HINDRANCES TO MALE INVOLVEMENT IN MATERNAL HEALTH CARE IN KWALI AREA COUNCIL, ABUJA, NIGERIA

BY

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DEDICATION

This work is dedicated to Almighty Allah, Most Gracious, Most Merciful for His love and care to all mothers.

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CERTIFICATION

I certify that this work was carried out by**YUSUF Nana Hauwa**in the Department of Health Promotion and Education, Faculty of Public Health, College of Medicine, University of Ibadan, Ibadan, Nigeria, under my supervision.

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ABSTRACT

Involving men in Maternal Health Care (MHC) has become important because of the realization that men's behaviour can significantly affect health outcomes of women and children. Male involvement in MHC is generally poor in many developing countries including Nigeria. Reasons for poor male involvement in MHC services have not been adequately documented. This study was therefore designed to determine hindrances to male involvement in MHC in Kwali Area Council, Abuja, Nigeria.

A community-based cross-sectional study was conducted among 370 candidates recruited from households in Kwali Area Council, Abuja using a four-stage sampling technique: Kwali Area Council from the 6 Area Councils of the FCT, wards selection, settlements selection and selection of respondents. A pre-tested interviewer administered questionnaire containing information on knowledge of MHC was assessed using a 23-point scale. Scores of $\leq$ 15 and >15 were categorized as low and high knowledge respectively. Levels of male involvement was assessed using a 6-point scale with scores of $\leq$ 4 and > 4 were categorised low and high involvement respectively. Three Focus Group Discussions (FGDs) were also conducted among men in 3 randomly selected wards out of the 10 wards in the Area Councils. The FGDs were tape recorded, transcribed and subjected to content analysis. The quantitative data were analysed using descriptive statistics and Chi-square test at 0.5% level of significance.

Mean age of the respondents was 37.9 ±9.5 years, educational status: no formal education (33.2%), Islamic education (21.1%),primary education (15.9%), OND/NCE (14.1%), HND/B.Sc (8.1%) and secondary education (7.6%). Respondents Religion: Christians (58.1%), Muslims (41.4%) and traditionalist (0.5%).Ethnical composition: Gbagi (78.1%), Ibo (6.2%), Hausa (3.2%), Yoruba (2.7%) and other tribes (9.8%). Marital Status: currently married (99.2%) with (15.9%) were in polygamous marriage. Most (84.3%) had heard of MHC services with health workers (25.8%) being the leading source of information among respondents. Many (68.9%) and (31.1%) of respondents had poor and good knowledge of MHC respectively. Witchcraft (45.7%) and family planning methods (46.9%) were perceived to be the causes of maternal mortality. Mean knowledge

score of respondents who had ever and never heard of MHC were 14.5±3.5 and 11.6±3.0 respectively. Only 42.0% of men had high level of involvement in MHC. Perceived hindrances to male involvement in MHC included poor knowledge of maternal health care (95.1%), negative health workers' attitude (83.4%), financial constraints (95.7%) among others. The FGD participants perceived MHC as care given to women from pregnancy till delivery. Maternal Health Care was perceived as women affairs accounting for the low male involvement. Significantly more of secondary school holders and above (50.5%) had good knowledge of maternal health care than other educational qualifications ($p<0.05$)

Poor knowledge, societal norms, negative Health workers' attitude, financial constraints among others constitute the main factors which militate against male involvement in maternal health care services. Community health education programme which focuses on reorientation on gender roles will improve knowledge of men on maternal health care issues. Continuing education training programme should be organized for health workers on attitudinal change to clients.

Keywords: Maternal Health Care, Male, Kwali Area Council, health workers attitude and societal norms

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ACRONYMS

ANC:	Ante-natal Clinic
CPR:	Contraceptive Prevalence Rate
EOC:	Emergency Obstetric Care
FANC:	Focus Ante-natal Care
FCT	Federal Capital Territory
FGD:	Focus Group Discussion
FMoH:	Federal Ministry of Health
FP:	Family Planning
HIV:	Human Immune Virus
HOD-	Head of Department
ICPD:	International Conference on Population and Development
IMF:	International Monetary Fund
IPTP:	Intermittent Prevention and Treatment during Pregnancy
ITN:	Insecticide Treated Nets
MCH:	Maternal and Health Care
MDG:	Millenium Development Goals
MHC:	Maternal Health Care
MMR:	Maternal Mortality Rate.
NDHS:	National Demographic and Health Survey
NPHCDA:	National Primary Health Care Development Agency
PPC:	Post-Partum Care
RH:	Reproductive Health
SPSS:	Software Package for Social Science
UNFPA:	United Nation Family Planning Association
UNICEF:	United Nations International Children Emergency Fund
UNPF:	United Nations Population Fund
USAID:	United States Agency for International Development
WHO:	World Health Organization

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CHAPTER ONE

INTRODUCTION

1.1 Background to the Study

Involving men in maternal health care has become important because of the realization that men's behaviour can significantly affect health outcome of women and children.The behaviour of men, their beliefs and attitudes affect the maternal health outcomes of women and their babies. Exclusion of men from maternal health care services could lead to few women seeking maternal health services and as a result worsen the negative maternal health outcomes for women and children. Increasingly, recognition is growing on global scale that involvement of men in reproductive health Policy and Services offer both men and women important benefits (Nantamu, 2011).

Men involvement in maternal health is one of the burning issues in the reproductive health programme, most especially in Nigeria, where 80% of men in the household are heads of their family (NDHS 2008). In most sub-Saharan African societies, men are at the apex of family and societal leadership. Men function as "gate keepers" to women's sexual and reproductive health because of many socio-cultural roles they play as husband, policy makers, local and national leaders (Kina and Ezekiel-Hart, 2009; Varga, 2001).

Globally, more than half a million women still die annually as a result of complications of pregnancy and childbirth. A proportionately high burden of these deaths is borne by developing countries, including Africa which Nigeria is part of, with maternal mortality ratio of 545 per 100,000 live birth and an estimated 55,000 deaths annually (Zubairu, 2010). In the developing countries 80 percent of birth occurs in the home and the majority of children who die do so at home, without being seen by a health worker (NDHS, 2008). It is noted that as many as 40 percent of child death could be prevented with improved family and community care and not necessarily high-tech health equipment but access to solid knowledge, support and basic supplies (NDHS, 2008; WHO, 2007; UNICEF,2004).

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In order to address this disturbing trend, the International Conference on Population and Development (ICPD) in Cairo 1994 urged that special efforts should be made to emphasize men's shared responsibility and promote their active involvement in maternal care (Isiugo-Abanihe, 2003). In spite of this, pregnancy and childbirth continue to be regarded as exclusively women's affairs in most African countries. A male companion at attendant care is rare in many communities. However, men are socially and economically dominant especially in Africa where they exert strong influence on their wives, determining the timing and conditions of sexual relations, family size, and access to health care. This situation makes men critical partners for the improvement of maternal health and reduction of maternal mortality.

To reduce maternal morbidity and mortality, interventions had been made in the areas of implementation of maternal health education. Previous studies on this maternal health education strategies has been continually showinggreat reduction in maternal morbidity and mortality that associated with pregnancy and child birth. However, existingstrategies to save mother and child had been less successful due to less emphasis placed on the adverse maternal outcomes because of social factors that surround decision making at home in obstetric care, (Orji, Adegbenro and Moses, 2007; Orji, Adeyemi and Esimai, 2003).

It has been suggested that fertility, particularly in developing countries would have been lower if women were in the position to decide when to become pregnant and how many children they want to have, because it is women that undergo all the sicknesses associated with pregnancy and delivery and they may lose their lives as a result of pregnancy and childbirth(Nwankwo and Ogueri, 2006). The husband's permission is required before a woman can take any step regarding her own health.

Though studies have been done on maleinvolvement in reproductive health (Kabagenyi, Jennings, Reid, Nalwadda, Ntozi and Atuyambe,2014), only few studies have examined the role of men in obstetric care despite the knowledge that in the African traditional setting, men determine where and when their spouses visit health care facility (Orji, et.al., 2007).

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While family planning services have traditionally targeted women, there is growing recognition that reproductive health is the joint responsibility of men and women. Given that men often have significant influences on a couple's contraceptive use (Shahjahan, Mumu, Afroz, Chowdhury, Kabir, Ahmed, 2013), pilot programmes to engage men have focused on increasing knowledge, enhancing spousal communication, and de-stigmatizing use of family planning methods. Renewed interests in involving men stem not only from women's reproductive health needs, but also to address men's own sexual health concerns, as well as efforts to achieve the Millennium Development Goals (MDGs) for reduction of maternal mortality and HIV transmission. Use of modern contraception and family planning services is integral part in the prevention of unwanted pregnancy, reduction of unsafe abortions, and promotion of childbirth spacing to lower maternal and child mortality risks in developing countries (Stover and Ross, 2010; Rosliza and Majdah, 2010). Family planning also promotes gender equity and greater educational and economic opportunities for women (Yue, O'Donnel and Sparks, 2010). Several small-scale in itiatives aiming to include men in reproductive health programs have had positive experiences (Kabagenyi, 2014; Blake and Babalola, 2002), but in-depth understanding of the rationale for men's low participation has been underexplored. This is urgently needed in the development and scale-up of evidence-based male-involvement maternal health care interventions.

1.2 Statement of the Problem

Maternal mortality remains a major health problem in Nigeria (NDHS, 2008). There is poor utilization of ante-natal care attendance in Nigeria (58%) compared with 98% attendance rate in developed countries (FMoH, 2008).

The maternal death that occurs as a result of complications during and following pregnancy and childbirth is becoming alarming. It has been recorded that a woman dies from complications in childbirth every minute – about 529,000 each year, the vast majority of them in developing countries. A woman in sub-Saharan Africa has a 1-16 chance of dying in pregnancy or childbirth, compared to 1 in 4,000 risk in a developing country(USAID, 2005).

Most of these complications develop during pregnancy. Other complications may exist before pregnancy but are worsened during pregnancy.The maternal mortality ratio in developing countries in 2013 is 230 per 100,000 live births versus 16 per 100,000 live births in developed countries (USAID, 2005).

Nigeria is only 2% of the World's population but account for over 10% of the World's maternal deaths in childbirth, (FMoH, 2005 and WHO, 2006). Reports have shown that more than three quarter of maternal deaths are due to direct obstetric causes such as haemorrhage, unsafe abortion, sepsis, ruptured uterus and hypertensive diseases of pregnancy (Mpemben and Killewo, 2007).The family decision making lies heavily on men, thus they take decision solely on their family health care (Consultative Council on Obstetric & Paediatric Mortality & Morbidity (CCOPMM), 2012).

Pregnancy and childbirth continue to be regarded exclusively as women's affair in most African countries. Men generally do not accompany their wives for antenatal care and are not expected to be in the labour room during delivery. However men are socially and economically dominant especially in northern Nigeria where they exert a strong influence over their wives, determining the timing and access to health care. This situation makes men critical partners for the improvement of maternal health and reduction of maternal mortality (Zubairu,2010).

Evidence has shown that women depend heavily on men for access to health and studies also revealed that men are the key decision makers for women's choice of health care (RH) services even though they have limited knowledge (NDHS, 2008 and Kinanee and Ezekiel-Hart, 2009).

Men's intimate involvement in sex and reproduction cannot be disputed. Yet for much of its history, the population field focused almost exclusively on the fertility behavior of women, paying little attention to men's roles in its study of the implications of population growth and fertility rates (Greene, and Ann, 2000).As a consequence, population policy was implemented almost exclusively through basic family planning programs serving women. If men were involved, they wereinvolved in a limited way, often to ensure

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contraceptive continuation and acceptabilityor to promote the diagnosis and treatment of sexually transmitted infections (Greene, Mehta, Pulerwitz, Wulf, Bankole and Singh, 2007).In view of the above, this study therefore determined to assess the involvement of men in maternal health care in Kwali Area Council of FCT, Abuja.

1.3 Justification

The purpose of this study was to investigate level of male/husband's involvement in maternal health care. Hopefully,this study has helped to generate findings that will help in improving male/husbands' perception and their level of involvement and participation in Maternal Health Care in Kwali Area of Council of Federal Capital Territory (FCT).

This study,without any iota of doubt, will makegreat contribution to the already existing body of knowledge on the involvement of men in women's reproductive health services particularly maternal health care for policy formation and community participation in Nigeria.

The findings of this study would definitely be useful for theacademic community as background information for further study in MCH. The data provided by this study will also serve as useful reference point for both students and other future researchers.

1.4 Research Questions:

This study answered the following research questions

1. What is the relevance of socio-demographic characteristics (like education, occupation, marital status) of the respondents to men's knowledge on maternal health care
2. What is the men's level of knowledge on maternal health care?
3. What are men's perceptions on maternal health care?
4. How are men involved in maternal health?
5. What are the barriers to men involvement in maternal health care?
6. What are the factors that can influence men involvement in maternal health care?

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1.5 Broad Objective

The general objective of this study was to ascertain the hindrances to involvement of male in maternal health care in Kwali Area Council.

1.5.1 Specific Objectives

The specific objectives of this study were to:

1. To examine the relevance of socio-demographic characteristics (like education, occupation, marital status) of the respondents to men's knowledge on maternal health care
2. Assess men's level of knowledge on maternal healthcare.
3. Exploremen's perceptions on maternal health care involvement.
4. Describe how men are involved in maternal health care.
5. Identify the barriers to men's involvement in maternal health care.
6. Identify factors that can influence men's involvement in maternal health.

1.6 Hypotheses

The following hypotheses were tested by the study

1. There is no significant association between respondents' level of education and knowledge of maternal health care.
2. There is no significant association between respondents' type of marriage and perception of maternal healthcare.
3. There is no significant association between respondents' occupation and participation in maternal health care.

1.7 Scope / delimitation of the Study

The study covered involvement of men in Maternal Health Care (MHC) in Kwali Area Council of FCTAbujaamong married men of age 18years and above with at least a child in the last five yearsin reference to male attendance of antenatal care with wife, male presence at wife's bedside during delivery, acceptance and practice of family planning with wife.Secondly the study covered male living in Kwali Area Council and does not encompass men living in the urban FCT and other parts of the country therefore the study only got to establish challenges being experience in the sub-urban center of FCT. Lastly,

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the study was only limited to men, but researcherstill acknowledge that challenges encountered in maternal healthcare affect both men and women.

1.8 Limitations of the study

The limitations of this study was that, some men considered it culturally appalling for the investigator to have considered issues that have to do with antenatal care, delivery, family planningwhich are women affairs with men. Few of them emphasised some negative psycho-social actions of women on health care that do influence their husband reactions. More also, some men find it difficult to really open up to answer questions relating to their family in which they considered as privacy and being phobia (fear of unknown consequences). Thus, as a result of these, the results were interpreted with caution and in order to maximize the validity of self-reports, extensive efforts were made to ensure confidentiality of responses and their spouses (wives) were excluded from the exercise this made the men free to express themselves as freely as possible.

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1.9 Operational definitions of terms

The definitions of key concepts used in this research are as follows:

Ante-natal Care Services: Ante-natal care services in this study refer to care/services to a mother and partner during pregnancy.

Delivery care services: in this study delivery care services refers to health care given to the pregnant mother after onset of labor until complete expulsion of the baby, placenta and membranes.

Family planning: refers to Child spacing for at least 2years by the couple, their decision taken and husband's involvement and participation in Family planning educationand choice of contraceptic methods.

Hindrance: this refers to factors such as culture; economics, institution and knowledge as it affect male involvement in maternal health Care.

Involvement: Involvement in this study refers to the level of men's knowledge, as it translates to participation such as their attendance with wife for ANC services,their stay at bed side of wife during delivery and their participation in family planning services.

Maternal Health Care: Maternal Care for the purpose of this study refers to Ante-natal Care delivery and Post-natal care; most especially Family Planning.

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CHAPTER TWO

LITERATURE REVIEW

This chapter presents a review of the literature relating tothe following sub-headings or sections: Prevalence of maternal mortality; Knowledge of Maternal health; Men's Perceptions on Maternal care; Level of Male involvement in maternal healthcare; The barriers to male involvement in maternal healthcare and Factors influencing male involvement in maternal health

2.1 Review of Concepts

Maternal health refers to the health of women during Pregnancy, child birth and the post partum period. While motherhood is often a positive and fulfilling experience, for too many, it is associated with suffering, ill-health and even death (WHO, UNICEF, UNFPA, World Bank, 2013).Maternal Health Care encompasses the health care, dimensions of family planning, preconception, prenatal and post natal care in order to reduce maternal morbidity and mortality.

Preconception care can include educations among women of reproductive age top reduce risk factors that might affect future pregnancy. The goal of prenatal care is to detect any potential complications of pregnancy early, to prevent them if possible and to direct the women to appropriate specialist medical services as appropriate.Postnatal care issues include recovery from childbirth, concerns about newborn care, nutrition, breast feeding and family planning.

2.2 Prevalence of maternal mortality

In 2010 there were an estimated 287,000 maternal deaths worldwide. Sub-SaharanAfrica Accountedfor 56percentof thesedeaths(WHO, 2012). International commitment to lowering the maternalmortality rate (MMR), such as the safe motherhood initiative of 1987 and the Millennium Development Goals (MDG) of the 1990s, have propelled a decline of 47percentin the global MMRbetween 1990 and 2010. Current global efforts,as embodied in MDG5, which calls for reducing the MMR by 75percentbetween 1990 and 2015(WHO, 2012). Factors credited with the decline in the MMR include improved care during pregnancy and delivery, a decreased birth rate, and greater education of women.

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Kenya, however, has been left out of this global trend. The last twoKenya Demographic and Health Surveys(KDHS), in 2003 and 2008-09, showeda persistentlyhigh MMR (KNBS and ICF International, 2010).

With high levels of maternal mortality persisting in developing countries, especially in Africa, there is increasing interest in identifying ways through which women can access appropriate care to prevent deaths during pregnancy. Although the number of maternal deaths has beendeclining, they are still far from the targets set by the Millennium Development Goals in most developing countries including Nigeria (detail in current situation below). The most recent estimates show that 358,000 maternal deaths occurred worldwide in 2008, with 99 percent of maternal deaths occurring in developing countries as a whole, and 87 percent in sub-Saharan Africa and South Asia (WHO 2010). The main reason for the high number of deaths is attributed to insufficientand poor-quality maternal health care during pregnancy and after delivery (Alva, 2012; Carroli, Rooney, and Villar 2001).

2.3 Determinants of Maternal Death

According to WHO (2008), a woman's chance of dying or becoming disabled during pregnancy and childbirth is closely connected to her social and economic status, the norms and values of her culture, and the remoteness of her home geographically. The greater the risk of death when a woman is poor and not cared for by relatives. There are four determinants to maternal death:

Delay One: Failure or delay in recognition of danger signs – 33 percent of maternal deaths.

Delay Two: delay in deciding to seek care – 40 percent of cases

Delay Three: delay in reaching appropriate care – 19 percent of cases.

Delay Four: delay in receiving appropriate care – 52 percent of cases (WHO, 2009; UNFPA, 2006 and World Bank, 2006).

Henry (2011) asserted that the importance of antenatal care by professional hands at well-equipped health facilities cannot be over-emphasised. The researcher opined that associated with the phenomenon of unbooked cases are the factors of illiteracy and poor economic status. He explained further that poverty, coupled with lack of education to

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appreciate the benefits of modern antenatal care and delivery services inhibit those individuals from availing themselves of these services, thereby jeopardizing their chances of a successful pregnancy period and delivery.

From this discuss, it can be seen that the major causes of death are avoidable. Obstructed labour with or without uterine rupture, is a result of neglect either by the patient not seeking prenatal and intra-partal care, or by the health provider not anticipating or not recognizing the existence of feto-pelvic disproportion or not recognizing abnormal. These facts are highlighted in the studies of Ibeh, (2008), Uzochukwu and Onwujekwu (2004), WHO (2010), Zubairu (2006), and Cheng (2009). Sangstand (2011) and suggested that Maternal Health should be done with free antenatal care, and Centralized deliveries with health personnel attending the birth. They asserted that education of women on these facts will play very important role in the prevention of prenatal death drastically.

2.4 Maternal Health

Maternal health can be seen as various facilities and programmes organized for the purpose of providing medical and social services for mothers. Such services include prenatal and postnatal services, family planning care (Healthy People, 2010).

Maternal health has emerged as one of the most important issue that determines global and national wellbeing(Ladipo, 2010). This is because every individual, family and community is at some point intimately involved in pregnancy and the success of childbirth (WHO, 2006). Despite the honour bestowed on women-hood and the appreciation of the birth of a new born baby, pregnancy and childbirth is still considered a perilous journey in the developing countries (Ladipo, 2010;Galadanchi 2009 and Ibeh, 2008;FMoH 2005).

A health service based intervention research known as the Men in maternal care study (MIM), was implemented in Kwazulu – Natal (KZN) in South Africa to evaluate whether it was feasible to involve men in antenatal and post natal care, and also whether this would be acceptable to health care providers, the clients and their partners. It is expected that men are culturally not expected to be involved in maternal related issues. Even if

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men want to be involved in maternal care, societal and health system norms often mitigate against this (Mullick, Kunene and Wanjiru, 2005).

It is asserted that improving maternal health outcomes for women in the developing countries is one of the targets of the United Nation's Millennium Development Goals so that men become equal partners with women in ANC. Kakof USAID noted that when people (male and female) are aware of each other's health needs, they are more likely to receive needed services (Kak, 2010).

2.5 Current situation and trend in maternal health care

Worldwide studies indicate that over the year, the maternal mortality ratio (MMR) has decreased, with South East Asia seeing the most dramatic decrease of 59% but Africa has only a decline of 27% (WHO, 2010). In the developing world, there are no regions that can meet the Millennium Development Goal of decreasing maternal mortality by 75% by the 2015 (WHO, 2010).

Poor maternal condition thus is a leading cause of death of women after HIV/AIDS, malaria, and tuberculosis.While ninety-nine percent of such deaths occur in developing countries, only 1in 4,000 women die due to such causes in the developed world (Kak, 2010; Ozumba, 2008and WHO, 2004). Everyday, about 1,500 women die from pregnancy or childbirth-related complication. In 2005, there were an estimated 536,000 maternal deaths worldwide (WHO,2008; USAID, 2007; Rikka-Luukkainen and Lindross, 2004).A total of 99% of all maternal deaths occur in developing countries, where 85% of the population lives (WHO, 2008). More than half of these deaths occur in Sub-Saharan Africa and one third in South Asia (WHO, 2008). The maternal mortality ratio in developing countries is 150 maternal deaths per 100,000 live births as against nine (9) per 100,000 live births in developed countries. Nigeria specifically has high maternal mortality ratio of 545 per 100,000 live births (WHO, 2008; NDHS, 2008; MDGs, 2005 and FMoH, 2003).

A woman's life time risk of maternal death is 1 in 7,300 in developed countries and 1 in 75 in developing countries, but the difference is more striking in Niger and Nigeria where

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women's lifetime risk of dying from pregnancy-related complications is 1 in 7 and 1 in 8 respectively compared to 1 in 4,800 in Ireland (WHO, 2008, Gribble and Haffey, 2008). According to reports from (WHO, 2008;UNICEF, 2008and USAID, 2007), the disturbing maternal mortality ratios cannot be explained by poor antenatal care attendance alone. Most of maternal deaths occur during delivery or postpartum periodand abortion due to unwanted pregnancy, and low women status in many obstetric cares.Increasing the proportion of birth attended by a qualified health workers and sponsorship of community based maternal and newborn care intervention are keys to reducing maternal mortality.

The direct causes of maternal deaths are haemorrhage, infection, obstructed labour, hypertensive disorders in pregnancy, and complication of unsafe abortion. There are birth-related disabilities too that affect many more women and go untreated like injuries to pelvic muscles, organs or the spinal cord. At least 20% of the burden of disease in children below the age of five is related to poor maternal health and nutrition, as well as quality of care at delivery (Nahar, 2011; Ladipo, 2010; WHO, 2008; UNICEF, 2005; Ronsmans, 2003; Thaddeus and Manne, 2002).

Globally, the contraceptive prevalence rate increased from 59% in 1990-1995 to 63% in 2000-2006 (WHO. 2008; NDHS, 2008): It is also noted that in some regions, it remains very difficult to reduce the considerable "unmet need" for family planning and the high rates of adolescent fertility. There were 48 births for every 1,000 women aged 19 years in 2006, only a small decline from 51 per 1000 in 2000.

A recent research (NDHS, 2008) had showed that the contraceptive prevalence rate (CPR) was 15% among newly married women using any method of contraceptive (NDHS, 2008) an increase in CPR from 13% in the NDHS, (2003). Furthermore, (NDHS, 2008 and Okereke, 2005) asserted that among women using contraceptive 10% used modern ranges from a high rate use of 32% in South West to only 3% in North West of the country, Nigeria.

Okereke (2005) reported that Nigerian women obtain approximately 610,000 abortions (a rate of 25 abortions per 1,000 women aged 15-45 years) yearly. The rate was much lower in the poor, rural regions of northern Nigeria than the more economically developed

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southern regions. It is asserted that access to proper medical attention and hygienic conditions during delivery can reduce the risk of complication and infections that may lead to death or serious illness for the mother and baby(NDHS, 2008andWHO, 2006). For example, Seventy percent (70%) of births in Nigeria are delivered at home which means the majority of births occur without quality delivery services (NDHS, 2008).

FMoH, Focused ANC, (2008)indicated in its statistics that only 58% of pregnant women attend at least one antenatal clinic visit, with slight increases of 2% some years after. This is much lower than 98% attendance rate in developed countries as indicated in the NDHS statistics, (NDHS, 2008). Even among those who attend the ANC there have been missed opportunities for key interventions such as tetanus toxoid immunization, malaria prevention through the use of Insecticide Treated Nets (ITNs) and Intermittent Prevention and Treatment during Pregnancy (IPTp), syphilis detection and treatment prevention of mother to child transmission of HIV and health promotion for appropriate health seeking behaviour . Another consequence of low ANC attendance is low utilization of health facilities for delivery(FMOH, FANC, 2008).

In the World Health Organization report (2008), it is asserted that just over 70%of women worldwide have at least one ANC visits with a skilled attendant (WHO, 2008). In industrialized countries, 98% of women have at least one ANC visits while in developing countries, the percentage drops to approximately 68%.

It is pertinent to note as some statistics show that there is a slight improvement in some regions of Nigeria (NDHS, 2008). For instance, 87% of mothers received antenatal care from a health professional in South-West and South-East zones, compared with 31% of mothers in the North West (Okonofua 2011; USAID, 2010 and Odeiegwu 2005;).Other studies like WHO, (2009), Uzochukwu (2004) indicated that improving maternal health, and reducing maternal deaths by 75percent throughout the world by 2015, will take the involvement of men in countries where it matters most.

2.6 The main interventions in maternal healthcare

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In specific terms, according to WHO (2008), to reduce pregnancy related deaths to the level where it will no longer be a major public health concern, concerted efforts should be made to ensure that skilled health personnel are always available to assist at delivery; improve health systems to increase availability,accessibility and affordability of emergency obstetric care; encourage delayed marriage and first birth for adolescents; address unwanted and poorly timed pregnancies, improve coverage and quality of prenatal and postpartum care.

Also, as pointed out in reports, actions should be taken to promote Cross-Sectoral linkages that will enhance the enactment ofenabling policies and political commitment; enhance community participation; address contextual factors such as poverty, access to economic resources, woman education and status, lack of male involvement, violence against women, and the special needs of adolescents (World Bank and IMF, 2005; WHO, 2008 and FMOH, 2008); Ozumba (2008), Franklin (2010).

The National Primary Health Care Development Agency (NPHCDA, 2009) introduced midwifery service scheme, where over 4,000 midwives were trained and posted to areas with highest maternal mortality rate, such as in the North-Eastern states to reduce maternal mortality and as a strategy to achieve MDGs.

2.7 Components of maternal health:

There are three components of maternal health care. These are Antenatal care, Delivery and Postnatal care.

2.8 Antenatal Care

Antenatal care is the comprehensive care that women receive throughout their pregnancy. Standard of maternal health care recommended by WHO consist of at least four antenatal visits, delivery at a facility, and postpartum care for mothers and newborns (United Nations Population Fund, 2009). To reduce maternal mortality health care need Ladipo and others recommends that health facilities should be made accessible, affordable, acceptable, and convenient to pregnant women (Nahar, 2011;Ladipo, 2010 and WHO,2006).

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It is asserted by Arulogun, (2010)and WHO, WARDC, (2008) that women who begin care early in their pregnancies have better birth outcome than women who receive little or no care during pregnancy. Arulogun, (2010) and Ronsmans,(2003) opined that prenatal care or ante natal care(ANC) is more than just health care. It includes education and counseling of husband and wife about how to handle different aspects of pregnancy, such as nutrition and physical activities and basic skills for caring for newborn. A study by Mullany, Becker and Hindin (2007) provided evidence that educating pregnant women and their male partners yields a greater net impact on maternal health behaviours compared with education of women alone. According to Mustapha(2010) and WHO (2003), women don't always know they are pregnant in their first month. That is why some people think a pregnancy is just nine months. Furthermore they noted that it is actually longer, as the average pregnancy is 280days. A pregnant woman expected date of delivery is counted from the first day of the last day of a normal menstrual period. Due date is estimated to be 38 to 40 weeks later. Most women give birth two weeks before or after that date (between 38 to 40 weeks).A baby is referred to as "premature" when a woman gives birth prior to 37weeks. A "full term" is the birth of a baby at 37weeks and a baby given birth to after 42 weeks is known as "post term" (Langer and Villar, 2002; WHO, 2003;Owolabi, 2008 and Henry, 2011) further noted that adequate antenatal care (ANC) and hospital delivery enables Obstetricians to diagnose complications at early stage when intervention will bring about correlation between unbooked mothers and increased risks of maternal adverse outcome.Arulogun, (2010) also asserted that specialists at this stage requires to provide adequate information for appropriate decision making. She further noted that the nutritionist has a role to play in pregnancy and routine antenatal counseling for all.

Furthermore, Mustapha (2010)pointed out that it is important to get prenatal care as a woman gets to know she is pregnant, and to keep all her appointments, even if she feels fine, as regular check-ups will let her know how her baby is doing and the doctor can identify small problems before they become bigger. According to Henry (2011), antenatal (ANC) attendance is an important element of a comprehensive maternal health strategy. Utilization of ANC provides opportunities for a full range of health promoting services

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that may include weight and blood pressure measurement, screening and treatment for Syphilis prevention and health education, prevention of mother-to-child transmission of HIV.

Ozumba (2008), Ronsmans (2003) and Arulogun, (2010) opined that a sensitive antenatal care should identify mothers with high risk pregnancies e.g. grand-multipara (women with five or more childbirths). These women are more likely to have hemorrhage during delivery. And also, women who are pregnant for the first time, the primigravidae are at increased risk of raised blood pressure, otherwise known as pre-eclampsia, and may eventually fit during delivery which is termed eclampsia.

According to some studies (NDHS, 2008;FMoH and FAN, 2007), the major objective of antenatal care is to ensure optimal good health for the mother and the baby. Such care from a trained provider is important to monitor the pregnancy and reduce morbidity risks for the mother and child during pregnancy and delivery.

The Importance of ANC therefore is for early detection of complication for treatment and birth preparedness. For this purpose, several studies recommend four antenatal care visits for women whose pregnancies are progressing normally with the first visit in the first trimester (ideally before 12weeks but not later than 16weeks), at 24-28 weeks and 32weeks and 36weeks(Villar and Abdulaziz,2008;Arulogun, 2010 and Nahar, 2011).

2.9 Delivery Services

According to a study by USAID, safe delivery is promoted by the encouragement of all members of families to seek the care of skilled birth attendants for child births, because all pregnant women can be at the risk of life-threatening complications (USAID,2008). The study posits that Frontline providers are trained and supervised to provide personal support, good surveillance (including use of the partogram) to identify potential complications, a clean environment, avoidance of unnecessary and potentially dangerous practices, and active management of their stage of labour, immediate care of the event of birth, asphyxia, hygienic cord care, immediate breastfeeding and a referral to high-level care if necessary (USAID, 2008).

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According to Nahar (2011), the period during labour, birth and the few hours after birth is critical in the continuum of care, as this period has the highest risk of death and disability for both mothers and newborns. Thus, the modern trend should be for an increasing proportion of births to take place in maternal centres, hospitals and health institutions where the pregnant woman will be attended to by skilled attendant. In maternal deaths/emergency obstetric care the woman is referred to higher level of care(Henry, 2011; Brown, 2009; WHO, 2009; Odeimegwu, 2005; FMoH, 2004 andLucas &Gilles, 2003).

It is found out in some studies (Adeyemi, 2010; Franklin, 2010; Mustapha, 2010) on maternal health in northern Nigeria that, up to 81percent of childbirths are supervised by personnel with no formal training in obstetric and neo-natal care. Similarly, UNICEF and ACCESSbaseline survey,(2005)and Okonofua,(2009) studies on safe motherhood in the same region show that 80 percent of women delivered their first child at home. One of the reasons that women listed for their non-attendant of health care facility while pregnant was that their husband/family members say it is unnecessary. Women studied also listed that they had no time to go to health facility, the facility being too far or too expensive as reason for giving birth at home. It is seen therefore, as advanced by FMoH,(2007) that the support given to pregnant women by their husbands is crucial to successfully prepare the women for safe childbirth.

2.10 Postnatal Care

Postnatal care (PNC) refers to routine emergency care provided in the period after birth until the baby is six weeks of age.The postnatal care services are designed to supervise process of recovery from the effects and injuries during the puerperium, to detect any abnormalities and to deal with them (FMoH, 2007). She should be protected against hazards such as puerperal infections. Postnatal care offers family planning so as to reduce the risk of the early occurrence of another pregnancy, and to establish breast-feeding(FMoH, 2007) (detail in benefit of family planning sub-heading).

2.11 Men's knowledge about maternal health

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Traditionally, maternal health issues have predominantly been seen and treated as a purely feminine matter (Carter, 2002). This was because women get pregnant and give birth. Although men's participation in maternal and child health (MCH) care services is low, they play a vital role in the safety of their female partners' pregnancy and childbirth. The exclusion of men from MCH services reinforced the erroneous notion that pregnancy and childbirth was uniquely feminine (Mullany, Lakhey, Shrestha, Hindin and Becker, 2009; Farquha, Kiarie, Richardson, Kabura, John and Nduati, 2004), and maternal units as exclusively meant for women (Mullany, et.al., 2009). It has however been discovered that some women's access and utilization of MCH services depend upon their partners (Kululanga, Sundby, Malata, and Chirwa, 2011).

A number of studies have highlighted the important role played by men in making decisions pertaining to maternal health issues and called for male involvement in MCH (Kululanga, Sundby, Malata and Chirwa, 2011). However, the men lack knowledge on maternal health issues that limits women's access to life saving treatment. On the other hand, intervention studies have shown that maternal health education interventions targeting both men and women have proved to increase knowledge in both men and women; increase health seeking behaviour among pregnant women; raise awareness and use of family planning (FP) in the postpartum period, and also increase awareness of dual protection for STIs (Kululanga, et.al., 2011).

2.12 Men’s Perception on maternal health care

According to Microsoft dictionary (2003-2007), perception is the process of using the senses to acquire information about the surrounding environment or situation. This is usually facilitated by the five sense organs of the eyes, nostrils, ear, tongue and skin. It could manifest as an attitude or understanding based on what is observed or thought.

Maternal health care issues are viewed traditionally. Predominantly, it’s being seen and treated as a purely feminine matter, Butawa et.al., (2010). This was because women get pregnant and give birth. Although men’s participation in maternal health care services is low, they play vital role in the safety of their female partners’ pregnancy. Furthermore, there is a belief that says man will lose strength if he sees a woman’s nakedness, Mullick

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et al (2005). On the other hand, male involvement in maternal health care has been perceived as loss of women's right to make decisions regarding pregnancy issue, therefore, men should not encroach in their territory(Onyango, Owoko and Oguttu, 2010).

Men who have experienced maternal mortality either as the death of friends or family members gave a variety of reasons for the problem. Some aid that the death was due to spiritual powers and could have been averted if the woman had been delivered by a traditional doctor/ herbalist (Lawoyin and Adewole, 2007). Furthermore, social and economic factors are related to the family. While some said that women bled to death at home because the husbands were not around and money was not available (Lawoyin et al.,2007;Nkuoh, Meyer and Nkfusai, 2010).

The cultural concerns go beyond the immediate of death. Culture according to the men, plays a major role in the way women are treated. Some men reported that in many places, where polygamy is practiced, women are treated as "baby factories" and the men disregard their role in providing proper care and support, both financially and physically(Lawoyin, 2007; Odimegwu and Okemgbo, 2008). Men perceived accompanying a spouse to ante-natal and post-natal care visits as a waste of time as there will be no service for them. (Byamugisha, Tumwine, Semiyaga and Tylleskar,2010).

However, negative or absent of husband involvement has detrimental effects on maternal health(Odimegwu and Okengbo, 2008). This is because of the men's influence on partners' access to health services.

2.13 Male involvement in maternal health care

Male involvement in maternal health care has been described as a process of social and behavioural change that is needed for men to play more responsible roles in maternal health care with the purpose of ensuring women's and children's well-being (United Nations: ICPD, POA, 2009). The concept of male involvement in maternal health is now being advocated as an essential element of World Health Organization (WHO) initiative for making pregnancy safer(World Health Organization, 2009). The impetus for the

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initiative was as a result of the 1994 International Conference on Population and Development (ICPD) held in Cairo, Egypt, which urges that special efforts should be made to emphasize men's shared responsibility and promote their active involvement in responsible parenthood, sexual and reproductive behaviour including family planning; prenatal, maternal and child health; prevention of sexually transmitted diseases, including HIV; prevention of unwanted and high-risk pregnancies; shared control and contribution of family income, children's education, health and nutrition; recognition and promotion of the equal value of children of both sexes. Male responsibilities in family must be included in the education of children from the earliest ages. Special emphasis should be placed on the prevention of violence against women and children (United Nations: ICPD, POA, 2009).

Maternal health is viewed as a gender issue(Horstman, 2004), and gender may influence the way men may get involved in maternal health care. It has been postulated that men and women have distinct roles that are important for survival of the family and society(Kendall, 2008). The most basic division of labour is biological, men are physically strong, and women are the only ones able to bear and nurse children. Gendered belief systems foster assumptions about appropriate behaviour for men and women and may have an effect on the type of work women and men perform. Gender systems are social institutions that ascribe the social characteristics of men and women, which provide meaning and guidance with regard to their roles, rights and obligations over the life course (Horstman, 2004). Gender norms have been attributed to lack of male involvement in maternal health care (Onyango, Owoko and Oguttu, 2010). For instance, men are not expected in some cultures to accompany their wives to the clinic. If they do, this is perceivedby their peers as a demonstration of weakness. On the other hand, male involvement in maternal health care has been perceived as loss of women's right to make decisions regarding pregnancy issue6; therefore,men should not encroach in their territory.

Butcontrary to this perception by males in developing world, there have indeed been a steady move for more male involvement in pregnancy and childbirth in countries in

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Western Europe. Since the 1970s, men in the UK have been participating in maternal care(Kululanga, Sundby, Malata and Ellen, 2012)

In Sweden, the value of the father's involvement in pregnancy, parent education, childbirth and the care of the newborn baby is emphasized in legislation (Government Office of Sweden, 2011), and so is Norway (International Labour Organization, 2005). The traditional approaches to maternal health care taken by health systems in most developing countries portray the gendered belief system. The services are female oriented thereby discouraging male involvement (Onyango, Oweko, Oguttu, 2010). However, it has been argued that individuals are not born with certain behaviour and personality characteristics, but learn role expectations (gender roles) imposed by a particul2ar society through processes such as modelling, imitation and applications of rewards and punishments (Sabbe and Aelterman, 2007). Therefore, people can learn and unlearn behaviour. Male involvement in maternal health care is a relatively new approach in some part of the world. Traditionally, maternal health care services have focused on women, with very little male involvement. Given that male involvement in maternal health care is a relatively new approach, and it touches on the sensitive nature of gender roles related to culture, social norms, values and beliefs; understanding people's perceptions about the programme is critical for its success. In addition, introductionof a new health or social and behavioural change activity, as is the case with male involvement in Malawi, is a fundamental step in designing appropriate interventions (Mullany, 2006). Understanding the differential meanings of male involvement to men, women and health care providers may lead to better predictions of future male participation.

2.14 Level of male involvement in maternal health care

Male involvement in maternal health care is a relatively new approach in developing countries. Traditionally, maternal health care services have focused on women with little male involvement. It touches on the sensitive nature of gender roles related to culture, social norms, value and belief, understanding people's perceptions about the programme is critical for its success.

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Male involvement is viewed as a foreign concept as they expressed lack of understanding male partners in maternal care services and the reduction in maternal mortality (Kululanga, 2012).

In the World population report of 2005, it was stated that "partnering with men is an important strategy for advancing reproductive health linked to the MDGs.Husbands often make decisions about family planning, their wives economic activities and use of household resources, including, doctors and for schools fees. These decisions influence the well-being and prospects of the whole family" (Kak 2010;UNFPA, 2005; WHO,2001).

Some studies have shown that men's involvement and active participation can make all the difference by discouraging early marriage, promoting girls education, fostering equitable relationships and supporting women's reproductive health and rights (Drenan, 2003; Dudgeon and Inhorn, 2004; Becker, 2009 and Green and Gein, 2005).

A study of Hispanic and non-Hispanic and other ethnicities in Americaby Bront-Tinker and Horowitz (2008) have shown that fathers were highly involved with their partners' pregnancies in a number of ways, except for attending a childbirth class. Of the people studied, 93 percent discussed pregnancy with partners, 93percent listened to the baby's heartbeat, 97 percent felt the baby's move, 42 percent attended the childbirth class.

In the European countries such as Germany and U.K. in every 1-10 of 119,000 that attend ANC classes had positive attitude and intended to repeat the practice for any subsequent deliveries as women preferred their husbands to be with them during labour and delivery because they believed that it decrease their anxiety and loneliness and men also want their presence in the delivery room to give a helping hand (Bronte-Tinkew and Horowitz, 2008).

According to Cheng (2009) and Yim (2000), Asia countries like China for instancehave 73.3 percent of men that attends ANC classes with wife while 71.1 percent were present in delivery room.However, in Hong Kong, men's presence in delivery room is limited as their men believe that only the medical team expertise is necessary in this area of care(Cheng, 2009)

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As asserted by Nejad (2005), countries like the middle-east have no tradition of the husband's attendance of ANC classes and their presence in the delivery room as the Arabs believe that pregnancy is purely women issue. In Africa, the presence of the men during delivery and their attendance with partners at the antenatal clinic are less common than in the western world and these have been related to tradition and culture (Nejad, 2005 and Yim,2000).

Some studies carried out in western part of Nigeria shows that the level of man's awareness of emergency obstetric conditions are very high particularly in relations to pregnancy signs and labour pain 53.2 percent, while 89.2 percent of men play useful roles during their partners obstetric condition (Odimegwu, 2005).In another study by Obayemi and Bello (2009), it was found that over 90 percentof husbands studied generally encouraged their wives to attend antenatal clinic, 83 percent said they pay antenatal service bills, pay for transport to the clinic and remind spouses of their clinic visits. The same study noted that of the more educated men studied 72.5 percent accompanied their wives to the hospital during their last delivery, while 63.9 percent were present at last delivery (Obayemi and Bello, 2009). Furthermore, in rural areas pregnant women were less likely to receive help with household chores from their husband during pregnancy, while in Urban areas, educated women were more likely to benefit from this (Olayemi and Bello, 2009).

2.15 Factors that Influence Male Involvement in Maternal Healthcare

Rationale for Male Involvement in Maternal Health Care

The International Conference on Population and Development (ICPD) in 1994 called organizations that historically had provided family planning and other reproductive health services to women to constructively involve men in their programs for the benefit of both men and women(Gyimah, Takyi and Addai, 2006).

A study of men's reproductive health knowledge in Uttar Pradesh, where the maternal mortality ratio is more than 700 deaths per 100,000 live births, found that men had little awareness of serious complications of pregnancy and childbirth. About half of the 6,700

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husbands interviewed, none could name one danger sign (Gyimah, Takyi and Addai,2006; Drennan, 2003) and Nigeria situation is similar to this.

It is important to note that women's ability to seek health care or implement lessons learned from health education intervention is often determined by the household head, usually the husband (Mullay, Becker and Hindin, 2006; Salem, 2004; Mejad, 2005).

Cheng (2009) and Uzochukwu and Onwujekwe (2004) asserted that in accordance with traditional development psychological bonding theories, motherhood is often associated with the primary care responsibility for the children, and fatherhood, on the other hand, is more often connected with a secondary care responsibility, with a stronger emphasis on the family's financial and material supply situation. In addition, Plaintin (2007), Zubairu (2010) are of the view that an essential argument is that men are powerful decision-makers in the home and society because of the socio-cultural environment in which socialization and early human growth and personality development occur.

2.16 Cultural and religious factors influencing male involvement in maternal health care

Lawoyin (2006), said that past study had shown that culture plays a major role in the way women are treated in societies. It is reported that in many places, where polygamy is practiced women are treated as "baby factories" and that men "disregard their role in providing proper care and support, both financially and physically". Furthermore, Okonofua (2009), affirmed that cultural beliefs and practices disempower women in particular which severely restrict women's ability to obtain antenatal delivery and postnatal care. He explained by quoting a government health officer thus:

> *"culturally, women in Pudha (a practice where a woman covers her body completely while going out so that it is not exposed to men other than her husband) are not allowed to go to the hospital during Pregnancy, their spouses go to the hospital on their behalf, since (women) are not allowed to see male doctor."*

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Okonofua (2009) also quoted another top health official who said that:

> *"In the rural areas, for a woman to ask for assistance when she is in labour is a sign of weakness."*

Lindross (2004), pointed out that in Nigeria, mostly in the northern part of the country, men dominate everything. Wives need their husband's permission for everything they do, even in matter of life and death. Teenage pregnancies are quite common because girls married at very young age, because an old tradition says that a girl should not menstruate in her mother's house. In same vein, Khawar (2010) asserted that the patriarchal system was apparent in the smallest unit of the society that is the home where the father or another male member was the head of the family. Patriarchal System establishes the domination of one (male) over the other (female).

FMoH, FANC (2008), Lindroose (2004) explained that in the Christian religious setting in the developing world, church is a favored place for delivery as it is believed that the holy setting will protect both the mother and the child from malicious spirits and witchcraft. In the study, up to 50 percent of health care services are provided by Christian religious organizations and in case of delivery, most of the child births are attended without any skilled personnel.In such under developed or developing countries up to 69percent of women still give birth in a traditional setting, either at home or in a church. Among the Muslims in the northern part of Nigeria, the women are required to ask for their husband's permission when they need to seek medical assistance.

However, there is a social change taking place in this area. According to recent research by Odimegwu (2004) on men's role in emergency obstetric care in Nigeria Women are allowed to make decision on health care behaviour during emergency obstetric conditions in the absence of the male partner.

According to Okonofua,(2009) and NDHS,(2008) it is affirmed that gender roles and customs in Nigeria affect women's health and welfare. They furtherstated that women have less access to education and employment than men. In a recent research in the Western part of Nigeria it is noted in their findings that socio economic class is a factor in MCH. It was observed thus: "A woman bled to death at home because the husband was

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not around and money was not available", "The caesarean section was delayed because the husband/family did not make funds available on time", "she should have been taken to the tertiary hospital, but they(husband/the family) did not do that because they did not have enough money" (Lawoyin, 2007; Mehruar 2006).

In addition, Lawoyin (2007) remarked that socio economic variables, education and age at marriage have inverse relationship with family-size measure. For instance, men with university education were reported to have fewer children, than men with no formal education.

Male involvement in maternal health care has been described as a process of social and behavioural change that is needed for men to play more responsible roles in maternal health care with the purpose of ensuring women and children well-being. All of the above will enable the man and other family members (where available) to be helpful and understand what the women are going through and get involved.

2.17 Role of men in maternal health care

The important role that male partners play in women's reproductive health is becoming increasingly recognized and more attention is being focused on how to incorporate men into reproductive health education and interventions in such areas as decision-making. ANC attendance with wife, their presence in the labour room with wife during delivery, family planning and breast feeding (USAID, 2004 and FMOH, 2005). Educational interventions for pregnancy health have traditionally been inadequate in addressing a woman's degree of influence within the household on health-related decisions particularly as compared with her partner/husband. Observational studies have shown that educating men about the importance of health care for the family increases the promotion of some health-seeking behaviours such as antenatal care (ANC) and child immunizations and enhances communication and support by men to their female partners (Mullany, Becker and Hindin, 2006: FMOH, 2007 and Lawoyin in 2007). The role of men is segmented into the following during pregnancy, labour, after delivery and in family planning. Thus, men have important roles to play during pregnancy and after childbirth when they become a father to the new born child. Their roles include

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understanding and appreciating the discomfort, anxiety and tiredness that pregnancy causes in women, taking over or helping with household work e.g. lifting or carrying of heavy loads, washing and scrubbing the floor, cutting of firewood, helping to take care of the older children and encouraging and supporting the pregnant woman by trying not to make demands on her or be critical of any fault they may observe in her, ensuring that the woman takes the appropriate nutrition and medicine by not only providing the money to buy these things by ensuring that the pregnant wife takes them regularly and understanding the danger signs during pregnancyand delivery so that he came know what to do to save the life of the mother and the baby in her uterus.

Role of men during labour

Any negative cultural belief such as 'men cannot share the discomfort and pain of labour' should be discarded.They should stay close to the woman during labour as practiced in developed countries. Such closeness will provide comfort and support to the woman during labour as the man/father can share the joy of the baby's arrival.

Role of men after delivery

Because of what the woman goes through during labour, that is, the physical and emotional experience, the woman needs a great deal of support from everyone. Thus, the men and other family members should assist the mother to cope with the new born baby's demand and allow the mother to have adequate rest to recover fully from child delivery. The mother should be reminded to keep regular appointment with the health centre for examination for danger signs in order to help the mother and baby before it is too late.

Role of men in family planning

To participate in the growth and development of the child in the area of child immunization, nutrition (exclusive and complimentary feeding), and growth monitoring and also the health of the mother. Participate in family planning services with wife (FMOH, 2005; Adeyemi, 2010).

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2.18 Family Planning

Family planning is the conscious effort by a couple to limit or space the number of children they want to have through the use of contraception (NDHS 2008). According to WHO (2005), family planning is sometimes used as a synonym for the use of birth control. It is most usually applied to a female-male couple who wish to limit the number of children they have and/or to control the timing of pregnancy. It expatiates family planning services as 'Educational, Comprehensive medical or Social activities which enable individuals to determine freely the number and spacing of their children and to select the means by which this may be achieved (WHO, 2005).

From NDHS (2008), data on maternal death, global levels are estimated to be between 500,000 per year, with approximately one-tenth of these deaths occurring in Nigeria alone. NDHS (2008) noted that available date indicates that Nigeria currently has one of the highest rates of maternal mortality in the World. The study also points out that 40% of these maternal deaths are due to complications of unsafe abortions as a response to get rid of an unwanted pregnancy that could have been prevented by effective family planning. Furthermore, Shiffman (2004) noted that in 1987, a Conference on safe motherhood in Nairobi, Kenya, drew international attention to the alarmingly high levels of maternal death in childbirth in developing countries.

2.19 Review of empirical studies

More recently, male involvement has become a popular theme designers, and policy makers, and population researchers.

In developed countries, efforts to involve men began to make women-oriented family planning clinics more inviting to men. Not much progress has been made over the past 20 years, though men are in general more welcome than they are in developing countries reproductive health clinics (Gordon and Demarco 1984).

In developing countries, the tendency has been to exclude men from reproductive health work other than Condom distribution.Milestones in this include: the international conference on population and development held in Cairo 1994 and the fourth World Conference on Women held in Beijing in 1995 where it was emphasized that men's

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attitude, knowledge, and ways of reaction, influence not only their own but also women's reproductive health(United Nations,2009).Parallel to this development, there is also a growing academic interest in how men live their lives, how they create their male identity and how they form relationships with others.

Male involvement in maternal health care has been described as a process of social and behavioural change that is needed for men to play more responsible roles in maternal health care with the purpose of ensuring women's and children's well-being. The concept of male involvement in maternal health is now being advocated as an essential element of World Health Organisation initiative for making pregnancy safer (WHO, 2009).

Male involvement is relatively new in Malawi and part of Africa including Nigeria. Traditionally, maternal health care services have focused on women, with very little male involvement in MHC is a relatively new approach, and it touches on the sensitive nature of gender roles related to culture, social norms, values and beliefs understanding people's perceptions about the programme is critical for its success.

Some men viewed male involvement as a foreign concept as they expressed lack of understanding between husbands in maternity. And they see pregnancy and child birth issues as women's business, however, men do play a supportive role like getting women to the hospital and providing financial and material resources. That is reaffirming the opinion that men are decision makers(WHO, 2009).

European countries, maternal and infant healthcare services do however, make efforts to involve the father. It is common practice that the father is invited to attend regular prenatal check-ups as well as the parent training that is usually offered to both parents. A quantitative study of 600 Danish fathers showed that 80% of them participated in parental preparation courses and prophlatic consultations. Madsen, Lind and Munck, (2002).

Despite these efforts to involve the fathers, many feel marginalized and peripheral in their contact with the mother and infant services. Chalmars and Mayer (1996).An important explanation as to why many fathers feel left out, despite the fact that they take part in parent groups, is that child birth or parent education classes tend to focus exclusively on

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women and motherhood, and childbirth issues are women and childbirth issues are women's business, however, men do play a supportive role like getting women to the hospital and providing financial support.

The increasing trend of fathers' participating at the birth is also evident in Ukraine and European countries. Father's attendance at the birth of their child has increased during the past decade from around 0% up to 52% (USAID, 2005).

Involving fathers during pregnancy can be identified as a factor that can positively influence their health, especially their psychological well-being.The women participants gave an impress that, culturally, childbirth is a source of power for women, a territory where they would not want men to invade for fear of losing that power. An association between husbands accompanying their wives to antenatal clinic/hospital and the quality of intimate relationship emerge from the data. A belief was portrayed that a "loving husband will accompany a wife to the antenatal clinic and escort her to the clinic for delivery.

2.19 Benefit of men involvement in family planning

Primary prevention based on reducing the number of unwanted pregnancy through effective contraception as asserted by (Omo-Agboja and Okonofua, 2009) is an important approach to resolving the problem of maternal mortality. To exclude men from family planning information and counseling services is to ignore the important role that men's behaviour and attitude can play in the couple's reproductive health safety. Traditionally, Nigeria men have played the role of decision makers.Improving their participation in the promotion of maternal health would strengthen their roles in decision making at the family, community and national levels. When men are involved, both men and women are more likely to communicate with each other better, make joint decisions about contraceptive use, discuss how many children they would like to have and be actively involved in child rearing and domestic chores. Ladipo, (2009), Adamu and Salihu (2002), Allen and Doherty, (2002) and Okereke,(2005) noted that access to family planning or contraceptive methods is also important strategy in reducing maternal mortality.

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Family planning service should make available simple, effective and safe contraceptive method that are compatible with the family's religion and culture, and also in keeping with their needs and resource (FMOH, 2007). The benefit of family planning if men are involved are listed below including meeting women's needs for modern family planning and the recommended standards of maternal and newborn health care that would result in major and immediate health benefits.Unintended pregnancies would drop by 77percent, from 17million to 4 million annually, unsafe abortions would decline and the numbers of women needing medical care for complications arising from unsafe procedures would also decline.Greater use of condoms for contraception would reduce the transmission of HIV/Aids and other sexually transmitted infections, thereby helping to curb the Aids pandemic. Reducing unplanned births would reduce public-sector spending for education and other services thereby reducing pressure on scarce resources (WHO, 2009 and United Nations Population Fund,2009).

Benefits of positive husband's involvement in maternal health care

The benefits of positive husband's involvement in maternal health care are wellarticulated in some studies e.g. Kunene et al, (2004), Mullany et al. (2009) and Varkey et al.(2004). USAID, (2009) defined positive male involvement in maternal health care as the mental and physical participation of males in maternal and prenatal health care and family planning in such a way as to increase maternal and infant survival rates and improve family planning outcomes. However, in developing countries such as Malawi, husband involvement in maternal health care is very low,coupled with maternal, neonatal and child health indicators which are very pooras indicated in research works by Aarnio Olsson, Chimbiri and Kulmala,(2009), Farquhar,Kiarie, Richardson, Kabura, John and Nduati,(2004) and Semrau et al. (2005). According to the 2010 Malawi Demographic and Health Survey (MDHS) maternal mortality ratio is estimated at 675 per 100,000 live births, neonatal mortality rate is at 31 deaths per 1,000 live births, infant mortality rate is at 66 deaths per 1,000 live births and child mortality rate is at 75 deaths per 1,000 live births (National Statistical Office and ICF Macro, 2011).

It is only recently that the Malawi health sector started implementing the recommendations of the International Conference on Population and Development-

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ICPD(1994) that stressed the need for male involvement in reproductive health (RH) in order to improve the health of women and children (Ministry of Health, 2009). However, negative or absenceof male involvement has detrimental effects on maternal health care Aarnio et al. (2009) and Odimegwu; Okemgbo, (2008) andBarker and Das, (2004).Generally, studies on barriers to male involvement in maternal health care conducted in developing countries have focused on factors that structurally hinder male involvement at the expense of understanding the core causes of such barriers. In addition, very little research on the barriers to male involvement in maternal health care has been conducted in some African and developing countries. There is need to generate evidence for policy formulation as well as designing and implementing male involvement programmes that remove causes of barriers to male involvement.

2.20 Hinderances to maternal health care

The 15thsession of the African Union on "Maternal Health Care and related issues Development in Africa" was held in Kampala in July 2010. It was there that Ugandan President Yoweri Museveni announced his country would not meet MDG by 2015, blaming slow progress on corrupt health care workers and insufficient funding (Kagumire, 2010). Insufficient funding is indeed a major hindrance to the full implementation of policies for safe motherhood. Uganda has not abided by the Abuja Declaration to assign 15 percent of national budgets to health care (Kagumire, 2010), and the Ministry of Health continuously faces shortfalls for maternal health services. The result on the ground is overcrowded maternal and antenatal wards, overworked health care staff and under stocked pharmacies in government clinics and hospitals. These conditions make it difficult for workers to ensure women receive appropriate care when they arrive for checkups and deliveries. Same situations obtain in Nigeria as this research revealed in the area under study.

Despite persistent domestic shortfalls, foreign donors only provide for some of the services to populations in need. Obstetric fistula, for instance, is one of the most common and debilitating complications of unsafe motherhood– yet the Ministry of Health in most developing countries, including Nigeria, provide little or no funding to correct it. Instead, international donors provide funds to some hospitals to perform corrective surgery,

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though the funding available is "too small to have a meaningful impact" (Manyire, 2010). Complaints of bribery indicate that the few supplies and services that make it to hospitals and health centres in these countries do not reach pregnant women free of charge(Kyomuhendo, 2003).

Maternal mortality rate can be significantly reduced when key issues to health care systems are addressed (Loranza, 2011).This requires full funding, political will and long-term commitment to maternal health and other public health isues.

Challenges in reducing MMR, however, often move beyond corruption and insufficient funding; it is well-documented that a range of social, cultural, and practical barriers also exclude women from the formal health care system (Gabrysch and Campbell, 2009). Other studies also found that the majority of pregnant women attend antenatal check-ups at health facilities, but difficulties in physical access compounded by cultural restrictions mean women's use of health facilities for Anti-natal care and delivery are limited in many of the African countries including Nigeria (MacKian, 2008).

2.21 Barriers to men involvement in maternal health care

The challenges to male involvement in maternal health programs

The high maternal mortality rate (MMR) are some factors that indicate a clear role for male in sexual and reproductive health. However, while many aspects of reproductive health (RH) care in some developed countries have improved, male involvement in RH is still under developedin developing countries including Nigeria (USAID, 2005).

The curriculum in health institutions for MCH training does not currently cover male involvement, and the strategic plans of government departments and non-governmental organizations (NGOs) do not ordinarily include indicators for male participation in maternal health care(USAID, 2005;Drennan 2003and Khana, 2000).

Galadanchi and Ibrahim (2009) noted that the traditional gender differences in most countries worldwide including Nigeria tend to impede the benefits of male involvement in reproductive health. This study viewed that maternal health care is usually considered a woman's concern both within households and at the policy levels, where strategies

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legislation rarely specify male involvement as a core component of RH/MCH interventions.

Focus of RH/MCH programs on women only leads to low levels of understanding, not just on the part of men, who have little notion of their role in reproductive health, but also on the part of service providers, who are not technically equipped, properly trained, or inclined to meet the needs of male clients. Men hold most of the positions of authority in the government and civil service and are managers in both the public and private health sectors (Abanihe, 2003; UNIFEMERAL, 2004;Waltson, 2005). Involving male in RH/MCH is therefore essential in order to draw attention to women's rights and improve the health status of both male and female.

It is widely recognized that male are often marginalized by maternal health services and are provided with limited access to basic information and knowledge to help them make informed choices and decisions in order to protect and promote their own health as well as that of their families (Platin 2007; Lawoyin, 2007 andWHO 2001).

Most health-related policies do not specifically refer to male involvement and fail to offer suggestions on how to involve the male in programme implementations.Gender-related policies tend to overlook the concept of equality and the role of male in promoting women's access to services and development opportunities.There is also the fear that more attention to male could jeopardize reproductive health services for women (FMoH, 2007).

Opposition to male involvement in MHC often comes from some male themselves. Some respondents point to male's reluctance to change their practices regarding reproductive health, their feeling of embarrassment and a belief that reproductive health/MHC remain the concern of women. Evidence also suggests that men's perception of risk limit their involvement in the reproductive health (Dudgeon and Inhorn, 2004; Drennan, 2003).

Despite all policies formulated by the Government of Nigeria in improving maternal health, effective delivery of maternal health care, Nigeria is still fraught with challenges. This is because there still exist some gaps which include: Health policies, programs and

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activities (which are sectored, uncoordinated and limited in scope), lack of a strong and cohesive networkof safe motherhood campaigns by the government and the civil society to drive the political and social system into action(Ladipo, 2010).In the study, inadequate fund allocation to programmes and delay in the release of funds allocation are found to result in ineffective programme implementation.Thus, male involvement is still a mirage in spite the fact that male dominate decision-making in our culture in Nigeria. Communities' non-involvement in planning and implementation of programme and interventions lead to non-ownership(Ladipo, 2010).

Therefore, in achieving maternal health and reducing maternal mortality by 75 percent in Nigeria in the year 2015, all hands must be on deck.

2.22 Gender issues

Women's ability to exercise their right to reproductive health and to negotiate their access to health services is directly affected by the gender, social cultural and economic inequalities they face.It is evidenced that reductions in maternal mortality are directly linked to improving girls' and women's educational opportunities. Over 40 million girls remain out of school worldwide (United Nations' Millenium Development Goals Report 2007; Global Campaign for Education, 2005). Girls and women are disempowered in multiple ways by not having their right to education fulfilled, they miss out on crucial messages about health and sex and are less likely to become economically independent (Ghaida and Klasen, 2004).

Control of finances and the decision making authority often with the husband or other male relatives are made difficult by culture and norms of the society. Studies have shown that 'many women have lost their live and that of their babies in pregnancy-related conditions, while awaiting a decision to be taken by such gatekeepers" (FMOH, 2007; Lucas and Gills 2003 and Odeimegwu, 2005).

One of the constraints placed on women is movement outside the home which limited their access to health facilities. This contributes to low levels of antenatal attendance, low rates of birth in health facilities, low attendance of postnatal services, poor newborn

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immunization, inadequate child care practices and poor health-care-seeking behaviour. This is especially true in the northern parts of the country (FMoH, 2007).

Male involvement is a fundamental step in designing appropriate interventions, (Mullary, 2006). Furthermore, research in male involvement in other reproductive health care such as family planning, PMCT, have been carried out severally but little had been done in male involvement in maternal health care. Thus, this research aims at exploring the hindrances and level of male involvement in maternal health in Kwali Area Council of FCT Abuja.

2.23 Women's empowerment and health outcomes

Gender equality and women's empowerment are important in the development of strategy that focuses on maternal health care. In June, 2007, the Federal Republic of Nigeria launched the National Gender policy to promote gender equality and sustainable development. This policy was derived from the constitution of the Federal republic of Nigeria, 1999 which guarantees the fundamental human rights of all its citizens and incorporates the principles of gender equality (FMoH, 2007, Green and Gein 2005).

Empowering women means enabling them to overcome social, economic and cultural factors that limits their ability to make fully informed choices, particularly in the areas affecting the most intimate aspect of their lives – their reproductive health. Women must have the means, both physical and psychological, to overcome the barriers to maternal and child health care (Qureshi and Shaikh 2007; Lucas and Gilles 2003).

One of the ways to promote women's economic empowerment is to allow them have good education, develop their skills through training opportunities and vocational studies, which will enable them have self-employment opportunities (Khawar, 2010and Oyewole, 2007).

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Table 2.1: Approaches to Involving Male in Sexual and Reproductive Health:

APPROACH	PURPOSE & ASSUMPTIONS	PROGRAMMATIC IMPLICATIONS
TRADITIONAL FAMILY PLANNING FOR WOMEN	Increase contraceptive prevalence; reduce fertility Inclusion of male is not necessary from an efficiency standpoint	Contraceptive delivery to women in the context of maternal and child health
1994 Cairo International Conference on Population and Development		
MALE AS CLIENTS	Address men's reproductive health needs	Extend same range of reproductive health services to men as to women Employ male health workers
MALE AS PARTNERS	Male have central role to play in supporting women's health	Recruit male to support women's health e.g. teach husbands about danger signs in labour, how to develop transportation plans, the benefits of family planning for women's health
MALE AS AGENTS OF POSITIVE CHANGE	Promote gender equity as means of improving men's and women's health and as an end in itself Addressing inequality requires full participation and cooperation of men.	Paradigm shift in how programs are structured and services are delivered. Broader range of activities, working with men as sexual partners, fathers and community members

Source: Green and Gein (2005)

Communication and couples decision making

Communication and decision-making playvital roles in assuring informed choice of family planning and reproductive health (MCH) behaviour (Oladeji, 2008). Effective communication and decision-making by both party is best for their health and to exercise their right to good-quality health care – (Rima 2002). It also includes whether to control their fertility and whether to use a family planning method before ever seeking contraception use.

Male play powerful and even dominant roles in reproductive health decisions, without considering their partners' wishes or the health consequences for themselves and that of

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their partner.However their action can have unhealthy and even dangerous results. In contrast, couples who talk to each other about family planning and reproductive health reach better decisions on health issues. Such couples are more likely to use contraception and use it wisely and effectively to prevent unwanted pregnancies(Beckman, 2002). With more information and encouragement, more male would be able to play positive roles in maternal health care. For example, a husband can help his wife to have safe pregnancy and give birth to healthy babies if he becomes better informed about maternal and child health care.Reproductive health programs can help male play supportive roles during pregnancy, delivery and breast feeding, (Thaddeus and Maine (2002). Increasing men's participation can be a promising strategy for achieving good reproductive health for all(Oladeji,2008).

Decision-making can be a complex process, but the ability of women to make decision that affects their personal circumstance is essential for their empowerment. A woman's decision and ability to control her fertility, her choice of contraceptive methods and maternal health care are in part affected by her status in the household and her own sense of empowerment. A woman who is unable to control other aspect of her life may be less able to control her health during and after pregnancy(NPC andNDHS, 2008).

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2.24 CONCEPTUAL FRAMEWORK

A conceptual framework presents a systematic way of understanding events or situations. It is a set of concepts, definition and propositions that explains or predicts events or situations by illustrating the relationship between variables (National Cancer Institute (NCI), 2005). Theories and models provide information insights and strategies for understanding individual behaviours before planning and implementing health intervention programmes. In this study, Ecological model was adopted to provide a clear explanation of the important variables linked to the study which should be assessed.

The Institute of Medicine has defined the ecological model as a model of health that emphasizes the linkages and relationships among multiple factors affecting health.An ecological approach, involves developing strategies to influence multiple levels and determinants of health.The social determinants of health "Health starts where we live, learn, works and play".Health equity which defined in healthy people 2020 as "attainment of the highest level of health for all people" and the elimination of disparities.And the life course framework, which is to over simplify it, a way of thinking about the interplay of risk and protective factors across the life span, almost like a 3-D version of the ecological model (Institute of Medicine, 2002).

Ecological model have been selected to guide this study. The ecological model comprehensively addresses public health issue such as maternal health. Each dimension can then be analyzed at five levels:

Intrapersonal: These are characteristics of men such as their knowledge of maternal health care, their perceptions on male involvement in maternal health care and their participation in maternal healthcare issues such as attendance of ANC with wife, stay at the bedside of wife during delivery and participation in family planning.

Interpersonal: These are personal processes and primary groups' influences on men perceptions on maternal health– that is formal and informal social networks and social support systems that include family, work group and friendship. These are part of the factors that can influence male involvement in maternal health.

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Institutional factors: These are social institutions that may be a barrier to male involvement. These barriers may be inadequate health facilities and attitude of health workers.

Community factors: These are relationship among organizations, institutional and informal networks within defined boundaries. These are more of gender roles in the society. Community norms are factors that can influence or hinder male participation in maternal health programmes.

Policy: These are government laws and policies on maternal health. The policies and laws do not encourage male involvement in maternal health which is one of the barriers to male involvement in maternal health.

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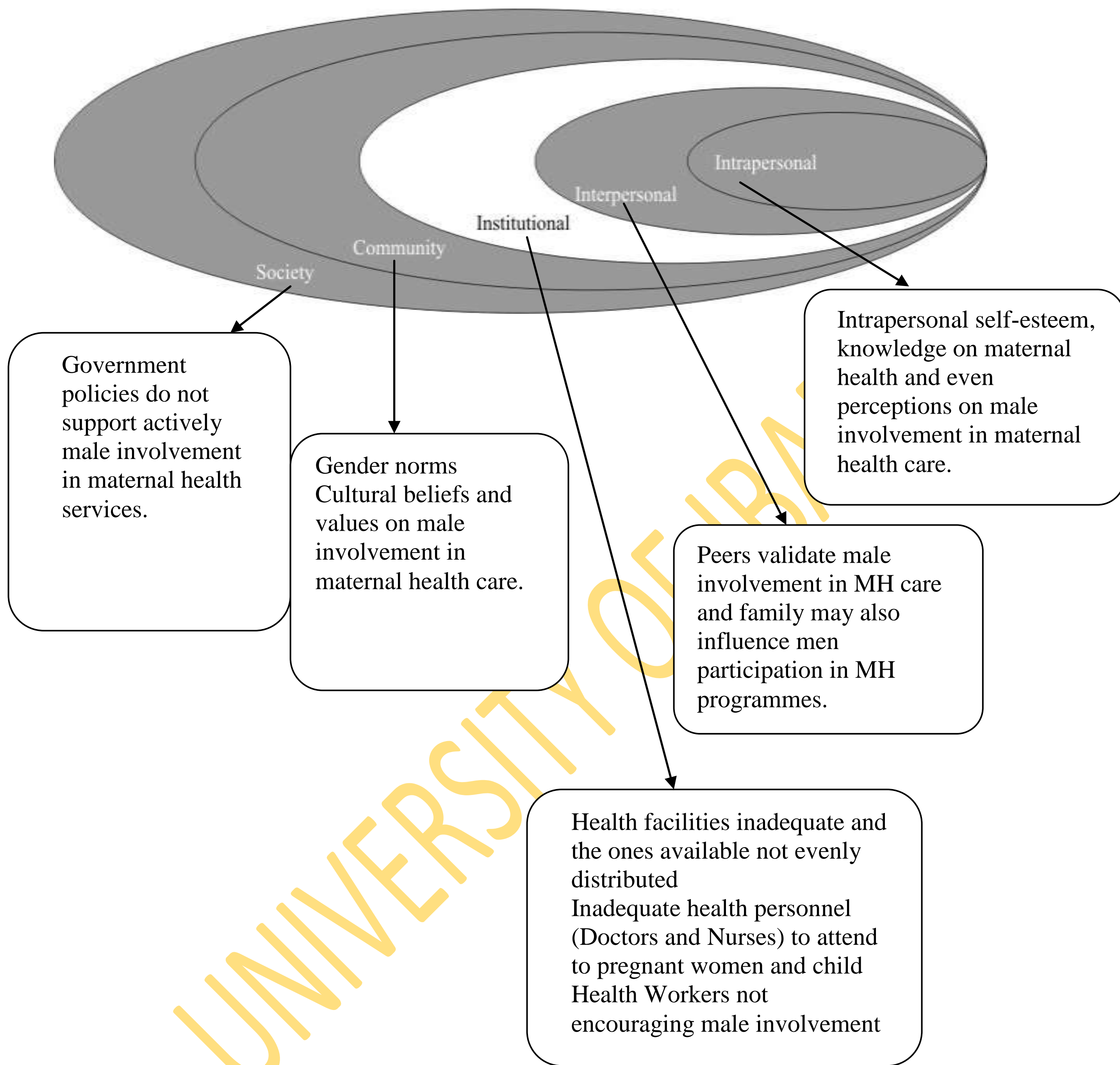

Figure 2.1: Application of ecological model to hindrance to maleinvolvementin maternal health care

Source: Epidemiology of Adiposity in Childbearing Ghanaian Women(Konan, 2010); Healthy Active Oregon (Moore, 2003).

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CHAPTER THREE

METHODOLOGY

This chapter presents a description of the study area and the research design. The other components of the methodology include the following: study design, the scope of the study, the study population, sample size, sample technique, methods and instruments for data collection, validity and reliability, data collection, data management and analysis, Ethical consideration and limitations of the study are also presented in this chapter.

3.1 Study Design

This is descriptive cross sectional study that utilized both qualitative (focus group discussion) and qualitative (semi-structured questionnaire) methods of data collection. Cross-sectional studies is simple in design and aimed at finding out the prevalence of a phenomenon, problem, attitude or issue by taking a snapshot of cross-section of the population. This obtains an overall picture as it stands at the time of the study. Such as to access demographic characteristics or community attitudes(Pelham, 2006).

This was designedto ascertain the hindrances to involvement of male in maternal health care in Kwali Area Council of FCT, Abuja.

3.2 Study Area

The study was conducted in Kwali Area Council. Kwali Area Council is one of the six Area Councils that make up the Federal Capital Territory (FCT). The council was randomly selected as a study area through a simple random sampling method of balloting. It is situated at the southern part of FCT. It shares boundaries with Gwagwalada Area Council to the North-East, Kuje Area Council to the East and Abaji Area Council to the South-West. It also shares boundary with Niger State to the North-West and with Nasarawa State to the South-East.

Kwali Area Council has a total population of 86,174 (43,413 men and 42,761 women). (NPC 2006). The Council is a rural area council of the FCT. The Area Council is made up of ten (10) political wards with 37 functional health care facilities spread across the wards.The area council also has one (1) secondary facility. The wards include: Ashara,

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Dafa, Kilankwa, Kundu, Kwali, Pai, Wako, Yangoji, Gumbo and Yebu. Some hard to reach settlement due to their terrain are found in Ashara , Pai, Wako, Yangoji and Yebu Wards.

The council's population is of mixed tribe namely the Gbagyis (Indigenes), Ebira, Ganagana and Hausa/Fulani. Other ethnic groups in Nigeria also reside in the Council Area. The main occupations of the people in the area council, especially the indigenes, are farming, fishing and petty trading. Most of the non-indigenes however are civil servants.

Kwali Area Council among other six area councils is a rural area council that belief more on traditional birth attendants and traditional healers rather than accessing or utilising the existing health centres man by midwives.

3.3 Target population

The target population was married men aged 18years and above that areresident in Kwali Area Council of FCT, Abuja.

3.3.1 *Inclusion Criteria*

The inclusion criteria for this study were married men of 18 years of age and abovewho have had at least a child in the last 5 years residing in Kwali Area Council of FCT Abuja.

3.3.2 Exclusion Criteria

The exclusion criteria for this study were unmarried men and those not residing in Kwali Area Council of FCT Abuja.

3.4 Study Variables

Two key dependent variables were derived from the conceptual framework. The first was the knowledge of men in maternal health care. This variable was operationalised through questions asked on ANC, causes of poor maternal health, importance of hospital delivery, husband at wife's bed side during delivery, reasons for family planning or child spacing and their involvement in family planning. The second was level of men's involvement, assessing their roles during their wife's pregnancy and after pregnancy.

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The independent variables are the socio-demographic factor such as age, educational status, social and economic status, income and religion of the respondents.

3.5 Sample

The sample population for this study was the people of Tunga Maji in Gwagwalada Area Council of FCT, Abuja. 10% of the study population was used for the FGDs.

3.6 Sample Size determination

The sample size for this study was determined using prevalence rate of 32.1% of a recent related research conducted on Birth Preparedness, Complication Readiness and Fathers Participation in Maternal Centre in Northern Nigeria(Zubairu, 2010)

The same size was calculated using the formula below:

$$n = \frac{z^2 (pq)}{d^2}$$

Where n = the desired sample size, z = confidence interval (95% which is 1.96).

d = level of precision (0.05) 5%

p = proportion of men involvement in MCH care (32.1%)

q = 1 – P = 0.679

$$= \frac{1.96(^2 \times (0.321 \times 0.679)}{(0.05)^2}$$

= 334.9 approximately 335

Ten percent of 335 was added to this sample size in order to make up for non-response and attrition.

3.7 Sampling Procedure:

A four stage sampling technique was adopted in selecting respondents for this study.

The first stage was the selection of Kwali Area Council from the 6 Area Councils of the FCT. The list of the six (6) area councils of the Federal Capital Territory (FCT) were

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compiled and coded 1-6 and thereafter Kwali area council was selected using the ballot method.

The second stage was selection of wards using simple random sampling of balloting. Kwali area council was stratified into upper, middle and lower class based on Area Council categorization. There are 3 wards in upper, 3 wards in middle and 4 wards in lower class. A ward was then chosen from each stratum. The wards selected were Kwali ward from the upper class, Kilankwa ward from the middle class, and Waku ward from the lower class using ballot method.

The third stage: The list of settlements were obtained from Kwali Area Council Authority. Based on the largeness and location of the 3 strata, five settlements were eventually picked proportionately (2 settlements in Kwaliward, 2 in Kilankwa ward and 1 from Wako ward being the least with small settlements). Snow balling method of sampling procedure was used to select 74 respondents in each of the settlements for the study excluding participants for FGDs. In descriptive studies a sample of 10-20% of the population is often used. The following were the selected settlements from each of the three (3) selected ward:

Kwali Ward: Kwali, Lambata, Bonugu, Shagari's Quarters, Galadima,
Kilankwa Ward: Kilankwa1, Kilankwa2, Small Sheda, Big Sheda and Piri.
Wako Ward: Wako, Sabongari, Gadabiyu, Sadu and Kibiriyi.
The formula used for calculating Quantitative sampling process was based on selection of settlements. Considering the instruments for data collection (Quantitative – questionnaire and Qualitative - FGD).

The fourth stage was the selection of participants for FGD. The participants were chosen from every household until the required participants were gotten.

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3.8 Sampling for FGD

The selected wards and settlements used for the questionnaire were used for the FGDs. One FGD was conducted from each of the selected wards. Each FGD group for this study consistsof 8participants respectively.

3.9 Instrumentsfor data collection

The study utilized both qualitative and quantitative methods of data collection.

Qualitative Method: Three (3) Focus Group Discussion (FGD) were conducted (one FGD in each stratum) of Kwali Area Council. A pre-test was carried out in a neighbouring town of Tunga Maji in Gwagwalada Area Council because of similarity in socio-demographic characteristics of the two Area Councils.

Respondents' views and experiences were addressed concerning maternal health such as perceived causes of maternal death, resultant complication from poor maternal care, men's role and involvement, possible ways to reduce maternal deaths, improvement of maternal health, decision taken on when to have another child and issues on family planning (child spacing).

Quantitative Method: Information from Focus Group Discussions (FGDs) were used as guide in modifying the draft semi-structured questionnaire developed from literature review. The questionnaire employed both open and closed ended questions.

The questionnaire had seven sections. Section A consisted of socio demographic information, section B was knowledge on maternal healthcare, section C, perception of Men's Involvement in Maternal Health care, Section D; Practice of men in Maternal Health Care, Section E; Role of men in maternal health care, Section F:Hindrance to men involvement in maternal health care and section G: Motivation to men involvement in Maternal Health Care. Copies of the questionnaires were administered by the interviewers and supervised by the researcher. Five (5) research assistants were employed for the quantitative data collection procedure. These research assistants were trained on the ethical considerations in research and how to collect data.

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3.10 Validity

To ascertain that the content appropriateness of the survey instruments was adequate to achieve the results it was meant for the questionnaire was presented to the researcher's supervisor and other experts in the Department of Health Promotion and Education, University of Ibadan, as well as lecturers in other related discipline for content and construct validity. Comments, suggestions and modifications from the expert's validations were studied carefully, explored and were used to improve the quality of the instrument in relations to research questions and hypothesis.

3.11 Reliability

To ensure that the survey instrument was reliable, the questionnaire was subjected to pre-test and the pre-test was carried out in Tunga-Maji (Gwagwalada Area Council). Ten percent (10%) of research population was used for the pretest. The result obtained was compared and corrected using pearson product moment correlation coefficient in order to obtain the reliability. A value of 0.617 was obtained which showed that the instrument was reliable.

3.12 Training of research assistants

Five male and one female research assistants (aged 18-23 years) were recruited for the study. Four of the research assistants were fresh graduates of College of Education, while the other two were adults who were secondary school certificate holders. They were fluent in English and Hausa languages. The research assistants were trained for two days. A time table was drawn for this period, with each day lasting 5 hours (10a.m-3p.m). The training commenced with self-introduction of the trainees, the investigator and the trainee, followed by background of the study and objectives. Contents of the training focused on interview techniques, interpersonal and communication skills. Demonstrations and role play was used to transfer skills especially for the focus group discussion (FGD). A copy of the instrumentswas given to each of the trainees to take home and read over for better understanding with the intention that issues generated should be discussed the following day.

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3.12.1 Procedure for Data Collection:

Visits were made to HOD's Health Department of Kwali Area Council, in company of a research assistant to intimate him of the research study, established rapport and a written permission was obtained for entrance into the communities used for the survey. At the community level, the chiefs were also visited for the same reasons and some of the chiefs participated as respondents. The instruments were administered by the researcher along with the trained research assistants. The collection of completed questionnaire was done on the spot as soon as completed and was reviewed for completeness. The researcherz also edited all copies of the questionnaire completed before they were batched and taking to the process location.

3.13 Data Management and Analysis

The completed copies of the questionnaire were serially numbered for control and recall purpose. Data collected were checked for completeness and accuracy on a daily basis for the period of data collection. The data collected were entered into the computer using analytical software package for social science (SPSS) version 17 that was used to analyze the quantitative data using descriptive statistics (frequencies distribution and percentage). Non-parametric test chi-square was used to test the statistical significance of results reported in cross tabulations. Finally, information obtained were summarized and presented in tables.

The qualitative data, were transcribed, sorted, categorized and analyzed thematically.

3.14 Ethical consideration:

A number of steps were taken to address the ethical issues inherent in the study. The Department of Health Promotion and Education, Faculty of Public Health, University of Ibadan sent a formal letter of introduction of the researcher and request to carry out this study to the Federal Capital Territory. Ethical Committee. Permission to use Kwali Area Council was approved by the Secretary FCT, Ethical Committee and permission was also obtained from Authority of Kwali Area Council, Kwali, Abuja.

In addition, Informed Consent by the participants was the basis for the participation in the research. Participation was voluntary and there was no victimization of participants.

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Confidentiality of each participant's response was maintained during and after the collection of data.

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CHAPTER FOUR
RESULTS

The chapter discusses the various findings that emanated from the quantitative (descriptive and inferential statistics) and from the qualitative (FGDs) data.

4.1 Socio-demograhic information of the respondents

The social-demographic characteristic of respondents is presented in Table 4.1. The ages of the respondents ranged from 20 to 79 years with a mean age group of 37.9± 9.5 years having more (40.8%) of the respondents within the age range of 30-39 year olds. Above half (58.1%) of the respondents in the study were Christians (figure 4.1) with more (37.8%) of them from Gbagi ethnic group. Respondents without formal education were more in the study and followed by those who had Islamic education (figure 4.2). The three-top among the list of respondents'occupations were; Farming (38.6%), Civil Servant (38.1%) and Trading (7.8%) (figure 4.3). Almost all (99.2%) of the respondents were married men living with their wives under the same roof of which larger proportion of them were into monogamous marriage.

The result generated from respondents'contribution to household needs revealed that majority (82.7%) of the respondents always contributed immensely to their households needs like foods, health (82.4%), child care (80.8%), transportation of wife to the clinic (76.2%) and provision of wife's clothing (76.2%). Above half (58.6%) of the respondents claimed having Television and video (51.9%). Little below half (42.4%) of them have their personal Car and Bicycle(23.8%) (table 4.1b).Respondents'contribution to household needs was compared with type of marriage of which majority of the respondents who were into monogamous marriage contributed to their household needs better than their counterparts who were into polyandry ($p<0.05$) (table 4.1c).

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Table 4.1: Socio-demographic characteristics of the respondents

(N=370)

Variable		Frequency	Percentage (%)
Age			
20-29		67	18.1
30-39		151	40.8
40-49		105	28.4
50-59		37	10
60-69		7	1.9
70-79		3	0.8
	Mean	37.9	
	Standard deviation	9.5	
Marital status			
Married		367	99.2
Cohabiting		3	0.8
Separated		1	0.3
Type of marriage			
Monogamous		311	84.1
Polygamous		59	15.9
Ethnic group			
Gbagi		289	78.1
Hausa		12	3.2
Yoruba		10	2.7
Ibo		23	6.2
Others (Ebira, Ninzon, Alago, Igala, Nupe, Urobo, Idoma, Tiv, Eggon,Arago, Abawa)		36	9.8
Total		370	100.0

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Table 4.1c: Respondents' contribution to household's expenses by type of marriage

Types of Family	Financial contribution to Child Care				Chi-Square Tests
	Full involvement (%)	**Patial involvement (%)**	**No involvement (%)**	**Total (%)**	
Monogamous	242(80.9)	67(97.1)	2(100.0)	311(84.1)	f = 13.416
Polygamous	57(19.1)	2(2.9)	0(0.0)	59(15.9)	0.001[b]*
Total	299(100.0)	69(100.0)	2(100.0)	370(100.0)	

* ($p<0.05$)

f - Fisher's Exact Test

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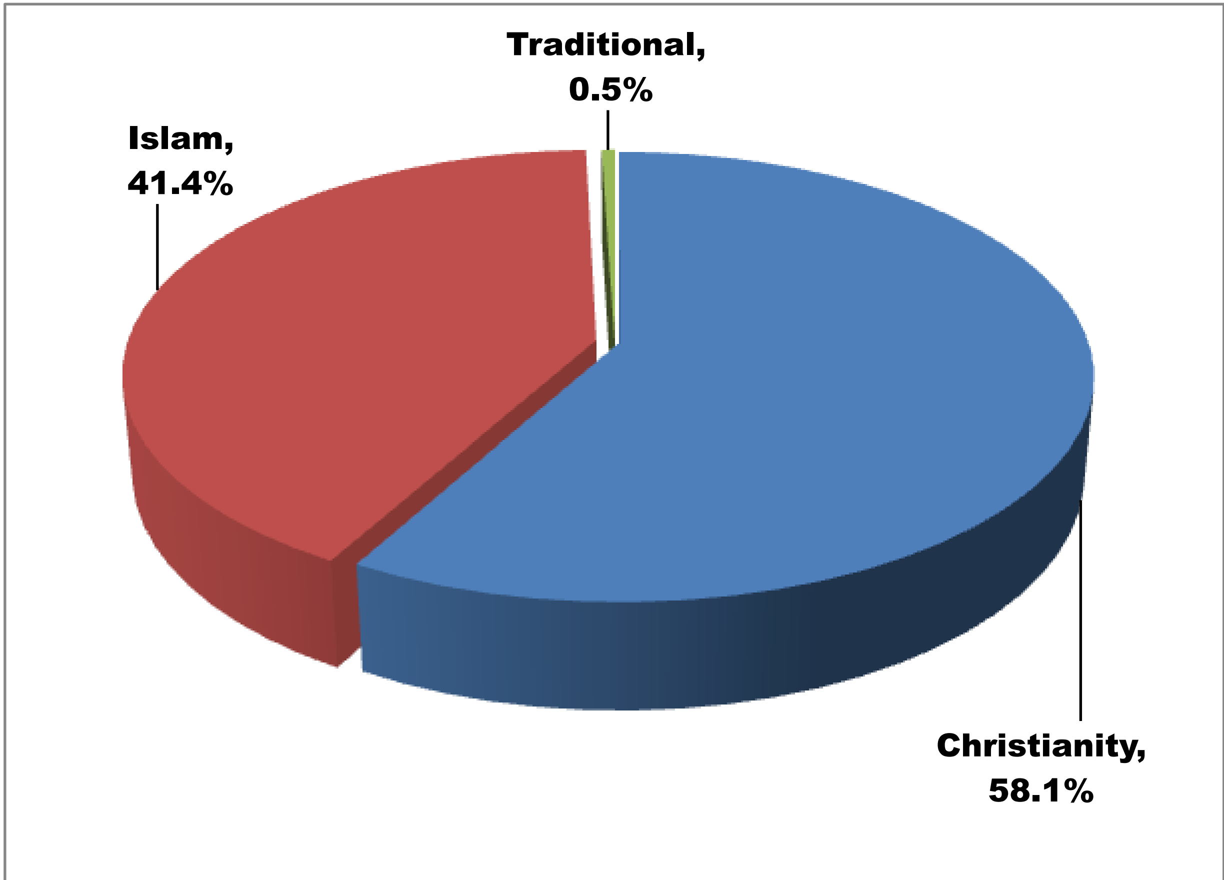

Figure 4.1: **Respondents'religion**

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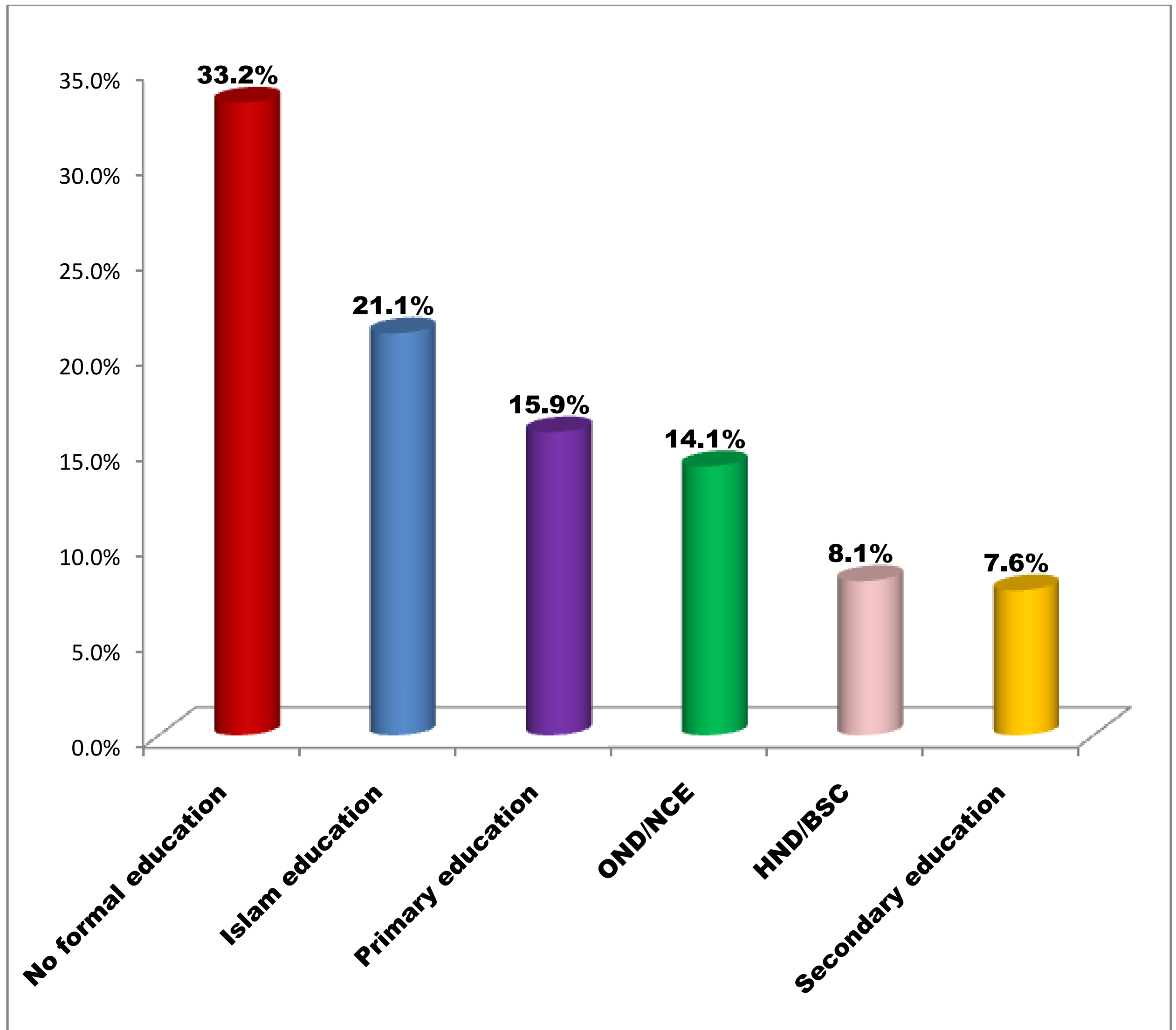

Figure 4.2: Respondents'level of educational qualification

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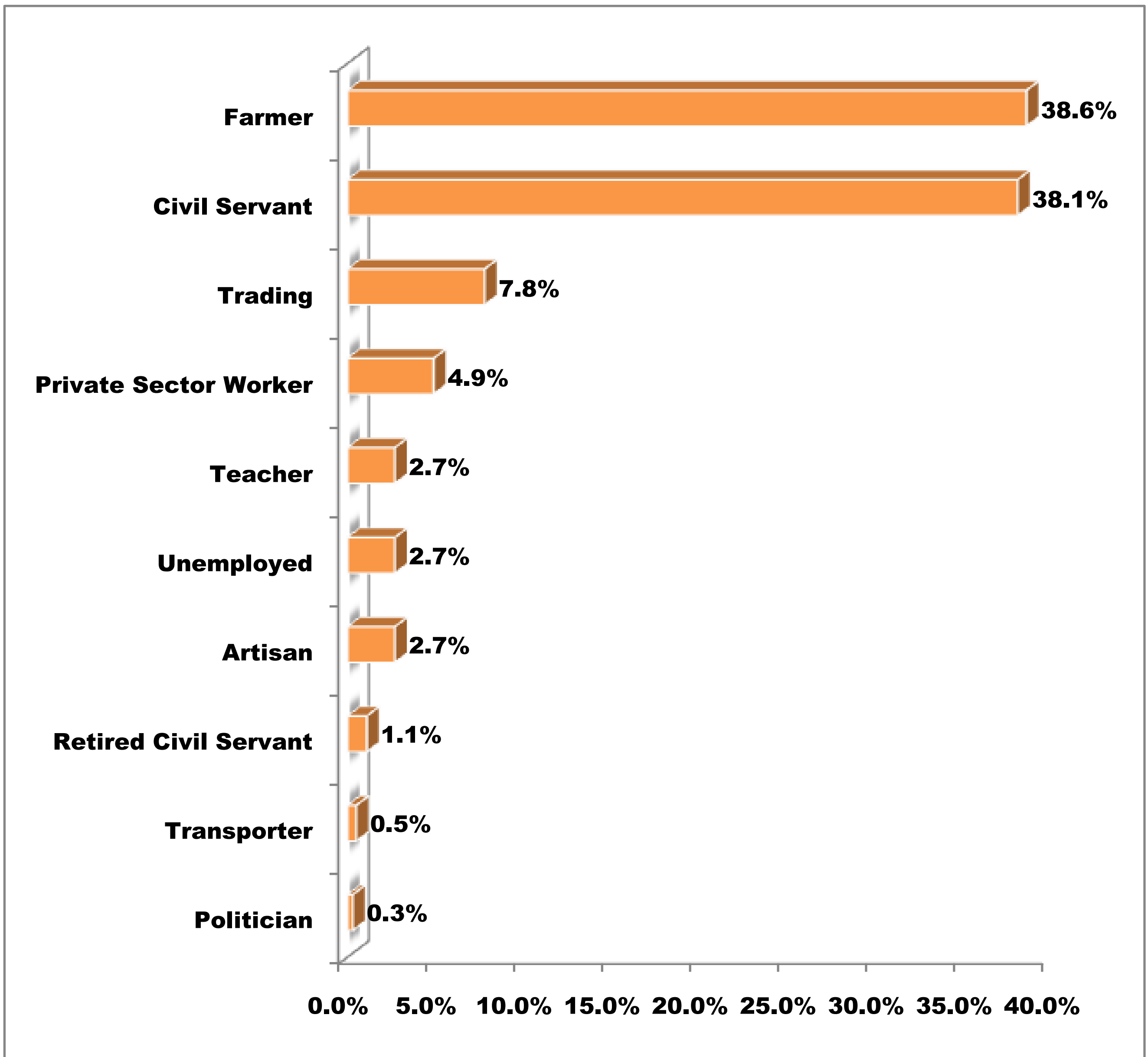

Figure 4.3: Respondents' occupational status

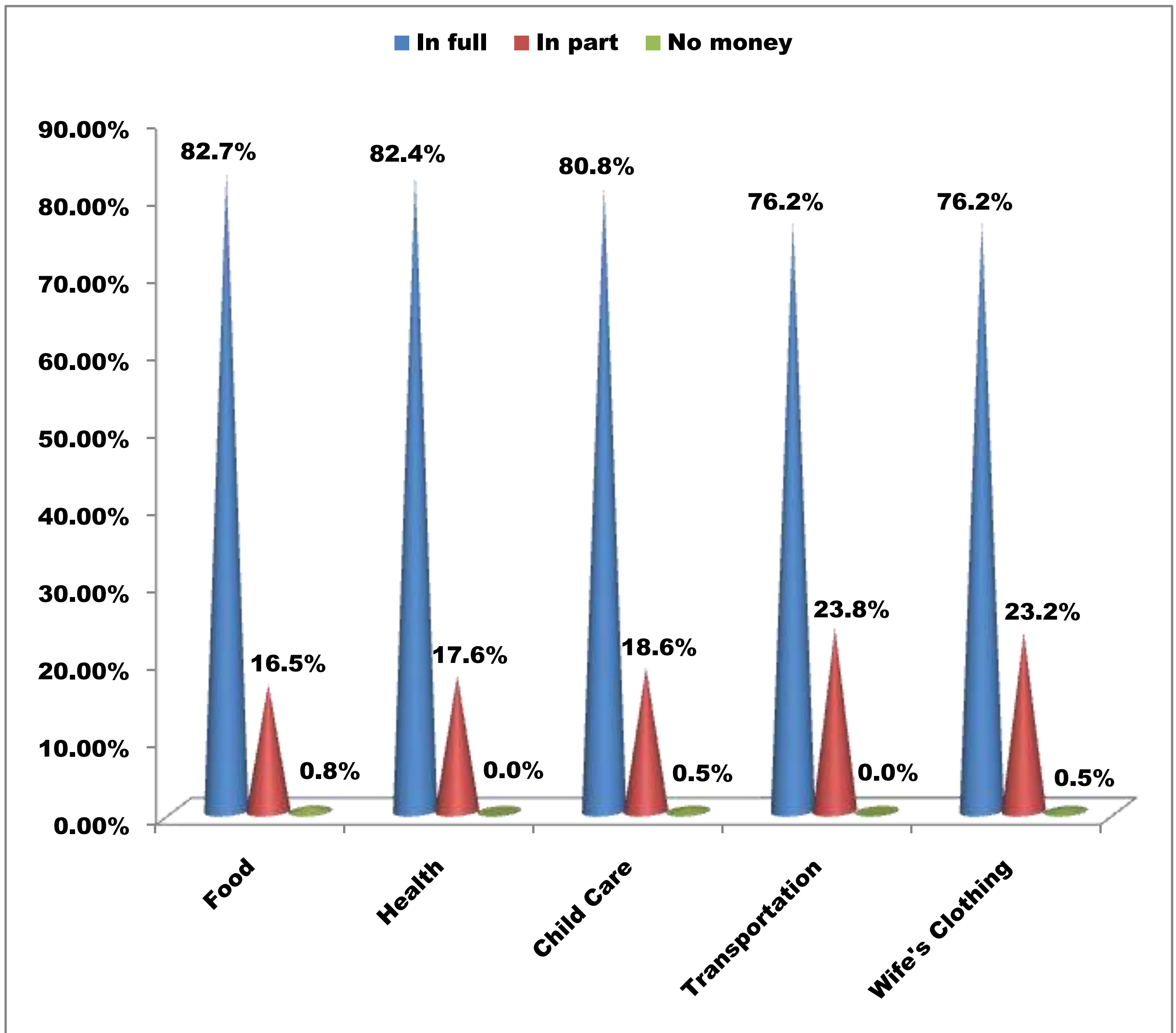

Figure 4.4: Respondents' contribution to household's expenses

4.2 Respondents’knowledge aboutmaternal health care

Mean level of awareness score of respondents who had ever and never heard of MHC were 14.5±3.5 and 11.6±3.0 with greater percentage (84.3%) of the respondents affirmed that they were aware of maternal health care of which more (25.8%) of them heard the information from health workers (table 4.2).

Nearly all (95.7%) the respondents have knowledge of prolonged labour as a pregnancy complication. Most (92.7%) of the respondents established that poor maternal health care could result into maternal death (table 4.2). Among the consequences of pregnancy complication acknowledged by the respondents were: Abortion (81.9%); Foetal death (Death of unborn baby in uterus) (87.3%); Pre-mature delivery (90.3%); Prolong labour delivery (95.7%) and Death of mother(96.8%) (see table 4.3). In the same vein, the result got on the respondents’ knowledge about causes of maternal mortality was almost similar to the above mentioned consequences of pregnancy complications except that more than half (67.8%)of the respondents who declined for HIV/AIDS, spiritual reasons and (destined to die) (57.3%) and family Planning (46.8%)causes maternal mortality.The causes of maternal mortality according to the respondents included: Excessive bleeding (93.5%); Delay in getting to the hospital (88.1%); Anaemia (83.5%); Prolong labour (93.5%); Caesarean section/ Operation (83.0%) and Lack of money/Poverty (89.5%) (see table 4.3).

Respondents’ overall knowledge mean score about maternal health care was discribed in table 4.2c below. Respondents who had poor knowledge about maternal health care were majority (68.9%) against those who were good in knowledge (31.1%).

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Table 4.2a: Respondents'awareness on maternal health care

Awarenessof maternal health care	No	%
Yes	312	84.3
No	58	15.7
Total	370	100.0
Mean	14.5	
Standard deviation	3.5	
Sources of information		
Radio	237	21.3
Health worker	287	25.8
Newspaper	130	11.7
Neighbors	192	17.3
Television	266	23.9
Total*	1112	100.0

* Mutually exclusive responses

The FGDs report showed that all Participants were in affirmation to findings from quantitative result as declared that they heard about maternal health care services prior to the time of the study and their sources of information was majorly through media (radio) and health workers (see appendix3as part of the FGD sessions).

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Table 4.2b: Respondents'level of knowledge about maternal health care

(N=370)

Knowledge statement	Yes (%)	No (%)
Poor Maternal Health Care result in maternal death	342(92.4)	28(7.6)
Pregnancy complications:*		
a. Abortion	303(81.9)	67(18.1)
b. Foetal death (Death of unborn baby in uterus)	323(87.3)	47(12.7)
c. Pre-mature delivery	334(90.3)	36(9.7)
d. Prolong labour delivery	354(95.7)	16(4.3)
e. Death of mother	358(96.8)	12(3.2)
Knowledge about causes of maternal mortality*		
a. Excessive bleeding	346(93.5)	24(6.5)
b. Delay in getting to the hospital	326(88.1)	44(11.9)
c. Anaemia	309(83.5)	61(16.5)
d. Prolong labour	346(93.5)	22(6.5)
e. Caesarean section/ Operation	307(83.0)	63(17.0)
f. Lack of money/Poverty	331(89.5)	39(10.5)
g. Spiritual reasons /Destined to die	157(42.4)	212(57.3)
h. HIV/AIDS	119(32.2)	251(67.8)
i. Family Planning causes maternal mortality	173(46.8)	197(58.2)

* Mutually exclusive responses

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Table 4.3 Respondents'overall knowledge mean score about MHC

Knowledge of MHC	No	%	Mean	Standard deviation
Good Knowledge	115	31.1	13.18	1.55
Poor knowledge	255	68.9	16.30	0.62
Total	370	100.0		

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4.3 Prevention of Maternal Mortality

From the result gathered on respondents' knowledge of prevention of maternal mortality, it was shown that 81.1% of the respondents acknowledged child spacing/family planning as a way to prevent maternal mortality and 98.1%of them affirmed that if expecting mothers attend ANC regularly, itwill prevent maternal mortality. In the same vein, 93.5% of the respondents recognised meeting with skilled attendant at birth as part of means to prevent maternal mortality. Other important fact on prevention of maternal mortality highlighted by the respondents was taking enough rest during pregnancy(91.6%).

To buttress the good knowledge of the respondents on prevention of maternal mortality, 91.9%of therespondents re-affirmed that women empowerment is one of components of maternal health and at the same time 93.8% emphasized on theimportance of male involvement in maternal health care (MHC). The areas of male involvement on maternal care on the priority list of the respondents were provision of household chores (63.8%) and assisting wife financially (27.3%)(table 4.6)

Table 4.4: Respondents'knowledge about prevention of Maternal Mortality (N=370)

Statement on prevention knowledge	Yes (%)	No (%)
Child spacing/family planning	300(81.1)	70(18.9)
Antenatal care	363(98.1)	7(1.9)
Skilled attendant at birth	346(93.5)	24(6.5)
Taking enough rest during pregnancy	339(91.6)	31(8.4)
Delivering at home with TBA	192(51.9)	178(48.1)
Delivering in the church to ward away evil spirits	144(38.9)	226(61.1)

* Mutually exclusive responses

Table 4.5: Means of prevention of Maternal Mortality (N=370)

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Women empowerment is one of the components of maternal health	No	%
Yes	340	91.9
No	30	8.1
Important of male in Involvement of MHC		
Yes	347	93.8
No	23	6.2
Area of male involvement on maternal care		
Assisting wife financially	101	27.3
Provision of household chores	236	63.8
Follow wife to ANC Visits	32	8.6
Educate wife on important of health care	1	0.3

To colloborate the above is the finding from the FGD wheremajority of participants in the FGDs sections agreed that abortion and prolong labour are pregnancy complications. The respondents were knowledge on the fact that excessive bleeding, lack of money/poverty and lack of family planning are causes of maternal mortality.However, some of the respondents strongly accepted the notions that believe in spiritual reasons (destiny to die) are causes of maternal mortality.They agreed that child spacing/ family planning, attendance of ANC and skilled attendants at birth are necessary for the prevention of maternal mortality. Some of the respondents remarked thus;

> *"A woman may die during labour if she loses plenty of blood". In addition lack of ANC attendance and home delivery without health worker's assistance can cause death or bring problem to pregnant women during child birth. (Civil Servant)*
>
> *"No matter how much you take care of a pregnant woman if she is destined to die she will die as witches and wizards could put hand on her pregnancy for her to die. (Chief)*
>
> *"Attending clinic every time can make pregnant woman deliver safely" (*Businessman*).*

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*"If only we allow our wives to go for family planning or allow her to rest enough it will prevent our women dying because of pregnancy or during child birth"(*Vulcanizer*).*

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4.4 Men's perceptions on maternal health care involvement

Emerging from the table below was the fact that respondents' perception on male involvement in maternal health care was high. Most (93.0%) of the respondents agreed that active male involvement in maternal health care will help improve maternal health and that men's attendance of ANC with wife will enlighten them on danger signs during their wives' pregnancy and delivery respectively. Little above three-quarter (79.5%) of the respondents were of the opinion that men should be involved in antenatal care of their wives and be at the bedside of their wife during delivery(59.7%). In the same vein, approximately 70.0% of the respondents agreedthat men should be involved in child spacing/family planning. However, 63.0% of respondents said that maternal health is basically women's affairs but nevertheless, women should be empowered to participate in decision making of the family (92.2%) (table 4.6)

The overall mean score for respondents'perception was drawn base on a 14 point scale, taken 75% of the overall score as a cut-off point for positive perception and it was found that few (11.9%) of the respondents have positve perception on maternal health care of their wives (table 4.6b).

Table 4.6a: Men's perceptions on maternal health care involvement

(N=370)

Variable	Agree (%)	Disagree (%)	Not Sure (%)
Active male involvement in maternal health will help improve maternal health	344(93.0)	13(3.5)	13(3.5)
Men attend ANC with wife are more educated on danger signs during pregnancy and delivery	344(93.0)	16(4.3)	10(2.7)
Men should be involved in antenatal care of wife	294(79.5)	52(14.1)	24(6.5)
Men should be at the bedside of their wife during delivery	221(59.7)	88(23.8)	60(16.2)
Men should be involved in Child spacing/family planning	260(70.3)	64(17.3)	46(12.4)
Maternal health is basically women's affairs	233(63.0)	107(28.9)	30(8.1)
Men should empower to participate in decision making of the family	341(92.2)	7(1.9)	22(5.9)

Table 4.6b: Overall mean score of respondents'perception on MHC

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Perception of MHC	No	%
Positive perception	44	11.9
Negative perception	326	88.1
Total	370	100.0

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4.5 Men support to wife during / after pregnancy

From the view of the respondents on the supports that should be given to their wives during / after pregnancy, almost all (98.6%) of the respondents were of the opinion that men should always encourage their wives to take adequate and required diet. Close to the same percentage (97%) of the respondents said that men should ensure that their wives taketheir daily routine drugs during pregnancy. Ninety-three percent of them said that men should be giving their wives supporting hand in household chores such as breaking firewood, sweeping the house and taking care of the children. Approximately (97.0%) of the respondents supported the view that men should be providing transportation for their wives when going for ante-natal clinic. Ninety-three of them agreed that husbands should support their wives for child spacing after deliverywhile 68.4% agreed that couples should go for family planning. Those who supported ensuring wife attending ANC care at least four times before delivery were (91.6%).

Table 4.7: Men support to wife during / after pregnancy (N=370)

Variable	Agree (%)	Disagree (%)	Not Sure (%)
Men should provide support to their wife by:	365(98.6)	4(1.1)	1(0.3)
a. Encouraging her to take adequate and required diet			
b. Ensuring she takes her daily drugs like fesolate & folic acid tablet	359(97.0)	5(1.4)	6(1.6)
c. Supporting her household chores such as helping her to break firewood, sweeping & taking care of older Children	344(93.0)	16(4.3)	8(2.2)
d. Providing transportation for her	357 (96.5)	8(2.2)	5(1.4)
e. Giving her support for Child spacing after delivery	344(93.0)	10(2.7)	16(4.3)
Men should decide when their wives will go for family planning	253(68.4)	49(13.2)	66(17.8)
Ensuring that wife attend ANC care at least four times before delivery	339(91.6)	25(6.8)	6(1.6)

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Participants in the FGD supported the idea of men's active involvement in maternal health care like accompanyingtheir wife to ANC and assisting in domestic work especially during pregnancy. However, some of the participants did not support or encourage men staying with their wives during labour as they claim it is basically women's affairs. Below are some participants'remarks:

> *"A man who attends ANC with wife and stay at bedside of wife during labour is said to be woman wrapper"*(a Carpenter).
>
> *"It is believed that issue concerning pregnancy and delivery are basically women's affairs in our locality"* (Driver).
>
> *"Attending ANC with wife and staying at bedside of wife during labour is good if only the society and the nurses/health workers allow them to do so"*(Driver).
>
> *"I don't think there is need to stay with my wife at the clinic because she will tell me whatever the nurses tell her to do / buy and I will buy them"* (Vulcanizer).
>
> *"Hajia, am I a woman that you expect me to attend ANC education with my wife? You want them to call me woman wrapper? I can give her transport fare". (A Farmer)*
>
> *"I have two wives and in order not to encourage jealousy between them, I will not follow any of them to ANC and will not stay by anyone of them at bed side during delivery"* (Farmer).
>
> *"Spiritually, I can't stand seeing blood during delivery. It will make me weak. So I send a woman like her to follow her to the clinic to deliver our baby". In our community, our culture don't allow that men should be seen in the clinic when women are there to deliver.*(A Community Chief).

Some of the discussants expressed their view in verbal statement such as:

> *"I give support to my wife by giving her transport fee to the clinic and make sure she takes her drugs (Teacher).*
>
> *"We do support our wives with house cores during pregnancy and after pregnancy to prevent abortion*"*(Bricklayer).*
>
> *"It is important to help wives when they are pregnant (Businessman).*

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From the above remarks, some of the discussants said that men should be supporting their wives and make provision for them to attend ANC, while in some cases they asked their relatives to help their wives to the clinic during labour. Nevertheless, somediscussants disapproved orthodox family planning.

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4.6 Role of Men in MHC

From the view of the respondents on supposed roles of men to their wives 67.0% of the respondents agreed to the fact that men are to attend ANC with wifeduring pregnancy and post-natal period.Close to this proportion 62.7% of the respondents declared that part of the role of men is to stay at bedside of wife during delivery to share the joy of arrival/birth of the baby (95.7%). Nevertheless, 89.2% of them preferred asking relatives to stay with wife during delivery. A large proportion (87.6%) of the respondents conceived that it is the role of men to ensure child spacing /family planning by involving themselves in using family planning method.Approximately 91.0% of the respondent said that men should see women empowerment as an essential role (table 4.7).

Table 4.8: Role of men in maternal health care

(N=370)

Supposed roles of men in MHC	Yes (%)	No (%)
To attend ANC with wife	250(67.6)	120(32.4)
Be at bedside of wife during delivery	323(62.7)	136(36.8)
Share the joy of arrival of the baby	354(95.7)	15(4.1)
Ask relatives to stay with wife during delivery	330(89.2)	39(10.5)
Ensure child spacingby using family planning	324(87.6)	45(12.2)
Empowerment of wife	336(90.8)	33(8.9)

Findings from the qualitative (FGDs) discussions supported the quantitative findings as majority of the participants declared that in all ramifications it is men's duty / role to take care of their wives whether under pregnancy or not, though most of these roles are assigned to female relatives. However, many, among younger participants,perceived women empowerment as important because their wives assist them in the care of the children and home generally.

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4.7 Respondents'involvement in maternal health care

This variable was considered awkward to most of the respondents, that is, the attendance of ANC with wife, his presence at bed side of wife during delivery and the follow up with wife for family planning. They saw it as women affair. However, some saw it as a worthy thing to do by men to reduce the woman's pain and maternal mortality. So men should be well educated on signs of dangers during pregnancy of wives and after.

Table 4.9 shows men participation in maternal health care. Less than half (32.7%) of the respondents said they accompanied their wife to ANC Care, 45.9% of them said they had sometimesstayed at the bedside of their wivesin the labour ward during delivery and51.9%of the respondents saidthat they followed their wivesto the clinic on family planning issue.

Table 4.9: Respondents'involvement in maternal healthcare

Practical Involvement	Yes (%)	No (%)
I accompany wife for antenatal	121(32.7)	249(67.3)
I was at the bedside of my wife during the delivery of our last baby	170(45.9)	199(53.8)
I follow my wife for family planning.	192(51.9)	178(48.1)
I support my wife during pregnancy and after delivery by helping her with some household chores e.g breaking of firewood and fetching of water	329(88.9)	41(11.1)
I always ensure that my wife had safe delivery by either a doctor or nurse/midwife attendant	368(99.5)	2(0.5)
I make sure she have regular medical check up	364(98.4)	5(1.4)
Buy fruits and vegetables for her to eat	363(98.1)	7(1.9)

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In addition, the FGD reports were in support of results from quantitative result as maternal health care issues were seen as women affairs. Below are some statements from the FGDs conducted;

> *"I am a businessman and my wife is a nurse. The time she had our last baby, she asked me to stay by her in the labour ward which I did. From what I experienced e.g. the pains she went through, I accorded her more respect and this makes me believe more on family planning." (Businessman)*
>
> *"I like to follow my wife during her delivery if only the nurses will allow me". (Civil Servant)*
> *"God almighty is the protector and the provider of all our needs. So I don't believe in family planning (Islamic Scholar)*

Generally, the respondents were asked if they practiced family planning, they were to also mention methods of family planning, meaning of HIV/Aids and how it is contracted. Most of them responded that they don't know. It was only very few participants that could mention two methods (Condoms and Injection) family planning. About two from the participants stated that HIV and AIDS is an infectious disease which has no cure.

A participant's view on family planning *"I and my wife space our children and not with the use of family planning".*

He was asked to know what he would do if the wife get pregnant within this period.

He said he will go out to meet another woman.

The researcher probed further to know what would happen if the woman get pregnant or the man contracted STI?He said,*"if she gets pregnant, he will ask her to abort it andif I contract STI, I will treat it without the partner and my wife knowing".*

Asked what he would do if the woman died because of abortion?

> He said*"the woman partner will not die but if she died, her family would take responsibility". (A Mechanic)*
>
> *"I know one or two types of family planning method which are pills and natural methods". (Driver)*

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4.8 Decision making process for family planning in the Family

This table shows respondent's decision making of the family as it concerns maternal health care accordingly. Majority (67.0%) of the respondents consented that decision on when the wife should get pregnant should be sealed by both husband and wife.In the same vein, 71.0% of the respondents said that both husband and wife should decide the number of children they want to have and place of delivery.

Two hundred and twenty (61%) of respondents agreed that both husband and wife should take decision on place of delivery when wife is pregnant. 88 (23.8%) said husband alone and 53 (14%) of respondents says only wife should take decision for place of her delivery.

Table 4.10: Decision Making process for family planning in the Family

(N=370)

Decisions	Husband (%)	Wife (%)	Both (%)	God (%)	Family (%)
When to get pregnant	87(23.5)	24(6.5)	246(67.0)	5(1.4)	0(0.0)
Number of Children	65(17.5)	34(9.1)	262(71.0)	7(1.9)	2(0.5)
Place of delivery	88(23.8)	53(14.3)	227(61.4)	2(0.5)	0(0.0)

Majority of discussants among the older men that participated in the qualitative (FGDs) conducted admitted that decision on when to get pregnant, number of children and place of delivery should be taken by both the husband and wife. However, many,especially among the youngFGD groups,stated that, since man is the head of the family, he should be the one to take decisions for the family.

> *"It is never done since the time of our forefathers, it is the man as the head of the family that takes decision on his family. The women are weak in nature, so their judgement are mostly not right"*-A young farmer

The issues relating to taking care of the children and household choreswomen should not be left out since they also have indispensable role to play.

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4.9 Decision taking in case of emergency care

This table shows decision taking in case of emergency care in the absence of husband. More than half (53.5%) of the respondents said that their wife usually go to their parents. 51.9%of the respondents said they expected their wives to use their discretion on what to do. 65.1% of the respondents did not support their wives going to her own parent to take decision for them while 51.4% did not like wives looking for relative before taking decision

Table 4.11: Decision taking in case of emergency care in absence of husband(N=370)

Decision taken during emergency	Yes (%)	No (%)
Go to husband's parent	198(53.5)	172(46.5)
Wait for the husband	83(22.4)	287(77.6)
Decide on her own	192(51.9)	178(48.1)
Go to her parent	129(34.9)	241(65.1)
Look for relatives	180(48.6)	190(51.4)

On a similar question raised in FGD sessions, most participants were in support of wives taking decision on their own to prevent maternal mortality or go to their (husband's) whom would have been informed about the state of their wives (as it was indicated in quantitative). Many of the participants said that if their wives could not take decision on their own, they should wait for them and not to go to their (wives) own parents while leaving their husbands' parents out.

> *"Is the world coming to an end, so the women are now more sensible to take decision on their own? If I am away from home and my pregnant wife is in labour/one problem or the other, she must report to my family to take the rightful decision because I would have told them to take care of my family in my absence".(Trader)*

> *"Not in this GSM era. If anything is wrong, my wife will call me immediately and even then she knows what to do as she does not have to wait for my arrival or see my parents before she report to the hospital. Everybody want to see mother and child survive and healthy". (Civil Servant)*

> *"My wife can take decision on her own because in this our time, things happen fast. A friend of my brother lost his wife because of delay to go to the hospital when she was bleeding and waiting for relatives because she had no money". (Teacher)*

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4.10 Hindrances to involvement of men in maternal health care

Among hindrances to men's involvement to maternal health care enumerated by the respondents included: Inadequate knowledge on maternal health careby men (95.4%); financial constraints(95.7%); inadequate health facility(91.9%); long waiting period before accessing care(87.3%) and health worker's negative attitude(82.7%).

Table 4.12: Hindrances to involvement of men in maternal health care

(N=370)

Hindrances	Yes (%)	No (%)
Inadequate knowledge on maternal health care	353(95.4)	17(4.6)
Financial constraints	354(95.7)	16(4.3)
Inadequate health facilities	340(91.9)	30(8.1)
Long waiting period before obtaining care	323(87.3)	47(12.7)
Health worker's attitude	306(82.7)	64(17.3)

Mutually exclusive responses

In addition to the quantitative result, the qualitative (FGD's) discussants in the young participants group, outlinedinadequate knowledge, poverty or lack of fund, unfriendly attitude of health workers, and insufficiency of health workers as men's hindrances to their involvement in ANC for their wives. Some discussants' remarks are quoted verbatim below:

> *"Our Cultures have made us not to appreciate the need for our involvement and to physically help our wives during and after pregnancy. This limits men in knowledge on what to do to improve maternal health and to reduce maternal death.Husbands who assist their wives during pregnancy are called women wrapper - Farmer.*

> *"Money is very important in all we do in the society. Lack of it make men not to go to the clinic. So we patronize traditional birth attendants and traditional healers when our wives are pregnant and after pregnancy as it is cheaper"-Islamic Scholar.*

> *"The clinic is far away from my village, the road is bad and this makes it difficult for me and so many others to take our wives and children to the clinic.And also there are no*

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enough skilled health workers in some of these clinics" - Applicant.

"The attitude of the health workers scare people away from the clinic. They don't answer people's questions directly and they are always frowning at us" -TraditionalSinger.

"The health workers delay us so much as we form long queues for hours without any service to us. One may go to the health centre in the morning and comes back home in the evening and this disturbs our work. This prevents our boss from releasingus any other time to attend clinic with my wife and children" -Teacher.

"Some women are the barriers to men involvement in MHC as they don't want their husband to attend ANC with them talk less of their husband staying with them at the clinic during child birth" – A Community Traditional Chief.

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4.11 Factors Motivating men's involvement in maternal health care

In an attempt to answer questions on factors that can motivate men involvement in maternal health care, almost all (96.8%) of the respondentsagreed that organizing public health education for men will motivate men to be involved in maternal health care of their wives. 97%of the respondents established that good communication between husband and wife will help a lot in motivating men involvement in MHC. 94.6% of the respondents said that husbands earning regular financial income will be of great assistance. A higher percentage (87.39) of respondents remarked that the provision of adequate health facilities will serve as motivating factors for men's involvement in maternal health care while 86.8% (321 respondents) cited health workers' friendly attitude for same purpose (motivating men's involvement in maternal health care.

Table 4.13: Factors Motivating men's involvement in maternal health care

(N=370)

Factors	**Yes (%)**	**No (%)**
Public health education	358(96.8)	12(3.2)
Good communication between husband and wife	359(97.0)	11(3.0)
Husband regular financial income	350(94.6)	19(5.1)
Adequate health facilities	323(87.3)	45(12.2)
Health worker's friendly attitude	321(86.8)	47(12.7)

Mutually exclusive responses

The FGD findingswere in consonant with quantitative results.From all the FGD's sessions, respondents stated the need of increasing male's knowledge and participation and improvement of communication between couples as factors for male involvement and participation in maternal health care. Some respondents urged Government to build more well equipped clinics in various communities and increase number of skilled health workers to decrease waiting hours of clients at the clinic. Majority of the respondents said that the most important thing that will assist women is improvement in men's income and the building health workers capacity for attitudinal change to clients / patients.

Below are some comments by participants:

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“Educate the traditional rulers and religious leaders to educate their men on care of their wives during and after pregnancy and remove any cultural perception that can prevent the active participation of male in MHC”-Civil Servant.

“It is good if our roads are taken care of to make it easy to get to the clinic to prevent delays and death of women in labour” - Businessman.

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4.12 Test of Hypotheses

Hypothesis 1

Ho: There is no significant association between respondents' level of education and knowledge of maternal health care

4.13 Association between respondents' level of education and knowledge of maternal health care

The result from the table showing the association between respondents' level of education and knowledge of maternal health care revealed that there was significant association between the two variables ($p<0.05$).This was also shown in the frequency table as those who had tertiary education had (48,8%) more knowledge and exposure to maternal health care than their counterparts meaning that, as level of education increases, the knowledge about maternal health care increases among the respondents(Table 4.14).

Table 4.14: Association between respondents' level of education and knowledge of maternal health care

Educational status	**Knowledge of maternal health care**			Chi Square
	Poor	**Good**	**Total**	
No Formal Education	113 (47.7)	36 (24.2)	149 (100.0)	
Primary Education	35 (14.8)	25 (41.7)	60 (100.0)	χ^2 =16.345
Secondary Education	48 (20.3)	33 (40.7)	81 (100.0)	DF = 3
Tertiary Education	41 (17.3)	39 (48.8)	80 (100.0)	p = 0.001
Total	237 (64.1)	133 (35.9)	370 (100.0)	

Decision:

Based on the result shown in table 4.12, the null hypothesis, which stated that there is no significant association between respondents' level of education and knowledge of maternal health care is therefore not accepted.

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Hypothesis 2

Ho: There is no significant association between respondent's type of marriage and perception of Maternal Health Care.

4.14 Association between respondent's type of marriage and perception of Maternal Health Care

Respondents'perception on maternal health care was tested with their type of marriage and it was found that there was no significant association with respondents' type of marriage and perception on maternal health care ($p>0.05$)(Table 4.15).

Table 4.15: Association between respondents' type of marriage and perceptions of maternal health care

Type of marriage	Perception level			Chi Square
	Negative	**Positive**	**Total**	
Monogamy	54 (14.7)	313 (85.3)	367 (100.0)	χ^2
Polygamy	1 (33.3)	2 (66.7)	3 (100.0)	DF = 1
Total	55 (14.9)	315 (85.1)	370 (100.0)	p = 0.367

Decision:

Based on the chi-square result shown in table 4.13, the null hypothesis, which stated that there is no association between respondent's type of marriage and perception of MHC is therefore accepted.

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Hypothesis 3

Ho: There is no significant association between respondent's occupation and participation on maternal health care

4.15 Association between respondent's types of occupation and involvement of male in maternal health care

Respondents' involvement of male in maternal health care was notstatistically significant to the types of occupation they were into ($p>0.005$) (Table 4.14).

Fisher exact test was used because of those variables with cell count less than 5.

Table 4.16: Association between respondent's occupation and participation in maternal health care

Occupation	Participation in maternal health care			Chi Square
	Yes(%) (n=347)	No(%) (n=23)	Total (N=370)	
Civil Servant	134(38.6)	7(30.4)	141(38.1)	χ^2 =4.056 Fisher exact test: P = 0.577[b]
Private Sector Worker (such as construction worker)	19(5.5)	0(0.0)	19(5.1)	
Farmer	132(38.0)	11(47.8)	143(38.6)	
Teacher	9(2.6)	1(4.3)	10(2.7)	
Others (Unemployed, Politician, Retirees)	14(4.0)	2(8.7)	16(4.3)	
Trading	27(7.8)	2(8.7)	29(7.8)	
Artisan	12(3.5)	0(0.0)	12(3.2)	

Decision:

Based on the chi-square result shown in table 4.14, the null hypothesis, which stated that there is no association between respondent's types of occupation and involvement of male in maternal health care is therefore accepted.

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CHAPTER FIVE

DISCUSSION, CONCLUSION, SUMMARY AND RECOMMENDATIONS

5.1 Discussion

This study assessed hindrance to male involvement in maternal health care in Kwali Area Council of Federal Capital Territory (FCT), Abuja, Nigeria. The implications of these behaviours for health planning are discussed in this chapter. This leads to recommendations to address the problem. The main issues discussed are grouped into nine: socio-demographic information, awareness on maternal health care, prevention of maternal mortality, male's perceptions on maternal health care involvement, males' support to wives during and after pregnancy, role of male involvement in MHC, respondents'involvement in maternal health care, decision making in the family, hindrances to involvement of male in maternal health care, and factors motivating male's involvement in maternal health care.

5.1.1 Socio-demographic information of the respondents

Many of the respondents whose ages ranged between 30-39 years old had better understanding about involving themselves in maternal health care and supporting their women in reproductive health related issues.They do not see it and not seeing it as gender role or responsibility was supported by studyconducted by Babalola and Adesegun (2009).

The fact that large proportion of the Gbagi ethnic group participated in the study was as a result of the site of the study (Kwali Local Government Area) which is situated at the centre of the sphere of Gbagis.A large proportion of respondents that has no formal education in this study survey showed that level of educational attainment is related to occupation of the respondents as many of them were farmers and traders.Those who were Civil Servants among them were of low cadres in their offices. Almost all of the respondents claimed being in monogamous marriage.This could be traced to their socio-cultural background as most Gbagis are Christians (table 4.1 &figure 4.3). This socio-cultural background of the respondents was also reflected in their contribution to household needs as it was compared with type of marriage of which majority of the

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respondents who were into monogamous marriage contributed to their household needs better than their counterparts who were into polygamous marriage.

5.1.2 Respondents' awareness on maternal health care

Greater proportion of the respondents that affirmed their awareness of maternal health care in this study was in contrast to the study by Kululanga, et.al., (2011) conducted on male involvement in maternal health care in Malawi (Nanjala and Wamalwa, 2011) in determinants of male partner involvement in promoting deliveries byskilled attendants in Busia, Kenya as well as that of Mullany *et al* (2006). ButWHO, in a randomised controlledtrial conducted in urban Nepal, established that educating mothers and spouses to understand the complications ofpregnancy and child birth led to an increased uptake of maternal and child health services.

Nearly all the respondents who have knowledge of prolong labour as a pregnancy complication in this study opposed the findings of Nanjala and Wamalwa, (2011) as majority of male partners exhibited very low knowledge regarding complications that are associated withpregnancy and delivery in their study.

5.1.3 Prevention of Maternal Mortality

The awareness or knowledge on prevention of maternal mortalitywas found among the respondents in this study.This result was in support of the findings of the study conducted by Kabwigu, (2001) on obstacles to maleparticipation in family planning among men of Kiyeyi - Tororo of Uganda as many of the participants concured on knowledge of child spacing/family planning as a way to prevent maternal mortality. In the same vein, almost all of the respondents affirmed that expecting mothers early and regular attendance of ANC will prevent maternal mortality.This finding was in consonant with the assertion byArulogun, (2010) and WHO, WARDC, (2008) that women who begin ANC early in their pregnancies have better birth outcome than women who receive little or no care during pregnancy and that prenatal care or ante natal care encompasses more than just health care. It includes education and counseling of husband and wife about how to handle different aspects of pregnancy(Ronsmans, 2003 and Arulogun, 2010). Such health education benefits at ANC were highlighted by the respondents in this study, which

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included meeting with skilled attendant at birth; taking enough rest during pregnancy;women empowerment importance of male involvement in household chores as well as his financial support to wife for maternal health care (MHC).

5.1.4 Men's perceptions on maternal health care involvement

The disposition of most respondents in this study to their active involvement in maternal health as a key to help improving maternal health and men attend ANC with their wife during pregnancy and delivery respectively as link with their knowledge about causes of maternal mortality and importance of preventive measure which is the main focus of maternal health care. This respondents' assertion was in support of USAID report that "Reducing maternal deaths by 75 percent throughout the world by 2015 will take the involvement of men in countries where it matters most" (USAID, 2010). Contrary opinion of men in this study about presumption that maternal health is basically women's affairs but nevertheless, that women should be empowered to participate in decision making of the family supported findings by Nantamu, (2011);Kabwigu (2001) and (Nepal Demographic and Health Survey, 2001).

5.1.5 Role of Male in MHC

The majority of the respondents'affirmation that men's attendance of ANC with their wives during pregnancy and post-natal period as part of the roles of men for ANC to their wives at home is a positive indicator of better understanding of the on-going maternal health care campgain. This study's result butressed the assertion that women were more likely to have better outcomes on child birth when their husbands got directly involved in maternal health care by attending ANC and supporting their wives during pregnancy (Kabakyenga et al.,2012; Story et al., 2012). Studies in South Asia have also found that women whose husbands show concern in pregnancy are more likely to utilize reproductive health services positively (Mpembeni et.al. 2007). Further, some studies have shown that, when men know the danger signs of pregnancy and delivery, they may act as life-saving agents, ensuring that their wives get appropriate attention in obstetric emergencies (Rahman et.al., 2011;Chowdhury et.al., 2007). The agreement by a large proportion of the respondents that it is the role of men to ensure child spacing /family planning by involving themselves in using family planning method and that men should

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see women empowerment in good stead colloborate d with the findings by Nantamu, (2011)and Kabwigu (2001) (table 4.7).

5.1.6 Respondents'involvement in maternal health care

The FGD's findings on this issue confirms the socio-cultural influence on male involvement on MHC was in agreement with the perception of participants in previuos studies such as conducted in Kenya that showed that certain male clients trust traditional healers but not hospitals and therefore do not attend ANC clinics (Reece, et.al., 2010). Several studies have also reported negative perceptions towards men attending ANC services. In one report, men who accompanied their wives to ANC services were regarded as weakling and being dominated by their wives. Respondents in this category of thoughts perceive that ANCs services are designed and reserved for women amd would consider it embarrassing to find themselves in such "female" places (Byamugisha, et.al., 2010; Mlay, Lugina and Becker, 2008; Msuya, 2006). Some women too did not like being seen with their male partner attending the ANC service especially on the issue of family planning up-take(Reece, et.al., 2010;Mlay, 2008) as it was reported in this study (table 4.9).

5.1.7 Decision Making in the Family

Majority of the respondents consent that decision on when wives should get pregnant should be sealed by both husband and wife as well as in number of children they want to have and place of delivery in this study colloborate with the report form Kak (2010); UNFPA, 2005 and WHO (2001)that joint decisions positively influence the well-being and prospects of the whole familyinstead of husbands only to make decisions about family planning, their wives economic activities and use of household resources, including, doctors and schools fees.

5.1.8 Decision taking in case of emergency care in the absence of the husband

The findings on decision taking in case of emergency care in the absence of the husbandrevealed the average respondents acceptance of authority of their parents, relation or extended family to make decision over their family maternal affair.This connote the negative influence that culure has on maternal health of the women in our

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society. Thus, as many sstudies have shown,‘many women have lost their live and that of their babies in pregnancy-related conditions, while awaiting a decision to be taken by such gatekeepers” (FMOH, 2007; Lucas and Gills 2003 and Odeimegwu, 2005).In the same vein, majority of the respondents would frown at wives who would go to her own parent to take decision for them on many matters. Communication and decision-making plays vital role in assuring informed choice of family planning and reproductive health (MCH) behaviour (Oladeji, 2008). Effective communication and decision-making by both party is best for their health – (Rima, 2002).

5.1.9 Hindrances to involvement of men in maternal health care

Among hindrances to men’s involvement to maternal health care that were enumerated by the respondentsin this study were in line with the findings of many previous studies conducted around the world. Such hindrances itemised in this study were to butress the previous findings.Respondents who said inadequate knowledge on maternal health care of men as hinderance to their involvement was similar to Nantamu, (2011) who claimed that “Men who attended ANC with their partners in his study did not have a significantly higher level of knowledge on maternal health care services compared to men who did not attend ANC with their partners’.The low educational level of some of the respondents was found to be significant reason why too few men escort their wives for ANC. The finding of this study is similar to findings in the studies carried out in Omoro County (Uganda) and in Kenya .In Kenya, un-educated men were found to be less likely to participate in reproductive health. The study in Omoro County revealed that educated men were positively associated with male participation in ANC (Tweheyo, 2009). Studies suggest that uneducated men tend to hold on to traditional belief which greatly impair inter spousal communication leading to low male involvement in reproductive health (Nzioka, 2001).

Financial constraint of respondents was also part of the hinderance of male involvement in MHC. It was found in this study that demand for money by some health workers before rendering services and lack of drugs supplies in the government health facilities, were the reasons some respondents give for not escorting the wivesto clinics for ANC. Ruhweza and others (2009) reported similar findings of household paying for health care

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in Jinja district, Uganda. The same study also reported that health workers told their clients who came for care in the government health facilities that there were no drugs at the health facility but on making payment, drugs suddenly became available (Ruhweza et al 2009). Thus, poverty is found to be a major bottleneck hindering men from accompanying their partner for fear of being embarrassed in case they fail to pay the health workers in accordance to demand. This could be subject to socio-economic status of the majority in this study as there were more famers and traders among the participants.

Inadequate health facility perceived as hinderance to ANC in this study colloborate d with Kululanga (2012). Long waiting period before accessing care complained of by the majority of respondents in this study was in consonant withTweheyo, (2009) and Mullick et al, (2005) which was also in agreement with findings from several studies that have reported long waiting time at the health facility as being one of the reasons for low number of male accompanying their partners for maternal health services.

The finding of this study colloborate s with the studies that have shown that distances traveled are indirectly associated with utilization of health services (Muki, 2009;Eijk Bles, Odhiambo, Ayisi, Bloklandet al, 2006).At the sametime, finding in this study is in agreement with the finding of a study done in Budondo sub county Jinja district that revealed that when services are near, men stop accompanying their wives to seek care (MFPED, 2002). This is most likely because most men view the provision of transport (which in most cases require riding a bicycle) for the wife to the health facility as the major reason for escorting the wife to the health unit.Yet this ceases to be the case when the health facility is within a walking distance. The finding of this study suggests that if we do not sensitize the community on the benefits of the man accompanying the wife during ANC then the intended benefit of bringing services near to the people will not achieve all its intended objectives of reducing maternal morbidity and mortality.

According to this study, poor attitude of health workers and fear of being harassed by health workers were some of the reasons contributing to low male involvement (more to FGD report). The finding of this study is consistent with other studies in Kenya where

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poor behaviour of service providers have been found to adversely affect male partner's capacity to use reproductive health services (Alka et al, 2005; Fapohunda and Rutenberg 1999). This is probably because men fear being the subject of verbal and emotional redicule, sometimes physical abuse and this prevent men from being involved (Breiding-Buss, 2002).

5.1.10 Factors Motivating men's involvement in maternal health care

Many of the facotors considered as hinderances in this study were also addressed as the motivational facotors that can propel men's involvement in maternal health care if they were to be positively handled and made as strategies to improve males involvement in MHC and as well stand as means to ameliorate maternal mortality. Other instances like level of education, good communication between husban and wife, husbands earning regular financial income and health worker's friendly attitude were observed as contributing positively to male involvement in ANC in the studies conducted by Reece, Hollub, Nangami and Lane, (2010); Nkuoh, Meyer, Tih, Nkfusai, (2010); Msuya, Mbizvo, Hussain, Uriyo, Sam and Stray-Pedersen, (2008

5.1.11 Association between respondents' level of education and knowledge of maternal health care

The result of the comparison between respondents' level of education and knowledge of maternal health care in this study that revealed statistical association is in agreement with the findings conducted in study in Uganda where men who had completed 8 or more years of education were twice more often involved in maternal health care of their wives compared with those with less than 8 years of education (OR =1.9; 95% CI: 1.1-3.3; $p \leq 0.05$) (Byamugisha, Tumwine, Semiyaga and Tylleskär, 2010). This was not confirmed in the study conducted in Kinshasa where the level of education of pregnant women or their male partner did not influence male participation (Ditekemena, Matendo, Koole, Colebunders, Kashamuka, Tshefu, Kilese, Nanlele and Ryder, 2011)(Table 4.14).

5.2 Conclusion

It can be deduced from this study's finding that the participants have inadequate knowledge and awareness in their involvement in maternal health care. The men

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themselves admitted that they lacked adequate knowledge because their partners did not tell them what they learnt from the clinics. The participants felt it was important to close the gaps in knowledge sharing on ANC by being informed adequately in most aspects of maternal health care. However many respondents still harbor reservations about being present during the delivery by their wives. This is derived from the fact that the socio-demographic profile of the participants reveal that a majority of the participants were aged 20 years and above, with low level of education, poor and gender biased due to cultural perception on male/female relationship.

Abortion is illegal in Nigeria.However more people still carried out abortion more than expected and is associated with maternal deaths. As such community family planning education must be more widely carried out and not only provision of clinic based family planning services and women should be empowered to use reproductive health facilities.
At the grassroots during the Focus Group Discussion (FGD) discussions have shown that participants perceived nurses/health workers as in friendly set of people thus leading most women to patronize the TBAs and churches for their deliveries and also promoting home delivery. The men were of the opinion that something must be done about this.
In this study, it is noted that developing countries, Nigeria inclusive may not meet the UNMDGs if innovative and effective intervention are not found, tried and evaluated.

5.3 Implications for reproductive health and education

The findings of this study have implications for reproductive health education intervention. The outcomes of this study shows that interventions aimed at State-of-the-art strategies are needed to provide support and counseling in order to reduce levels of maternal mortality through systematic involvement of male spouses. Improvement in each sector and good practices in these identified areas will greatly assist in giving health intervention for both men and women at home: (i) law and policies; (ii) institutional reforms; (iii) community-level interventions; and (iv) individual behaviour change strategies. With this, (i) it is essential to focus on the male involvement in prevention of maternal and child mortality, not just on services for its survivors; (ii) prevention is best achieved by empowering women and reducing gender disparities, and by changing norms and attitudes which foster predisposing factors to women morbidity and mortality; and

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(iii) interventions should employ a multi-sectoral approach and work at different levels: individual, community, institutional, and laws and policies. Non involvement of men in maternal health may be common in Nigeria as a whole, but there are promising approaches available to begin working toward its elimination.

The data generated called for usefulness of practitioners and in guiding policymakers on the regulation of activities in the informal sector. The result also suggests that little could be achieved in reducing maternal morbidity and mortality without significant changes in the Nigerian culture and beliefs. Beliefs such as the claim that men have right over their wives behaviours, male child preference, women not having rights to challenge their husbands' actions, using violence to control a nagging wife and undermining women's autonomy should be changed. To actualize this there should be link between the health educators/health workers and the mass media where programmes on male involvement in maternal healthare addressed.

5.4 Recommendations

The recommendations made based on the findings in this study are as follows:

1. In expanding men's role, the traditional rulers and religious leaders should be made aware of cultural barriers that hinder male involvement in maternal health care issues (ANC, Delivery and family planning, for example the belief that pregnancy is a "woman's affair" should be discarded and advocate for their removal.
2. There is need for orientation / training of Nurses / Health Workers from time to time to accommodate male active involvement and participation in ANC sessions during delivery by the wife and be involved in family planning services.
3. Political office holders and policy makers should make policy and enact laws that encourage male involvement in maternal health care.
4. Orientation programme for health workers on positive attitudinal change is madeto increase patronage of reproductive health services by both men and their wives.

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5. Adequate health facilities that promote maternal and child health care should be put in place by the Government especially in rural and sub-urban areas and this should be highly accessible and affordable to low income earners.
6. Structural adjustment should be made at the labour room that will provide privacy to couples.
7. Public health education programme that centred on good communication between husband and wife and husband regular financial income should be constantly organized at grassroot level to assist men in understanding challenges that confronted women labour and child raising, facilitated through government resources for easy accessibility.
8. The secondary and tertiary schools syllabus should include issues on male involvement in maternal health care to improve maternal health and reduce maternal mortality.

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REFERENCES

Aarnio P, Olsson P, Chimbiri A, Kulmala T (2009). Male involvement in antenatal HIV counseling and testing: exploring men's perceptions in rural Malawi. AIDS Care: Psychological and Socio-medical Aspects of AIDS/HIV. 21: 1537-1546. Accessed on 12-06-2010 at www.popcouncil.org/frontier/frontiersfinalrpts.html

Abdul-Aziz I. (2008): Africa: Little Progress on Maternal Mortality.Source: http/allafrica.com/stories/200807310015.html Retrived on Tuesday, July 22, 2014.

Adamu Y.M. and Salihu H.M. (2002): Barriers to use of antenatal and Onstetric Care services in rural Kano, Nigeria. Jobstet Gynarcol. 22 (6): 600-3

Adeyemi A. (2010): Safe Abortion, Baseline Assessment Report of the PPFA – 1. Benue and Nasarawa States, Nigeria

Adeyemi, E.O. (2009): Socio-Economic differentials in Health Care: Implications for Maternal Mortality in Nigeria.Department of Sociology, Lagos State University, Ojo, Lagos State.Source: Paa 2009. Pinceton.edu/download.aspx

Allen Kabagenyi, Larissa Jennings, Alice Reid, Gorette Nalwadda, James Ntozi and Lynn Atuyambe, 2014. Barriers to male involvement in contraceptive uptake and reproductive health services: a qualitative study of men and women's perceptions in two rural districts in Uganda; *Reproductive Health* 2014, 11:21 doi:10.1186/1742-4755-11-21: The electronic version of this article is the complete one and can be found online at:http://www.reproductive-health-journal.com/content/11/1/21

Alva Soumya, 2012. Gender Attitudes and Male Involvement in Maternal Health Care in Rwanda.ICF Macro. Email: salva@icfi.com Abstract prepared for submission to the Annual meetings of the Population Association of America, San Francisco, May 2012.pp.2-5

Armin R. (2010) Empowering women to slash mother and child deaths.Eastern Mediterranean: Health Journal Vol. 13. No. 6

Arulogun. O. (2010): Educational Issues in Pregnancy and Women's Health: A lecture note. Department of Health Promotion and Education. Faculty of Public Health, College of Medicine, University of Ibadan, Ibadan; p.2-4

Aziz H. (2010); Improving Women Health, Future Generations, Traveled, Frontline, WV 26807/t: (304) 358-2000 Source: info@future.org.

Aziz H., (2010): The training of a local woman as a community statistician to help communities monitor their progress.Source: info@future.org.

Babalola, S., & Adesegun, F. (2009). Determinants of use of maternal health services in Nigeria - looking beyond individual and household factors BMC Pregnancy and Childbirth, 9 (43), 2393-2943.

Becker. S. (2009): Couples and Reproductive Health. Johns Hopkins University.beyond individual and household factors *BMC Pregnancy and Childbirth*, *9*(43), 2393-2943.

Blake M, Babalola S: Impact of a male motivation campaign on family planning ideation and practice in Guinea. In *Field Report No.13*.Baltimore, MD: Johns Hopkins University Bloomberg School of Public Health, Center for Communication Programs; 2002; p11-21. Retrieved from RL: http://pdf.usaid.gov/pdf_docs/PNACS563.pdf *webcite* 22/07/2014.

Blanc AK. (2001): The effect of power in sexual relationships on sexual and reproductive health: An examination of the evidence. Studies in Family Planning 32(3):189-213.

Bronte – Tinkew J, and Horowitz A. (2007), Men's Pregnancy Interventions and Prenatal Behaviours. What they mean for fathers' involvement with their children Source: www.childtrends.orgAccessed on 22/07/2014

Brown S. (2009): Maternal and newborn health, 62nd session of the World Health Assembly (WHA), Geneva, Switzerland.

Byamugisha R, Tumwine JK, Semiyaga N, Tylleskär T (2010): Determinants of male involvement in the prevention of mother-to-child transmission of HIV programme in Eastern Uganda: a cross-sectional survey;*Reprod Health* 2010, **7:**12.

Carroli G, Rooney C, Villar J: How effective is antenatal care in preventing maternal mortality and serious morbidity? An overview of the evidence.*Pediatric and Perinatal Epidemiology* 2001, 15(Suppl. 1):1-42.

Cheng (2009); Normal Labour and delivery: Departments of obstetrics, Gynaecology and Reproductive Science, University of California.

Chowdhury, R.I., M.A. Islam, J. Gulshan, and N. Chakraborty. (2007); Delivery Complications and Healthcare-Seeking Behaviour : The Bangladesh Demographic and Health Survey, 1999-2000. *Health & Social Care in the Community* 15(3): 254-264.

UNIVERSITY OF IBADAN

Consultative Council on Obstetric & Paediatric Mortality & Morbidity (CCOPMM); CCOPMM Stillbirth Sub-committee recommendations; Data & research request form updated 4 May 2012: VPDC Bulletin: Issue 5: Assessed on 21/08/2014

Davie M and Bath P. (2001) "The Maternal Information Concerns of Somali women in the United Kingdom" (S. 237 – 245) I Journal of Advance Nursing. Vol. 36, nr 2.

Ditekemena J, Matendo R, Koole O, Colebunders R, Kashamuka M, Tshefu A, Kilese N, Nanlele D, Ryder R, (2011): Male partner voluntary counselling and testing associated with the antenatal services in Kinshasa, Democratic Republic of Congo: a randomized controlled trial.*Int J STD AIDS* 2011, 22(3)**:**165-170.

Draper J. Whose welfare in the labour room (2005): A discussion of the increasing trend of fathers' birth attendance. Midwifery 1997; 13(3):132-138.

Drennan M. (2003), Reproductive Health, New Perspectives on Men Participation Population Reports Series J. No. 46 Baltimore: John Hopkins School of Public Health Population Information Program: 7-8.

Dudgeon, M and Inhorn, M (2004) Men's influence on women's reproductive health, medical anthropological perspectives" Social Science & Medicine 59: 1379-1395.

Eijk, Van A., Bles, H., Odhiambo, F., Ayisi, J., Blokland, I., Rosen, D., et al. (2006). Use of antenatal services and delivery care among women in rural western Kenya: A community based survey.Reproductive Health, 3,2.

Farquhar C, Kiarie JN, Richardson BA, Kabura MN, John FN, Nduati RW. et al., (2004). Antenatal Couple Counseling Increases Uptake of Interventions to Prevent HIV-1 Transmission. Journal of Acquired Immune Deficiency Syndromes. 2004;37(5):1620–1626. doi: 10.1097/00126334-200412150-00016.

FMOH (2004): A Survey of Maternal Health and Indices in Nigeria. Abuja, Nigeria.

FMOH (2005): Men's Role during Pregnancy and after Delivery. Training Manual for Community – Based Reproductive Health Promoters.

FMOH (2005): Safe Motherhood in Nigeria.Patterns of Household Practices. In Federal Ministry of Health

FMOH (2008): Focused Antenatal Care (FANC): An orientation package for Health Care Providers. Participants' Version.

FMOH, (2005): Training Manual for Community Based Reproductive Health Promoters. Publication: the Vision Project, distributed by COMPASS.

UNIVERSITY OF IBADAN

FMOH, (2007): Nation Policy on the Health and Development of Adolescents and Young People in Nigeria.

FMOH, (2008): A Guide for essential Practices for the family planning provider.

Franklin T. (2010); Women Improving Health Future Generations. WV26807/t: (304) 358-2000. Source: info@future.orgAccessed on 22/07/2014.

Galadan Shehu. H and Ibrahim S. (2009): Childbirth Across Cultures. Childbirth in Nigeria.

Galadanchi H.S. (2009) Maternal Health in Northern Nigeria a far cry from ideal BLOG 114:44-52.

Government Office of Sweden (2011): Parental Leave Act, SF S, 1995:584. 1995:584. 1995. 24-5-1995. Retrived from http://www.sweden.gov.se/sb/d/5807/a/104 985.

Green A. and Gein N. (2005): Exclusion, inequality and Health System Development: the critical emphases for maternal and child health Bulletin of the World Health Organization Vol. 83 P6 Source: http://www.who.int/bulletin

Greene Margaret E., Mehta Manisha, Pulerwitz Julie, Wulf Deirdre, Bankole Akinrinola and Singh Susheela, 2007. Involving Men in Reproductive Health: Contributions to Development; Background paper to the report Public Choices, Private Decisions: Sexual and Reproductive Health and the Millennium Development Goals.Millennium Project; p.4.

Greene, Margaret E., and Ann E. Biddlecom. 2000. “Absent and Problematic Men: Demographic Accounts of Male Reproductive Roles.” Population and Development Review26(1): 81-115; Jacobson, Jodi. 2000.

Gribble and Haffey, (2008): Reproductive Health in Sub-Saharan Africa. Maternal Mortality Source: UNAIDS/WHO, Report on the Global HIV/AIDS Epidemic. www.prb.org/pdf08/reproductivehealth_subsaharanafrica Accessed on 22/07/2014.

Gyimah S.O., (2006): Challenges to the reproductive Health needs of African Woman: On religion and Maternal Health Utilization in Ghana. Social Science and Medicine, Jun; 62(12): 2930-2944.

Healthy People 2010, Maternal, Infant, and Child Health, Centers for Disease Control and Prevention. p1-2. http://www.healthypeople.gov/ Retrived: 22/07/14.

Henry V. (2011): Northern Nigeria Maternal, Newborn and Child Health Programme.Ahmadu Bello University.Department of Community Medicine, Zaria, Nigeria. Source: The Open Demography Journal, Volume 4, Pp. 11-21

UNIVERSITY OF IBADAN

Horstman R. (2004): Role of husbands in maternal healthin Morang district, Nepal. In: Gender and the role of men in reproductive health. Netherlands Interdisciplinary Demographic Institute. Pg. 39-58.

Ibeh; (2008); Is Poor Maternal Mortality a problem of care utilization?African Journal Reproductive Health Vol. 12, No. 2.

Institute of Medicine (2002): The future of public health in the 21st century. Washington, D.C.: The National Academies Press. 105.

International Labour Organization (2005): Modern daddy: Norway's progressive policy on paternity leave. World of Work Magazine 54, 1-52. Geneva, Switzerland. Retrieved from http://www.ilo.org/wow/Articles/langen/WCMS_081359/index.htm Accessed on 22/07/2014 .

Isiugo-Abanihe, (2003) Male Role and Responsibility in Fertility and Reproductive Health in Nigeria by the Centre for Population Activities and Education for Development (CEPAED).B9 GAAF Building, 110 and 112 Oyo Road, Ibadan.Pp.89-71.

Izugbana C., Ibisomi, Ezeh. A.C. (2010): Women and High Fertility in Islamic Northern Nigeria.Journal of Family-jfprhc.com volume 4, Issue 3, Pages 193-2041.

Kabakyenga, J.K., P.O. Östergren, E. Turyakira, and K.O. Pettersson. (2012): Influence of Birth Preparedness, Decision-Making on Location of Birth and Assistance by Skilled Birth Attendants among Women in South-Western Uganda. *PloS ONE*7(4): e35747.

Kak, (2010): Men Key to Reducing Maternal Deaths in Developing Countries.Published by the Bureau for Legislative and Public Affairs, U.S. Agency for International Development, p5.

Kendall D. (2008): Sociology in Our Times: The Essentials. 7th edition ed. Belmont, CA, USA: Wadsworth, Cengage Learning.

Khana (2000): Challenges and Opportunities for Male Involvement in Reproductive Health in Cambodia.Produced by the United State Agency for International Development (USAID) 35-39.

Kinanee JB, Ezekiel-Hart J: Men as partners in maternal health: Implications for reproductive health counselling in Rivers State, Nigeria.*Journal of Psychology and Counseling* 2009, 1:039-044.

Konan, E.R., (2010). "Epidemiology of Adiposity in Childbearing Ghanaian W omen" Public Health Theses. Paper 138; p.16

KululangaL.I., SundbyJ., MalataA. and Ellen C., (2012): Male Involvement in Maternal Health Care in Malawi; African Journal of Reproductive Health 16(1).

UNIVERSITY OF IBADAN

Ladipo (2010): Delivery of an Effective Maternal and Child Health Services in Nigeria.Source: www.doc.sto.comAccessed on 22/07/2014.

Langer A. and Villar J, (2002), Are women and providers stratified with antenatal care? Views on a standard and a simplified, evidence based model of care in four developing countries. BMC Women's health 19, 2:7

Lawoyin Taiwo O, Olusheyi O C Lawoyin & David A Adewole.2007. Men's Perception of Maternal Mortality in Nigeria: *Journal of Public Health Policy* 28, 299–318 (1 September 2007) doi:10.1057/palgrave.jphp.3200143.

Lorenzo S.B. (2011) Infant mortality and pregnancy loss; resources for families (upd-ed.) Washington DC.

Lucas A.O. and Gilles H.M. (2003): Short Textbook of Public Health. Fourth Edition:
Mehruar, H.A. (2006): Socio-Cultural Factors Affecting Men's use of Family Planning Methods in Iran. Journal of Social Sciences and Humanities of Schiraz University Vol. 24, No. 2 (Ser. 47)

Mejad M. (2005): Couples' attitudes to the delivery room during child birth. La Revue de Sante de la mediterranee orientale, Vol. 11. No. 4

Ministry of Finance Planning and Economic Development (2002): Uganda Population, Reproductive Health & economic development.

Mlay R, Lugina H, Becker S. (2008): Couple counselling and testing for HIV at antenatal clinics: views from men, women and counsellors.*AIDS Care*, 20**:**356-360.

Mpembeni, R.N., J.Z. Killewo, M.T. Leshabari, N. Siriel, A.J. Massawe, D. Mushi, and H. Mwakipa. 2007. Use Pattern of Maternal Health Services and Determinants of Skilled Care during Delivery in Southern Tanzania: Implications for Achievement of MDG-5 Targets. *BMC Pregnancy and Childbirth* 7(1): 29.

Msuya SE, Mbizvo E, Hussain A, Uriyo J, Sam NE, Stray-Pedersen B. (2006): HIV among pregnant women in Moshi Tanzania: the role of sexual behaviour , male partner characteristics and sexually transmitted infections. *AIDS Res Ther*Vol, 3**:**27

Msuya SE, Mbizvo EM, Hussain A, Uriyo J, Sam NE, Stray-Pedersen B. (2008): Low male partner participation in antenatal HIV counselling and testing in northern Tanzania: implications for preventive programs.*AIDS Care*, 20(6)**:**700-709.

Muki M (2009) Factors affecting utilization of Natal services by HIV positive pregnant women in Jinja district. 24-29.

UNIVERSITY OF IBADAN

Mullany BC, Lakhey B, Shrestha D, Hindin MJ, Becker S (2009). Impact of husbands' participation in antenatal health education services on maternal health knowledge.J Nepal.Med.Assoc.48: 28-34.

Mullany BC. (2006): Barriers to and attitudes towards promoting husbands' involvement in maternal health in Katmandu, Nepal. Social Science & Medicine Vol 62(11):2798-2809.

Mullany, B.C., S. Becker, and M.J. Hindin. 2007. The Impact of Including Husbands in Antenatal Health Education Services on Maternal Health Practices in Urban Nepal: Results from a Randomized Controlled Trial. *Health Education Research* 22(2): 166-176.

Mullick S. Kunene B. and Wanjiru M. (2005),Involving men in maternal care;Health service delivery issues: p.124-135. available at www.who.int accessed 20 October 2008.

Mustapha. O.G. (2010) Why ante-natal is vital to safe delivery. Source: thenationonlineng.net/...ante-natal-is-vital-to-safe-delivery-/Page1.html; Accessed on 22/07/2014

Nahar, S. (2011): Women-Focused Development Intervention reduces delays in accessing emergency Obstetric Care in Urban Slums in Bangladesh: BMC Pregnancy and Childbirth II(1): 11.

Nanjala M. and Wamalwa D., (2011): Determinants of Male Partner Involvement in Promoting Deliveries bySkilled Attendants in Busia, Kenya; African Medical and Research Foundation, HIV/AIDS Programme P.O. Box 30125-00100, Nairobi, KenyaTel: 254-729-509-455 E-mail: mildrednanjala@gmail.com; African Medical and Research Foundation, Child and Reproductive Health ProgrammeP.O. Box 30125-00100, Nairobi, KenyaTel: 254-733-229-992 E-mail: david_wamalwa@yahoo.com.

Nantamu D.P., (2011): Factors associated with male involvement in maternal health care services in Jinja District, Uganda; dissertation submitted in partial fulfilment for the award of the degree of Master of Public Health of Makerere University.

Ndyanabangi. B. (2010): Presentation during UNFPA Overview of 6th Country Program Implementation: Mid-year review (2009-2010) Stakeholder meeting. Abuja.

Nejad, M. (2005): Couples' attitude to the husband's presence in the delivery room during childbirth. Kerman University of Medical Services and Health Services, Kermen, Islamic Republic of Iran.La Revue de Sante de la Mediterranee Orientale, Vol. 11, No. 4.

UNIVERSITY OF IBADAN

Nepal Demographic and Health Survey (2001), Family Health Division, Ministry of Health, His Majesty's Government, Katmandu, Nepal &New ERA, Katmandu, Nepal & ORC Macro, Calverton, MD: 10-14.

Nigeria Demographic and Health Survey.(2008): Fact Sheet. Nigeria National Population Commission, Abuja. Source: www.population.gov.ngAccessed on 22/07/2014.

Nkuoh GN, Meyer DJ, Tih PM, Nkfusai J. (2010): Barriers to men's participation in antenatal and prevention of mother-to-child HIV transmission care in Cameroon, Africa.*J Midwifery Womens Health*,**55**(4)**:**363-369.

Nwankwo BO, Ogueri E 2006. Influence of husband's decision on the use of modern contraceptives among rural and urban married women in Imo State, Nigeria. International Journal of Tropical Medicine, 1(40): 140-144

Nzioka C. Perspectives of adolescent boys on the risks of unwanted pregnancy and sexually transmitted infections: Kenya. Reproductive Health Matters,2001, 9(17):108–117.

Obaid A. (2007): How men can become partners in Maternal Health, United Nations Population Fund (UNFPA): in a statement for World Population Day.

Odeimegwu C. (2005): Men's Role in Emergency Obstetric Care in Osun State of Nigeria. Teaching Hospital, Ile-Ife, Nigeria.African Journal of Reproductive Health/La Revue Africaine de la Sante Reproductive, Vol. 9.

Odimegwu Clifford, Okemgbo Christian N., (2008). Men's perceptions of masculinities and sexual health risks in Igboland, Nigeria; *International Journal of Men's Health* 7(1): 21-39.

Okereke H.C. (2005): Maternal and Child Health Prospects in Nigeria. The Internet Journal of Pediatrics and Neonatology. Volume 5, Number 2.

Okonofua F.E. (2009): Perceptions of Policy Makers in Nigeria. Towards Unsafe Abortion and Maternal Mortality.International Perspectives on Sexual and Reproductive Health.Vol. 35, N4.

Oladeji. D. (2008): Communication and Decision Making Factors, influencing couples interest in Family Planning and Reproductive Health Behaviour in Nigeria, Olabis Onabanjo University. Ago-Iwoye, Nigeria.

Olawepo R.A. and Okedare E.A. (2006): Men's Attitudes towards family Planning in a Traditional Urban Centre: An example from Ilorin, Nigeria. Department of Geography, University of Ilorin, J. Soc. Sci, 13 (2): 83-90.

UNIVERSITY OF IBADAN

Olayemi O, Bello FA, Aimakhu CO, Obajimi GO, Adekunle AO. (2009): Male participation in pregnancy and delivery in Nigeria: a survey of antenatal attendees.Journal of Biosocial Sciences Vol. 41, No. 4, 493-503. *(UK, international)*

Olayemi O. and Bello F. (2010): Male participation in pregnancy and delivery in Nigeria: a survey of antenatal attendees. Department of Obstetrics and Gynaecology, University of Ibadan, Ibadan, Nigeria.Retrieved on 18-05-2011.

Onyango M, Owoko S, Oguttu M. (2010): Factors that influence male involvement in sexual and reproductive health in Western Kenya: A Qualitative study. African Journal of Reproductive Health; Vol. 14(4):33-43.

Orji E.O, Adegbenro C.O, Moses O.O et al. Men's Involvement in Safe Motherhood, J Turkish-German Gynecol Assoc, Vol. 8(3); 2007:240-246.

Orji EO, Adeyemi AB, Esimai OA., 2003. Nigerian Demographic and Health Survey 2003: Key findings. ... Article | PubMed |; Journal of Public Health Policy28, 299–318.

Orji EO, and Adeyemi A.B, (2003): Liberalization of Abortion Laws in Nigeria. The intergraduates Perspective. J. Obstet Gynaecol. 2003: 23(1): 63-6

Owolabi A.T. (2008): Maternal Complications and Perenatal Outcomes in booked and unbooked – Nigeria Mothers. Department of Obstetrics, Gynaecology and Perinotology, College of Sciences, Obafemi Awolowo University of Ile-Ife, Nigeria. Singapore Medj 49(7): 526

Oyewole E.O. (2007): Male Involvement in Household Nutrition Security in Oyo State, Nigeria.University of Ibadan, Department of Public Health Nutrition, Ibadan: Ph.D Thesis.

Ozumba. A. (2008): Improving Maternal Health in Developing countries, the Nigeria experience source: www.unn.edu.ng/home/index.php/inaugral. Retrieved on 22/07/2014

Paavilainen, M, 2013: Men´s socio-demographic background and maternal health care utilization in Ethiopia; Master´s Thesis, 60 pages Supervisor: Professor Matti Salo International Health, August 2013.

Peacock, D. (2003). Men as partners: Promoting men's involvement in care and support activities for people living with HIV/AIDS. Expert Group Meeting on ''The role of men and boys in achieving gender equality'', Brazil. http://www.un.org/women Retrieved on 22/07/2014

UNIVERSITY OF IBADAN

Platin, (2007): Father and Health Outcomes. The case of Europe, School of Public Health and Society, University of Malo, Publications of WHO Regional Office for Europe. Source: http://www.whoint/pubrequest

Qureshi N. and Shaikh.B. (2007): Women's empowerment and Health: The role of institutions of Power in Pakistan, Eastern Mediterranean Health Journal.Vol. 13, No. 6.

Rahman, M., S.E. Haque, and M. Zahan.(2011). Factors Affecting the Utilization of Postpartum Care among Young Mothers in Bangladesh.*Health & Social Care in the Community* 19(2): 138-147.

Reece M, Hollub A, Nangami M, Lane K. (2010): Assessing male spousal engagement with prevention of mother-to-child transmission (PMTCT) programs in western Kenya.*AIDS Care,*vol.22(6)**:**743-750.

Rima Khalaf Hunaidi, quoted in a U.N. press release, "U.N. Human Development Report Finds Arab Countries Lagging Behind," July 3, 2002, at http://www.escwa.org.lb/information/press/un/2002/july/3.html. Accessed on 3/7/2014.

Ronsmans C. (2003): Maternal Mortality and access to Obstetric Services in West Africa.Tropical Medicine and International Health. Vol 8 (10): Pages. 940-948.

Rosliza A, Majdah M: Male participation and sharing of responsibility in strengthening family planning activities in Malaysia. *Malays J Pub Healt Med* 2010, 10(1):23-27.

Ruhweza M, Baine S O, Onama V, Pario G (2009), Financial risks associated with health care consumption in Jinja Uganda. African Health Sciences,Vol. 9(S2):586-589.

Sabbe E, Aelterman A. (2007): Gender in teaching: a literature review. Teachers and eaching: Theory and Practice 2007; 13(5):521-538.

Saiqa Mullick, Busi Kunene and Monica Wanjiru, 2005. Involving men in maternity care: health service delivery issues: Agenda Special Focus 2005. The study was conducted by the Reproductive Health Research Unit (RHRU) of the University of Witwatersrand, in collaboration with the KZN Department of Health, FRONTIERS in Reproductive Health Program of the Population Council and Family Health International and funded by USAID. P.124-125.

Salem, R. (2004) Men's surveys: New findings.The INFO Project Balmore: John Hopkins Bloomberg School of Public Health.Population Reports, series M, No. 18.

Sangstad, O.D. (2011): Reducing Global Neonatology Vol. 99(4): 250-257.

UNIVERSITY OF IBADAN

Shahjahan M, Mumu S, Afroz A, Chowdhury H, Kabir R, Ahmed K: Determinants of male participation in reproductive healthcare services: a cross-sectional study. *Reprod Health* 2013, 10:27 .

Shiffman, J. (2004): Generating Political Priority for Safe Motherhood.African Journal of Reproductive Health. Vol 8, N3 Pp 6-10.

Singh A. and Arora A.K. (2008): How much do rural Indian husbands care for the health of their wives: Department of Community Medicine, PGIMER, Chandigarh – 160012, India original Article: Vol. 33/issue:1/page. 19-25
Source: http://www.promote.com/affiliates/idevaffiliate.php?id=2599.

Stover J, Ross J: How increased contraceptive use has reduced maternal mortality. *Matern Child Healt J* 2010, 14(5):687-695. Publisher Full Text.

Thaddeus S, Maine D. (2002): Too far to walk: Maternal Mortality in Context. Social Science and Medicine 1994: 38, 1091-110

The American Heritage Dictionary (2007): Definition of Childbirth English Language, Fourth Edition.

Tinuade A, Ogunlesi (2005): The Pattern of Utilization of Parental and Delivery Services in Ilesa, Nigeria. The Internet Journal of Epidemiology. Volume 2, Number 2.

Tormeytta.G. (2008): Ways to support your wife during Pregnancy: The family and the Society.

Tweheyo.R (2009), Determinants of male participation in skilled antenatal and delivery care in Amoro County Gulu district. MPH dissertation Makerere University School of Public Health.

UN Millenium Project (2005): Who's got Power Transferring Health Systems for Women and Children. Task Force on Child Health and Maternal Health, UNDP.

UNFDP (2005): The Promise of Equality, Reproductive Health and the Millenium Development Goals.The UNDP's annual State of the World Population Report.

UNFPA (2010): Avoiding avoidable deaths among pregnant women in Nigeria.Source: www.pointblanknews.com/Articles/artopn2602.html.

UNFPA, (2003): Reduce Maternal and Newborn Deaths in Nigeria: Federal Ministry of Health and UNFPA.

UNICEF (2007) Nigeria Multiple Indicator Cluster Survey: Abuja: National Bureau of Statistics.

UNIVERSITY OF IBADAN

UNICEF, (2001) Children's and Women's Rights in Nigeria: A wake-up call. Situation Assessment and Analysis, Abuja.

United Nations Conference (ADF 2008), Achieving gender equality and women's empowerment in Africa.Addis Ababa, Ethiopia Progress Report.

United Nations. Report of the International Conference (2009): Population and Development. A/CONF. 171/13/Rev.1, 11-34. 1995. Cairo, Egypt. Retrieved from http://www.ippf.org/en/About/ICPD+Program me+of+Action.

UNPF (2009): Investing in Family Planning and Maternal and Newborn Health. Guttmacher Institute.

USAID/West Africa,, (2004): Implementing Partners in Maternal and Child Health Project. USAID Boost Emergency Obstetrics and Newborn Care in Niegria.

Uzochukwu and Onwujekwe (2004).Community Satisfaction with the quality of Maternal and Child Health Services in South East Nigeria.East Africa Medical Journal Vol. 81. 6

Varga, C.A. (2001) Young Men and Sexual and Reproductive Health Programs: A Review of Relevant Literature, African Journal of Reproductive Health 5(3), 175-195.

Villar and Bergsjo. (2002); Views on a Standard and a simplified, evidence based model of care in four developing countries. BMC Women's Health.Vol. 19. No. 2 Pp. 7.

Walston, N. (2005). Challenges and opportunities for male involvement in reproductive health in Cambodia.Policy Project.Washington (DC): USAID.http://www.synergyaids.com/documents/MaleRHInvolvement_Cambodia.pdf Retrieved on 22/07/2014watch/daw/egm/men-boys2003/EP5-Peacock.pdf.

WHO (2003): Pregnancy, Childbirth, Postpartum and Newborn care. A guide for essential practice Geneva.

WHO (2006): Measuring Progress Towards the Health Millenium Development Goal. Source: www.who.int/mdg. Assessed on July 15th, 2012

WHO (2008): Countdown to 2015 for Maternal, Newborn and Child Survival. The Lancet 371 (9620): 1215-1308

WHO (2010): Eliminating Preventable Maternal Mortality and Morbidity through the empowerment of women; Follow-up to fourth World Conference on women.

WHO Country Office, Nigeria (2007): Annual Report, Abuja: World Health Organization: p.9

UNIVERSITY OF IBADAN

WHO, (2006): Standards for Maternal and Neonatal Care, Geneva.Assessed on 15/07.2012.

WHO, (2009): Maternal and newborn health, 62nd WHA, Geneva, Switzerland

WHO, UNICEF, UNFPA, (2004): Maternal Mortality, Estimates developed by UNICEF, WHO, UNFPA, WHO Geneva, Switzerland.Assessed on 15/07.2012.

WHO.(2009): Monitoring of the achievement of the Health-related Millenium Development Goals.Sixty Second World Assembly. Provisional agenda item 12.6

WHO. Retrieved from http://whqlibdoc.who .int/hq/2002/WHO_FCH_RHR_02.3.pdf Retrieved on 10-10-2009.

World Health Organization. (2002): Programming for male involvement in reproductive health: Report of the meeting of WHO regional advisers in reproductive health WHO/PAHO, Washington, DC, USA, Geneva, Switzerland: Retrieved on 10-10-2009.

Yim W. (2010); Chinese husband's presence during labour: A Preliminary study in Hong Kong International Journal of Nursing Practice. Vol. 6: 89-96.

Yue K, O'Donnel C, Sparks PL: The effect of spousal communication on contraceptive use in Central Terai, Nepal.*Patient Educ Couns* 2010, 81(3):402-408.

Zubairu I. (2010). Birth Preparedness' Complication in Readiness and Father's Participation in Maternal Care in Northern Nigeria Community. African Journal of Reproductive Health. Vol. 14, No. 1

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Appendix I

INFORMED CONSENT FORM FOR RESEARCH STUDIES

Title of Research Project: **Hindrance to Male Involvement in Maternal Health Care in Kwali Area Council of the Federal Capital Territory (FCT), Abuja, Nigeria**

Researcher: **Yusuf Nana Hauwa** ***PleaseTick Box***

I confirm that I have read and have understood the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	☐
I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my rights being affected.	☐
I understand that, the information will be audio taped and transcribed and that I will not be identified in any report subsequently produced by the researcher.	☐
I accept that taking part in a descriptive and cross-sectional study that any risks associated with this have been explained to me.	☐
I agree to take part in the above study.	

______________________ __________ __________________

Participant’s Name Date Signature

______________________ __________ __________________

Name of person taking consent Date Signature

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Researcher Date Signature

The contact detail of Researcher is:

Health Promotion and Education Unit, Primary Health Care Development Board (PHCDB), Area 3, Garki, Abuja.

Appendix II

Focus Group Discussion Guide

Men's Perceptions and Involvement in Maternal Health Care in Kwali Area Council, Abuja, FCT

1. (a) What do you consider as maternal health care

Probe: meaning, composition, content, where it is obtained, and who renders the service.

(b) What do you think that poor maternal health could result to?

(c) What are the causes of maternal death in this community?

2. (a) What is male involvement?

Probe: Their understanding of what it should be, reasons why it is important and type of involvement.

(b) What is your opinion about men attending ANC with their wives?

(c) What are the various forms of support that men should give their wife during pregnancy and after delivery *(probe for all the supports)*

3. (a) What do you understand as family planning?

(b) What can you say about women using family planning?

(c) Is your wife using family planning, if "Yes" what method and if "No" why?

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(d) Probe further

4. (a) What do you understand by women empowerment

   (b) In your own opinion, who do you think should empower women?

   (c) What are the various forms of empowerment that are necessary for women?

   (d) What forms of empowerment do you have in place for your wife?

5. What are the roles you think men can play in maternal health care?

6. What are the barriers to male involvement in maternal health *(social, cultural and economic factors?)*

7. What are the strategies that can be used to motivate men to actively involved in maternal health care?

8. What are your suggestions on how to improve maternal health care?

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Appendix III

QUESTIONNAIRE

MALE PERCEPTION AND PRACTICE IN MATERNAL HEALTH CARE IN KWALI, AREA COUNCIL

Good day sir. My name is Hajia (Mrs.) Nana Hauwa Yusuf, a post graduate student of Health Promotion and Education Department, Faculty of Public Health, College of Medicine, University of Ibadan. I am carrying out this study on "Men Perception and Practice in Maternal Health Care in Kwali Area Council, Abuja" This is part of the requirement for the award of MPH in Population and Reproductive Health Education. I sincerely request your cooperation in completing this questionnaire accurately. Your answer will be confidential. And no names, addresses or anything that could identify an individual will be used in publishing the results. I appeal to you to give your frank and honest opinion to the questions. Realizing that information that you provide will help in advancing knowledge and science on the improvement of maternal health care.
Thanks for your cooperation.

Date……………………………… Time………………………..

Town/Section…………………….. Serial No……………………

SECTION A: SOCIO DEMOGRAPHIC INFORMATION
Instruction: Tick as appropriate

1. Age: (As at last Birthday)…………..
2. Religion:
   - Christianity ☐
   - Islam ☐
   - Traditionalist ☐

   Others (specify)…………………..
3. Marital Status:
   - Married ☐
   - Cohabiting ☐
   - Separated ☐
   - Divorced ☐
   - Widow ☐
4. Type of family:
   - Monogamous ☐
   - Polygamous ☐

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5. Level of Education:

No formal education ☐

Primary education ☐

Islamic education ☐

Secondary education ☐

OND/NCE ☐

HND/BSC ☐

Master/PhD ☐

6. Ethnic group:

Gbagi ☐

Gwandara ☐

Ganagana ☐

Ebira ☐

Hausa ☐

Yoruba ☐

Ibo ☐

Others please specify…………………..

7. What is your occupation:

Civil servant ☐

Private sectors worker ☐

Farmer ☐

Self employed ☐

Unemployed ☐

Others please specify………………..

8. What is your financial contribution to the following house hold expenses on the table below:

	Household Expenses	In Full	In Part	Provide no Money
a.	Food			
b.	Health care costs			
c.	Transportation			
d.	Wife's Clothing			
e.	Child care			

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9. Does your household have or own the following?

		Yes	No
a.	Radio		
b.	Television		
c.	Video		
d.	Car		
e.	Bicycle		

SECTION B:KNOWLEDGE ON MATERNAL HEALTH CARE

10. Have you heard of maternal health care before?

(a) Yes ☐ (b) No ☐

Poor maternal health care result in maternal death

(a) Yes ☐ (b) No ☐

11. The following are complications of pregnancy? ***(Tick all that apply)***

S/n	Complications	Yes	No
a.	Abortion		
b.	Foetal death (death of unborn baby in uterus		
c.	Pre-mature delivery		
d.	Prolong labour		
e.	Death of the mother		

12. The following are causes of maternal mortality ***(Tick all that apply)***

S/n	Causes	Yes	No
a.	Excessive bleeding		
b.	Delay in getting to the hospital		
c.	Anaemia		
d.	Prolong labour		
e.	Caesarean section/ Operation		
f.	Lack of money/Poverty		
g.	Spiritual reasons /Destined to die		
h.	HIV/AIDS		
i.	Family Planning		

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13. The following can prevent maternal mortality ***(Tick all that apply)***

S/n	Prevention	Yes	No
a.	Child spacing/ family planning		
b.	Antenatal care		
c.	Skilled attendant at birth		
d.	Taking enough rest during pregnancy		
e.	Delivering at home with TBA		
f.	Delivering in the church to ward away evil spirits		

14. What are your sources of information on maternal health?

S/n	Sources	Yes	No
a.	Radio		
b.	Television		
c.	Newspaper		
d.	Neighbors		
e.	Health worker		

15. Women empowerment is one of the components of maternal health

(a) Yes ☐ (b) No ☐

16. it is important for male to be involved in maternal health care

(a) Yes ☐ (b) No ☐

17. What is male involvement in maternal care?

…………………………………………………………………………………………

…………………………………………………………………………………………

SECTION C: PERCEPTION ON MEN INVOLVEMENT IN MATERNAL HEALTH

S/n	Perceptions	Agree	Not sure	Disagree
19.	Active male involvement in maternal health will help improve maternal health and reduce maternal death.			
20.	Men who attend ANC with wife are more educated on danger signs during pregnancy and delivery.			
21.	Men should be involved in:			
	1. Antenatal care (ANC) of wife			
	2. Be at bedside of wife during delivery			
	c. Child spacing /family planning			
22	Maternal health care is basically women's affair.			
23	Men should empower their wife to enable her participate in			

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	decision making of the family.			
24	Men should provide support to their wife by			
	1. encouraging her to take adequate and required diet			
	2. ensuring she takes her daily drugs like fasolate tablets and folic acid tablets			
	3. supporting her with household chores such as helping her to break firewood, of the floor and taking care of older children			
	4. providing transportation for her care			
	5. giving her support for child spacing after delivery			
25	Men should decide when their wives will go for family planning.			
26	It is the role of men to ensure that wife attend ANC care at list 4 times before delivery			

SECTION C: PRACTICE OF MEN IN MATERNAL HEALTH CARE

S/n	Practice	Yes	No
27	I accompany wife for antenatal		
28	I was at the bedside of my wife during the delivery of our last baby		
29	I follow my wife for family planning education		
30	Do you support your wife during pregnancy and after delivery by Helping her with some household chores e.g. breaking firewood		

31. During your wife's last delivery, who accompanied her to the clinic…………………

32. Who decide for the following?

	Decision	Husband	Wife	Both	Family
a.	When to get Pregnant				
b.	Number of Children				
c.	Place of delivery				

33. When my wife is in need of emergency care in my absence she can:

S/n		Yes	No
a.	Go to husband's parents		
b.	Wait for the husband		
c.	Decide on her own		
d.	Go to her parent		
e.	Look for relatives		

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34. What areas are you involved in maternal health care?

a……………………………………………

b…………………………………………..

c……………………………………………

SECTION D: ROLE OF MEN IN MATERNAL HEALTH CARE

35. The following are roles of men in maternal health care

S/n		**Yes**	**No**
a.	Attend ANC with wife		
b.	Be at bedside of wife during delivery		
c.	Share the joy of arrival of the baby		
d.	Look for relatives		
e.	Ensure child spacing by using family planning methods		
f.	Empowerment of wife		

g. Please specify others

…………………………………………………………………………..…………………………

……………………………………………………………………………...............................

SECTION E: HINDRANCE TO MEN INVOLVEMENT IN MATERNAL HEALTH CARE

36. The following are barriers to men involvement in maternal health care

S/n		**Yes**	**No**
a.	Inadequate knowledge on maternal health care		
b.	Financial constrain		
c.	Inadequate health facilities		
d.	Long waiting period before obtaining health care		
e.	Health workers' attitude		
f.	Cultural constrain		
g.	Government policies		

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h. Please specify others …………………………………………………………………..

……………………………………………………………………………………………

SECTION F: MOTIVATION FOR MEN INVOLVEMENT IN MATERNAL HEALTH CARE

37. The following can motivate men to actively participate in maternal health care (**Tick all that apply**)

S/n		**Yes**	**No**
a.	Public health education		
b.	Good communication between husband and wife		
c.	Husband regular financial income		
d.	Adequate health facilities		
e.	Health workers friendly attitude		
f.	Community leaders involvement in maternal health programmes		
g.	Influence by the family member		

h. please specify others …………………………………………………………………..

……………………………………………………………………………………………

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Appendix IV

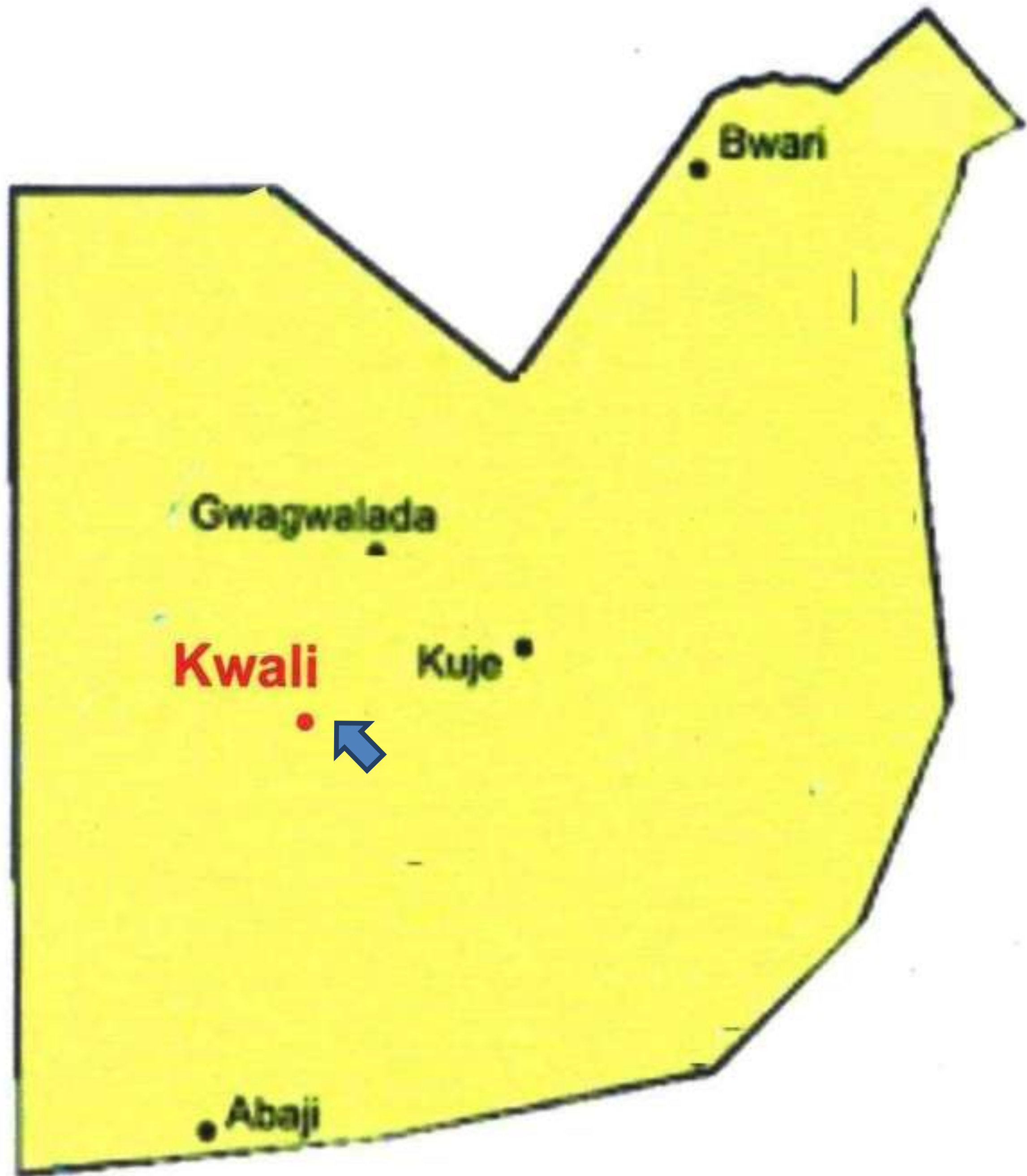
Some of the pictures taken at FGD sessions

The Researcher with some of the FGDs participants at PHC Kwali

The Researcher with some of the FGDs participants at PHC Piri

Appendix V

Map of Federal Capital Territory, Abuja



Appendix VI

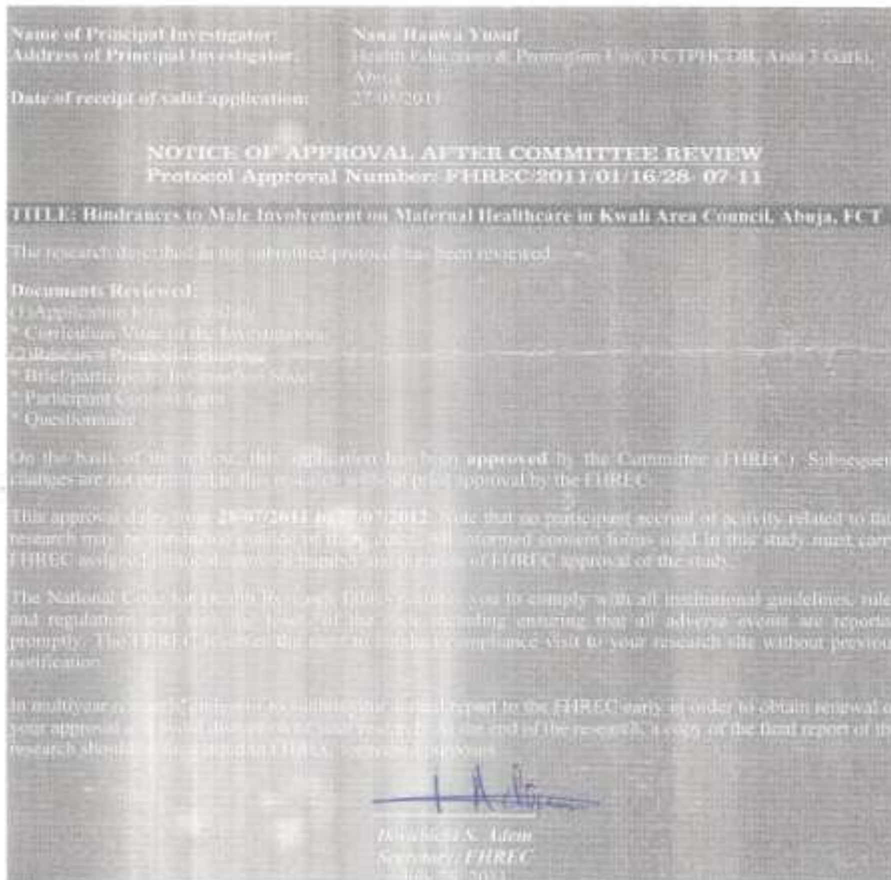
Ethical approval

FEDERAL CAPITAL TERRITORY

HEALTH RESEARCH ETHICS COMMITTEE

Research Unit, Room 10, Block A Annex, HHSS

FCT Secretarial No. 1 Kapital Street Area II, Garki, Abuja - Nigeria



Name of Principal Investigator: Nana Hauwa Yusuf

Address of Principal Investigator: Health Education & Promotion Unit, FCTPHCDB, Area 3 Garki, Abuja

Date of receipt of valid application: 27/0[illegible]/2011

NOTICE OF APPROVAL AFTER COMMITTEE REVIEW

Protocol Approval Number: FHREC/2011/01/16/28- 07-11

TITLE: Hindrances to Male Involvement on Maternal Healthcare in Kwali Area Council, Abuja, FCT

The research described in the submitted protocol has been reviewed [illegible]

Documents Reviewed:

[illegible] Application [illegible]

* Curriculum Vitae of the Investigators

[illegible] Research Protocol [illegible]

* Brief/participants Information Sheet

* Participant Consent Form

* Questionnaire

On the basis of the review, this application has been **approved** by the Committee (FHREC). Subsequent changes are not permitted in this research without prior approval by the FHREC.

This approval dates from **28/07/2011 to [illegible]/07/2012**. Note that no participant accrual or activity related to this research may be conducted outside of these dates. All informed consent forms used in this study must carry FHREC assigned protocol approval number and duration of FHREC approval of the study.

The National Code for Health Research Ethics requires you to comply with all institutional guidelines, rules and regulations and with the tenets of the Code including ensuring that all adverse events are reported promptly. The FHREC reserves the right to conduct compliance visit to your research site without previous notification.

In multiyear research, endeavour to submit your annual report to the FHREC early in order to obtain renewal of your approval [illegible]. At the end of the research, a copy of the final report of the research should be forwarded to FHREC [illegible].

[illegible] S. Adem

Secretary, FHREC

[illegible] 2011