate on the woman leading to limited male partner knowledge on pregnancy.

The 2004, Malawian Health Survey (MHS) in Malawi asked male respondents about their knowledge on pregnancy complications. The data depicted that two in three men

(65%) had no knowledge of any signs or symptoms that indicate that the pregnancy may be in danger. The most often cited sign of pregnancy complication is vaginal bleeding (11%). Abdominal pain and swelling of hands and feet are mentioned by 8% each of men, whilest high fever and difficult labour are mentioned by 7% and 6% of men, respectively.

Studies depict that there is a general lack of interest on the part of men in some countries in Africa in their partners‟ reproductive health (WHO, 2005). Men often do not have access to relevant and basic information on maternal health issues, and on their role in promoting maternal health. This consequently results in a majority of men lacking or having insufficient information and knowledge with regards to maternal healthcare. Communicating with men has been reported by some researchers to pose challenges for programmes, which historically have focused on serving women (Young & Kol, 1999). A study in Zimbabwe reported that, most men misinterpreted campaign messages promoting male involvement to mean that decisions should solely be left to men (Young and Kols, 1999). Sometimes couple dialogue may be the problem, once there is a communication breakdown for one reason or the other, the whole family function fails. Kasolo and Ampaire (2000), highlighted an example of a breakdown or distortion in communication among couples when they reported that some men did not want to discuss ANC attendance with pregnant women because they considered pregnant women to nag a lot, in addition, they are seen as sick people in some rural communities in Ghana.

2.3 Knowledge on male involvement in ANC and PNC Services

Inadequate knowledge about ANC, delivery and PNC and its yielding benefits derived from it for the mothers and newborns have negatively affected patronage of maternal health services. Often times pregnant women especially adolescents, may

not be aware of the problems that result from not attending maternal health services (Mutale et al., 1991). Lack of knowledge about dangers of not seeking health care in pregnancy and delivery, including inability to make independent decisions were major barriers to seeking health care among pregnant women in Uganda (Mutua, 2004).

Men play critical and salient roles in women's ability to seek health care, yet more often, they are uninformed about women's reproductive health needs or their own. It is believed that when male and female are aware of each other's health needs, they are more likely to receive services. It is imperative to note that to increase male involvement in maternal health services requires the providers to gain in-depth knowledge and understanding of the men's health perspectives, behavior and practices (Nyane, 2007). Although pregnancy is treated not as an illness, it creates a lot of physical and emotional demands on the mother. The health awareness about the demands of pregnancy on the part of the husband and other family members could result into the necessary support the pregnant woman needs from the family members including the husband. The husband is often the primary decision maker, and wife's economic dependence on her husband gives him greater influence on major household decisions as was reported in Nepal by Britta and others (2004) where 50% of the women had the final decisions about their own health care made by their husbands (Nepal Demographic and Health Survey, 2001).

2.4 Levels of male involvement between ANC and PNC Services

Educational interventions for pregnancy health have primarily been inadequate in addressing a man's degree of authority in his household on health-related decisions. About 210 million women become pregnant each year with 30 million (15%)

developing complications resulting into over half a million maternal deaths due to low male involvement (WHO, 2005). Developing countries account for more than 99% of all maternal deaths; about a half occurring in sub Saharan Africa (SSA), and a third in South Asia, (UNICEF, 2008). Observational studies have shown that educating men about the importance of health care for the family increases the promotion of some health-seeking behaviors, such as antenatal care (ANC), postnatal care (PNC) and child immunizations (Johansson et al, 1998). Health seeking behaviors enhances communication and support of female partners. Involving men in ANC and PNC services would be important to achieving Zambia's Millennium Development Goals. Special efforts would be made to emphasize men's shared responsibility and promote their active involvement in responsible parenthood, sexual and reproductive behavior (Petal, 1995). Comprehensive male involvement includes; encouraging men to become more involved and supportive of women's needs, choices, and rights in sexual and reproductive health; and addressing men's sexual and reproductive health needs and behavior.

A researched done in India found that majority of husbands in the state accompany their wives for their first check up to confirm pregnancy; but the women generally went alone or with the other female members of the family for subsequent visits (Barua, 1998). The study revealed that husbands neglected wives' health care during pregnancy, except for the alert for the need for ANC registration, and a balanced meal. Childbirth or delivery and post-partum periods were found to be exclusively women's affairs.

CHAPTER THREE

METHODS

3.1 Study Design

This was a Cross-Sectional study design, using a mixed method (involving both Quantitative and Qualitative methods of data collection). It was conducted in the Nandom District to assess the level of male partner involvement in Antenatal Care (ANC) from May to July 2018. It was largely a community-based research, however, an observational technique was employed at the only District Hospital as a qualitative method of study: involving two (2) sets of Focus Group Discussions (FGDs) comprising (accompanying) male partners and pregnant women. The two (2) groups was made up of ten (10) participants in each set. A total of 38 participants-males and females took part in the FGDS.

3.2 Study Site

Location

The Nandom District of the Upper West region, lies in the north western corner of the Upper West Region of Ghana and bounded to the East and South by the Lambussie and Lawra Districts respectively, and to the North and West by the Republic of Burkina Faso. The total area of the District is put at 404.6 square km. This constitutes about 3.1% of the Region's total land area. The District is constituted by 8 communities with 86% of the inhabitants living in rural areas. The population density is approximately 114 per square kilometer. It is the most densely populated District in the region.

Population

The population of Nandom District as projected by the 2015 Ghana Health Services (GHS) was 49,766 representing 6.6 percent of the region's total population. Male constitute 49% and females represent 51%. About 85.0% percent of the population live in rural communities, and are largely peasant farmers. The population of the district is youthful (under 15 years) (37.3%) depicting a broad base population pyramid which tapers off with a small number of elderly persons 60 years and above (10.7%). The total age dependency ratio for the District is 82.8%, the dependency ratio for males is higher (87.0%) than that of the dependency ratio for females (79.0%).

Health

The District Health Administration (DHA) serves as the district highest implementing agency and the headship of the Ghana Health Service in the District. Primary health care services are provided to community members through the hospital, health centers and CHPS compounds.

There are five sub-districts which deliver and offer comprehensive packages of public health services. These are Baseble, Gengenkpe, Ko, Puffien and Nandom sub-districts. All five sub-districts are being served by four health centers and one polyclinic.

The district has one hospital, which is an agency hospital established by the Catholic Church at Nandom, and a polyclinic at Ko by government and being managed by the Catholic Church.

In an effort to reach all settlers in the district, the District had implemented the Community-Based Health Planning and Services (CHPS) programme with six CHPS compounds in operation at Yirpelle, Tuopare, Guo, Naapaal, Kokoligu and Bu.

Human resource in the Nandom district is the most critical and needed resource in the health sector. The district faces the challenge of inadequate number and mix of staff needed for provision of quality health service. Midwives, Medical Assistants and Pharmacy Assistants are most critical.

There are 110 trained Traditional Birth Attendants (TBAs), 73 Community-Based Surveillance Volunteers (CBSVs), 166 Community Based Agents (CBAs) and 68 Health Promotion Assistants (Population and Housing Census, GSS 2010). All the aforementioned stakeholders aid in the provision of quality and equitable health care to indigenes especially in the thematic area of maternal, neonatal, and child health outcomes, within the district. Their unenviable roles go a long way to alleviate maternal and child morbidity and mortality. There are also five chemical sellers in the district but most of these chemical sellers are located in Nandom and KO townships. The shops serve as sources for first aid drugs for the mass of the populace in the district. Health services are made accessible in the district through 13 static health facilities and 109 outreach points.

Below is a map showing location of the District in Ghana. Its closeness to Burkina Faso offers it a strategic location for international interactions and exchanges.

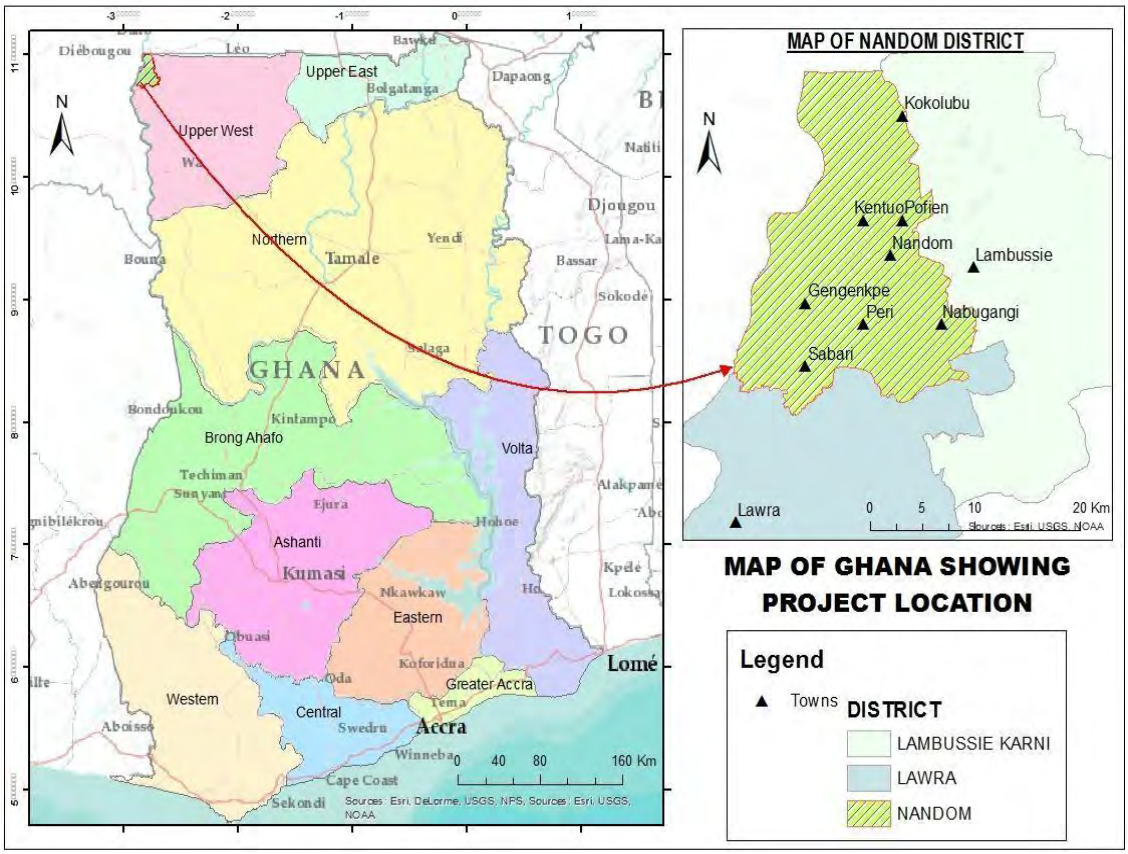

Figure 3. 1: Map of Nandom district

3.3.1 Quantitative Method

The quantitative method of study involved a systematic sampling technique to identify the needed households with male participants for questionnaire administered interviews: This method comprised 255 respondents of 263 targeted men (Non-response questionnaires were 8). That of the Qualitative study was aimed at male partners who had already participated in the Quantitative study in the community. Again, with regards to the Qualitative study: Focus Group Discussions (FGDs) made up of pregnant women and their accompanied partners, formed four (4) separate groups of 19 respondents in each group. A purposive sampling method was used to choose the Nandom District Hospital (only referral hospital). About 30% (121 respondents of the calculated

sample size was gotten from the observational technique at the Nandom District Hospital: involving male partners who had accompanied their pregnant spouses to ANC.

a) Inclusion Criteria

1. Men Aged ≥ 18years
2. Have a child or children
3. Last child should be ≤ 5 years at their last birthday.

b) Exclusion Criteria

Men who have no children (male partners who have emotional reservations in the death or otherwise of their children).

1. Men whose last child was aged more than 5years at their last birthday was excluded to minimize the problem of recall of bias at the time of birth through to his/her childhood.

2. Men with children who are 5 years and below at their last birth day but had not consented to participate in the study were excluded.

3.3.2 Qualitative Method

a) Inclusion Criteria

The focus group discussions were held with women within their reproductive age group (15-49 years) and men 18 years and above who have children of the age not above five years. Men who will join the focus group discussions were recruited from those who participated in the quantitative aspect of the study.

b) Exclusion Criteria

NIL.

3.4 Study Variables

a) Dependent variable

Male involvement in ANC attendance in the Nandom district.

b) Independent variables

The independent variables were grouped as: Socio demographic characteristics. The socio demographic characteristics that were looked at were age, educational level, and marital status, living together, occupation, number of children and religion, and residence.

Cultural factors like segregation of gender roles, role of other family members and taboos were considered. Health facility factors like provision made for men at ANC centers, men allowed in labour and delivery rooms, staff attitude and waiting time were considered.

Table 3. 1: Variables of the study

Objective	Independent Variables	Conceptual Definition: Independent Variable	Scale of measurement	Data Collection Method	Type of statistical Analysis
To determine factors that affect male ANC Participation	Predisposing Factors	Age, sex marital status, Educational level, Employment status, number of children	Discrete, Binary Nominal, Ordinal	Questionnaire, Records	Univariable & Bivariate analysis, Logistic Regression
	Enabling Factors	Cost of ANC trip, time spent at ANC, Programs organized at ANC, staff Attitude	Nominal, Continuous, Ordinal	Questionnaire, Records	Univariable & Bivariate analysis, Logistic regression
	Reinforcing Factors	Ever discussed ANC, Knows of any other man who attends ANC	Binary	Questionnaire	Univariable& Bivariate analysis, Logistic regression
To assess the level of male Involvement in ANC	Percentage who attends or have ever Attended ANC	Male Participation and reasons: Why they attend, how many times, they have attended.	Nominal, Ordinal, Discrete	Questionnaire	Univariable & Bivariate analysis, Logistic regression, Descriptive Analysis
To Recommend strategies of Improving the existing Situation	Recommend-ations teased From interactions with clients, Health workers	Views from clients on how to increase male partner ANC Participation	Nominal	Questionnaire	Descriptive analysis

3.5 Sample Size

Sample size for the cross-sectional survey was calculated using the Cochran's formula:

$$N = \frac{Z^2 \times P(1-P)}{d^2} \qquad Z = 1.96$$

Based on the following conditions:

Prevalence of involvement (p) = 0.05

Confidence interval = 95%, alpha 0.05

$$N = \frac{1.96^2 \times 0.05(1-0.05)}{0.05^2}$$

N = 403

Worst acceptable margin of error (d) = 5%.By default most biomedical data are measured at Confidence Interval (CI 95%), hence the acceptable worst margin of 5%.

The acceptable figure 384 is adjusted by 5% for non-response arriving at a sample size of 403 for both quantitative and qualitative studies. Thus, 255 male partners who met the selection criteria were selected from the households of the four communities for the quantitative study.

The Qualitative study was made up of 38 males and females in separate groups of four (4) for the Focus Group Discussion Survey (FGDS), and 121 men who accompanied their partners to ANC at the Nandom District Hospital (NDH) for the Observational study.

3.6 Sampling Method

3.6.1 Quantitative study

The Nandom district had 5 sub-districts. Out of these sub-districts, 3 were selected as the study locations. The names of the 5 sub-districts were written on five pieces of similar looking papers and folded. They were put in a cup, shaken and three were picked for the study. Out of the 3 sub-districts, the 4 communities were selected following the same pattern as the study locations, mentioned above. A systematic sampling of households were done using a sampling interval (calculated of the total households over the sample). The first household to be interviewed was randomly selected by an intersection on the map of Nandom using the tip of a pencil. From the first house, next house was selected using the same interval till the required number of households corresponding to the required sample size from a particular community was obtained. The direction of movement was determined by writing down the options on pieces of paper and randomly selecting one. If any house had more than one family and more than one male spouse meeting the criteria, one was selected by balloting. If a house did not have a man meeting the criteria, the next house was contacted. If a man had more than one partner with a child less than 5 years, the interview was conducted on the youngest child. For participants who would not grant an interview immediately, a convenient time was scheduled for the interview. About 50 households per each community was obtained, thus multiplied by 4 communities for the total quantitative sample size. Interviews were granted to 1 man per house.

3.6.2 Qualitative study

From the same selected communities, four (4) Focus Group Discussions (FGD) were held. Two focus groups of male volunteers were obtained by asking men aged 18

years and above with children to participate in a focus group discussion, preferably, men from the quantitative study were contacted. The first group was made up of ten men aged 18 –35years. Second group was made up of ten men aged 36 years and above. Two groups of female volunteers were also obtained by asking women in their reproductive age who had children to participate. The first group was made up of ten women aged 15–35 years and the second group made up of ten women aged 36 years and above.

3.6.3 Observational Technique

The Nandom District hospital was purposively sampled. Pregnant women attending ANC, and their male partners participated in the Focus Group Discussion Survey (FGDS): using a checklist with probes. Consent was obtained from each participant. The hospital is the only referral medical institution in the District. The intention here was to record or have an observational experience of male partners who followed their wives for ANC checkups. The technique used obtained 30% of the qualitative sample size that is 121 from the 403 sample size of the entire study. The findings from this part of the study was to help validate the responses obtained from the community-based study.

3.7 Data Collection Method and Tool

3.7.1 Quantitative data

The data was collected using an interviewer administered structured questionnaire shown in Appendix C. Together with trained research assistants, the questionnaires were administered to each participant. The questionnaire was designed making reference to questionnaires used by other researchers (Sham-UNA Umar, KNUST). The information sought in the questionnaire included: Socio-demographic

characteristics like age, educational level completed, occupation, marital status, living together, religion and number of children. With regards to involvement in Antenatal care (ANC): e.g. accompanying the partner to health facility, making joint plans for antenatal care and emergency, providing physical and financial support and having discussions on issues relating to the pregnancy constituted some enabling and reinforcing factors.

3.7.2 Qualitative data

The focus group discussion was conducted using a focus group discussion guide or checklist (Appendix B) eliciting details through probes. The issues discussed included views on cultural norms, perceptions of gender roles, perceptions of male friendliness of health facilities and attitudes of peers and the community at large to male involvement in maternal healthcare.

The discussions were facilitated by trained research assistants who were more fluent in the Dagaare language of the Indigenes than the principal investigator. The principal investigator served as the assistant moderator. A male research assistant facilitated the men's discussion groups and a female research assistant facilitated the women's discussion groups that of women responses were used to confirm the truth in males' responses. The discussions were conducted in the Dagaare language, which is the spoken local dialect. Demographic information on the participants were obtained and each participant was given a number tag. They were being referred to by the numbers given during the discussion. The discussions were tape recorded and notes were also taken so that non-verbal behaviors could be noted down to help during interpretation and analysis. The discussions were held at a venue provided by the assemblyman of the area and participants were served some snack at the end of

the discussion session. There was triangulation of responses from both men and women FGDS and the quantitative study.

3.8 Training of Research Assistants

Four (4) research assistants were recruited and trained to help with the administration of the questionnaire and two (2) research assistants were recruited to facilitate the focus group discussions. Due to the fact some people may not be fluent in the English language, the principal investigator together with the research assistants went through the interpretation of the questions into the local dialects to ensure uniformity in the interpretation of the questions. The research assistants were also taken through communication skills, interviewing skills, and ethics in research. The two (2) research assistants who facilitated the focus group discussions were taken through the focus group discussion guide to familiarize themselves with the guide. All the research assistants were given a summary of the background to the study and what the study objectives were.

3.9 Quality Control

The principal investigator trained and supervised the research assistants. Each questionnaire had interviewers initial and code to facilitate cross checking of the completed questionnaire. The completed questionnaires were checked for completeness, any inconsistencies and corrected on the field. Data was doubly entered into SPSS (Statistical Package for Social Sciences) version 21 on the same day. The audio recordings of the focus group discussions were played back to ensure complete recording of the whole discussion. The tapes were labelled with the group name, title and date. Transcription of the recorded discussions were done as soon as possible after the discussion.

3.10 Ethical Consideration

Ethical clearance was sought from the Ghana Health Service Ethics Review Committee (GHSERC) (017/05/18). Permission was given from Nandom District Health Administration (NDHA) as well as the Nandom District Assembly (NDA) before the research started. The consent of the chiefs, assembly men and opinion leaders of the community was sought before the research was undertaken. Also Community health workers, and midwives within the municipality were informed. Informed consent was given from the participants prior to administering the questionnaire.

Answered and returned questionnaires indicated the absolute consent of the respondents. No member was coerced to take part in the study. Participation was voluntary and there was no penalty for anyone who refused to participate. The procedure employed in the study was of no physical or emotional harm. Participants were provided with health education and told the benefit of the study. The data obtained was analyzed solely for the objective of the study and utmost discretion was exercised in the handling of the personal information provided. Participant confidentiality and anonymity was assured. The questionnaires were secured in a locked cupboard. There were no known risks of the study to the participants

3.11 Ethical Issues

1. Ethical clearance was obtained from the Ghana Health Service Ethical Review
2. Committee on Research Involving Human Subjects.
3. Permission to carry out the research was obtained from the Nandom District
4. Assembly.

5. Community entry was done with the help of the Assemblymen of the 3 sub-districts. He did help in obtaining permission from the local traditional leaders, especially the paramount chief.
6. The purpose of the study, the benefits and rights of the subjects and the procedure involved was explained to all participants. They were assured of confidentiality and a voluntary informed consent was obtained from all participants. Voluntary participation was indicated by signing or thumb printing a consented form.
7. There was no payment done to the participants but members of the focus group discussions were served some snacks.
8. Electronic data files were secured by a password known by only the principal investigator and Supervisor. All hard copies of data sheets and tapes were kept in a locked file cabinet that can only be accessed by the principal investigator and supervisor.
9. Research assistants accessed them only when they had been given permission.
10. Data files and tapes were kept for five years after which they were destroyed.
11. This research was fully self-funded. I had no conflict of interest in this research

Collected data was stored on my personal computer and my Drop box. My supervisor was the only person who had access to the data collected. No form of compensation was given to the study participants. I had no conflict of interest in the study.

3.12 Data Processing and Analysis

3.12.1 Quantitative data

Data was entered into SPSS version 21 and cleaned and also exported into Stata version 15, a statistical software package (*StataCorp.2007. Stata Statistical Software. Release 15*. StataCorp LP, College Station, TX, USA) for analysis. Patterns in the variables were examined by descriptive statistics. The mean age was calculated before it was categorized into groups and the modal age group found. Frequencies and proportions were calculated for the categorical variables like educational level, marital status, number of partners, living together, occupation, number of children and religion. Cross tabulations would be done and Pearson Chi-square test was used to compare proportions of the categorical variables. Differences were considered significant when $p< 0.05$. All factors found to be significant were included in a logistic regression model to examine the association between the factors and the outcome variable. The results would be presented in tables, and frequencies.

3.12.2 Qualitative data

Recordings of the discussions were translated into English and transcribed. A general description of the participants were first done. Thematic content analysis would be carried out. The data would be coded and categorized and common themes identified. Analysis of the cultural norms, perceptions of gender roles, and perceptions of male friendliness of health facilities and attitudes of peers and the community at large to male involvement in ANC was done. Appropriate quotes were included to clarify the themes.

3.12.3 Pre-Testing

Pre-testing of the questionnaire and focus group discussion guide was done in Lawra District, an old district capital in the Upper West region of Ghana. A district with similar characteristics. This helped in testing the feasibility of the sampling procedures and appropriateness of the data collection tools. It also helped in ascertaining the clarity of the questions in the questionnaire. Appropriate modifications were then made to fine-tune the methodology

CHAPTER FOUR

RESULTS

4.1 Introduction

A total of 403 male partners who met the inclusion criteria were approached in three (3) sub-districts and the study explained thoroughly to them. Thus, questionnaires were administered and 395 questionnaires were returned correctly answered. The study, therefore achieved 98% response rate.

Four focus group discussion was held. Ten participants were approached per group and all turned up for the discussion except one male and female participants. Hence, a total of 19 females and 19 males participated in the FGD respectively, in the four separate groups. The 19 males were recruited from males who took part in the quantitative study. A total of 38 participants who took part in the quantitative study, gave a 99% response rate.

4.2 Demographic characteristics of respondents

The age range of respondents was 22 years to 60 years old with a mean age of 34 years ($\pm$9.95). The average monthly income among respondents who earned an income was Ghc 376.00 per month. The detailed demographic information is presented in (Table 4.1). Majority of them were married (78.7%), 13.9% were single whiles those who were separated were 7.3%. With regards to religion, Christians formed the majority (78.0%) and the rest were Muslims and traditionalist 22%. In all, most of them were famers (47.9%) who worked in the informal sector of employment (64.3%). Other occupations were Artisans (14.2%), Civil servants (10.9%) and traders (4.3%).

Table 4. 1: Socio-Demographic characteristics of study participants

Variables	Number	%
Age group		
<25 years	76	19.2
25-34 years	150	38.0
35-44 years	95	24.1
>45 years	74	18.7
Marital status		
Single	308	13.9
Married	34	78.7
Separated	53	7.3
Religion		
Christian	308	78.0
Muslim	34	8.6
Traditional	53	13.4
Employment status		
Formal Employed	51	12.9
Informal	254	64.3
Unemployed	90	22.8
Occupation		
Artisan	56	14.2
Farmer	189	47.9
Civil/ public servant	43	10.9
Trader/ businessman	17	4.3
None	90	22.8
Number of children		
<3	185	46.8
3-4	114	28.9
>4	96	24.3
Earning per month		
<Ghc 500	181	45.8
Ghc 500-999	24	6.1
>Ghc 1000	46	11.7
No income	144	36.5

Source: field data, Nandom 2018

4.3 Enabling Factors and perceptions surrounding ANC attendance

Studies depict that there are some enabling factors that influence a man to follow the partner to the ANC center, during and after pregnancy. This study examined these factors as well as the perceptions of men regarding active involvement of male partners in maternal health care.

4.3.1 Perceptions regarding the acceptability of men in ANC

When respondents were asked whether they thought their families and friends would consider it acceptable for a man to accompany his wife/ partner to ANC, the overwhelming majority (98.5%) confirmed yes, whilst only 1.0 and 0.5% responded no and don't know respectively. Again, a majority of 98.2% also believed that their communities will consider it acceptable for a man to accompany their partner to ANC.

Regarding respondents' perceptions about the ANC services, 66.3% were of the view that it was very helpful and 33.7% also said that it was helpful.

4.3.2 Enabling Factors influencing ANC attendance

This section presents the detailed results on the enabling factors influencing men to visit the ANC with their partners.

Table 4. 2: Enabling factors in attending ANC among male partners

Variables	Number	(%)
Means of transport to the center		
Walk	76	19.2
Car/public/private	40	10.1
Moto bike	279	70.6
Cost of transport		
Expensive	354	89.6
Not expensive	41	10.4
Distance to facility		
≤10km	52	13.2
>10km	343	86.8
Amount spent on transport to ANC		
≤10 Ghc	72	18.2
>10 Ghc	323	81.8
Rating of distance/Km to ANC		
Very far (≥5)	327	82.8
Far (3-4)	53	13.4
Close (1-2)	15	3.8

Source: field data, Nandom 2018

Table 4.2 show the enabling factors that were examined among respondents and it can be observed that the main means of transport to the health facility was by motorbike (70.6%). Majority of the respondents spent more than Ghc 10.00 on transportation from their home to the nearest ANC facility. However, a few also spent less than Ghc 10.00 on transportation to the ANC. Largely, respondents viewed transport fares as expensive (89.6%).

4.4 The levels of male partner participation in ANC

Male participation was found among 92.4% of the respondents. Among those who have participated or accompanied their spouse to the health facility, average attendance was recorded to be 5 times.

Table 4. 3: Male partner participation in Maternal and Child health

Variables	Number	(%)
Accompanied wife to ANC		
Ever accompanied	365	92.4
Never accompanied	30	7.6
Number of ANC visits by males		
<4 times	99	27.1
4-5times	98	26.9
>5 times	168	46.0
Rating of time spent		
Long	313	79.2
Normal	68	17.2
Short	14	3.5
Attitude of staff		
Very friendly	129	32.7
Friendly	116	29.3
Normal	150	38.0
Description of entire ANC setting		
Very Friendly	145	36.7
Friendly	94	23.8
Normal	156	39.5

Source: field data, Nandom District 2018

Respondents rated the time they spent at the ANC facility as long (79.2%), Normal (17.2%) and short (3.5%). Attitudes of health workers or staff viewed by respondents were friendly (32.7%) and very friendly (29.3%) (Table 4.3).

4.4.1 Reinforcing factors influencing ANC Attendance

The Table 4.4 presented detailed information on reinforcing factors regarding male partner participation in maternal and child care services.

Table 4. 4: Reinforcing factors influencing ANC participation

Variables	Number	(%)
Man has held a discussion on ANC with wife		
Yes	353	89.4
No	42	10.6
Man has held a discussion on ANC with Health		
Yes	167	42.3
No	228	57.7
Man has held a discussion on ANC with Friends		
Yes	307	77.7
No	88	22.9
Man has read about ANC		
Yes	367	92.9
No	28	29
Man Knows of other men who attends ANC		
Yes	366	92.7
No	29	7.3

Source: field data, Nandom District 2018

4.5 Predisposing, Enabling and Reinforcing factors influencing ANC

This section presented factors such as demographic factors (predisposing), health systems (enabling) and reward, influence and motivation (reinforcing factors) that influenced men's attendance to ANC with their partner.

Bivariate analysis of enabling factors influencing male partner involvement in maternal healthcare service. All the demographic factors studied were found to be significantly associated with male partner participation in ANC. Participation was higher among men within 25 – 34 years age group (*p=0.004*) and also among married men (82.2%). Men who were unemployed and those who were Christian had the

greater proportion of ANC participation (66.6% and 77.8% respectively) and *p=0.001 and* ***p<0.001*** respectively. Additionally, number of children and earning per month (Ghana cedis) were also found to be statistically significant ***(p≤0.002 and p<0.001*** (Table 4.5).

Table 4. 5: Bivariate analysis of enabling factors influencing male partner involvement in maternal healthcare service

Variables	Column total	Men participation in ANC		P-value
		Did not participate	Participated	
Age group				
<25 years	76 (19.2)	11 (36.7)	65 (17.8)	0.004*
25-34 years	150 (37.2)	15 (50.))	135 (37.0)	
35-44 years	95 (25.0)	2 (6.7)	93 (25.50	
≥45 years	74 (18.7)	2 (6.7)	72 (19.3)	
Marital status				
Single	55(13.9)	8(26.7)	47(12.9)	<0.001*
Married	311(78.7)	11(36.7)	300(82.2)	
Separated	29(7.3)	11(36.7)	18(4.9)	
Employment status				
Formal Employed	51(12.1)	0(0.00)	51(14.0)	<0.001*
Informal	254(64.3)	19(63.3)	71(19.5)	
Unemployed	90(22.8)	11(36.7)	243(66.6)	
Religion				
Christian	308(78.0)	24(80.0)	284(77.8)	0.006*
Muslim	34(8.6)	6(20.0)	28(7.7)	
Traditional	53(13.4)	0(0.0)	53(14.5)	
Occupation				
Artisan	56 (14.2)	2 (6.7)	54 (14.8)	<0.001*
Farmer	189 (47.9)	8 (26.7)	181 (49.6)	
Civil/ public servant	43 (10.9)	0 (0.0)	43 (11.7)	
Trader/ businessman	17 (4.3)	1 (3.3)	16 (4.4)	
None	90 (22.8)	19 (63.3)	71 (19.5)	
Number of children				
<3	185(46.8)	23(76.7)	162(44.4)	0.002*
3-4	114(28.9)	5(16.7)	109(29.9)	
>4	96(24.3)	2(6.7)	94(25.8)	
Earning per month/Ghc	181(45.8)	4(13.3)	177(48.5)	**<0.001***
<500	24(6.1)	2(6.7)	22(6.0)	
500-999	46(11.7)	4(13.3)	42(11.5)	
>1000	144(36.5)	20(66.7)	124(34.0)	
No income				

NB: Statistical significance was observed at p-value<0.05; p-values marked with * means the observed measurement was statistically significant; percentage (%) totals were presented in columns; test of significance: Fishers' exact test

Table 4.6 provides the results of the bivariate analysis among the enabling factors and male partner involvement in ANC attendance. It was observed that factors such as amount spent on transport to ANC center, respondents cost of transportation and distance to the facility were found to be statistically significant with men's attendance to ANC (*p*=value 0.001 each). Major transportation method to the ANC center was however, not found to be statistically significant (*p*-value= 0.44) (Table 4.5).

Table 4. 6: Bivariate analysis of enabling factors influencing male partner involvement in maternal healthcare service.

Variables	Column total	Men participation in ANC		P-value
		Did not participate	Participate	
Type of means to ANC				
Walk	76(19.2)	10(33.3)	66(18.1)	
Car/private/public	40(10.1)	4(13.3)	36(9.9)	0.072
Motor bike	279(70.6)	16(53.3)	263(72.1)	
Amount spent on ANC				
<15ghc	137(34.7)	2(6.7)	135(37.0)	<0.000*
≥15ghc	258 (65.3)	28 (93.3)	230 (63.0)	
Cost of transportation to ANC				
Expensive	354(89.6)	22(73.3)	332(91.0)	<0.000*
Not Expensive	41(10.4)	8(26.7)	33(9.0)	
Distance to facility (Km)				
<10	52(13.2)	12(40.0)	40(11.0)	<0.000*
>10	343(86.8)	18(60.0)	325(89.0)	
Rating distance(Km) to facility	327(82.8)	23(76.7)	304(83.3)	0.447
Very Far (≥5)	53(13.4)	6(20.0)	47(12.9)	
Far (3-4)	15(3.8)	1(3.3)	14(3.8)	
Near (1-2)				
Perceptions about ANC				
Very helpful	262(66.3)	8(26.7)	254(69.6)	<0.000*
Helpful	133(33.7)	22(73.3)	111(30.4)	

NB: Statistical significance was observed at p-value<0.05; p-values marked with * means the observed measurement was statistically significant; percentage (%) totals were presented in columns; test of significance: Fishers' exact test

From Table 4.7, all factors studied were found to be statistically significant with men involvement in ANC. Reinforcing factors such as holding discussion with wife, health worker and or friend had a p-value of 0.001, 0.003 and 0.001 respectively. Reading or haven heard about ANC and knowing any other man attending ANC were also significant (p-value= 0.001 and 0.001).

Table 4. 7: Bivariate analysis of reinforcing factors influencing ANC by males

Variables	Column total	Men participation in ANC		P-value
		Did not participate	Participate	
Man held discussion with wife				
No	42 (10.6)	23 (76.7)	19 (5.2)	<0.001
Yes	353 (89.4)	7 (23.3)	346 (94.8)	
Man held discussion Health worker				
No	228 (57.7)	25 (83.3)	203 (55.6)	0.003*
Yes	167 (42.3)	5 (16.7)	**162 (44.4)**	
Man held discussion with friend				
No	88 (22.3)	20 (66.7)	68 (18.6)	<0.001*
Yes	307 (77.7)	10 (33.3)	297 (81.4)	
Man read or know about ANC				
No	29 (7.3)	18 (60.0)	11 (3.0)	<0.001*
Yes	366 (92.7)	12 (40.0)	354 (97.0)	
Man Knows other men who attends ANC				
No	366(92.66)	12(40.0)	**11(3.0)**	<0.001*
Yes	29(7.3)	18(60.0)	**354(97.0)**	

NB: Statistical significance was observed at p-value<0.05; p-values marked with * means the observed measurement was statistically significant; percentage (%) totals were presented in columns; test of significance: Fishers' exact test

4.5.1 Multivariate logistic regression of factors associated with male partner participation in ANC

Predisposing factors are those characteristics that make an individual likely to adopt a particular lifestyle or behaviors. Predominately antecedents in a person's life that motivates behaviors; his values, knowledge, attitudes and beliefs. The multivariate logistic regression among predisposing factors showed that marital status was significantly associated with male partner involvement in ANC. Compared to single men, men who were separated or divorced had 88% less likelihood of accompanying their partner to the ANC with a p-value=0.003 (AOR:0.12 95% CI: 0.03-0.48). Also, married men had 2.87 times higher odds of attending ANC with their partners with reference to single men adjusting for all other variables, however, was not statistically significant (p-value=0.149, AOR:2.87). Men who had more than 4

children also had 4 times higher odds of attending ANC with partners compared to those who had less than 4 children (p-value=0.193; AOR: 4.86; 95% CI:0.45-52.45).

Table 4. 8: Multivariate logistic regression of predisposing factors and male partner participation

Variable	P-value	COR (95% CI)	P-value	AOR (95% CI)
Age group (years)				
<25	Ref	1	Ref	1
25-34	0.3204	1.52 (0.66-3.51)	0.293	0.53 (0.16-1.73)
35-44	0.0025*	7.87 (1.61-38.49)	0.316	4.12 (0.26-65.49)
>45	0.0107*	6.09 (1.25-29.69)	0.231	8.83 (0.25-31.28)
Marital status				
Single	Ref	1.00	Ref	1
Married	0.0007*	4.64 (1.75-12.35)	0.149	2.87 (0.69-12.05)
Separated	0.0155	0.28 (0.09-0.84)	0.003	0.12 (0.03-0.48)
Religion				
Christian	Ref	1.00	Ref	1
Muslim	0.0542	0.39(0.15-1.05)	0.074	0.17(0.03-1.19)
Traditional	0.0357*	Empty	Empty	
Occupation				
Artisan	Ref	1.00	Ref	1
Farmer	0.8265	0.84(0.17-4.08)	0.475	0.44(0.05-4.13)
Civil/ public servant	0.2129	Empty	Empty	Empty
Trader/ businessman	0.6763	0.59(0.05-7.11)	0.092	0.07(0.00-1.54)
None	0.0034	0.14(0.03-0.65)	0,529	0.47(0.05-4.83)
Number of children				
<3	Ref	1.00	Ref	1
3-4	0.0206	3.10(1.13-8.48)	0.787	1.23(0.28-5.44)
>4	0.0039	6.67(1.50-29.67)	0.193	4.86(0.45-52.45)

NB: A measurement is statistically significant at p-value<0.05; AOR: adjusted odds ratio; OR: Crude odds ratio*: statistically significant; 95%CI: confidence interval; Ref: reference group.

Enabling factors are those characteristics that make an individual likely to adopt a particular behavior. Major enabling factors found to be significantly associated to male partner participation in ANC were amount of money spent on transportation to ANC, distance to ANC and respondents' perceptions about how programmes are organized at ANC. With reference to those who viewed transportation cost as not expensive, those who viewed it as expensive were 92% and had 0.08 lower odds of ANC attendance with partner (*p<0.001*; AOR: 0.08). Again, compared to those who

lived in more than 10 km to the nearest ANC center, those who lived in less than 10 km had 14 times higher odds to attend ANC (AOR:14.4; 95% CI:4.02-51.66; *p<0.001*).

Table 4. 9: Multivariate logistic regression of enabling factors and male partner participation

Variable	P-value	COR (95 %CI)	P-value	AOR (95% CI)
Age group				
<25 years	Ref	1	Ref	1.00
25-34 years	0.3204	1.52 (0.66-3.51)	0.830	0.87 (0.25-3.04)
35-44 years	0.0025*	7.87 (1.61-38.49)	0.224	3.32 (0.48-23.00)
>45 years	0.0107*	6.09 (1.25-29.69)	0.628	1.77 (0.17-18.02)
Marital status				
Single	Ref	1.00	Ref	1.00
Married	0.0007*	4.64 (1.75-12.35)	0.528	1.51 (0.42-5.47)
Separated	0.0155	0.28 (0.09-0.84)	0.003	0.11 (0.03-0.47)
Number of children				
<3	Ref	1.00	Ref	1.00
3-4	0.0206*	3.10 (1.13-8.48)	0.266	2.20 (0.55-8.85)
>4	0.0039*	6.67 (1.50-29.67)	0.428	2.35 (0.29-19.32)
Cost of transportation to ANC				
Expensive	Ref	1.00	Ref	1.00
Not Expensive	0.0024*	0.27 (0.11-0.67)	0.0000*	0.08 (0.02-0.30)
Distance(Km) to the Health facility				
<10	Ref	1.00	Ref	1.00
>10	0.0000*	5.42 (2.38-12.34)	0.0000*	14.41(4.02-51.66)
Amount spent on transportation from home to ANC				
<15ghc	Ref	1.00	Ref	1.00
≥15ghc	0.0008*	0.12 (0.03-0.53)	0.016*	0.15 (0.03-0.70)
Perceptions about how ANC is organized				
Very helpful	Ref	1.00	Ref	1.00
Helpful	0.0000*	0.16 (0.07-0.38)	0.0001*	0.16 (0.05-0.50)

NB: A measurement is statistically significant at p-value<0.05; AOR: adjusted odds ratio; OR: Crude odds ratio*: statistically significant; 95%CI: confidence interval; Ref: reference group.

(Table 4.10), Predisposing factors such as age, marital status and number of children were adjusted for. Reinforcing factors that were significantly associated with ANC

involvement were; holding discussion with wife or partner (AOR: 18.60; *p<0.001*) and reading or haven heard about ANC (AOR: 34.79; p<0.002). Again, men who had seen other men followed their partners to ANC had 4.2 times higher odds to attend ANC, with a *p< 0.001* (AOR: 4.2; 95%CI: 0.37-48.44).

Table 4. 10: Multivariate logistic regression of reinforcing factors and male partner participation

Variable	P-value	COR (95% CI)	P-value	AOR (95 CI)
Age group				
<25 years	Ref	1	Ref	
25-34 years	0.3204	1.52 (0.66-3.51)	0.430	0.48 (0.08-3.01)
35-44 years	0.0025*	7.87 (1.61-38.49)	0.534	2.30 (0.17-31.60)
>45 years	0.0107*	6.09 (1.25-29.69)	0.721	1.64 (0.11-24.64)
Marital status				
Single	Ref	1.00	Ref	
Married	0.0007*	4.64 (1.75-12.35)	0.462	2.02 (0.31-13.25)
Separated	0.0155*	0.28 (0.09-0.84)	0.184	0.22 (0.02-2.06)
Number of children				
<3	Ref	1.00	Ref	1
3-4	0.0206*	3.10 (1.13-8.48)	0.300	2.8 (0.41-18.78)
>4	0.0039*	6.67 (1.50-29.67)	0.896	1.16 (0.13-10.11)
Held ANC discussion with Wife/Partner				
No	Ref	1.00	Ref	1
Yes	<0.001*	59.83 (17.61-203.3)	<0.001	18.60 (3.8-89.24)
Man held ANC discussion with health worker				
No	Ref	1	Ref	1
Yes	0.0032*	3.99 (1.48-10.79)	0.961	1.04 (0.23-4.78)
Man held discussion of ANC with Friend				
No	Ref	1.00	Ref	1
Yes	<0.001*	8.73 (3.75-20.34)	0.720	0.73 (0.13-4.05)
Have read or heard about ANC				
No	Ref	1	Ref	1
Yes	<0.001*	164.54 (30.02-91.71)	0.002*	34.79 (3.53-34.28)
Knowing man who attends ANC with wife				
No				
Yes	**Ref**	1.00	Ref	
	<0.001*	48.27 (15.12-54.09)	0.250	4.2 (0.37-48.44)

NB: A measurement is statistically significant at p-value<0.05; AOR: adjusted odds ratio; OR: Crude odds ratio*: statistically significant; 95%CI: confidence interval; Ref: reference group.

4.10 QUALITATIVE STUDY

4.11 Presentation of Qualitative Results

A focus group discussion was conducted among two groups of men (aged 18-35 years and 36-60 years) comprised of ten participants each. The discussions were held on factors such as community and men's perception regarding accompanying their partners to ANC centers, their reasons for haven attended and their experiences or satisfactions with ANC, delivery and PNC services. Responses have been analyzed and grouped under major themes and sub- themes for thematic review.

4.12 Enabling Factors influencing participation

Community's perceptions and acceptability of men involvement in maternal and child healthcare were explored. Major themes identified were acceptable practice, a community norm: penalty upon default and divine mandate.

4.13 Acceptable practice

Most of the participants confirmed that men accompanying their partners to the health facility for ANC or other maternal health service was an acceptable practice. And the communities have strict adherence in terms of bylaws to such a practice. The following quotation provides evidence to their responses:

> *"It is acceptable by my community and even other neighboring communities for Men to send their pregnant partners to the hospital right from the day of conception*, but because of our work-farming, it is difficult most times, I have gone 4 times (32 year old farmer, male FGD).

> *"I am 6 months pregnant and told by the Dr. my baby is Male: I am very excited that my husband reminds me to attend because he says I am sick, so no farming for me" (33 year old trader and mother of 2 children, Female FGDs)*

4.14 Community norm of a penalty upon default

It was also revealed that one community namely Yirpelle in Baseble sub-district had just instituted strict measures and systems that ensured men accompanied their pregnant partners to the health facility for healthcare right from conception to postpartum (but mostly in ANC contacts at the facility). It was also found out that there existed punishment or penalty of funds for any man who defaults, and even pregnant women who refuse to attend ANC. This recorded higher ANC attendance with an average of 5 and more in the community.

> *"It is a penalty of Ghc20.00 for men in Baseble Yirpelle, who refused to take their wives to the CHPS Compound if the pregnancy is less than 3 months, and to the Nandom district hospital if the pregnancy is beyond 3 months, and even the health center depending on the community since health centers are few in each sub-district"* (45 year old farmer, male FGD).

> *"Even in the absence of their male partners, the family head will nominate a male, that is a brother, an uncle or any relative to take the pregnant woman to the hospital, even in times of delivery which is the ultimate outcome"* (28 year old trader, male FGD).

4.15 Reasons for men accompanying partners to ANC

Men follow their partners to the hospital for various reasons. During the focus group discussions, men expressed their reasons for attending ANC or delivery with their partners. Main themes identified were divine responsibility and to ensure family wellbeing.

4.16 Divine responsibilities

Men see it as a divine responsibility to accompany their pregnant spouses to access health care. According to their responses, they see it as a call for men by God Almighty to ensure that their wives are well, especially when pregnant.

"I surely do that as stated in the bible, I am a roman catholic, and it is my sole responsibility to protect and ensure God's creation on earth", (50 year old farmer, male FGD)

"Because of my religious faith. I am Roman Catholic, and my faith in God teaches care for your wife and children even when they are unborn" (36 year old farmer, male FGD).

"It is absolutely the responsibility of a male partner to care for her expectant wife during pregnancy" (25 year old mason, male FGD)

4.17 Ensure Family wellbeing

It was also discovered that men followed their spouses to ANC, delivery and postnatal care because they wanted to ensure the wellbeing of their offspring and their wives. According to them accompanying their spouses to ANC clinics would keep them abreast with the state of their health at every particular time.

"Pregnant women are sick people, hence need special aid, we even except them from certain household, farm jobs and duties." (40 year old farmer, male FGD).

"Because of the welfare of my wife and the unborn baby, it is a lot trouble if the outcome is death. It is expensive these days, for funerals". (55 year old farmer, male FGD).

Because I need more family members or Kinsmen, in fact a successor after my death, (57 year old farmer, male FGD).

4.18 Respondents view of the entire setting of the ANC center

Respondents were asked about their view or perceptions about the entire setting of ANC centers and their experiences from following their partners to the center. Most

of them were of the view that, the centers are not male friendly, and that it was not welcoming enough for men to go there. They expressed the views that the design of the centers had no place for men to stay whiles they waited for their partners or spouses. Majority of respondents in FGDs indicated Normal for the ANC setting.

> "*The ANC setting is definitely not male accepting, we were separated far away from our pregnant wives, even your presence is not welcomed at the delivery room, the central government must help men with male oriented policies"* (27 year old mason, male FGD).

> *"Not male friendly, because we are not treated us partners in maternity issues, even classes of education at the ANC level are lacking. For instance, reading and detailing materials on subjects such as pregnancy and its complication, nutrition, labour, hemorrhage, CS. among others are not in existence in the Nandom hospital and health centers said"* (39 years teacher, male FGD).

> *"My husband ends my visit to the ANC at the OPD because men are not allowed into the ANC area" (24 old Civil servant and mother of one, Female FGDs).*

4.19 Improving services at the ANC as recommended by Males

Various suggestions came out of participants as to how to improve maternal health services in order to encourage male partner involvement. Major suggestions identified were ANC education classes for men, male inclined design settings,

computerized ANC operations, and change of abusive attitudes of health workers, instead professionalism was called for. Suggestions on education for men:

"*Male partner classes at the center should be organized to create an enabling environment for male partners from all over Nandom to deliberate on their participation in ANC, labour/childbirth, among other vital topics of education"* (30 year old civil servant, male FGD).

Others also suggested good reception for male partners:

> *"Male partners should be warmly welcomed by midwives and nurses/gynecologists and the welfare/conditions of pregnant wives should be well explained to them for properly for decision making"* (52 year old teacher, male FGD).
>
> *"Male partners especially husbands should be allowed into the delivery rooms to give their partners moral support in Labor"* (28 year old trader, female FGD)

There were suggestion for the upgrade of infrastructures such as the health centers, roads, and ambulances. Provide more CHPS in all communities, computerized operations, and increase the work force and its mix at medical facilities.

> "*Communities like my own (Kuo-Tom) are very big, and have bad roads, hence ambulances refuse to come, in times of emergencies. I will suggest the upgrading of our Health centers into polyclinics with qualified staff to care for us and other neighboring communities."* (32 year old farmer and mother of 3, female FGDs).
>
> "*The ambulances in Kuo-Tom do not respond when called in times of need, they say bad roads" (39 year old farmer and mother of 5, Female FGDs)*
>
> *"We need more humane, and comfortable resting areas at the ANC setting for males especially so we can conveniently interact with one another and wait for the good news. More male nurses should be posted to the ANC centers*

since they understand our issues promptly and better" (30 year old Civil servant, male FGD).

A change of attitudes of nurses and health workers was suggested by participants as shown in the comments below.

"*We need a change in attitude of some of our nurses. We need professional nurses and not abusive nurses"* (29 year old Teacher and mother of 2, Female FGDs).

Based on the FGDs among the females and males of 4 sets of groups consisting of younger age groups juxtaposed with elderly age group ranges, some themes and sub themes were recorded via probes.

Younger Females and Males suggested the following:

"Most men have travelled to Kumasi and Sunyani for jobs, so they can remit to us in Nandom, so we attend ANC by ourselves, you know we are farmers and have no money" (24 year old farmer and mother of 2, Female FGDs).

Our male children have all ran away to southern Ghana especially Kumasi for work, we are poor peasant farmers, so not many accompany our partners because we need to work on our farms since we are in the raining season, but we have heard about ANC on radio and via durbars organized by CHPS nurses" (27 year old Carpenter, Male FGDs).

"We the young married men in Nandom need jobs so we can work for money to take our wives to ANC because we will buy fuel more than Ghc15.00 into Motors, since the ANC centers are far from home especially when she is more than 3 months, you need to go Nandom Hospital for ANC services and others" (29 year old Mason and brick layer, Male FGDs).

Elderly Females indicated lack of awareness in their time, however, applauded interventions now by GHS via the CHPS concept, on the other hand elderly males hardly accompanied their partners because of their work and long hours spent at ANC clinics.

"*I have attended ANC with my wife 3 times because I am always on the farm, so I can feed my family. The two times I attended, the whole day was spent at the ANC facility to the neglect of my farm*" *(52 year old farmer, Male FGDs).*

"In my time there were no CHPS nurses, and as illiterates we only realized pregnancy after several months sometimes after 4 or 5 or 6 months' time, so I gave birth at home, that is my first daughter, I nearly died ooooh my son, but now we hear about maternal issues on radio, and through our chiefs with CHPS nurses, you can see our community is far from Nandom hospital" (58 old year farmer and petty trader, mother of 6, Female FGDs).

On the whole, there were mixed views from the two sets of FDGs with regards to their ages and sex. Younger males (18-36 years old) depicted the need to have jobs in Nandom resulting in their stay back home (Nandom) so they could escort their partners or wives to ANC since, a majority of them were in the known of ANC and its numerous benefits. Again, they expressed the need for computerized operations at ANC especially at the main hospital to aid reduce service times, so they could return to their farms. A responsive ambulance systems, good roads among other indirect services were demanded largely by younger males and females together.

On the contrary, elderly men and women applauded the efforts by GHS, CSOs, FBOs, among others for the numerous interventions in Nandom,

because they lacked those kind of interventions in their days, thus home delivery was the norm, coupled with its demerits, and mainly fatal outcomes. They also called for jobs so their male children especially can stay at home to care for their wives and generations unborn. This evident in the quotation;

" I am 55 years old, a farmer and mother of 6,we need our male children home, and not in Kumasi looking for non-existing jobs, thus tell the president from your study and sine you live in Accra to: to give us jobs in Nandom, because the farming is not lucrative thus, we poor" (55 year old farmer, Female FGDs)

CHAPTER FIVE

DISCUSSIONS

5.1 Introduction

This study was undertaken to examine the factors influencing male partner involvement in maternal healthcare: mainly ANC participation in the Nandom District of the Upper West region-Ghana. Factors examined included predisposing, enabling and reinforcing factors.

5.2 Demographic characteristics of respondents

The mean age and range of the respondents was 34 and 25-44 years old (62%) respectively. Most of the respondents were engaged gainfully in the informal sector of employment (64.3%).This exemplifies the socio-economic nature of most rural areas of Ghana. The major occupation found in the Nandom District was predominately farming, trading, carpentry, masonry and dressing making. The 2010 National Census of Ghana reported that over 60% of Ghanaians were engaged in the informal sector (GSS, 2011). Respondents occupational status reflected their earnings per month as the majority (45.8%) of them earned less than Five hundred Ghana cedis(GHc500.00) per month, (Mangeni, Mwangi, Mbugua, & Mukthar, 2013).

5.3 Level of male partner participation in ANC.

This study examined the levels of male partner participation in ANC att8155572Fendance. The study revealed that male partner participation was very high as most respondents (92.4%) stated they joined their partners to the ANC center. The level of ANC participation found in this study was higher than what was found in most researches in Ghana, and Africa. Doe (2013) found 24% of participation in Ghana in the Ablekuma District. Also, Craymah et al., (2017) and Byamugisha et al.

(2011) found 35% and 24 % respectively in Ghana and Mbale district, Uganda. Similar to this study, Mitchell, (2012) also reported that 85.5% of male participants accompanied their wives/partners to the ANC clinic in the Nkwanta South District-Ghana.

Some of the reasons for the high proportion of males in ANC attendance were disclosed through the focus group discussions held with participants. It was revealed that most of the communities had instituted strict, deterring and punitive measures which made ANC visits mandatory-for a man to accompany the partner to the health center when pregnant. This may have been influenced by the Twenty Ghana cedis (Ghc20) fine paid by the household or partner to the Chief, into designated bank account. The said money when amassed was used as an emergency and revolving loan scheme to expectant mothers, especially in times of need. Again, the household was taxed if the pregnant women defaulted deliberately on her monthly ANC visits. The men also talked about their desire to have a successor to their lineage, so they had to make all conditions possible for the wife to deliver safely and have the baby alive. Others saw it as an obligation and responsibility to follow their wives to the hospital or health center for proper care. In a qualitative study on barriers to male involvement in ANC in rural Mozambique, it showed that contrary to the findings made by this current study, the men in those rural areas had no community instructions or sanction measures to enforce men to accompany their partners to ANC. The study further reported that men who did faced ridicules and stigmatization from other members of the community, thus lowering their self-esteem among their peers in the community.

This current study revealed that men not only accompanied their wives to the ANC center more than once and actually almost half (46.0%) had followed their partners for more than 5 times.

An assessment of men's experience in ANC also revealed that many respondents (62%) see the attitudes of healthcare workers as friendly. In Ghana, an earlier study done in Anomabo in the Central region, reported that men felt free to go for ANC visits with their partners because of the encouragement and humane treatment they received from health workers (Craymah et al., 2017). However, in the qualitative interviews, some participants disclosed some challenges they go through whiles waiting for their partners at ANC centers. Some of these challenges are lack of place for male partners to stay, rest wait, and abusive and sometimes inhumane attitudes of some nurses towards them. Again, most of the respondents observed that ANC services setting had not been designed to accommodate men who attend hence the inconveniences they experienced.

5.4 Predisposing factors and male ANC participation

The predisposing factors are notably demographic factors of a person which naturally predisposes him or her to other factors (Ditekemena et al., 2012). This study found that factors such as age group of respondents ($p<0.004$), marital status ($p<0.001$) and employment status ($p<0.001$) were statistically significant with ANC attendance among these men. Similar results were found with the number of children that a man has, their religion, earnings per month and occupation. Craymah et al., (2017), similarly found a significant association between partner's education ($p< 0.05$), marriage ($p< 0.020$, living arrangements, and number of children. The study by Kariuki & Seruwagi, 2016 , showed that male involvement in ANC was very

low(6%) and attributed to socio-demographic factors such as education (*p<0.001*), marriage(*p<0.001)* and age *(p<0.044*). Lower earnings (p<0.023) reduced male involvement in contrast.

This study found a significant association with the number of children and male involvement in ANC. Men who had more than 4 children were 6 times more likely to attend ANC with partners compared to those who had less (COR: 6.67; 95%CI: 1.50-29.67; *p<0.0039*). In contrast, two studies done in Gambia and rural Mozambique reported that male involvement reduced as more children were born (Audet et al., 2016; Lowe, 2017).

5.5 Enabling factors influencing male partner involvement in ANC clinics.

Enabling factors can be described as supporting factors in the social or physical environment of the people that provide them the easiness to do something. In relation to health facility or visiting Anti-natal (ANC) center, things such as the availability, proximity and the cost of receiving a service come to play.

The study found that motorbikes and bicycles were the main means of transport (70.6%) used to the ANC center as compared to private or commercial cars. It was not surprising because in most communities in the Northern partner of Ghana, transportation on daily basis is mostly done by bicycle/motorbike (Ditekemena et al., 2012). It is considered as cheap and more reliable form transportation in the Northern part of Ghana. The implication of this major means of transport is that most men may find it easier riding with their partners to the ANC center without or with less hindrance: as major transportation such as car or commercial vehicles were sometimes scarce to come by in most rural and northern communities.

This study also found that most respondents travelled long distances to the health center or the ANC centers to access care. The majority of them lived in more than 10 kilometers to their nearest ANC center. This condition is particularly likely to cause or discourage frequent attendance of ANC by men as many studies have found long distance as a confounder or barrier to male participation in ANC (Lewis et al., 2015; Lowe, 2017; Mangeni et al., 2013; Maputle, 2016). Compared to men who lived in more than ten(10) kilometers were 14 times likely to visit the ANC center with his partner (AOR:14.4; 95%CI: 4.02-51.66). Also, those who spent more than Fifteen Ghana cedis (Ghc15.00) on transport on each ANC visit were 85% less likely to frequently visit ANC center with their partners. Similar findings were reported by (Brittain, 2014; Craymah et al., 2017; Lowe, 2017; Lucy I Kululanga , Johanne Sundby, 2018).

Furthermore, this study found a significant association between the amount spent on transportation ($p<0.001$), distance to the ANC center ($p<0.001$), respondents' views about ANC services (p-value<0.001) and male partner participation in ANC. Craymah et al., (2017) also found that enabling/disenabling factors and male involvement in ANC showed that distance to the health facility (< 5 km: 40% versus more than 5 km: 15%) and attitude of health workers (yes: 39% versus no: 0%) were the enabling/disenabling factors significantly ($p< 0.05$) associated with male involvement in antenatal(ANC).

This study again found that men who viewed organization of ANC programmes at the centers revealed that very helpful had higher odds to ANC attendance than those who viewed it as less helpful (AOR: 0.16; 95% CI: 0.05-0.50; p-value=0.0001). The organization of ANC centers that is, in terms of its structure/design and services has to provide influence greatly on men's perception and their attitudes towards ANC

attendance. In Gambia and Mozambique and other parts of Ghana, previous studies also showed similar findings made by this study (Audet et al., 2016; Lowe, 2017; Mitchell, 2012).

5.6 Reinforcing factors and males ANC participation

Reinforcing factors are those motivations and rewards that encourage a good behavior and that is **used** to shape or provoke a desired behavior or action (Ibrahim et al., 2016). People turn to put up or do certain things because of the motivation they may have to do so (Aborigo, Reidpath, Oduro, & Allotey, 2018). This study found that majority of the male participants (89.4%) had held discussions with their wives or partners about ANC services whilst only 42.3% had held any discussions regarding ANC services with a healthcare worker. It was also encouraging to find out that almost all the male respondents have heard or read about ANC. This is important because such knowledge would help them become more abreast with ANC information and also give them more understanding about the services given by the center thereby increasing their participation. Most men had heard or read about ANC via regular durbars organized by the registered nurses of CHPS Compound, and the community leaders especially their chiefs. This was very much evident in Baseble-Yirpelle, a sub-district in Nandom.

Another well-known motivation is seeing other males take their wives to the hospital (Aborigo et al., 2018; Kululanga, Sundby, Malata, & Chirwa, 2012). This study found that a high proportion of (92.7%) the respondents also disclosed they know other men who accompanied their partners to the ANC centers. It was encouraging to notice that because of such actions or activities: the resultant effect would induce other men to also learn and put-up such habits, of ANC participation.

Similar to other studies such as (Chattopadhyay, 2011; Chris, 2015; Kaji & Niehof, 2013; Mitchell, 2012), a bivariate analysis done by this study confirmed a statistically significant association between these reinforcing factors as discussed above as having influenced male participation in ANC services. This study observed that men who had held discussions on ANC with their wives were 18 times more likely to attend ANC clinics with the wives as compared to those who did not (AOR:18.60; 95% CI: 3.8-89.24, p-value<0.001).

Similarly, this study found that compared to men who did not know or have not seen other men going to ANC with their wives, those who knew had a very high odds of attending ANC with the partner and this was statistically significant at p-value= 0.002 (AOR:34.79; 95% CI:3.53-34.28). This finding is inconsistent with a previous study done in Maligita and Kibibi in Uganda, men will rather stay home and ask questions about ANC from the wife or on the media than to visit the ANC center thus low odds of attendance was found among those men (Singh, Lample, & Earnest, 2014).

CHAPTER SIX

CONCLUSION AND RECOMMENDATIONS

6.1 Introduction

The study revealed very high participation or attendance at ANC by male partners with their wives. Participation was low among those who were divorced or separated, those who were in informal employment, and those less than 25 years of age.

Enabling factors such as means of transport, distance to the ANC facility and amount spent on transport had significant influence on male partner attendance to ANC. Men who lived in less than 10 kilometers to the nearest ANC center, those who spent less amount of money on transportation were found to attend ANC clinics more than those who spent higher amounts of money. It was also revealed that men who viewed ANC services as very well organized or very helpful were more likely to attend or accompany their partners or be involved in ANC services than those who did not see it as helpful. It implies more educative and useful programmes should be organized and male inclined.

Having a discussion or talking about ANC with partners had a greater influence on attendance as men who had discussions with their partners had high odds of ANC attendance than those who did not. It was depicted that men who had witnessed other men accompany their wives to ANC had a greater motivation for ANC attendance. That means, as more men follow their partners to ANC the possibility of other men imitating such good habits will increase or rise.

Finally, key influencing factors noted through a qualitative-focus group discussion approach was a community institution of strict and deterring measure of a twenty Ghana cedis (Ghc20.00) fine for defaulting men and pregnant women who refused

ANC deliberately. The said money was deposited in a community operated bank account with the Nandom Rural Bank with elected signatories. The money served as a revolving and a microfinance source of funding for the economic empowerment of especially pregnant women for trading purposes dubbed "Pregnant women in Trade" and also for emergencies (as borrowed funds) in times of delivery or others. This sole gesture of greater community mobilization and involvement, an undeniable public health intervention strategy is worth replicating in other districts in Ghana, thus with the sole aim of increasing male partner involvement in ANC in Ghana. In addition, a call for male friendly settings in terms of architectural designs and male oriented programmes, notably ANC classes for men on very salient topics such as nutrition, hygiene, emergency preparation/complications, and physical activity, among others is worth emulating. Finally, professional attitudes and "not abusive attitudes" from healthcare workers is the key to high male partner involvement as echoed by participants in the focus group discussion.

6.2 Recommendations

The following recommendation were made based on the findings from the study in the Nandom District of the Upper West region-Ghana:

Recommendations for policy makers, planners and implementers

- To improve male partner involvement in maternal healthcare services in Nandom, policy making, planning, and implementation should focus on adopting strategies to involve men and their roles in the community. The ability to access healthcare services among pregnant women who lived in far communities away from health centers or CHPS Compounds can be possible if they have their partners support. Attendance to ANC was 92% thus the existing supportive schemes in place

should be studied further to see how it can be rolled out in other districts in Ghana.

Recommendations for health care facilities and service providers

- To improve upon the overall effect of healthcare services, male friendly ANC settings and purposive programmes should be organized.
- Spousal interpersonal relationships should be incorporated into male ANC classes.
- Men who willingly accompany their partners to ANC clinics, should be attended to first(Men are usually seen as aiding partners, and as moral boosters)
- The CHPS concept should be strengthened for better outcomes.
- Health promotions as a strategy should be strengthened with exciting activities like community durbars, Maternal Health video shows, jingles on mass media, and finally the use of community volunteers for early pregnancy referrals.

Recommendations on future research

- This study should be replicated in other areas of the country including the urban areas using combinations of indicators or factors to assess the levels and trends of the extent of involvement by men in maternal healthcare services.
- Future studies should involve the participation of men in all the levels of maternal health care notably Preconception, ANC, Labour, Delivery, and Post- partum periods. Special attention should be aimed at getting men into the labour rooms to aid shorten labour and make it a pleasant experience for their partners.

- Behavioral theories should be used to explore ANC male partner involvement in Ghana, for an exhaustive comparative analysis of predictors.

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APPENDICES

APPENDIX A: INFORMATION SHEET

I am Frank Domah, a student of University of Ghana, School of Public Health. I am conducting a research on the topic; Male partner involvement in Antenatal Care in the Nandom district of the Upper West region.

Purpose of the Study

The purpose of the study is to assess the level of involvement by male partners with regards to maternal health in the Nandom district of the Upper West region. This is also a prerequisite for the award of an MPH degree.

Participant Role

The study will involve both expectant mothers and their partners in answering questionnaires.

Participants' involvement:

- **Duration /what is involved:** Expectant mothers and their partners will be expected to cooperate and spend about thirty minutes of their time with the field team.
- **Potential Risks:** participant would be a bit strained with time and a bit uncomfortable given the nature of the questionnaires aside the above, the would be no harm to the expectant mother and male partner.
- **Benefits:** health policy makers, Nandom district hospital, and district health administration would be more informed with issues concerning male partner involvement in maternal health in the district.
- **Costs:** no cost would be incurred by both expectant mothers and their male partners except for cost which are already factored in the expenditure of the principal interviewer.

- **Compensation:** Money has being allocated for participant refreshment.
- **Confidentiality:** confidentiality would be ensured among study participants, that is expectant mothers and partners. Questionnaires would also be entered into a computer with a STATA software for analysis. It would be secured with a password which would be accessible to only the principal researcher and his supervisor. Any declaration of any findings would only be possible through a prior approval from all the participants involved.
- **Voluntary participation/withdrawal:** participation is purely voluntary and every participant has the right to withdraw from the study at any point in course of the study.
- **Outcome and Feedback:** outcomes of the findings will be made available to all key stakeholders.

- **Funding information:** Support for the project, both in the form of supervision and fieldwork costs including costs of transportation to Nandom district will be borne by Mr.

  Frank Domah, principal investigator for the study.

- **Conflict of Interest:** it is owned by the principal investigator. the findings realized from this study would be shared with interested stakeholders. The study would be made available to the public as well as any interested organization. With no identification disclosure.

Compensation

Expectant mothers and male partners would incur no financial costs for participating in the study neither would any payment be made for participating. Participants would

be served with refreshments during the interview. Participants would be engaged for less than 30minutes should they agree to take part in this study. Participants have the reserve right to continue or to withdraw from the study at any time.

Confidentiality

You are assured of your privacy and confidentiality. The information participants will share with the principal interviewer, would not be shared with any other person except the research team.

All information would be coded and your name would not be included in any of our writings.

Therefore, no one will be able to identify the participant by name.

Potential Risk / Benefit

This study is an academic work and there are no direct benefits for participating. However, findings from this research would serve as an important base or reference for researchers to refer to generally in researches concerning male partner involvement in maternal health issues in the Nandom district of the Upper West region. In addition, the research would add to academic knowledge.

Data Storage and Usage

The data collected would be kept safe and stored under lock with key. Findings from the research would be shared with the School of Public Health at the end of the study. Collected data would be entered into STATA 15 software for the purpose of analyses.

I would like you to read this consent form and sign, if you agree to participate in this study.

Respondents / participants only:

On my own accord, I hereby consent to be part of the study based on my understanding of what the study entails.

CONSENT FORM

I acknowledge that I have seen the information sheet, read and understood. I have agreed to participate in the study voluntarily

Sign/Thumbprint…… Witness's Sign…….

Date…… Date…….

Name of Researcher: ……

Researcher's signature……

Date……

APPENDIX B 1: FOCUS GROUP DISCUSSION GUIDE FOR MEN.

FGD facilitator…… **FGD Note taker**……

Date……/……/…… **No. of participants**……

Time…… **Facility**……

Identify respondent according to selection criteria, Introduction and Purpose. Introduce topic (length of FGD approx. 45minutes, confidentiality, and informed consent)

Demographic Characteristics of participant

Age……. **Occupation**…… **Education**……

Marital status…… **No. of children**……**Religion**……

ENABLING FACTORS IN ATTENDING ANC AMONG MALES

1. Do you please attend ANC with your wife? Probe for further information?
2. Is it acceptable by the community for men to accompany wives to ANC? Probe further?
3. Does your family and friends accept men who accompany their wives to ANC?
4. How much is your total fare to an ANC visit with your wife?
5. How expensive is it?
6. How far is the ANC center from your house?
7. How do you view programs organized at the ANC?

REINFORCING FACTORS IN ATTENDING ANC AMONG MEN

8. Do you hold discussions on ANC with the following people? Probe for more information.

A. Wife

B. Health worker

C. Friend

9. Do you know about ANC, and from where: probe for more sources?

10. Do you know men who are attend ANC with their wives

MEN EXPERIENCES WITH ANC

11. Have you ever accompanied your wife to ANC?

12. How many times during her pregnancy?

13. What made you accompany your wife?

14. How many minutes did you spend at ANC?

15. What kind of treatment did you experience at the ANC center?

16. Can you tell me about the entire setting at the ANC facility as a man?

17. Do you think accompanying your wife will encourage her to visit ANC every time and early?

18. What do you think should be improved at the ANC center? Probe for more information.

THANK YOU

APPENDIX B 2: FOCUS GROUP DISCUSSION GUIDE FOR PREGNANT WOMEN.

FGD facilitator……..… **FGD Note taker**……

Date……/……/…… **No. of participants**…….……

Time…… **Facility**……..

Identify respondent according to selection criteria, Introduction and Purpose. Introduce topic (length of FGD approx. 45minutes, confidentiality, and informed consent)

Demographic Characteristics of participant

Age……. **Occupation**…… **Education**……

Marital status…… **No. of children**…… **Religion**……

ENABLING FACTORS IN ATTENDING ANC BY EXPECTANT MOTHERS

19. Do you attend ANC with your partner?
20. Is it acceptable by the community for men to accompany wives to ANC? Probe further.
21. Does your family and friends accept men who accompany their wives to ANC?
22. What is the cost to an ANC visit?
23. How expensive is it?
24. How far is the ANC center from your house?
25. Tell me about programmes organized at the ANC?

REINFORCING FACTORS IN ATTENDING ANC BY PREGNANT WOMEN

26. Do you hold discussions on ANC with the following people? Probe for more information.

D. Husband

E. Health worker

F. Friend

27. Tell me about ANC?

28. Do you know men who attend ANC with their wives?

WOMEN EXPERIENCES WITH ANC

29. Do you get accompanied to ANC by your husband?

30. How many times during your pregnancy?

31. Give me reasons why your husband accompanied you to ANC?

32. How many minutes did you spend at ANC?

33. What were your experiences with Staff at ANC?

34. Probe for more information.

35. Can you tell me about the entire setting at the ANC facility as an expectant mother?

36. Do you think being accompanied by your husband will motivate you to attend ANC regularly and timely?

37. What do you think should be improved at the ANC center? Probe for more information?

THANK YOU

APPENDIX C: PARTICIPANTS INFORMATION SHEET

SCHOOL OF PUBLIC HEALTH
COLLEGE OF HEALTH SCIENCES
UNIVERSITY OF GHANA

Project Topic:
MALE PARTNER INVOLVEMENT IN ANTENATAL CARE: A STUDY IN THE NANDOM DISTRICT OF THE UPPER WEST REGION, GHANA.

Introduction

I am Frank DOMAH, a graduate student from the School of Public health, University of Ghana, and Legon. I am undertaking a research study on the topic "MALE PARTNER INVOLVEMENT IN ANTENATAL CARE: A CASE STUDY IN THE NANDOM DISTRICT OF THE UPPER WEST REGION, GHANA." The purpose of the study is to identify the factors contributing to no or low male partner involvement in maternal health care in the Nandom District of the Upper West region. This informed consent is to ensure that participants understand the purpose and their responsibilities in the research before they decide whether to participate or not participate.

Study procedure

This is a research study that would involve answering questions to an interviewer using a questionnaire to assess enabling, predisposing, and reinforcing factors, perceptions with male partners regarding ANC, Acknowledge of maternal health among partners in general, and finally their level of involvement from ANC to postpartum. The questions have three sections which include socio-demographic characteristics of respondents; sex, age, household type, location, religion, occupation, level of education, among other factors. The second part comprises questions on enabling factors in attending ANC among men, the third encompasses reinforcing factors in attending ANC among men. The last set of questions include

men experiences with ANC. The whole study will last for about one month but your participation will only be for today which will take about 30 minutes.

Voluntary participation

Participants have the right not to participate in the study or to withdraw from the study at any time without any consequences should you choose to withdraw, the information provided earlier would be discarded outright. Each individual is entitled to ask questions at any point in the study for clarification. Any aspect of the questions that are not well understood will be clarified by the interviewer.

Risk and benefits

No risks are associated with the participation of this study except that it will take part of your precious time and the need to provide some personal information. The benefits of the study to the population will be among other things include; to determine the contributing factors to no or low male partner involvement in maternal health care so as to inform policy makers on how to direct the available and limited resources into curbing maternal morbidity and mortality within the Nandom district among other districts, thus a national policy for all. The study will not pose any foreseeable physical risk to the study population or the community at large. Neonatal morbidity and deaths will be averted via a study like this and families will be happy with children born healthy and very much alive. “”Your joy will be endless”.

Compensation

No payment will be made for your time.

Confidentiality

All information provided during this research will be protected as much as possible. No discussion will be held regarding the research outside the team. All responses will be treated as confidential as no names will be placed on the questionnaires.

This research has been reviewed and approved by Ghana Health Service Ethics Review Committee.

In case of any concerns, kindly Contact the following persons

Ghana Health Service
Ethical Review Committee Administrator
Administrator

Miss Hannah Frimpong
Hannah.Frimpong@ghsmail.com
O5O7041223

Ghana Health Service
Ethical Review Committee

Miss Abena Nana Kwaa
nanatuesdaykad@yahoo.com
0244712919

Frank Domah
STUDENT ID
Email Address

020-7208599, 0264900787
10635149
macariodomah@yahoo.com

APPENDIX D: QUESTIONNAIRE

UNIVERSITY OF GHANA SCHOOL OF PUBLIC HEALTH

DEPARTMENT OF EPIDEMIOLOGY AND DISEASE CONTROL

RESEARCH TITLE: "MALE PARTNER INVOLVEMENT IN MATERNAL HEALTHCARE IN THE NANDOM DISTRICT'

QUESTIONNAIRE FOR RESPONDENTS

Introduction

Good morning/afternoon. I am a student at the University of Ghana. I will be conducting several meetings with people like you in this facility to find out your views and ideas concerning male involvement in ANC". Be assured that your responses will not in any way be linked to your identity. You are kindly requested to answer the questions below by indicating a tick or writing the appropriate answer when needed.

THANK YOU

QUESTIONNAIRE ID: …….....

SECTION I SOCIO-DEMOGRAPHIC CHARACTERISTICS

1. Age of respondent? __ __ years

2. Marital status

i. Single ☐ ii. Married ☐ iii. Separated ☐

iv. Divorced ☐ v. Widowed ☐ vi. Cohabitation ☐

3. Education level

i. Primary ☐ ii. J.H.S ☐ iii. S.H.S/Tech./Voc./O-Level ☐

iv. O-Level ☐ v. Tertiary ☐ vi. No informal education ☐

4. Religion

i. Christian ☐ ii. Muslim ☐ iii. Traditional ☐

Other (Specify)…….....

5. Employment Status

i. Employed ☐ ii. Unemployed ☐

6. What is your main occupation

i. Artisan (carpenter, mason, plumber, driver, etc.) ☐ ii. Farmer ☐

iii. Civil/Public servant ☐ iv. Trader/Businessman ☐ v. other (specify)

7. How much do you earn per month? GHC…….

8. Number of children:……

SECTION II: ENABLING FACTORS IN ATTENDING ANC AMONG MEN

9. By what means would you go to ANC?

i. Walk ☐ ii. By taxi ☐ iii. By trotro ☐ iv. Private car ☐

Other (Specify) …….

10. Do you think your community consider it acceptable for a man to accompany his wife/ partner to ANC?

i. Yes ii. ☐ No ☐ iii. Don't know ☐

11. Do you think your family and friends consider it acceptable for a man to accompany his wife/ partner to ANC?

i. Yes ii. ☐ No ☐ iii. Don't know ☐

12. How much would you/do you spend on transportation to the ANC on each visit?

GHC……

13. How do you view the cost of transport to ANC?

i. Expensive ☐ ii. Not expensive ☐ iii. Cheap ☐

14. What is the estimated distance between your residence and the facility?

……...KM. area of residence …….

15. How do you rate the distance from residence to facility?

i. Very Far ☐ ii. Far ☐ iii. Near ☐ iv. Very near ☐

16. What is your perception about programs organized at the ANC?

i. Very helpful ☐ ii. Helpful ☐ iii. Not helpful ☐

iv. Complete waste of time ☐ v. Don't know ☐ other (specify) ……

SECTION III: REINFORCING FACTORS IN ATTENDING ANC AMONG MEN

17. Have you ever held a discussion on ANC with any of the following people;

18.

A. Wife or partner i. Yes ☐ ii. No ☐ Not sure ☐

B. Health worker i. Yes ☐ ii. No ☐ Not sure ☐

C. Friend i. Yes ☐ ii. No ☐ Not sure ☐

18. Have you heard or read about ANC from any source before?

i. Yes ii. No ☐ iii. Not sure ☐

19. If yes, please indicate source……

20. Is there any man you know who attends ANC with his wife/partner?

i. Yes ii. No ☐ iii. Not sure ☐

SECTION IV: MEN EXPERIENCES WITH ANC

21. Have you ever accompanied your wife to ANC?

i. Yes ☐ ii No ☐ iii. Not sure ☐

If the answer to question 21 above is yes, answer the questions below:

22. How many times during the entire pregnancy period? ……..

23. What motivated you/ personal reasons to accompany your wife to ANC?

……

……

……

24. How long did you spend at the ANC? ……Hours ……Minutes

25. How will you rate the time spent the facility?

i. Long ☐ ii. Normal ☐ iii. Short ☐

26. How will you describe the attitude of staff at the facility?

i. Very friendly ☐ ii. Friendly ☐ iii. Normal ☐ iv. Not friendly ☐

v. Not sure ☐

27. How will you describe the entire ANC setting during your visit?

i. Very friendly ☐ ii. Friendly ☐ iii. Normal ☐ iv. Not friendly ☐

v. Not sure ☐

Do you believe you accompanying your wife to the facility will motivate her to visit the ANC in a timely manner?

i. Yes ☐ ii. No ☐ iii. Not sure ☐

28. Is there anything you recommend to be improved to enhance men participation in ANC?

Please State…… ……

……

……