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MALE PARTNER INVOLVEMENT IN MATERNITY CARE IN ABLEKUMA SOUTH DISTRICT, ACCRA, GHANA

BY

ROSELINE DANSOWAA DOE

(STUDENT ID: 10397290)

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DECLARATION

I, Roseline Dansowaa Doe, declare that this work is the result of my own original research and that this dissertation, either in whole or in part has not been presented elsewhere for another degree. Where reference has been made to the work of others, they have been duly acknowledged. I have no conflict of interest in this research.

SIGNATURE: _____

DATE: _____

ROSELINE DANSOWAA DOE (STUDENT ID – 10397290)

PRINCIPAL INVESTIGATOR

RESEARCH SUPERVISOR

DR AYAGA A. BAWAH, Ph.D.

SCHOOL OF PUBLIC HEALTH

UNIVERSITY OF GHANA

SIGNATURE: _____

DATE: _____

DEDICATION

I dedicate this work to all men who like my husband, Mr. Frederick Doe, were highly involved and offered immense support throughout their partners' maternity care.

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Above all, God deserves the greatest appreciation for it is by His grace that I have come this far.

ABSTRACT

BACKGROUND

Male partner involvement has been recognised as a key factor in improving maternal health and reducing maternal mortality in settings where men play key role in decision making in the household. Aspects of reproductive health like family planning and treatment of STI have seen improvement where male involvement has been encouraged. Ghana has a high maternal mortality rate of 350/ 100,000 live births with a slow decline towards its goal of 185/ 100,000 live births by 2015. Male partner involvement is one of the strategies that can be used to accelerate the decline in maternal mortality and improve maternal health.

OBJECTIVE

The objective of this study, conducted in Ablekuma South District of Ghana was to determine the level of male partner involvement in maternity care and identify factors that influenced their involvement.

METHODS

A cross-sectional survey using interviewer-administered structured questionnaire was conducted among 422 men aged 18 years and above with children 5 years and below. The survey was complemented by 4 focus-group discussions; two female groups and two male groups. Male involvement was measured using a composite measure of 5 key points. Pearson Chi-Square was used to test association between the various factors and the level of male involvement and logistic regression analysis was carried out to determine the influence of these factors on the level of male involvement. Thematic Content Analysis of the focus-group discussions was also done.

RESULTS

The mean age of participants was 32.9 years (SD=8.2). Overall, 26.4% had high level of involvement, 55.2% had moderate level of involvement and 18.4% had low level of involvement. The period with the highest proportion of high male involvement was during labour and delivery. Younger age (18-25years vs. 26-35years: OR=0.28, 95%CI: 0.12, 0.66) and the couple living with other family members negatively impacted on the level of male involvement. On the other hand, higher level of education (Tertiary: OR=40.57, 95%CI- 3.16, 520.32; Senior Secondary: OR=7.73, 95% CI- 1.61, 37.15; Junior Secondary: OR=6.62, 95% CI: 1.35, 32.41) and the couple living together (OR= 13.12, 95%CI 6.86, 25.08) had a positive influence on the level of male involvement. Healthcare institution barriers to male partner involvement included poor staff attitudes, restrictions on male access to labour and delivery rooms and unwelcoming health facility environment. Social stigma associated with men playing what is perceived as feminine roles within the community was another barrier.

CONCLUSION

Male involvement in maternity care was not optimal. Improving male-friendliness of health facilities in terms of infrastructure, organisation of services and staff attitudes and education of the community especially men to sensitise them against the negative attitudes towards male participation in maternity care can improve male involvement.

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LIST OF ABBREVIATIONS

CI	Confidence interval
FGD	Focus Group Discussion
GDHS	Ghana Demographic Health Survey
GMHS	Ghana Maternal Health Survey
GSS	Ghana Statistical Service
LB	Live Birth
MDGs	Millennium Development Goals
MMR	Maternal Mortality Ratio
PNC	Postnatal care
SD	Standard deviation
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization

DEFINITION OF TERMS

Antenatal care: The care given to a woman during her pregnancy by a health care professional.

Intrapartum care: The care given to a woman during labour and delivery by a health care professional.

Male involvement: Refers to men participating in and having joint responsibility with women in all areas of maternity care.

Male partner: The man biologically responsible for the pregnancy of a woman.

Maternal health: Refers to the health of women during pregnancy, childbirth and the postpartum period.

Maternity care: Refers to the care given to a woman during her pregnancy, labour, delivery and the postpartum period by a health professional.

Postnatal care: The care given to a woman from the delivery of the placenta up to six weeks after delivery by a health care professional.

Skilled Attendance: Refers to childbirth managed by a skilled attendant under the enabling conditions of a functional emergency obstetric care and referral system.

Skilled Attendant: Refers to an accredited health professional such as a licensed midwife, doctor or nurse who has adequate proficiency and the skills to manage normal (uncomplicated) pregnancies, childbirth and the immediate postnatal period, and also in the identification, management and referral of complication in women and newborns.

CHAPTER ONE

INTRODUCTION

1.1 BACKGROUND

As 2015 approaches, the world is looking forward to the achievement of the millennium development goals (MDGs) set by world leaders at the United Nation. One important goal is to improve maternal health (MDG 5) with a target of reducing maternal mortality ratio by 75% and universal access to reproductive health services by all women. The global maternal mortality ratio is 210 per 100,000 live births (World Health Organisation, 2012). In 2010, there were 287, 000 maternal deaths with 99% contributed by developing countries. Over 50% of these occurred in Sub-Saharan Africa (United Nations, 2012). To achieve the Millennium Development Goal 5, there must be a 5.5% annual reduction in maternal mortality but the figures in 2010 showed a reduction rate of 2.6% in Sub-Saharan Africa (WHO, 2012).

Ghana, like many other developing countries has a high maternal mortality ratio of 350 per 100,000 live births, a far cry from the target of 185 per 100,000 live births for 2015 (WHO, 2012). Supervision by skilled health attendants during pregnancy, delivery and the post-partum period has been recognised as key in the reduction of maternal mortalities (Campbell & Graham, 2006). This is one of the key intervention areas of the MDG Acceleration Framework for Ghana. (Ministry of Health, 2011). The Ghana Demographic Health Survey (GDHS) 2008 showed that 78% of pregnant women made at least 4 visits to the ante-natal clinic. This is the minimum number of visits recommended by the World Health Organisation (WHO). Only 57% of births were attended by skilled

professionals. Forty-Two per cent (42%) of births occurred at home without professional supervision and 23% had no post-natal care (Ghana Statistical Service et al, 2009a, 2009b).

A lot of programmes and interventions have been put in place to promote maternal health and thus reduce maternal mortality. Maternal health issues have often been seen as feminine or as a 'woman thing' so most of these interventions have focused on women. They have aimed at women empowerment, increasing female autonomy and their decision-making powers. These are laudable but whereas women autonomy may increase maternal health service utilisation, increasing women autonomy alone has not always been associated with increased utilisation of maternal health services (Fotso, Ezeh, & Essendi, 2009; Mistry, Galal, & Lu, 2009). In our socio-cultural environment, men still wield a lot of power in decision-making in the family (Story & Burgard, 2012). Some women's access to and utilisation of maternal health services depend on their male partners. Involving male partners and encouraging joint decision-making will lead to greater utilisation of health services and thus better maternal outcome (Story & Burgard, 2012.; Allendorf, 2007; Mullany, Hindin, & Becker, 2005).

The three main delays that affect access to maternal health care are the delay in deciding to receive care, delay in reaching the service delivery point and delay in receiving care at the facility. Male partner involvement among other factors can significantly influence the first two delays. The decision to seek care in some homes is made by the man or requires the man's approval. Seven per cent of the women who delivered at home in the GDHS (2008) stated lack of permission as the reason for not going to a health facility. For those who obtain permission, there may be delays in obtaining the permission. There may also

be delays in reaching the point of the service because of lack of personal resources and relying on the male partner to make resources available to be able to reach the point of service delivery. As many as 45% stated lack of money as the reason for not accessing health care (GSS et al, 2009a). A lot of women depend on their male partners for funds to access health care.

Male partner involvement is a key factor that cannot be ignored in the quest for improvement in maternal health (USAID, 2010). When men are part of ante-natal and post-natal clinic, they partake in the education given at these clinics. This leads to increase in men's knowledge of and appreciation of the need for these services. They are able to identify danger signs and so facilitate women's utilisation of health care services especially in emergencies (Tweheyo, Konde-Lule, Tumwesigye, & Sekandi, 2010; Kakaire, Kaye, & Osinde, 2011; Kunene et al., 2004). When women are educated together with their partners, not only do the men also learn but the women are better able to assimilate and comply with information so acquired (Mullany, 2006; Mullany, Lakhey, Shrestha, Becker & Hindi, 2009).

A lot of effort is being made to increase male involvement in reproductive health. Areas of reproductive health that have seen improvement as a result of male involvement include: contraception and family planning and treatment of sexually-transmitted infections (Dudgeon & Inhorn, 2004). Various factors including cultural, socio-economic, demographic, policy issues and conditions at health facilities influence male partner involvement in maternity care (Mullany, 2006; Nanjala & Wamalwa, 2012). A number of researches concerning male involvement in reproductive health have been carried out but very little has been done locally to assess the level of male involvement in

maternity care and the factors that determine it. In our bid to improve maternal health in Ghana and reduce our maternal mortality ratio, there is the need to assess our men's involvement in maternity care and to determine factors that affect their involvement. These factors can then be taken into consideration when planning interventions to improve maternal health and make them more effective. Men are often branded as the problem in women's utilisation of maternal health care services but if we listen to their side of the story and identify factors that influence their involvement, men could actually be part of the solution.

1.2 STATEMENT OF THE PROBLEM

Developing countries continue to have a high maternal mortality ratio (240/100,000 live births), about 15 times that of developed countries (16/100,000 live births) (United Nations, 2012). The situation in Sub-Saharan Africa is worse with a maternal mortality ratio of 500/100,000 live births. Ghana, a Sub-Saharan African country has a maternal mortality ratio of 350/100,000 live births, a long shot from its target of 185 per 100,000 live births for 2015. Some progress has been made since 2000 when this goal was set but the rate of the decline has been very slow. Ghana's annual rate of reduction in maternal mortality is 2.6% but to achieve our goal for 2015, there should be a 5.5% reduction annually (WHO, 2012; United Nations, 2012). This poor performance has persisted in spite of numerous programmes and interventions carried out in the country that are aimed at reducing maternal mortality. Ablekuma South District, a sub-metropolitan area of the Accra Metropolitan Assembly is not exempt from this national problem. Institutional data for the year 2012 from the Mamprobi Polyclinic which serves over 65% of the pregnant women in the Ablekuma South District showed a slight increase in antenatal clinic

attendance but a decrease in the number of deliveries over the previous year's (2011) figures. Antenatal attendance increased from 42,446 to 43,082 and the number of deliveries decreased from 4,216 to 3,755 (Mamprobi Polyclinic, 2013).

One of the key factors contributing to the high maternal mortality is women's low utilisation of health services and thus, the services of skilled professionals during the ante-natal, labour and post-partum period. From the GDHS (2008), 22.2% of pregnant women did not make the minimum recommended 4 visits to the antenatal clinic. Forty-two per cent (42%) delivered at home without skilled health professionals' supervision and 23% had no post-natal care. Of those who did not seek health care, 45% and 7% respectively stated lack of money and not obtaining permission from spouse as the reasons.

In our socio-cultural setting, men wield a lot of power in decision making in the home and they play a vital role in the health seeking behaviour of women. Funding and permission to seek maternity care often come from the male partner. Male partner involvement in maternal care is perceived to be low and has therefore contributed to the slow pace of the decline in maternal mortalities. There are various factors that could affect or determine male partner involvement in maternity care. These include socio-demographic factors, cultural factors, economic factors, religious factors, programme factors and health facility factors. In Ghana, not much work has been done on male involvement in maternity care. The levels of male partner involvement in maternity care and the factors that determine this in the study area, Ablekuma South District, have not been clearly elucidated. Most researchers focus on women, but if men are to be involved, then research must also be targeted at them to get their perspective. This study focuses on

men and seeks to assess the level of their involvement in maternity care and determine the factors that influence it in the Ablekuma South District, Accra, Ghana.

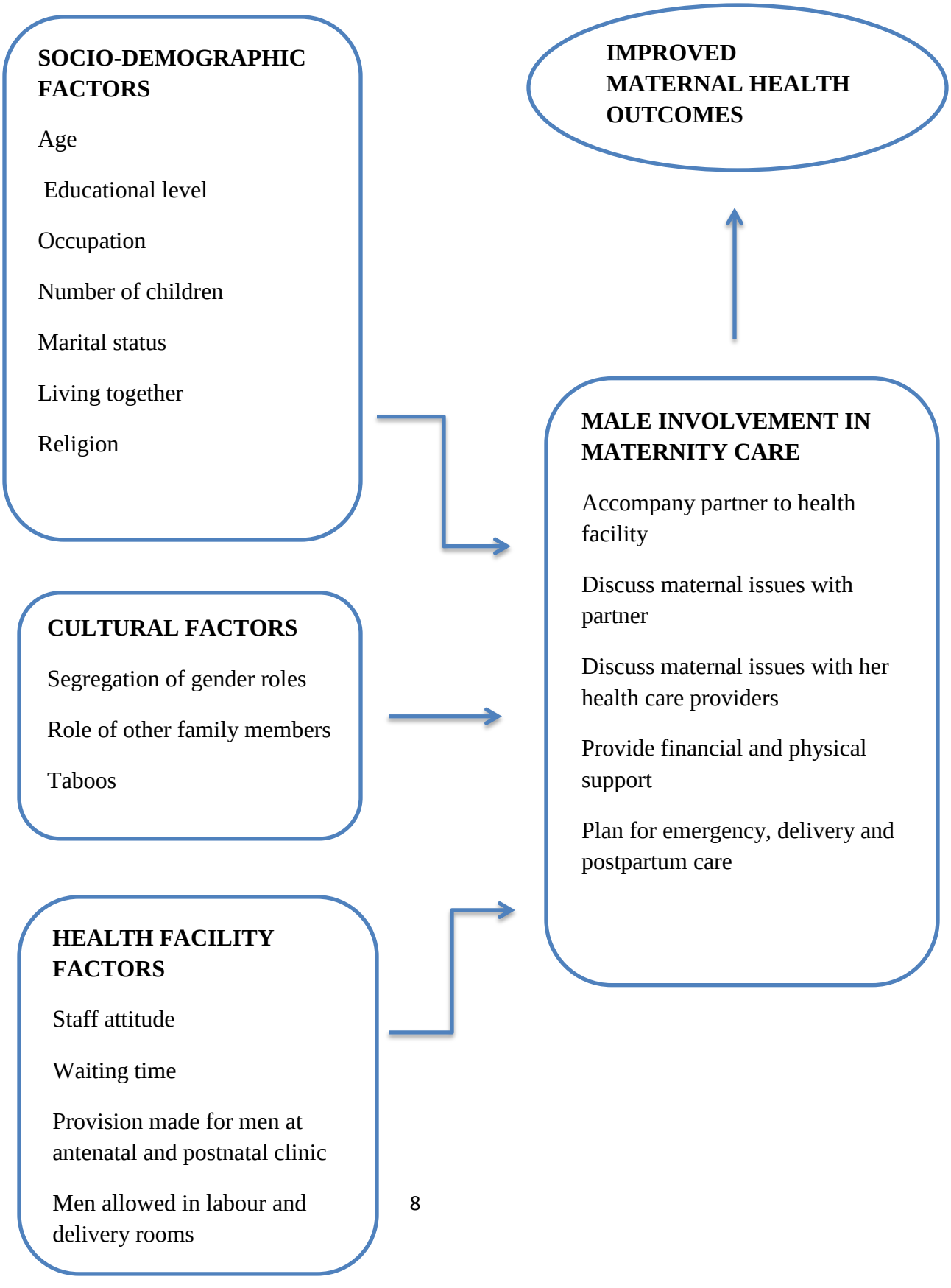
1.3 JUSTIFICATION

The findings of this study will give the male perspective of factors that determine their involvement in maternity care in Ablekuma South District. These factors when taken into consideration will lead to planning appropriate programmes that will engender greater male involvement in maternity care. Based on this information, service providers can provide a more male friendly service and include men in their activities. It is anticipated that results of this research will bring to the fore critical issues related to male involvement in maternity care and how these could be addressed to help inform on policies to improve male participation. It will help formulate policies that remove barriers to male participation. This will translate into greater utilisation of health services by women resulting in a decrease in maternal mortality and ultimately accelerating the attainment of the MDG 5. Given the diverse nature of the population of Ablekuma South District, the findings of this study could also inform policy-making and service provision as far as maternity care is concerned in other districts and the country as a whole. Information from this study will also contribute to existing knowledge in this area and serve as the basis for further study.

1.4 CONCEPTUAL FRAMEWORK

A man's involvement in the maternity care of his partner may be affected by his socio-demographic characteristics like age, educational level, occupation and religion. The type of marital union (formally married, unmarried or cohabiting), and whether or not they live together may also be important factors in determining the level of involvement. Cultural norms that segregate gender roles may not encourage men to take part in activities that are tagged as feminine. Other family members like mothers and mothers in-law may be seen as the ones responsible for issues related to pregnancy and delivery and so men may be reluctant to get involved. Some taboos may prohibit male involvement in some aspects of maternity care. Factors within the health facility may or may not encourage male involvement in maternity care. Health facilities' readiness to accommodate men who accompany their partners, male friendliness of the services and restrictions on the areas in the facility that can be accessed by men may influence male involvement. Male involvement ultimately leads to improved maternal health outcomes by increasing women's utilisation of health services.

Figure 1: Conceptual framework of male partner involvement in maternity care



1.5 OBJECTIVES

1.5.1 GENERAL OBJECTIVE

To determine the level of male partner involvement in maternity care and the factors that influence their involvement in Ablekuma South District of Accra, Ghana.

1.5.2 SPECIFIC OBJECTIVES

1. To determine the level of male involvement in the antenatal and postnatal care of their partners.
2. To assess the level of male partner involvement during labour and delivery.
3. To determine factors that influence male partner involvement in maternity care.

CHAPTER TWO

LITERATURE REVIEW

Maternity care (antenatal, intrapartum and postnatal care) has often been seen as a feminine issue. Men, women and even healthcare providers usually see issues to do with pregnancy and delivery as a woman's domain so the emphasis has been on women, with low male involvement (Kululanga, Sundby, & Chirwa, 2011; Kakaire et al., 2011). Men have however been identified as key to reducing maternal mortality and improving maternal health in developing countries (USAID, 2010). Men cannot be left out if we are to accelerate the progress towards the achievement of the millennium development goal 5 (MDG 5). Involving men in various aspects of reproductive health has led to increased uptake of family planning and contraception and treatment of sexually-transmitted infections.(Mullany et al., 2009; Bustamante-Forest & Giarratano, 2004). Bawah (2002) found that communication among couples about family planning had a positive impact on the contraceptive behaviour of women. In a cervical cancer screening programme, male involvement resulted in a higher return for follow-up (Mutyaba, Mirembe, Sandin, & Weiderpass, 2009).

The level of male involvement in maternity care varies across communities and countries. There are various factors that could determine the level of male involvement. These could be socio-demographic, cultural or even inherent in the health delivery systems (Byamugisha et al., 2011; Mullany, 2006; Nanjala & Wamalwa, 2012). Awareness of these factors is important in the formulation of policies and provision of services that encourage male involvement and remove barriers to their participation in maternity care.

MALE INVOLVEMENT

The term 'male involvement' is used in this context to refer to men having knowledge of and participating in maternal health issues. That is, acting together with women as partners and supporting decisions and activities that will improve women's health (Mullany et al., 2005; Byamugisha et al., 2011). It encourages communication and negotiation among couples. It does not imply male dominance (exclusive male control) and does not seek to decrease female autonomy. In fact male unilateral decision-making may reduce healthcare utilisation among women(Story & Burgard, 2012). There has been fear that male involvement may lead to patriarchal domination and decrease female autonomy. Mullany et al. (2005) found that women, their husbands and healthcare providers were all in favour of a more male-friendly maternity care services that will foster greater male involvement. A lot of maternal health programmes have focused on women and some have over-emphasised women empowerment, female autonomy and their decision-making powers (Mumtaz & Salway, 2009). Whereas women autonomy may increase maternal healthcare service utilisation, increasing women autonomy has not always been associated with increased utilisation of health services (Fotso et al., 2009; Mistry et al., 2009). Male involvement could be a leveraging mechanism working in concert with improved female autonomy to improve service utilization as stated by Mullany et al., (2005): "Perhaps if men feel less threatened or left out, they will in fact be more supportive of changes in women's status and autonomy".

LEVELS AND MEASUREMENT OF MALE INVOLVEMENT

Male involvement is a composite variable with no single standard scale of measurement (Byamugisha et al., 2011). Within different socio-cultural settings, what is considered as male involvement may vary and even within the same setting, what men and women consider as male involvement may vary. There is therefore an inherent difficulty in categorising and measuring male involvement. Various key points have been put together as a summary measure for male involvement.

Byamugisha et al. (2011) used a six-point involvement index:

1. The man attends ante-natal clinic with his partner
2. The man knows partner's ante-natal clinic appointments
3. The man discusses ante-natal interventions with his partner
4. The man supports partner's ante-natal visits financially
5. The man has taken time to find out what happens in the ante-natal clinic
6. The man has sought permission to use condoms during the current pregnancy

Each activity was given a score of one (1) if performed and zero (0) if not performed. A score of 4-6 was considered as high involvement and a score of 0-3 was seen as low involvement.

Mullany et al. (2005) used four points in their work:

1. Discussion on maternal health
2. Helping with household chores
3. Jointly making arrangement for delivery
4. Being present at the hospital

High involvement: the man performs 2 or more of the above activities.

Low involvement: the man performs one or none of the above activities.

Such key measures have been used by other researchers, demonstrating varying levels of male involvement. Majority (74%) of the men in the study by Byamugisha et al. (2011) in Eastern Uganda had low involvement index. Only 5% accompanied their partner to the ante-natal clinic but Tweheyo et al. (2010) had a high percentage of 65.4% accompanying their partners in Northern Uganda. In Kathmandu in Nepal, Mullany et al. (2005) found that 40% of male partners accompanied their partners to ante-natal clinic, 57% helped reduce work load at home, 74% per cent were involved in making at least one fixed arrangement for birth and 75% had discussions on the woman's health. Husbands in Guatemala showed high male participation during delivery of their babies, 78% either accompanied their wives to the health facility or were present during the delivery. Given that a lot of health facilities in our sub region do not allow men to be present during delivery, accompanying the wife to the hospital is considered adequate participation.

Various methodologies have been employed in research in this area. They include both quantitative and qualitative methods. A lot of research on male involvement has focused on women's point of view, but women's memories and their reports of their husband's participation in their pregnancy could be just a reflection of their feelings about the quality of their relationships (Carter, 2002). A few have focused on men which gives a reflection of their point of view. For most studies, participants with children aged 5years or less were included to allow adequate recall of what happened during the pregnancy.

Carter (2002) and Nasreen et al. (2012) had participants with children aged 5 years and below as cut-off points. Tweheyo et al. (2010) set their cut-off point as participants who have children below 2 years whiles Nanjala and Wamalwa (2012) included participants with children aged 0 – 12 months.

ROLE OF MEN IN MATERNITY CARE

Male involvement has been recognised as having great impact on women's access to and utilisation of maternal healthcare services which leads to a better outcome for both mother and baby. Decision-making in the home is largely done by men. All three aspects of maternity care (antenatal care, intrapartum care and postnatal care) are of importance.

Antenatal care

Antenatal care is very essential in reducing maternal morbidity and mortality. It is the care given to the pregnant woman from the time of conception to delivery. WHO recommends that every pregnant woman should make at least 4 visits to the ante-natal clinic during her pregnancy (WHO, 2001). From the GDHS (2008), 78% of the pregnant women in Ghana made at least 4 visits to ante-natal clinic. Kakaire et al. (2011) in their study in Uganda found 94% of the women made at least 4 visits to the antenatal clinic. In Bangladesh, Story and Burgard (2012) found only 58% of the women made at least one visit to antenatal clinic. Some women's utilisation of antennal care is affected by their male partners because of the men's role in decision making and also their control over the funds needed to make such visits (Bedwell, Houghton, Richens, & Lavender, 2011; Nasreen et al., 2012). Education on maternal health issues are often given at antenatal clinic. When men are present at such clinics, it increases their knowledge of the

importance of antenatal care and they become more supportive of their spouses and then encourage them to attend these clinics (Kululanga et al., 2011; Mullany, 2006). It has also been found that when pregnant women are educated together with their husbands, they learn and retain more information than when they are educated alone. Mullany et al. (2009) found a nearly two-fold increase in their knowledge scores.

One other important aspect of antenatal care where male involvement is critical is birth preparedness and complication readiness. These include: attending ante-natal clinic, having a plan for birth attendant, deciding on place of delivery, saving money for transport or making transportation arrangements and recognition of danger signs. When men are involved in these activities, they facilitate the recognition of danger signs, the decision to seek help, and also provide the necessary support for women to obtain the needed care (Kakaire et al., 2011; Dudgeon & Inhorn, 2004; Carter, 2002). Assessing men's knowledge on birth preparedness, Nasreen et al. (2012) found low levels of knowledge with only 13% arranging emergency transport. In a study by Kakaire et al. (2011), 25.9% of the women had education on pregnancy and childbirth complications, 44.3% saved money in case of pregnancy complications and 65.7% made plans for place of delivery. About 43% of them had their male partners providing transport or giving money for transport at the time of labour. Seventy-two per cent (72%) of women in the study by Nanjala and Wamalwa (2012) expected that their male partners will set aside funds to be used to access maternity care and 54% indicated that they wanted their male partners to accompany them to their health facilities for ante-natal care and delivery.

Intrapartum care

Male involvement during labour and delivery include discussing the place of delivery, making financial provision and accompanying their partners or being present at the time of delivery. This will increase the percentage of deliveries attended by skilled health personnel. Apart from being available to help in times of complications that require referral, they also provide emotional support (Kakaire et al., 2011). Some women have equated their husband's involvement with the degree of their love. Some health facilities do not allow male partners in the delivery room. However the man accompanying the partner to the health facility or being in the premises of the facility has been found to be helpful(Carter, 2002).

Views on male partner presence at labour or at delivery are split. Whereas some women want their partners to be present, others feel it is unnecessary and awkward to have the man present (Mullany, 2006). In a study in Russia by Bakhta and Lee (2010) 68% declined having the husbands present. Most women desire having a support person but a lot of them prefer a female relative with mothers being the most popular choice (Maimbolwa et al, 2001).

Postnatal care

The postnatal period is a critical time during which a lot of maternal morbidity and mortality can occur. Education on care of the new born, family planning and contraception are given during the ante-natal period but the post-natal period is the period for emphasis and implementation of what has been learnt. Male involvement will

increase uptake of contraception and family planning. In the Ghana Demographic Health Survey (2008) 23% of the women did not have any postnatal care.

FACTORS AFFECTING MALE INVOLVEMENT IN MATERNITY CARE

Several factors have been identified as having influence on male involvement in maternity care. These can be broadly categorised into socio-demographic, cultural and health service delivery factors.

Socio-demographic factors

A man's age, level of education, occupation, and marital status may affect their involvement in their partner's maternity care. Older men and those with higher levels of education were found to be more likely to assist their partners in making a birth plan (Kakaire et al., 2011; Byamugisha et al., 2011). The proportion of men accompanying their partners to clinic increased as age increased in a study by Nkuoh et al., (2010). Levels of income also had some influence. Nanjala and Wamalwa (2012) found spouses of men with higher income were more likely to be assisted by their partners to seek skilled attendance at birth. Some men see their primary responsibility as being the financiers and therefore would rather go to work than accompany their partners to clinic (Kakaire et al., 2011; Nkuoh et al., 2010). Marital status also seemed to affect the level of male involvement. Carter (2002) in a study found that women who were formally married were more than twice as likely to receive support from their husband compared to those who were in consensual union. Generally, having knowledge about ante-natal services, danger signs and symptoms and birth preparedness increased the likelihood of a man

being involved in issues related to the partner's pregnancy (Kakaire et al., 2011; Tweheyo et al., 2010; Mullany, 2006).

Cultural factors

Cultural beliefs, taboos and segregated gender roles during pregnancy and delivery and the post-partum period greatly affect men's involvement in maternity care. Pregnancy and its related issues are sometimes seen as a woman's affair that doesn't require men's participation (Kululanga et al., 2011; Kakaire et al., 2011; Nkuoh et al., 2010). In the study by Nanjala and Wamalwa (2012), almost half of the men (48.2%) said that they will be ridiculed by their peers and perceived as being ruled by their wives if they were seen accompanying their wives to a health facility. In some societies, there are mores that discourage or belittle husband's attempt to get involved in their wives pregnancy issues. Such men are sometimes called names (Mullany, 2006). The role played by other relatives especially females like mothers and mothers-in-law influence the level of male involvement (Mullany, 2006; Carter, 2002). These women are seen as being responsible for pregnancy related issues.

Health Delivery System factors

The health delivery systems often have factors that do not encourage male involvement. Some health facilities do not make provision for men to be present at ante-natal care, labour and delivery and post-natal care. Sometimes, men are actively prevented from entering the labour ward even though they may wish to be present (Nkuoh et al., 2010; Mullany, 2006). Lack of adequate space and privacy make some men embarrassed to be present (Kakaire et al., 2011). Long waiting time at some facilities also discourage men

as most of them will want to go back quickly to their jobs (Nkuoh et al., 2010). Men want to be respected and treated as men so where health providers' attitudes are seen to be disrespectful, men are less likely to participate in the maternity care (Kululanga et al., 2011; Kakaire et al, 2011). Fifty-four per cent (54%) of the men in the study by Nanjala & Wamalwa (2012) said the health workers were harsh.

Strategies that have been used to involve men include: mass education, large group counselling, peer education and modification in the service delivery to include incentives for male involvement (Kululanga et al., 2011; Mullany, 2006).

From the literature, there is evidence that the level of male involvement varies from one community to the other and the socio-cultural and service delivery systems factors that affect them also vary. It is important to determine from each community, the factors that are significant. Research that focus on women; indirectly confirm the notion that pregnancy and its related activities are largely feminine issues. There is the need for research such as this one that focuses on men to get their perspective on maternity care.

CHAPTER THREE

METHODS

3.1 STUDY DESIGN

The study was a mixed method (quantitative and qualitative) study. It was a community based study carried out in Korle Gonno a suburb of Ablekuma South District of Accra, Ghana. A cross sectional descriptive survey using interviewer administered structured questionnaire was conducted among men aged 18years and above. Four (4) focus group discussions were conducted with separate male and female groups to help explore further 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 maternity care.

The study was carried out over a six (6) week period from 20th May to 28th June 2013.

3.2 STUDY AREA

Ablekuma South District is one of the eleven (11) Sub-Metropolitan Districts of Accra Metropolitan Assembly. It is bounded on the east by the Odododiodio constituency, on the west by Weija constituency, on the south by the Gulf of Guinea (sea) and on the north by Ablekuma Central and North constituencies. Ablekuma South District has eight (8) suburbs with a population of 251,000 according to the Ghana Population Census (2000). The eight suburbs are Gbenu, Mampong Okai, Mamprobi, Korle Gonno, Korle Bu, Chorkor, Mamsralor and New Mamprobi. The study was carried out in Korle Gonno. Korle Gonno is an urban community with the predominant ethnic group being the Gas

Figure 2: MAP OF ABLEKUMA SOUTH DISTRICT

followed by the Akans and Ewes. It is bounded in the north by the Guggisberg Avenue (road) which separates it from Korle Bu. To the south it is bounded by the Gulf of Guinea (sea). It shares boundary to the west with Mamprobi, demarcated by the Eduardo Mohdlanor road. To the east, it is separated from the Korle Lagoon by the extension of the Ring Road West.

Korle Gonno has a total population of about 27,826 with a slight male preponderance. There are 14,426 males forming 51.8 % of the population and 13,400 (48.2%) females. The population of men 18years and above is 11,615. The predominant occupations of the

people are fishing, trading and civil service. There are a few private health facilities in the community with no Government hospital in Korle Gonno itself. The community is however very close to and patronise the Korle Bu Polyclinic and the Mamprobi Polyclinic which are all Government health facilities within the district. The Korle Bu Teaching Hospital which is a referral centre is also close by.

3.3 STUDY POPULATION

Cross Sectional Survey

The study population was men 18years and above who had children aged 5years or below at their last birthday. Men who had no children or whose last child was aged more than 5years at their last birthday were excluded. Those whose children were older than 5years were excluded to minimise the problem of recall of activities at the time of the pregnancy, labour, delivery and the postpartum period.

Focus Group Discussion

The focus group discussions were held with women in or above the reproductive age group (>15years) and men 18 years and above with children irrespective of the age of the children. Men and women without children were excluded.

3.4 VARIABLES MEASURED

a) Dependant variable: Male involvement (composite measure)

Male involvement was measured as a composite measure using the following 5 points which were equally weighted:

1) The man accompany partner to health facility

2) The man discusses maternal health issues with partner

3) The man discusses maternal health issues with her health care providers

4) The man provides financial and physical support to his partner

5) The man is involved in planning for emergency, delivery and postpartum care.

Each of these five points was allotted a score of one (1) when a male participant performed the activity and zero (0) when the activity was not performed. A total score was computed for each participant and the level of involvement was categorised as high, moderate or low as follows: a score of 4 - 5 was considered high level of involvement, a score of 2 - 3 was considered moderate level of involvement and a score of 0 - 1 was considered low level of involvement. The participants' level of involvement in each aspect of maternity care that is antenatal, labour and delivery and postnatal care was assessed.

An overall level of involvement in the maternity care of their partners was also assessed by combining their scores for the three aspects of maternity care. For the overall score, a score of 11 -15 was considered high level of involvement, a score of 6 – 10 was considered moderate level of involvement and a score of 0 -5 was considered low level of involvement.

b) Independent variables:

The independent variables were grouped as:

- Socio demographic characteristics

The socio demographic characteristics that were looked at were age, educational level, marital status, living together, occupation, number of children and religion.

- Cultural factors

Cultural factors like segregation of gender roles, role of other family members and taboos were considered.

- Health facility factors

Health facility factors like provision made for men at antenatal and postnatal clinic, men allowed in labour and delivery rooms, staff attitude and waiting time were also looked at.

3.5 SAMPLE SIZE

The 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) = 50%

Confidence interval =95%, alpha 0.05

Power =80%, beta 0.8

Worst acceptable margin of error(d) = 5%

The computed figure 384 was adjusted by 10% for inconsistencies and incompleteness arriving at a sample size of 422.

3.6 SAMPLING METHOD

Quantitative data

One suburb of the district was selected for the study by simple random sampling. The names of the eight suburbs were written on eight pieces of similar looking papers and folded. They were put in a cup, shaken and one (Korle Gonno) was randomly picked. There are about 2490 houses in Korle Gonno with a well laid out street system. Systematic sampling of houses was done using a sampling interval of 5. The first household to be interviewed was randomly selected by randomly selecting an intersection on the map of Korle Gonno using the tip of a pencil. From the first house, every 5^{th} house was selected till the number of houses corresponding to the required sample size was obtained. The direction of movement was determined by writing down the options on pieces of paper and randomly selecting one. One man meeting the inclusion criteria was interviewed per house. If any house had more than one man 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 could not grant an interview immediately a convenient time was scheduled for the interview.

Qualitative data

From the same randomly selected suburb, two groups of male volunteers were obtained by asking men aged 18 years and above with children to participate in a focus group discussion. The first group was made up of eight (8) men aged 18 – 35 years and the

second group was made up of eight (8) men aged 36 years and above. Two groups of female volunteers were also obtained by asking women 15 years and above with children to participate in a focus group discussion. The first group was made up of eight (8) women aged 15 – 35 years and the second group was made up of eight (8) women aged 36 years and above.

3.7 DATA COLLECTION METHOD AND TOOL

Quantitative data

The data was collected using an interviewer administered structured questionnaire. Together with trained research assistants, we administered the questionnaire one on one to each participant and filled in their responses on the questionnaire. The questionnaire was designed making reference to questionnaires used by other researchers. 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.
- Involvement in antenatal care: 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.
- Involvement in labour and delivery: : e.g making joint plans for the labour and delivery, accompanying the partner to health facility, being present in the labour and delivery room, providing physical and financial support and having discussions on issues relating to the labour and delivery.

- Involvement in postnatal care: e.g accompanying the partner to health facility, making joint plans for the postnatal care, providing physical and financial support and having discussions on issues relating to the postnatal period.

Qualitative data

The focus group discussion was conducted using a focus group discussion guide 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 maternity care. We discussed how these influence male involvement and they also made suggestions as to how male involvement in maternity care could be increased in the community.

The discussions were facilitated by trained research assistants who were more fluent in the Ga language than the principal investigator and 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. The discussions were conducted in the Ga language, which is the commonest spoken local dialect. Demographic information on the participants was obtained and each participant was given a number tag. They were referred to by the numbers given during the discussion. The discussions were tape recorded and notes were also taken so that non-verbal behaviours 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 agreed upon by all participants. Each discussion session lasted approximately 90 minutes. Participants were served some snack at the end of the discussion session.

For both qualitative and quantitative data collection, an inform consent was obtained after the purpose of the study, the benefits and rights of the subjects and the procedure involved were explained to all participants.

3.8 TRAININIG OF RESEARCH ASSITANTS

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. Because it was anticipated that some of the men 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 also 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 supervised the research assistants. Each questionnaire had the interviewers initial and code to facilitate cross checking of the completed questionnaire. The completed questionnaires were checked for completeness and any inconsistencies on the field. Data was doubly entered into SPSS (Statistical Package for Social Sciences) version 16 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 and date. Transcription of the recorded discussions was done as soon as possible after the discussion.

3.10 DATA PROCESSING AND ANALYSIS

Quantitative data

Data was entered into SPSS version 16 and cleaned and also exported into Stata version 11 for analysis. Patterns in the variables were examined by descriptive statistics. The mean age was calculated before it was categorised into groups and the modal age group found. Frequencies and proportions was calculated for the categorical variables like educational level, marital status, number of partners, living together, occupation, number of children and religion. Cross tabulations were 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 are presented in tables and graphs.

Qualitative data

Recordings of the discussions was translated into English and transcribed. A general description of the participants was first done. Thematic content analysis was carried out. The data was coded and categorised and common themes identified. Analysis of the 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 maternity care was done. Appropriate quotes are included to clarify the themes.

3.11 ETHICAL ISSUES

1. Ethical clearance was obtained from the Ghana Health Service Ethical Review Committee on Research Involving Human Subjects.

2. Permission to carry out the research was obtained from the Sub Metropolitan Health Directorate of the Ablekuma South Sub Metropolitan District.

3. Community entry was done with the help of the Assemblyman of Korle Gonno. He also helped in obtaining permission from the local traditional leaders. Korle Gonno currently does not have a substantive chief so the local traditional opinion leaders were contacted.

4. The purpose of the study, the benefits and rights of the subjects and the procedure involved were 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 consent form.

5. There was no payment done to the participants but members of the focus group discussions were served some snack.

6. Electronic data files have been secured by a password known by only me the principal investigator. All hard copies of data sheets and tapes have been kept in a locked file cabinet that can only be accessed by the principal investigator. Research assistants accessed them only when they had been given permission.

7. Data files and tapes will be kept for five years after which they will be destroyed.

8. This research has been fully self-funded. I have no conflict of interest in this research**.**

3.12 PRE-TESTING

Pre-testing of the questionnaire and focus group discussion guide was done in Mamprobi a suburb in the Ablekuma South 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

In all, four hundred and twenty two (422) men who met the inclusion criteria were approached individually to participate in the cross sectional survey. After the study and its purpose were explained to them, they all gave their consent to be participants. After checking the filled questionnaires for completeness and inconsistencies, four hundred and twenty (420) were deemed complete for analysis. Two (2) were excluded on account of incomplete data.

Four focus group discussions were held. Eight participants were approached per group and all turned up for the discussion except one female participant. Three of the focus groups therefore had eight participants each and the fourth group had seven participants.

SOCIO-DEMOGRAPHIC CHARACTERISTICS

The mean age of the participants in the cross sectional survey was 32.9 (SD: 8.2) with a range of 18 – 57years. The modal age group was the 26-35 year group with 203 participants (48.3%). The average number of children per participant was 2.4 (SD: 1.2) with a range of 1 – 9. Majority (299) of the participants representing 71.2% were married. The proportion of the men with no formal education, primary, secondary and tertiary level education was as shown in table 1. Three hundred and ninety nine (80.7%) were Christians and 69 (16.4%) were Moslems. There were 8 (2.9%) traditionalists with 3 (0.7%) belonging to other religions. Table 1 shows the socio-demographic characteristics of the participants.

Table 1: Socio demographic characteristics of participants (N=420)

VARIABLE	CATEGORY	FREQUENCY	PERCENTAGE (%)
Age(years)	18 – 25	75	17.9
	26 – 35	203	48.3
	36 – 40	75	17.9
	>40	67	15.9
Marital status	Married	299	71.2
	Single	20	4.8
	Cohabiting	63	15.0
	Divorced/separated	38	9.0
Educational level completed	No formal education	14	3.3
	Primary	28	6.7
	Junior secondary	117	27.8
	Senior secondary	204	48.6
	Tertiary	57	13.6
Occupation	Unemployed	40	9.5
	Self employed	218	51.9
	Civil/public servant	162	38.6
Religion	Christianity	339	80.7
	Islam	69	16.4
	Traditional	9	2.2
	Other	3	0.7
Number of children	1	107	25.5
	2 – 4	291	69.3
	5 or more	22	5.2

MALE INVOLVEMENT IN ANTENATAL CARE

Three Hundred and forty-eight (82.9%) of participants lived with their partners at the time of their pregnancy; and 72 (17.1%) did not live with their partners. Of those who lived together, 165 (47.4%) had other family members living with them. About half, 85 (50.3%) of these family members were the man's mother, 38 (23.0%) were the woman's mother and 44 (27.7%) were siblings from both sides.

The most recent pregnancy was planned in 173 (41.2%) of cases and unplanned in 247 (58.8%) of situations. Three Hundred and eighty-one (90.7%) of the men were aware their partners attended antenatal clinic and knew the specific facility in which they had the care. One Hundred and forty-one (33.6%) were however not involved in the decision-making on where the woman received antenatal care. Joint plans for emergency situations in the pregnancy were made by 265 (63.1%) of participants. Most of them, 243 (91.7%) said they put money aside for emergency. One hundred and one participants (24.0%) accompanied their partners at least once to the antenatal clinic and 319 (76.0%) never did. Of those who accompanied their partners, 77 (76.2%) did so once, 21 (20.8%) made two to three visits and only 3 (3.0%) did so four or more times.

Women in the focus group discussion expressed the desire to have their partners accompany them to the antenatal clinic as exemplified by the following comments:

> *For me, I want the men to go to the hospital with us so they see how we are treated at the hospital. Also, there are some instances that the doctor will advise the man on some issues concerning our pregnancy. If they go to the hospital with us the nurses may attend to us early*. – 25year old trader (female discussion group)

> *It is very good when your husband accompanies you to the hospital. It may happen that when you tell him about what the doctor says he will think you are lying but when you go with him he won't say you are lying*. – 36 year old trader (female discussion group)

Some of the men had other reasons for wanting to accompany their partners as indicated by a 40 year old fisherman:

> *Yes, we have to accompany them to the hospital. Because there are some women who take money from you that they are going to the hospital but they might not go. But if you go with her, you will be sure that indeed she has been to the hospital. Some can even pick someone's medication prescription on the floor and tell you the doctor asked them to buy it just to get money from you.*

Fifty-two (51.5%) of those who visited the antenatal clinic found the staff attitude to be unfriendly; 42 (41.6%) found them to be friendly and 7 (6.9%) were indifferent. A male focus group discussion participant lamented:

> *Sometimes you take your wife to the hospital and the treatment the nurses give you is too bad. They will tell you sit here, don't go here. go there, it's really bad.*

The time spent at the facility was assessed to be too long by 63 (62.4%) but 38 (37.6%) found it to be reasonable.

All the participants provided some form of physical or financial support to their partners. Three hundred and twenty-five (77.4%) provided funds for antenatal visit. Helping with

household chores and reminding the woman of her antenatal visits were other forms of support given. Some women enumerated the kind of support they expect from their partners:

> *When you are pregnant, your husband must be able to pamper you. He must also provide for your financial and physical needs. As a husband he must also give you support in your daily activities, and when you are visiting the hospital, he has to go with you.* -39year old hairdresser (female discussion group)

The men had even more to add on:

> *I also think, there are certain little things women need especially when they are pregnant. If you already have children, you have to assist the woman in looking after them in the morning so that they will go to school. You must also make sure she doesn't over work*. -42year old teacher (male discussion group)

Three hundred and forty-six (82.4%) discussed health issues relating to the pregnancy with their partners but only 94 (22.4%) did so with their partners' healthcare providers. Women expect their partners to discuss their pregnancy issues with them:

> *When I am visiting the hospital, even if he cannot go with me, when I come home he should ask me what went on at the hospital and what the doctor said and must also do it for me.* -37 year old trader (female discussion group)

Male involvement was assessed using a five point index which included:

1) The man accompanies partner to health facility

2) The man discusses maternal issues with partner

3) The man discusses maternal issues with her health care providers

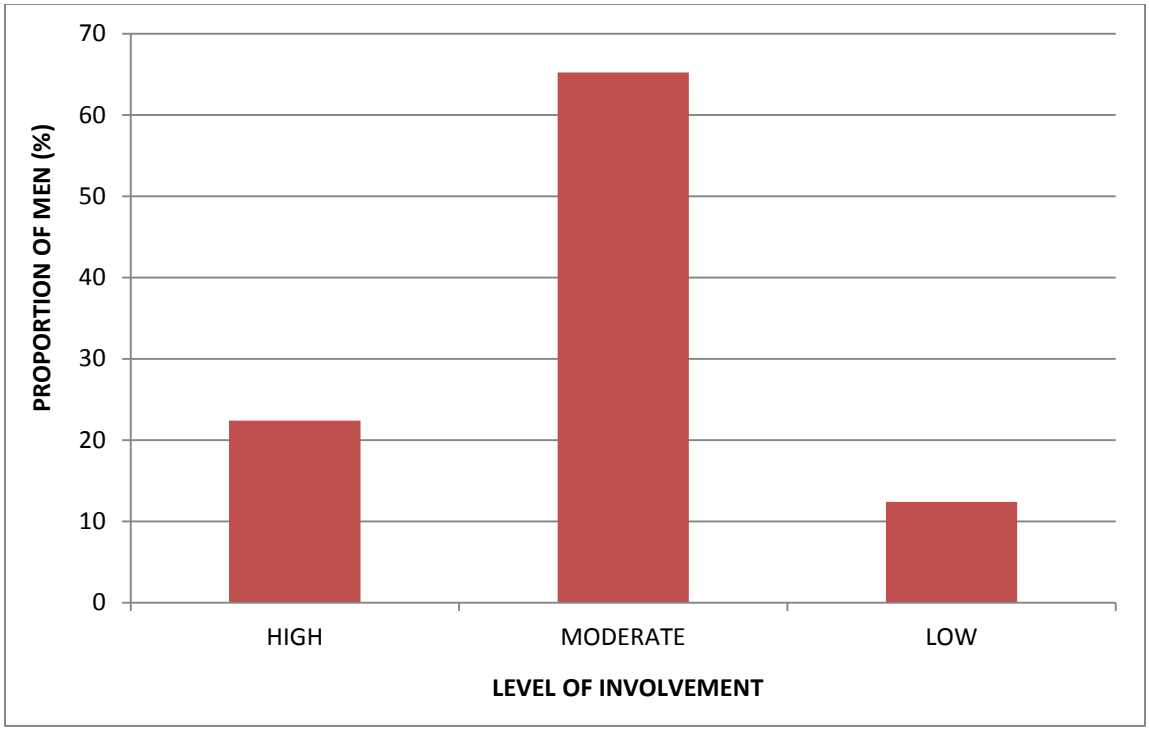
4) The man provides financial and physical support

5) The man is involved in planning for emergency, delivery and postpartum care

(The scoring scale was as reported on page 23 in the chapter on methodology)

The level of male involvement in antenatal care was as follows: 94 (22.4%) had high level of involvement; 274 (65.2%) had moderate level of involvement and 52 (12.4%) had low level of involvement as shown in figure 3.

Figure 3: Level of male involvement in antenatal care.



LEVEL OF MALE INVOLVEMENT DURING LABOUR AND DELIVERY

The number of participants who lived with their partners at the time of labour and delivery was 308 (73.3%), a slightly lower number than it was during pregnancy. However, a higher percentage, 166 (39.5%) accompanied their partners to their health facility at the time of labour and delivery. Of those who did not accompany their partners, majority, 215 (84.6%) delegated someone else to take the woman to the health facility. Only 23 participants (5.5%) indicated that male partners were allowed in the labour and delivery rooms. Two hundred and thirty-six (56.2%) said men were not allowed whiles 161 (38.3%) did not know if men were allowed. Participants who were present at the labour and delivery rooms were 21 (5.0%) but 259 (64.9%) wished they were present. The desire to be present was re-echoed by participants of the focus group discussion as illustrated by the following responses:

> *For me, I will like to be there but the doctors will not allow me to go inside. According to the doctors, the hospital has a lot of women in labour so I cannot be allowed to enter. I heard in abroad if your wife is in labour, you can go and stand beside her and be shouting push, push, push but here it is not like that*. -29year old driver (male discussion group)

> *You see it will be very good if you are with her. When a woman is going through some difficulty and you are with her, it shows how caring you are.*
> -47 year old trader (male discussion group)

The women also wish their partners could be allowed into the labour ward with them.

> *When it gets to the time, the nurses do not allow them to go to the labour ward with us. But I think they must be allowed to go to the ward with us so that they will know that delivering is not easy. When you are there shouting you will hold him firmly and squeeze him. When they get to know that, they won't joke with us the next time we ask something from them. They will also treat us good.* -27year old seamstress (female discussion group)

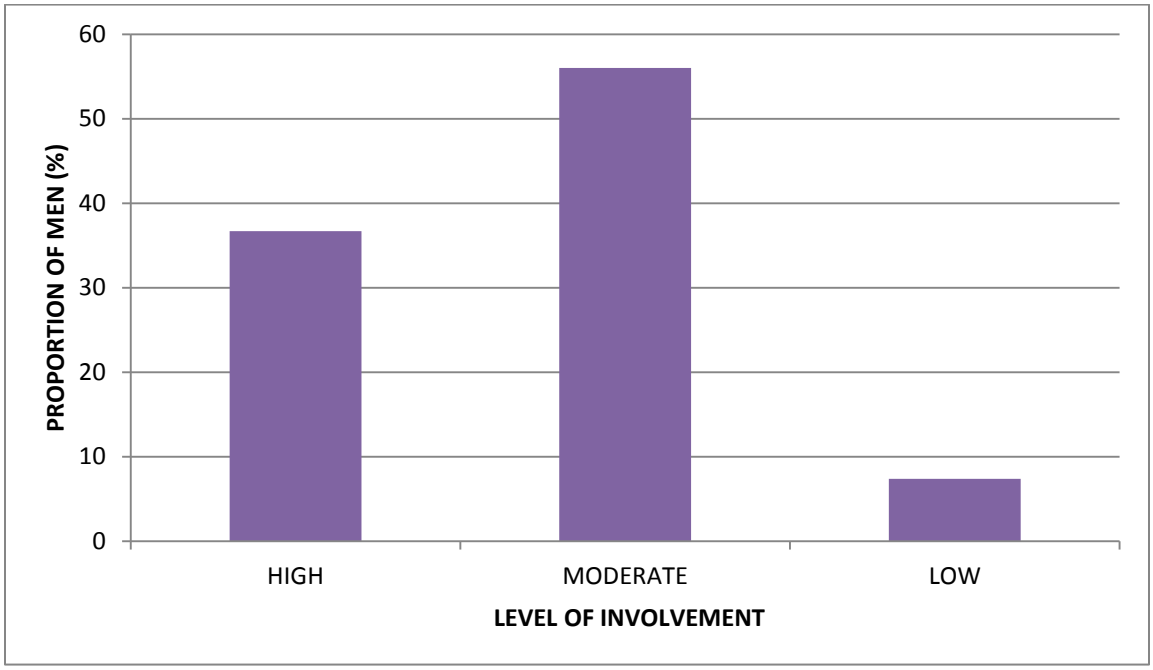
> *I will like him to go to the hospital with me when I'm in labour. When it happens like that, you will even forget the pains you are going through and focus on what he is saying. It makes you have some hope and love him more. The nurses sometimes scream at us and treat us so badly but when your husband is in the delivery room, they won't treat us that way.* -41year old trader (female discussion group)

When asked about their opinion on who should be allowed into the labour and delivery room if only one person could be allowed, 205 (48.8%) felt the husband should be the one, 132 (31.4%) said it should be the woman's mother, 71 (16.9%) said it should be the man's mother and 12 (2.9%) felt a sibling should be allowed in.

Joint plans for labour and delivery were made by 323 (76.9%) but 97 (23.1%) made no prior plans. All participants provided a form or physical or financial support with 373 (88.8%) providing funds for the labour and delivery. Three hundred and sixty (85.7%) discussed health issues relating to the labour and delivery with their partners but only 154 (36.7%) had such discussions with their partners' healthcare providers.

Using the five-point male involvement index, the level of male involvement in labour and delivery was as follows: 154 (36.6%) had high level of involvement; 235 (56.0%) had moderate level of involvement and 31 (7.4%) had low level of involvement as shown in figure 4.

Figure 4: Level of male involvement in labour and delivery

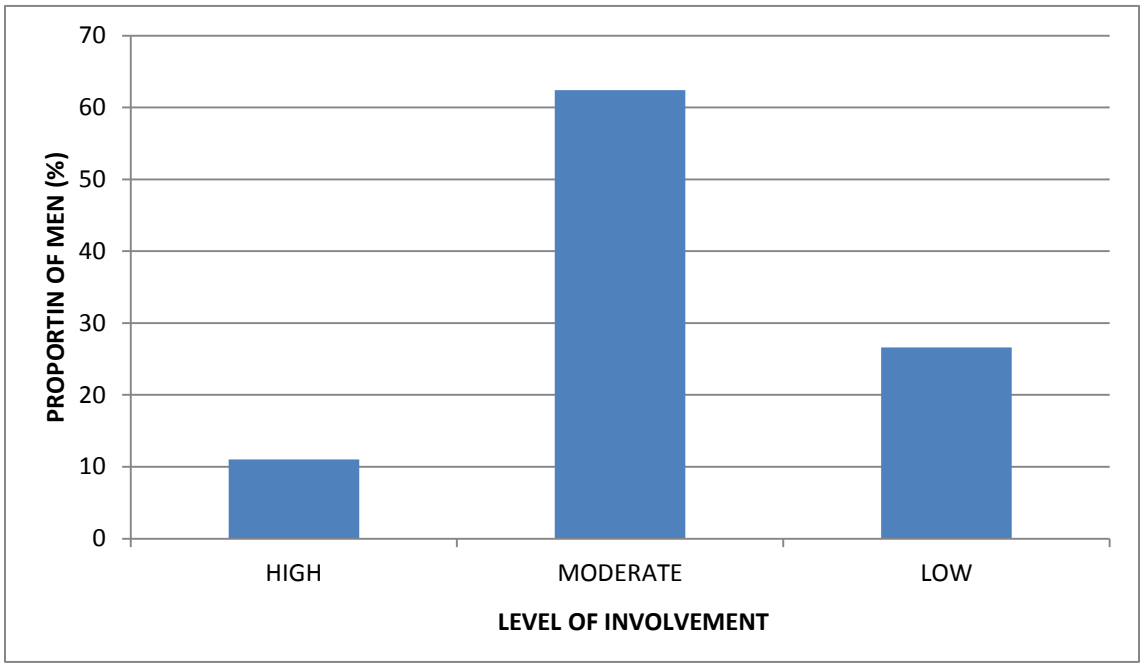


LEVEL OF MALE INVOLVEMENT IN POSTNATAL CARE

One hundred and eighty-five (44.0%) of participants did not live with their partners after delivery and 235 (56.0%) did. Of the women who did not live with their partners, 160 (86.5%) lived with their mother; 22 (11.9%) lived with the mother-in-law and 3 (1.6%) lived with a sibling. Three hundred and forty (81.0%) never accompanied their partners to the postnatal clinic but 80 (19.0%) did.

One hundred and fifty-five (36.9%) had discussions on issues relating to the postnatal period like family planning with their partners but 265 (63.1%) did not. Only 47 (11.2%) had any such discussions with their partner's health provider but 372 (88.8%) did not. Three hundred participants (71.4%) were involved in making prior plans for their partners postnatal care and 120 (28.6%) were not. All participants (100%) provided some form of physical or financial support to their partners. Using the five-point male involvement index, 46 (11.0%) had high level of involvement, 262 (62.4%) had moderate level of involvement and 112 (26.6%) had low level of male involvement as shown in figure 5.

Figure 5: Level of male involvement in postnatal care.



OVERALL LEVEL OF INVOLVEMENT IN MATERNITY CARE

Putting the level of involvement in all the three aspects of maternity care together, a total score was obtained and the overall level of involvement in maternity care was follows: one hundred and one (26.4%) had high levels of involvement; 232 (55.2%) had moderate level of involvement and 77 (18.4%) had low level of male involvement. Figure 6 shows the overall level of male involvement in maternity care.

Figure 6: Overall level of male involvement in maternity care.

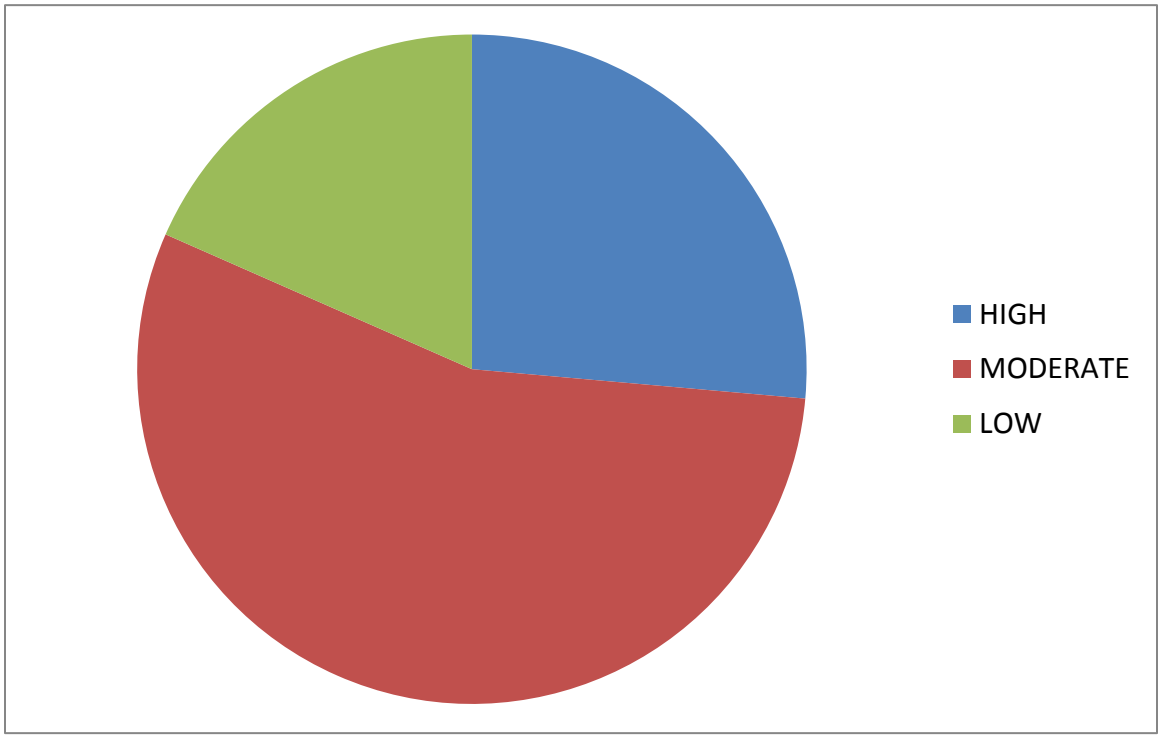


Table 2: Level of male involvement in antenatal care, labour and delivery and postnatal care

PERIOD OF CARE	LEVEL OF MALE INVOLVEMENT (N=420), n(%)		
	High	**Moderate**	**Low**
Antenatal	94 (22.4%)	274 (65.2%)	52 (12.4%)
Labour & Delivery	154 (36.6%)	235 (56.0%)	31 (7.4%)
Postnatal	46 (11.0%)	262 (62.4%)	112 (26.6%)

Table 3: Proportion of participants who performed each of the five key activities used in the measurement of male involvement

ACTIVITY	PERIOD OF MATERNITY CARE n (%)		
	Antenatal	**Labour&Del**	**Postnatal**
The man accompanies partner to health facility	101 (24.0%)	166 (39.5%)	80 (19.0%)
The man discusses maternal issues with partner	346 (82.4%)	360 (85.7%)	155 (36.9%)
The man discusses maternal issues with her health care providers	94 (22.4%)	154 (36.7%)	47 (11.2%)
The man provides financial and physical support	420 (100%)	420 (100%)	420 (100%)
The man is involved in planning for emergency, delivery and postpartum care,	265 (63.1%)	323 (76.9%)	300 (71.4%)

Some of the reasons given by participants who did not accompany their partners to the clinic or for labour and delivery were; being busy at work, not living with their partner at the time, rumours about how men are badly treated at the health facilities and that the women were strong enough to go on their own.

FACTORS AFFECTING LEVEL OF MALE INVOLVEMENT IN MATERNITY CARE

SOCIODEMOGRAHIC FACTORS

A significant association was found between the level of male involvement and age, marital status, educational level completed occupation, religion and the number of children.

Participants in the 18-25 year group had the highest proportion (54.7%) of low male involvement. The lowest proportion (5.3%) was among the 36-40 year group. The odds of having a high level of involvement among the younger age group (18-25) was 0.28 times that of the 26-35 year group. (OR =0.28, 95% CI: 0.12, 0.66)

Participants who were single had the highest proportion (75%) of men with low involvement; followed by those who were cohabiting (41.3%) and those who were separated/divorced (31.6%). Those who were married had the lowest proportion of participants with low male involvement (8.0%) and the highest level of male involvement (34.1%). Table 4 shows socio-demographic factors associated with the level of male involvement.

Table 4: Socio-demographic factors associated with the level of male involvement. (Pearson Chi Square test)

VARIABLE		Overall Male Involvement			Chi-square	P-value
		Low	Moderate	High		
Age	18 - 25years	54.7%	40.0%	5.3%	90.36	<0.0001
	26 - 35years	13.8%	58.6%	27.6%		
	36 - 40years	5.3%	60.0%	34.7%		
	Above 40years	6.0%	56.7%	37.3%		
Marital status	Married	8.0%	57.9%	34.1%	102.84	<0.0001
	Separated/divorced	31.6%	55.2%	13.2%		
	Cohabiting	41.3%	54.0%	4.7%		
	Single	75.0%	20.0%	5.0%		
Educational level completed	No formal education	57.1%	42.9%	0.0%	49.32	<0.0001
	Primary	25.0%	67.9%	7.1%		
	Junior Secondary	19.7%	59.0%	21.4%		
	Senior Secondary	18.6%	55.4%	26.0%		
	Tertiary and above	1.8%	43.9%	54.4%		
Occupation	Civil/Public servant	13.0%	51.9%	35.2%	47.40	<0.0001
	Self-employed	15.6%	61.5%	22.9%		
	Unemployed	55.0%	35.0%	10.0%		
Religion	Traditional	55.6%	44.4%	0.0%	16.42	0.012
	Christianity	17.1%	53.4%	29.5%		
	Islam	18.8%	65.2%	15.9%		
	Other	33.3%	66.7%	0.0%		
Number of children	1 Child	40.2%	47.7%	12.1%	54.43	<0.0001
	2-4 Children	11.0%	56.4%	32.6%		
	5 or more Children	9.1%	77.3%	13.6%		

The Chi-square statistic is significant at the 0.05 level.

Some men alluded to the fact the type of relationship and the circumstances surrounding the marriage can affect the level of involvement:

> *There are some people who meet the woman and the main aim in his mind is to hit and run so if later on pregnancy comes, he will be forced to marry the woman. When it happens like that the man would not love the woman as he is supposed to.* -49year old trader (male discussion group)

> *When you are forced to love someone, you might not love her completely. If for instance you give birth out of wedlock, it's sometimes difficult to take care of her*. -47year old mason (male discussion group)

Those with no formal education had the highest proportion of low male involvement (57.1%) and those who had completed tertiary level education had the lowest proportion of low male involvement (1.8%). Those who had completed Junior or Senior secondary school showed similar proportions of low male involvement (19.7% and 18.6% respectively). The proportion with high level of involvement was highest (54.4%) among those who had completed tertiary education. The odds of having high level of involvement was 40.57, 7.73 and 6.62 times that of no formal education for tertiary, senior secondary and junior secondary education respectively. (Tertiary - 95% CI: 3.16, 520.32; Senior secondary - 95% CI: 1.61, 37.15; Junior secondary - 95% CI: 1.35, 32.41)

Those who were unemployed had the highest proportion (55.0%) of low male involvement. Both civil/public servants and the self-employed had similar proportions of low level of male involvement, 13.0% and 15.6% respectively. But the civil servants had a slightly higher proportion of high male involvement (35.2%) compared with the self-

employed (22.9%). Men in the focus group discussion gave a link between employment and income and the extent of involvement:

> *Every man that is not able to cater for her woman, 80% of the problem is from the pocket. If you don't have money on you, you will be disgraced. So people will like to do it but their pocket won't allow them.* -50year old fisherman (male discussion group)

> *When she has given birth you must spend extra on her and the most difficult one of all is when she goes through operation, it makes you financially weak and you can disgrace yourself if you don't take care, that is why sometimes some people run away leaving their wives at the hospital.* – 49 year old trader (male discussion group)

Belonging to the Christian or Islamic religion increased the odds of high male involvement compared with being a traditionalist (Christianity: OR=15.17, 95%CI: 2.55, 90.21; Islam OR= 17.34, 95%CI: 2.48, 121.45)

Those with 2 to 4 children had the highest proportion (32.6%) of high level involvement. Those having their first child and those who had 5 or more children had 12.1% and 13.6% of high level involvement respectively.

Table 5 shows the results of the bivariate logistic regression of socio-demographic characteristics affecting male involvement in maternity care.

Table 5: Socio-demographic factors influencing male involvement in maternity care. (Bivariate Logistic Regression)

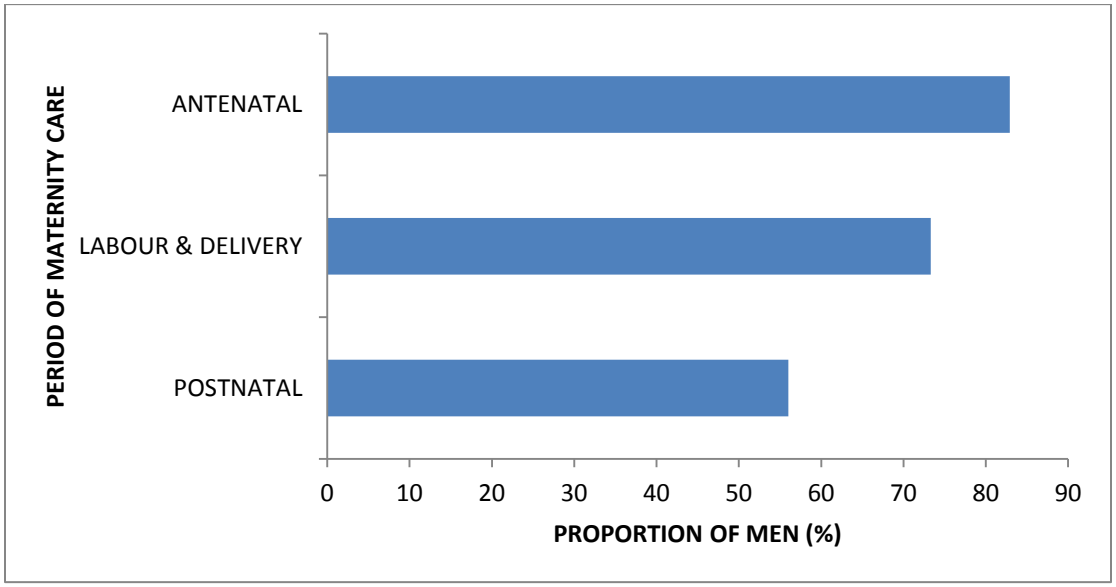
High Overall Male Involvement In Maternity Care				
Socio-demographic Characteristics	**Odds Ratio**	**P-value**	**95% Confidence Interval**	
Age				
18 - 25years	0.28	0.00	0.12,	0.66
36 - 40years	2.39	0.18	0.66,	8.62
Above 40years	1.96	0.35	0.48,	7.98
26 - 35years*	1.00			
Marital status				
Married	2.73	0.06	0.97,	7.67
Single	0.34	0.18	0.07,	1.65
Cohabiting	0.76	0.65	0.24,	2.45
Separated/Divorced*	1.00			
Educational level completed				
Primary	2.82	0.24	0.50,	15.77
Junior Secondary	6.62	0.02	1.35,	32.41
Senior Secondary	7.73	0.01	1.61,	37.15
Tertiary and above	40.57	0.00	3.16,	520.32
No formal education*	1.00			
Occupation				
Unemployed	0.66	0.44	0.22,	1.92
Self-employed	2.06	0.09	0.90,	4.70
Civil/Public servant*	1.00			
Religion				
Christianity	15.17	0.00	2.55,	90.21
Islam	17.34	0.00	2.48,	121.45
Other	9.67	0.16	0.40,	234.78
Traditional*	1.00			
Number of children				
1 Child	0.87	0.74	0.39,	1.95
5 or more Children	0.82	0.86	0.10,	6.49
2 - 4 Children*	1.00			

***Reference category**

SOCIO-CULTURAL FACTORS

From the pregnancy period through the labour and delivery to the postnatal period, the proportion of men who lived together with their partners decreased from 348 (82.9%) through 308 (73.3%) to 235 (56.0%).

Figure 7: Proportion of men living together with their partners during the different periods of maternity care



In all the three aspects of maternity care, there was significant association between the couple living together and the level of male involvement (P<0.001). During the antenatal period, 44.4% of men who did not live with their partners had low male involvement whiles only 5.6 % had high level of involvement. This was similar to those who did not live with their partners during the postnatal period, 47.0% of them had low level of male involvement whiles only 6.5% had high level of involvement. For those who lived with their partners during the labour and delivery time, only 2.6% had low level of

involvement but 47.7% had high level of involvement. During antenatal care, living together increased the likelihood of high male involvement (OR=13.12, 95% CI: 6.86, 25.08). During labour and delivery and the postnatal care, not living together reduced the likelihood of having high male involvement (labour and delivery- OR= 0.10, 95%CI: 0.04, 0.24; postnatal care- OR=0.13, 95% CI: 0.08, 0.22)

Having other family members living with the couple had a significant association with the level of male involvement (P=0.037). Not living with other family members increased the likelihood of high male involvement (OR=2.37, 95% CI: 1.20, 4.67). The specific family member who lived with the couple however did not have any significant association with the level of male involvement (P=0.164).

Focus group participants felt other relatives have responsibilities during maternity care especially mothers and mother-in-law:

> *The In-laws also have the responsibility to take care of the woman. Our in-laws are very experienced in those things and they have to comfort the woman*. -52 year old trader (male discussion group)

> *Since I realized that there are some things that our mothers can do but the wives can't do, I always advise my wife to go to either her mother or my mother when she is pregnant. Things like massaging the head and other things, these days, these ladies do not know how to do it. Me for instance you won't get it easy with me if you did not massage my child's head very well.* -49year old carpenter (male discussion group)

> *If it's your first time, then there is no problem staying with your mom. She will teach you how to massage the head of the child. There are also*

certain things you might not know so when you stay with her she will teach you on how to handle it. I will not stay with my husband when I deliver unless he has married me, because marrying me is something that he has to do. - 30year old trader (female discussion group)

The pregnancy being planned or unplanned had a significant association with the level of male involvement (P<0.0001). The pregnancy being unplanned reduces the likelihood of having high male involvement (OR=0.16, 95% CI: 0.07, 0.38).

Men being involved in the decision making on where their partners had antenatal care also had a significant association with the level of involvement (P<0.0001). Those who were involved in the decision making on where their partners had antenatal care had only a proportion of 1.8% having low level of male involvement. For those who were not involved in the decision making, 33.3% had low level of male involvement. The odds of having high level of male involvement when the man was involved in the decision making on where the partner had antenatal care was 27.40 times that of cases where the men were not involved (OR=27.4, 95%CI: 10.58, 70.94).

A man's level of involvement was also significantly associated with his desire to be present with his partner in the labour and delivery room (P=0.006) and who he thinks must be present in the labour and delivery room with the labouring woman (P < 0.0001). The proportion of those who desired to be present who had high level of involvement was 40.5% compared with 25.0% of those who did not wish to be present. Those who thought the husband was the person who should be present in the labour and delivery room had the lowest proportion of low male involvement (1.5%) and the highest proportion of high male involvement (53.7%). They were also the ones who desired most to be present at the

labour ward (85.3%). When a man felt that other family members should be present in the labour ward and not him, he was less likely to have a high level of involvement (the woman's mother- OR= 0.09, 95% CI: 0.03, 0.33; the man's mother- OR=0.10, 95% CI: 0.03, 0.39). Table 6 shows the sociocultural factors influencing male involvement in maternity care.

Table 6: Sociocultural factors influencing male involvement in maternity care (Bivariate Logistic Regression)

High Male Involvement In Maternity Care				
SOCIO-CULTURAL FACTOR	**Odds Ratio**	**P-value**	**95% Confidence Interval**	
Couple living together	13.12	0.00	6.86,	25.08
Couple not living together*	1.0			
Couple not living with other family members	2.37	0.01	1.20,	4.67
Couple living with other family members*	1.0			
Pregnancy unplanned	0.16	0.00	0.07,	0.38
Pregnancy planned*	1.0			
Man involved in decision making on place of antenatal care	27.40	0.00	10.58,	70.94
Man not involved in decision making on place of antenatal care*	1.0			
Man not desiring to be present on the labour ward	0.51	0.08	0.24,	1.08
Man desiring to be present on the labour ward*	1.0			
The man's opinion on who should be present at the labour and delivery room				
Mother	0.09	0.00	0.03,	0.33
Mother in law	0.10	0.00	0.03,	0.39
Siblings	0.16	0.13	0.02,	1.70
Husband *	1.0			

***Reference category**

There were no taboos prohibiting male involvement but there was strong concern about how they will be perceived by relatives and other people around if they are seen assisting their partners. Some focus group discussion participants had these to say:

> *When you are in a self-contained house where nobody sees you, you can do those things. You see, when doing those things in the open, people around you might insult you. I will like to do it but the things people will say will hurt you. I know even my sister and other siblings will make fun of me. People will say that she has charmed me. But what I know is that you have to assist her in everything.* -43year old trader (male discussion group)

> *I quite remember when my wife recently give birth, I took her to postnatal clinic and as people saw us they really loved that but others started saying I'm a fool, how can I accompany my wife to the hospital.* -39 year old clerk (male discussion group)

> *When a man washes for you, they will say you have charmed him meanwhile it might not be true. This is even worse when you are living in a compound house anyone at all that passes will think of something negative.* – 37year old seamstress (female discussion group)

> *My husband likes doing a lot of little things for me but if my in law hears that, she will talk a lot with insults. As a result of that my husband doesn't like doing a lot of things for me anymore, thinking my in law will talk too much.* – 28year old trader (female discussion group)

HEALTH FACILITY FACTORS

The likelihood of a man accompanying the partner more than once was significantly associated with his assessment of staff attitude and the time spent at the health facility per visit (P=0.001). Of those who found the staff to be unfriendly, 98.1% accompanied their partners once and 1.9% accompanied them 2 or more times. More than half (54.8%) of those who found the staff to be friendly accompanied the3opooooooooooooooooir partners two or more times. Of those who assessed the time spent at the health facility to be too long, 93.3% accompanied their partners once and 6.3% did so two or more times. Over half (52.6%) of those who assessed the times to be reasonable accompanied their partners two or more times. Eighty-Three per cent (83%) of those who accompanied their spouses more than once were those who found the time spent at the facility to be reasonable. The odds of accompanying the partner not more than once when the staff attitude is assessed to be friendly is 0.027 times the odds when it is assessed to be unfriendly. (OR= 0.027, 95% CI: 0.003, 0.224). The odds of accompanying the partner not more than once when the time spent at the facility per visit is assessed to reasonable is 0.13 times the odds when it is assessed to be too long. (OR= 0.126, 95% CI: 0.032, 0.500). Table 7 shows the health facility factors associated with the frequency with which the men visited the health facilities with their partners. Members of both the male and female focus group discussions had a lot to say about the health facilities:

> *The problems at the hospital are enormous. The nurses are not friendly at all. Some of the words they utter are too ugly. What is too humiliating is where you do not have any money at all. They will tell you, this place is*

Table 7: Health facility factors associated with the frequency with which the men visited the health facilities with their partners.

	Proportion making visit (%)			
FACTOR	**>2 Times**	**Once**	**Chi square**	**P-value**
Staff Attitude				
Unfriendly	1.9	98.1	38.15	0.001
Friendly	54.8	45.2		
Indifferent	0	100		
Time spent at facility per visit				
Too long	6.3	93.7	28.03	0.001
Reasonable	52.6	47.4		

Table 8: Health facility factors influencing the frequency with which the men visited the health facilities with their partners. (Bivariate Logistic regression)

	Accompanying partner to the health facility not more than once			
FACTOR	**Odds ratio**	**P-value**	**Confidence interval**	
Staff Attitude				
Friendly	0.027	0.001	0.003	0.224
Unfriendly	1.0			
Indifferent	-			
Time spent at facility per visit				
Reasonable	0.126	0.003	0.032	0.500
Too long	1.0			

for staff so do not pass there, this place is for pregnant women, you are not supposed to pass there. -45year old driver (male discussion group)

But sometimes too, you will go to the hospital and they will tell you do not sit here; this place is for pregnancy people. When you get there and there is no place for you, it is sometimes disheartening. -38 year old trader (male discussion group)

Sometimes if the man accompanies you to the hospital, the nurses can utter some words that won't encourage him to go with you the next time you ask him to. -33year old trader (female discussion group)

Most often, it depends on the way the nurses will treat them. At times some of the nurses will treat them well whereas some other days they will be very bad in treating them when they accompany you to the hospital. – 41 year old hairdresser (female discussion group)

When participants of the focus group discussion were asked to make suggestions for improvement in the level of male involvement, the following were some of the suggestions made:

- Health workers should invite male partners to the clinic either by writing or through phone calls.

  We want the doctors to invite our husbands to the hospital and counsel them on the things they have to do. It is possible the doctor can write it on a paper so that we take it to the man but it is not all of us whose husband

can read so it is better he calls them. -30year old housewife (female discussion group)

- Staff should have a friendlier attitude towards male partners when they attend clinic.

  Then tell the nurses and the midwives too that they should smile a little and stop their in-human behaviour. – 34 year old mechanic (male discussion group)

- Adequate space and chairs should be provided at the clinic so that male partners can feel comfortable to be there.

  Where the women who have just delivered are, there are no seats beside the bed so you cannot sit beside her. At least the hospital must provide two seats beside the bed so that people visiting must sit and comfort them. -46year old businessman (male discussion group)

- Male partners should be allowed in the labour ward.

  Every man must be allowed to go to the maternity ward with his wife so that if they need any help you will be able to help. -44year old trader (male discussion group)

- The time spent at the health facility should be reduced especially if the man accompanies the partner.
- Educational campaigns should be carried out in the community to sensitise men on the need to get involved in maternity care.

> *Like the way you have gathered us here, the men have to be educated so that they know the essence and the kind of effects that the women go through during child birth and delivery*. -32 year old trader (female discussion group)

The factors emerging out of the focus group discussions were similar among both the older age group (36years and above) and the younger age group (35years and below).

On multivariate logistic regression, the factors that remained significantly associated with the level of male involvement in maternity care were as shown in Table 9.

Table 9: Multivariate logistic regression analysis of factors associated with level of male involvement in maternity care

VARIABLE	Adjusted Odds Ratio	[95% Conf.	Interval]	P-value
Age				
18-25yrs	0.92	0.38	2.23	0.851
36-40yrs	2.71	1.08	6.81	0.034
41 and above	3.71	1.28	10.79	0.016
26-35yrs	1.00			
Marital status				
Married	0.12	0.03	0.45	0.001
Single	0.14	0.02	1.05	0.055
Cohabiting	0.12	0.03	0.48	0.003
Separated/Divorced	1.00			
Educational level				
Primary	3.04	0.50	18.67	0.23
Junior Secondary	12.69	2.28	70.72	0.004
Senior Secondary	7.93	1.44	43.86	0.018
Tertiary	52.31	5.47	500.41	0.001
No formal education	1.00			
Occupation				
Unemployed	0.77	0.25	2.41	0.652
Self employed	1.28	0.63	2.60	0.488
Civil/Public Servant	1.00			
Number of children				
2-4 children	1.67	0.78	3.60	0.187
5 or more children	0.83	0.16	4.47	0.833
1 child	1.00			
Living together				
Couple living together	9.18	3.38	24.89	0.000
Couple not living together	1.00			
Planned or unplanned pregnancy				
Planned pregnancy	2.27	1.11	4.61	0.024
Unplanned pregnancy	1.00			
Involvement in decision on place of antenatal care				
Involved	4.76	2.57	8.82	0.000
Not involved	1.00			

CHAPTER FIVE

DISCUSSION

The study found majority of the men in Ablekuma South district being moderately involved in the maternity care of their partners with about 1 in 4 (26.4%) being highly involved and 1 in 5 having low level of involvement. The proportion of high level involvement was similar to findings in a study by Byamugisha et al. (2011) in Mbale district, Uganda, who found 26.0% of the participants to have a high male involvement. He however found 74.0% of the participants to have a low male involvement index. (Byamugisha et al., 2011 categorised their male involvement index into high and low with no moderate group). The period with the highest proportion of high male involvement was during labour and delivery. This is probably due to the fact that this period is seen as a crucial time and rightly so because most maternal mortalities occur around this period. The postnatal period had the lowest level of male involvement. When a woman has a safe delivery of a healthy baby, it is often considered the end of the pregnancy period and so less attention is given to the postnatal period. Although the proportion of men with low involvement was low, the key points that involved contact with the health facility and health professionals were the points that scored the lowest. These were; the man accompanying the partner to the health facility and holding discussions with health care providers concerning the female partner's maternity care. This is a cause for concern because it is during contact and discussions with the health professionals that men can acquire the needed knowledge, behavioural and attitudinal change that can positively impact on their contribution to reducing maternal morbidity and mortality.

Only few of the men accompanied their partners to the antenatal clinic (24.0%) and even fewer did so to the postnatal clinic (19.0%). This was lower than findings made in the study of Kakaire et al., (2011) in Kabale, Uganda, who found 42.9% of the women had been accompanied by their husbands to the antenatal clinic and 43.4 % to the labour ward. The finding was however higher than that from Mbale, Uganda by Byamugisha et al. (2011) where only 5% of the men accompanied their spouses to the antenatal clinic. (The study in Kabale was among women with obstetric complications) Tweheyo et al., (2010) in their study in peri-urban Gulu district in Northern Uganda had a high proportion of the men (65.4%) making at least one visit to the antenatal clinic.

The highest proportion accompanying their partners to the health facility was during labour and delivery. About 40% of the men accompanied their partners to their health facilities but only 5% of the men were present in the labour and delivery rooms with their partners. This was largely due to the fact that most of the health facilities do not allow male partners into the labour and delivery rooms. Majority of the men desired to be present and about half of them felt that if only one person should be allowed into the labour and delivery room, it should be the male partner. In a study in Nepal by Mullany (2006), about half of the couples preferred to have the husband present during labour if given the option. Both men and women in this study as well as that of Mullany (2006) mentioned lack of space and privacy on the labour ward as another deterrent. Sometimes, even in places where men are allowed in, they feel excluded in the whole process. Steen, Downe, Bamford & Edozien (2012) describes fathers' confused feeling about their status in maternity care; they are there neither as patients nor as visitors.

Some reasons given for men not accompanying their partners included busy work schedule and not living together with their partners but the one often mentioned was facility-related factors. Poor staff attitudes, lack of seating space for the men, restricted male access to various areas within the facility and the length of time spent per visit to the facility were found to negatively affect the level male of involvement.

After the first contact with the health facility, making subsequent visits was highly affected by the above factors. Men seem to share their experiences with their colleagues, and so even those who have never visited the health facility may be discouraged by the experiences of their colleagues. During the male focus-group discussion, even those who had never been to the health facility with their partners spoke passionately about these issues.

Byamugisha et al. (2011) also found similar factors to be barriers to male participation in maternity care. If men are to accompany their partners to the clinic, the health facilities must make provision for them and make them feel welcome. In a meta-synthesis of fathers' encounters with pregnancy, birth and maternity, Steen et al., (2012) reported that some men felt unwelcome when they managed to make time to attend antenatal clinic. They were treated as spectators. When men feel that their presence is a nuisance, they are unlikely to repeat the visit or encourage their colleagues to do so. Friendly staff attitudes encourage men to accompany their partners and to be involved in their maternity care.

Men feel their primary responsibility is to work and provide financial support so if they find the time spent at the health facility to be too long and a waste of their working hours, they are unlikely to accompany their partners. Mullany (2006) and Carter (2002) both found that non-availability of men during maternity care was often job-related. Tweheyo

et al., (2010) found long waiting time to be a barrier to attendance in 41.7% of male partners in his study

The presence of support persons is known to greatly affect women's satisfaction with maternity care and enhances better birth outcome (Mullany, 2006; Sauls, 2002) In their study on the assessment of the effect of psycho-social support during childbirth in Ibadan, Nigeria, Morshaso-Bello et al., (2009) found that women who did not have company during labour and delivery were five times more likely to deliver by caesarean section, had longer duration of the active phase of labour and higher pain scores. Male partners formed the highest proportion of companions in their study.

In cases where there is need for referral in emergency situations, the availability of the male partner will greatly facilitate such transfers. This is because in our local setting, relatives are sometimes called upon to help in the arrangement of transport and other logistics in emergency situations. Kakaire et al., (2011) affirm a similar situation in their study in Uganda and found delays occurring during referrals to include unavailability of transport, failure to meet transport cost and the absence of someone to accompany the referred patient. Male partners being present can reduce these delays. The role of the promptness with which these things are done in reducing maternal morbidity and mortality cannot be overemphasised.

The proportion of participants having discussions on their partner's maternal health issues with their health providers was also found to be low across all the various aspects of maternity care. This was to be expected given the low proportion who accompanied their partners to the health facilities. Such discussions are crucial in equipping the male partners to offer appropriate, adequate and effective support to their female partners. The

other key points of male involvement, that is, offering support and planning for emergencies will not be effective if the men do not have the right information. When men lack knowledge on maternal health issues, it limits what they can do. Mullany (2006) in a study in Nepal had some men expressing their frustration about not knowing what actions to take because of their low knowledge of maternal issues. Some women in the focus-group discussions lamented about the fact that even when they inform the men of the advice they have been given at the antenatal clinic, e.g. the need for adequate rest, their partners do not believe them. So they wanted men to follow them to their health facility to hear these pieces of advice for themselves.

The study found a large proportion of the men having discussions with their partners on maternal health issues relating to their pregnancy, labour and delivery but a rather low proportion had discussions concerning postnatal issues like family planning. Probably, the proportion in the post-natal period was low because unlike the antenatal, labour and delivery, they see the dangers associated with childbirth to be over once a woman delivers successfully and has a healthy baby. They therefore do not see the need to have further discussions. Also, a large proportion of the women (44.0%) did not live with their partners after delivery. Most of them moved to live with either their mothers or the man's mother and issues concerning the postnatal period are often seen as the responsibility of these older women.

Family planning is a crucial issue to be discussed and implemented during the postnatal period. Male involvement in family planning is associated with high uptake and continuation rates. Although the average number of children per person among the study population was less than three, more than half of their pregnancies (58.8%) were

unplanned. One would have therefore expected a greater interest in discussing family planning. The high level of unplanned pregnancies could be a reflection of the low male involvement in post-natal care.

Birth preparedness and complication readiness is very important in reducing delays in accessing care in the time of emergency and hence reducing morbidity and mortality. These include recognition of dangers signs, a plan for the place of delivery, transport arrangements and saving money for emergencies (Kakaire et al., 2011) . In this study, 2 out of 3 (63.1%) participants made joint plans with their partners for emergency situations during the pregnancy. Most of them indicated putting some money aside as the main provision made. A slightly higher proportion made joint plans for the labour and delivery and postnatal periods. The study, however, did not assess the adequacy of the provision made. In the study by Kakaire et al., (2011) the cost of hospital care and transport was paid for using the woman's own money in 44.3% of situations, 25.7% by the husband and in 30.0% of situations it was paid by other relatives. Joint decision making was found to be associated with significantly higher levels of male involvement in maternal health by Mullany (2005). Burgard and Story (2012) also found joint decision-making to be associated with greater utilisation of maternal health services by women,

All the men provided physical and financial support in one form or the other. Most of them indicated financial support which is similar to findings by Byamugisha et al. (2011) who found 97% of the men providing financial support to their spouses to attend ANC. In a study in Cameroun, 64.7% of the participants indicated that financial support was all that was required of the man (Nkuoh et al., 2010).

The men generally were interested in the maternity care of their partners and indicated preparedness to support them and be involved. But the challenge was knowing what constitutes appropriate and adequate support. Because men do not interact much with health care professionals, they may not know how they can participate and the kind of support to give to their partners.

There are several other factors that affect male involvement in maternity care. These include socio-demographic, socio-cultural and health facility factors.

The younger age group (18-25years) were found to be less likely to be highly involved. These younger ones are more likely to be unmarried, students or employed and the pregnancies are more likely to be unplanned. This may account for their low level of involvement. Byamugisha et al. (2011) and Nanjala & Wamalwa (2012) did not find any significant association between age and male involvement.

Those who were formally married are more likely to be involved in their partner's maternity care. Such men feel a sense of responsibility towards their partners and so provide support and show more interest in what goes on in their pregnancy. Tweheyo et al. (2010) found the men who were formally married to be more likely to attend antenatal clinic with their partners compared with those who were not formally married.

In this study, higher levels of education were found to be associated with higher levels of male involvement in maternity care. Kakaire et al. (2011) found similar association. Byamugisha et al., (2011) found men who had attained secondary education or higher, two times more likely to have a high male involvement index. Nanjala and Wamalwa (2012) and Tweheyo et al. 2010 all found a significant association between level of education and the level of involvement. This association may be mediated by their high

income-earning potential. They may therefore be able to patronise private health facilities where men are more welcome to participate in their partner's maternity care. They may also have better access to information concerning pregnancy outside the health facility, for example via the internet. Education may also enable them to discard negative cultural norms and attitudes.

Employment also seems to be associated with the level of involvement. The unemployed were less likely to be involved in their partner's maternity care. One would have expected that the unemployed will have more time on their hands to accompany their partners and to help with household chores among others. The underlining cause for this finding may be the lack of funds. Some men in the focus-group discussion lamented how sometimes, financial difficulties served as a deterrent to accompanying their partners for fear of being embarrassed by their inability to pay fees and other expenses. Nanjala and Wamalwa (2012) in a study in Busia, Kenya, found fees charged at the health facilities to be one contributing factor to low male involvement in childbirth activities.

The study found the level of involvement among those having their first child to be lower than those having subsequent children. This was at variance with the expected enthusiasm of first time parents, particularly the involvement of the men (Gabrysch and Campbell, 2009). This finding may be a result of the fact that a lot of the first pregnancies were among the younger age group and also the high percentage of unplanned pregnancies. Unplanned pregnancies were associated with lower male involvement. Experiences in the first pregnancies could also influence male participation in subsequent pregnancies. Carter (2002) noted that such experiences may give pregnancy and birth a

heightened urgency and meaning that in turn lead to increased partner involvement subsequently.

In Ablekuma South District, specifically Korle-Gonno, where the study was conducted, they tend to have multi-generational households. A large proportion of the couples have other family members living with them in the same house, mothers and siblings being the most frequent. The presence of other family members, however, did not have much effect on the level of male involvement except when it comes to helping in household chores where in both the male and female focus-group discussions, there was concern about what family members and friends would say about such a man. On the side of the men, the fear of being called a "weakling" deterred them from helping and for the women; the fear of being accused of having charmed their partners also deterred them from asking for help from their partners

The socio-cultural practice which had a significant effect on the level of male involvement was the practice of pregnant women moving in with either their own mothers or partner's mother especially around the labour, delivery and postpartum period. When the women move in with these older women who are presumed to be more experienced in pregnancy issues, the men relinquish some of their responsibilities to them. Carter (2002), in her study in Guatemala, found that although men are more likely to advise their pregnant partners to see healthcare providers when there are problems, these older relatives are more likely to tell them what to do. This may lead to poor maternal and birth outcomes if such pieces of advice are not the right ones. Mullany (2006) found similar roles played by mothers or mothers-in-law who took pride in their ability to accomplish feats without medical intervention. Occasionally, such relocation

implied a change from a higher level health facility to a low level health facility without comprehensive emergency obstetric care which may in itself contribute to poor maternal birth outcome.

There were no taboos that prohibited men from getting involved but concerns about what peers would say were the negative influence. Cultural segregation of gender roles was found to be a major cause of low level of male involvement. Some household chores were considered as a woman's duty and not appropriate for a man to carry out. Nanjala and Wamalwa (2012) and Byamugisha et al. (2011) found similar negative effects of such social stigma in their studies. Carter (2002) however noted that men are more likely to cross traditional gender boundaries during their partners' pregnancy and birth. They may for instance be more willing to cook for themselves and their other children while the woman is pregnant of has just given birth.

Most of the suggestions made by members of both the male and female focus-groups for improving male involvement had to do with the health facilities. Contrary to the notion that men are just not interested in their partner's maternity care, this study revealed that men are interested but the health facility factors were strong barriers to their involvement. Male friendly health facilities with adequate provision made to accommodate men and friendly staff attitude will encourage male involvement. Findings from various researchers have been consistent with this (Byamugisha et al., 2011; Mullany, 2006 and Nanjala & Wamalwa, 2012).

Some have suggested that when a man accompanies their partner, they should be attended to first and fast so that the men don't spend too much time at the facility. Kululanga et al. (2011) in their study in Malawi found this as one of the strategies used by health facilities

to improve male involvement. There was however concern that this incentive may work when there are few men attending clinics but as the number increases, this may not be practical. There was also the suggestion to give the male partners a written invitation to come to the clinic or even if possible phone calls should be made by health care providers. Perhaps, educating men within communities and in formal settings about the importance of male involvement will help sustain men's interest and involvement even in the absence of incentives and coercion as the health facilities come up with sustainable strategies.

Nasreen et al. (2012) in their study in rural districts in Bangladesh found that giving men educational messages using their informal gatherings was effective in increasing their knowledge on maternal health care issues. Mullany (2006) found major shifts in hospital policy as an important first step in introducing couple-friendly maternity services.

LIMITATIONS OF THE STUDY

- The study included only men with their last child aged 5 years or less in order to minimise the possible problem with recall but there was no way of ensuring accuracy of the recall of activities surrounding their partners' last birth.
- Participants were assured of confidentiality and encouraged to give honest responses but there is still the possibility of some participants giving socially desirable responses.
- The socio-demographic characteristics of respondents as presented in the results were the situation at the time of the study although the study solicited information from the past 5 years. The assumption therefore is that, these characteristics would not have changed much over the period.

CHAPTER SIX

CONCLUSIONS AND RECOMMENDATIONS

CONCLUSION

The level of male involvement in maternity care in the Ablekuma South District was not optimal. A man's involvement in his partner's maternity care is influenced by varied factors which may relate to the man (socio-demographic factors), the community (socio-cultural factors) and the health facility and health care providers. There is need for concerted effort from all these stakeholders if success will be achieved in improving male involvement in maternity care.

The health care delivery system is best placed to spearhead this effort by providing facilities with infrastructure designed to accommodate and welcome men to participate in maternity care. Attitudinal change among health care providers to friendlier attitudes will foster greater male involvement. Organisation of service delivery in a way that is sensitive to the time constraints of the male partners will encourage more men to accompany their partners to the health facilities. Negative socio-cultural norms can be addressed as men, their partners and health care providers have more interaction.

These critical issues brought to the fore as a result of this research will help formulate policies that remove barriers to male participation in maternity care and translate into greater utilisation of health services by women. Ultimately, this should result in improved maternal health and reduced maternal mortality and accelerate the achievement of the Millennium Development Goal 5.

RECOMMENDATIONS

- The District Health Management Team in collaboration with the community leaders should organise educational campaigns within the communities to educate community members especially the men, on the importance and benefits of male involvement in maternity care. Such campaigns can also address negative sociocultural norms and attitudes. Satisfied peer educators can also be used to encourage their colleagues to get involved in maternal issues.
- Health facilities should restructure their maternal health clinics to make them more male friendly. Adequate space and privacy must be provided. The policy of not allowing male partners into the labour wards must be reviewed and the labour wards redesigned to accommodate them. The organisation of service delivery must aim at reducing the time spent at the facility per visit. Health facilities must devise strategies to invite men to the antenatal and postnatal clinics. Health care providers must be trained in interpersonal skills and encouraged to have a friendlier attitude towards their clients and their partners.
- To improve maternal health and reduce maternal mortality in Ghana, one of the key strategies the Ministry of Health and the Ghana Health Service can use, is increased male involvement in maternity care.
- Given the sociocultural diversity in the country, more research must be encouraged in this important area to enable the design of culturally appropriate and sensitive male friendly services throughout the country.

SUGGESTION FOR FURTHER RESEARCH

1. A study to assess the male-friendliness of the health facilities providing maternity care in the country focusing on the infrastructure, timing of services and staff attitudes. The challenges faced by care providers and the health facilities in providing male-friendly maternity services must also be explored.
2. An intervention study employing the above recommendations in order to evaluate what the impact of these recommendations will be on male involvement and maternal health when implemented.

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APPENDICES

CONSENT FORM (A): Consent form for participants in the cross sectional survey.

CONSENT FORM (A)

PRINCIPAL INVESTIGATOR:

Dr. Mrs Roseline Dansowaa Doe

School of Public Health

University of Ghana

Email: roselinedoe16@yahoo.com

Cell phone: 0244 25 98 56

I am (…… assisting) Roseline Doe, a student of the School of Public Health, University of Ghana, Legon. I am conducting a research on the topic:

MALE PARTNER INVOLVEMENT IN MATERNITY CARE IN ABLEKUMA SOUTH DISTRICT, ACCRA, GHANA

You are kindly requested to volunteer to participate in this study. Please read through the following information on the research carefully to know why the research is being conducted and what will be involved before making your decision to participate. You can listen as I read through the information for you or you may also give it to somebody to read it to you. If you have any questions or need any clarification on any aspect of the

study, please do not hesitate to ask. If you decide to participate in this research, you will be required to indicate your voluntary consent by signing or thumb printing an informed consent form. You will be given a copy of the signed informed consent form.

PURPOSE OF THE STUDY

This study seeks to determine the level of male involvement in maternity care and the factors that influence their involvement in the Ablekuma South District.

STUDY PROCEDURE

You have been asked to participate in this study because you are a man whose partner has a child who was five years or younger at the last birthday. Participating in this research will involve a one-time answering of a questionnaire which will last about 20 minutes. Information this questionnaire seek to acquire from you include your demographic data and your involvement during the pregnancy, labour, delivery and the postpartum care of your last child.

BENEFITS

There is no immediate direct benefit to you but the information obtained will help in planning maternity care services that will encourage greater male involvement and remove barriers to their participation in maternity care and ultimately help to reduce maternal mortality in Ghana.

COSTS

There are no financial costs involved on your part but you have to sacrifice some of your time to participate in the research. The study will also pose no risk at all to you. No

invasive procedures will be carried out on you but some of the questions asked may be personal and private in nature.

CONFIDENTIALITY

The researcher and her team will make every effort to ensure that all information obtained from you is held in the strictest confidence. The data from this study can only be accessed by the research team. The report from the research will not be linked to your identity or person.

VOLUNTARINESS

Your participation in the study is encouraged but it is completely voluntary. You are at liberty to participate or to refuse to participate in the research. You are also free to withdraw from the study at any time. Either way there will be no consequence to you.

You may contact the principal investigator if you have any further questions or concerns.

This research has been reviewed and approved by Ghana Health Service Ethical Review Committee. If you have any questions about your rights as a research participant or you have any complaints about how you have been handled during this research, you may contact the Ghana Health Service Ethical review Committee:

<u>CONTACT PERSON</u>

Nana Abena Kwaa

Mobile: +233 (0) 244 712919

Email: nanatuesdaykad@yahoo.com

If you have read and understood the information above and are willing to participate in the research, please indicate by signing or thumb printing below. Thank you very much.

INFORMED CONSENT

I have read the foregoing information / the foregoing information has been read to me or interpreted to me and I have fully understood the purpose, procedures, benefits and cost of this research. I understand that I can withdraw from the study at any time without any consequence to me. I have been given opportunity to ask questions I had and they have been satisfactorily answered.

I consent voluntarily to participate in this study titled:

MALE PARTNER INVOLVEMENT IN MATERNITY CARE IN ABLEKUMA SOUTH DISTRICT, ACCRA, GHANA

Name of participant: ----------

Signature/thumbprint: ----------Date----------

PRINCIPAL INVESTIGATOR OR RESEARCH ASSISTANT

I have explained the purpose, procedures, benefits and cost of this research as well as the confidentiality of participants' information.

Name ----------

Signature of Interviewer----------Date: ----------

CONSENT FORM (B): Consent form for participants in the Focus Group Discussion.

CONSENT FORM (B)

PRINCIPAL INVESTIGATOR:

Dr. Mrs Roseline Dansowaa Doe

School of Public Health

University of Ghana

Email: roselinedoe16@yahoo.com

Cell phone: 0244 25 98 56

I am (…… assisting) Roseline Doe, a student of the School of Public Health, University of Ghana, Legon. I am conducting a research on the topic:

MALE PARTNER INVOLVEMENT IN MATERNITY CARE IN ABLEKUMA SOUTH DISTRICT, ACCRA, GHANA

You are kindly requested to volunteer to participate in this study. Please read through the following information on the research carefully to know why the research is being conducted and what will be involved before making your decision to participate. You can listen as I read through the information for you or you may also give it to somebody to read it to you. If you have any questions or need any clarification on any aspect of the

study, please do not hesitate to ask. If you decide to participate in this research, you will be required to indicate your voluntary consent by signing or thumb printing an informed consent form. You will be given a copy of the signed informed consent form.

PURPOSE OF THE STUDY

This study seeks to determine the level of male involvement in maternity care and the factors that influence their involvement in the Ablekuma South District.

STUDY PROCEDURE

Participating in this research will involve a group discussion with seven (7) other participants which will last for about ninety minutes. Information we seek to acquire from you includes your views on cultural norms, your perceptions of gender roles, perceptions of male friendliness of health facilities and attitudes of peers and the community at large to male involvement in maternity care.

BENEFITS

There is no immediate direct benefit to you but the information obtained will help in planning maternity care services that will encourage greater male involvement and remove barriers to their participation in maternity care.

COST

There are no financial costs involved on your part but you have to sacrifice some of your time to participate in the research. The study will also pose no risk at all to you. No invasive procedures will be carried out on you.

CONFIDENTIALITY

The researcher and her team will make every effort to ensure that all information obtained from you is held in the strictest confidence. Although the discussions will be tape recorded and notes will be taken, the report from the research will not be linked to your identity or person. The data from this study can only be accessed by the research team.

VOLUNTARINESS

Your participation in the study is encouraged but it is completely voluntary. You are at liberty to participate or to refuse to participate in the research. You are also free to withdraw from the study at any time. Either way there will be no consequence to you.

You may contact the principal investigator if you have any further questions or concerns.

This research has been reviewed and approved by the Ghana Health Service Ethical Review Committee. If you have any questions about your rights as a research participant or you have any complaints about how you have been handled during this research, you may contact the Ghana Health Service Ethical Review Committee:

<u>CONTACT PERSON</u>

Nana Abena Kwaa

Mobile: +233 (0) 244 712919

Email: nanatuesdaykad@yahoo.com

If you have read and understood the information above and are willing to participate in the research, please indicate by signing or thumb printing below. Thank you very much.

INFORMED CONSENT

I have read the foregoing information / the foregoing information has been read to me or interpreted to me and I have fully understood the purpose, procedures, benefits and cost of this research. I understand that I can withdraw from the study at any time without any consequence to me. I have been given opportunity to ask questions I had and they have been satisfactorily answered.

I consent voluntarily to participate in this study titled:

MALE PARTNER INVOLVEMENT IN MATERNITY CARE IN ABLEKUMA SOUTH DISTRICT, ACCRA, GHANA

Name of participant: ----------

Signature/thumbprint: ----------Date----------

PRINCIPAL INVESTIGATOR OR RESEARCH ASSISTANT

I have explained the purpose, procedures, benefits and cost of this research as well as the confidentiality of participants' information.

Name ----------

Signature of Interviewer----------Date: ----------

FOCUS GROUP DISCUSSION GUIDE

Welcome and thank you very much for agreeing to be part of this focus group discussion. As explained to you earlier, the information we seek from you includes your views on cultural norms, your perceptions of gender roles, perceptions of male friendliness of health facilities and attitudes of peers and the community at large to male involvement in maternity care. Feel free to share your honest and candid opinion. Once again we wish to assure you of confidentiality and anonymity.

1) What do you think is the role or responsibility of men during their partner's pregnancy?

   Probe for role during labour and delivery?

   Probe for role during the postpartum period?
2) What is the role of other members of the family especially females like mothers, mothers in-law and siblings?
3) What are the cultural norms or taboos in this community that affect male involvement in maternity care?
4) What would you think of a man who accompanies the pregnant wife to the hospital?

   Probe: What about a man who helps with the household chores?
5) What experiences at the health facilities encourage men to accompany their partners to the antenatal clinic and postnatal clinic?

   Probe: What about being present during labour and delivery?
6) What factors at the health facilities discourage men from accompanying their partners to the antenatal clinic and postnatal clinic?

Probe: What about being present during labour and delivery?

7) Are there any other factors that you think affect men's involvement in maternity care?
8) What suggestions can you make as to how male involvement in maternity care could be encouraged in this community?
9) What further comments can you make on the issues we have been discussing?

Thank you very much for your time and for sharing your opinion on the issues discussed.

FOCUS GROUP DISCUSSION INFORMATION SHEET

GROUP…….. DATE……..… TIME……..……

GROUP DESCRIPTION……...

MODERATOR…… ASSISTANT……..…

Study ID number	Age	Marital status	Educational level completed	Occupation	Religion	Number of Children	Age of last child

QUESTIONNAIRE

MALE PARTNER INVOLVEMENT IN MATERNITY CARE IN ABLEKUMA SOUTH DISTRICT, ACCRA, GHANA

STUDY ID: …… HOUSE NUMBER: …….

INTERVIEWER: …….. DATE: ……..

SOCIODEMOGRAPHIC CHARACTERISTICS

1. Age: .....
2. Marital status: ( ) Married =1 ( ) Single =2 ( ) Separated/Divorced =3

   ( ) Cohabiting =4 ( ) Other (Specify) =5
3. Educational level completed:

   ( ) No education =1 ( ) Primary =2 ( ) Junior Secondary =3

   ( ) Senior Secondary =4 ( ) Tertiary and above =5
4. Occupation: ( ) Unemployed =1 ( ) Private sector =2

   ( ) Government sector =3
5. Religion: ( ) Christianity =1 ( ) Islam =2 ( ) Other =3
6. Number of children: …….
7. Age of last child (years): ( ) <1=1 ( ) 1=2 ( ) 2=3 ( ) 3 =4

   ( ) 4 =5 ( ) 5 =6

ANTENATAL CARE

8. Were you living together with your partner at the time of her pregnancy?

   ( ) Yes =1 ( ) No =2

   (If no, skip to question 11)

9. Were there other family members living with you?

   ( ) Yes =1 ( ) No =2

10. If yes, which family member was living with you?

    ( ) Her mother =1 ( ) My mother =2 ( ) Siblings =3 ( ) Others (specify) =4

11. Was the pregnancy planned? ( ) Yes =1 ( ) No =2

12. Did she attend antenatal clinic? ( ) Yes =1 ( ) No =2 ( ) Don't know=3

13. Where did she attend antenatal clinic? …… =1 ( ) Don't know =2

14. Were you involved in the decision on where she had antenatal care?

    ( ) Yes =1 ( ) No =2

15. Did you make any joint plans for emergency situations during the pregnancy?

    ( ) Yes =1 ( ) No =2 (if no, skip to question 17)

16. If yes, please specify the preparation made:

    ( ) Put money aside for emergency =1 ( ) Made transport arrangement=2

    ( ) Decided on where to go in case of emergency =3 ( ) Others (specify) =4

17. Did you ever accompany your partner to the antenatal clinic?

    ( ) Yes =1 ( ) No =2 (if no, skip to question 21)

18. If yes, how many times did you accompany her?

    ( ) Once =1 ( ) Two – three times =2 ( ) 4 or more times =3

19. How would you describe the attitude of the staff?

( )Friendly =1 ( )Unfriendly =2 ( ) Indifferent =3

20. How would you assess the time you had to spend at the health facility?

( ) Reasonable =1 ( )Too long =2

21. If no, why were you never present? ……

……..

22. What support did you provide your partner during her pregnancy?

( ) Provided funds for ANC visits =1

( ) Reminded her of her ANC visits =2

( ) Helped with household chores =3

( ) Others (specify) =4

23. Did you discuss health issues relating to the pregnancy with your partner? . ( )Yes =1 ( )No =2

24. Did you discuss health issues relating to the pregnancy with her health care providers? ( )Yes =1 ( )No =2

LABOUR AND DELIVERY

25. Were you living together with your partner at the time of her labour and delivery?

( ) Yes =1 ( )No =2

26. Did you accompany your wife to the health facility at the time of labour and delivery?

( )Yes =1 ( ) No =2 ( ) Did not deliver in a health facility =3

27. If you did not accompany her, how did she get to the health facility that day?

( ) I delegated somebody to take her =1 ( ) She went alone =2

( ) Others (specify) =3 ( ) Don't know =4

28. Did you make any joint prior plans for labour and delivery during the pregnancy?

( ) Yes =1 ( ) No=2

29. What support did you provide your partner during her labour and delivery?

( ) Provided funds for her labour and delivery =1

( ) Helped with household chores while she was away =2

( ) Others (specify) =3

30. Did you discuss health issues relating to the labour and delivery with your partner?

. ( ) Yes =1 ( ) No =2

31. Did you discuss health issues relating to the labour and delivery with her health care providers? ( ) Yes =1 ( ) No =2

32. Are male partners allowed to be present during labour and delivery in the facility she attended? ( ) Yes =1 ( ) No =2 ( ) Don't know =3

33. Were you present at the labour and delivery? ( ) Yes =1 ( ) No =2

(If yes, skip to question 36)

34. If no, why were you not present? ……....

……

35. Do you wish you were present? ( ) Yes =1 ( ) No =2

36. In your opinion if one person should be allowed in the labour room with the labouring woman, who should it be? ( ) Husband =1 ( ) Mother =2

( ) Mother in law =3 ( ) Others (specify) =4

POSTNATAL CARE

37. Did your partner live with you after delivery? ( )Yes =1 ( )No=2

38. If no, who did she live with?

( )Her Mother =1 ( ) My Mother =2 ( ) Others (specify) =3

39. Did you ever accompany your partner for her postnatal visits to the health facility?

( )Yes =1 ( )No =2

40. If no, why were you never present? …….

……

41. Were you involved in making prior plans for her postnatal care?

( ) Yes =1 ( )No =3

42. What support did you provide your partner during the postnatal period?

( )Provided funds for her up keep =1

( )Helped with household chores =2

( )Others (specify) =3

43. Did you discuss health issues relating to the postnatal period like family planning with your partner? ( )Yes =1 ( ) No =2

44. Did you discuss health issues relating to the postnatal period like family planning with her health care providers? ( )Yes =1 ( )No =2

THANK YOU VERY MUCH