

**MALE'S KNOWLEDGE AND INVOLVEMENT IN MATERNAL HEALTH  
CARE OF THEIR WIVES IN SABO COMMUNITY,  
IBADAN, OYO STATE**

**BY**

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## ABSTRACT

Maternal health refers to health of women during pregnancy, childbirth and postpartum period and it is an essential component of reproductive health. Community diagnosis in Sabo community revealed that women present late at the primary health care because they needed to take permission from their husband. Those declined by their husband secretly hid their hospital card in the health facility as well some women went ahead to carry out family planning without the consent of the husband. There is paucity of data on men's knowledge and involvement in maternal health care, therefore this study was designed to investigate knowledge and level of involvement of men in maternal health care of their wives in Sabo Community, Ibadan Oyo State.

A community based cross-sectional study was conducted among 367 married men that are resident in the community using a multistage sampling technique: stratification of the community into five strata, proportionate sampling of number of respondents in each stratum and systematic selection of respondents. A pre-tested interviewer administered questionnaire containing information on knowledge with a 30-point scale. Score of <15, 15-22 and >22 were rated as poor, fair and good knowledge respectively. Level of men's involvement was assessed based on a 10-point scale with scores of (0-7) and >7 categorised as poor and good involvement respectively. Perception on men's involvement was assessed on a 10-point scale with scores (0-7) and >7 categorised as negative and positive perception. The data were analysed using both descriptive and inferential statistics, Fishers test and Chi square test at 0.5% level of significance. Mean age of the respondents was  $40.3 \pm 8.8$  while 99.2% were muslim. More than three quarter practiced monogamy (76.3%), 71.4% had secondary education while 13.4% and 5.7% had tertiary and Islamic education, respectively. Majority (97.0%) were Hausa and those that were self-employed accounted for (94.6%). Respondents' knowledge score revealed that 4.6%, 65.7% and 29.7% had poor, fair and good knowledge of maternal health care, respectively. Only 22.3% of the respondents had good level of involvement in maternal health care while majority (73.8%) had positive perception on involvement in maternal health care. Factors influencing men's involvement in maternal health care included too busy at work (75.2%), wrong belief that morbidity is a normal consequence during pregnancy (82.0%), religious belief on the use of contraceptive method (45.2%) among others. Significantly those in the younger age were more

involved in maternal health care and those that had at least secondary school education had more knowledge on maternal health care

Male's knowledge was found to be good but their level of involvement of men in maternal health care was low in spite of the positive perception on men's involvement in maternal health care. Public enlightenment and training programmes should be organized for the men to improve their knowledge and involvement in maternal health care in order to mitigate the preventable deaths of mother and child during and after pregnancy.

Keywords: Maternal health care, Male involvement, Male perception

Word count: 493

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## **DEDICATION**

I dedicate this to God almighty for the divine health, provision and guidance. All glory to him for the completion of this project. Also I dedicate it to my late Parents; Alhaji Adeleke and Folake Arewa and my uncle late Eng. Stanley Fagbohunge for their unending love and care.

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**Mopelola Joy AREWA**

## CERTIFICATION

This is to certify that this study was carried out by AREWA, Mopelola Joy in the department of Health Promotion and Education, Faculty of Public Health, College of Medicine, University of Ibadan, Nigeria under my supervision.

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## GLOSSARY OF ABBREVIATIONS

<b>MHC</b>	Maternal Health Care
<b>WHO</b>	World Health Organization
<b>MMR</b>	Maternal Mortality Rate
<b>MDG</b>	Millennium Development Goal
<b>NPC</b>	National Population Commission
<b>UNFPA</b>	United Nations Population Fund
<b>FMOH</b>	Federal Ministry of Health
<b>UNICEF</b>	United Nation for International Children Emergency Fund
<b>USAID</b>	United States Agency for International Development
<b>UNAIDS</b>	United Nations Programme on HIV/Acquired Immune Deficiency Syndrome
<b>ICPD</b>	International Conference on Population and Development
<b>STIs</b>	Sexually transmitted Infections
<b>RH</b>	Reproductive Health
<b>ANC</b>	Antenatal Care
<b>MOHSW</b>	Ministry of Health and Social Welfare
<b>PMTCT</b>	Prevention of mother-to-child transmission
<b>KDHS</b>	Kenyan Demographic and Health Survey
<b>SSWH</b>	Society for the Study of Women's Health
<b>CCOBPMM</b>	Consultative Council on Obstetric & Pediatric Mortality and Morbidity

## OPERATIONAL DEFINITION OF TERM

**Maternal Health:** Maternal health is the health of women during pregnancy, childbirth, and the postpartum period. It encompasses the health care dimensions of family planning, preconception, prenatal, and postnatal care in order to ensure a positive and fulfilling experience in most cases and reduce maternal morbidity and mortality in other cases (Wikipedia).

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## CHAPTER ONE

### 1.1 Background to the study

Maternal health has been described as the broad apparent and currently accepted means of providing preventive, curative, protective and rehabilitative health care for mothers (Lucas and Gilles, 2003). It refers to health of women during pregnancy, childbirth and postpartum period and it is an essential component of reproductive health. Maternal health has been identified as one of the challenging issues that are of public health importance especially in low and middle income country (Taiwo, Olusheyi and David, 2007). There has been little significant change in some countries experiencing high maternal mortality (WHO, 2000; WHO, 2006) such as sub-Saharan Africa, including Nigeria being on the top list (UNICEF, 2006; NPC, 2004). According to (Daniel, Stephen and Sue, 2012) some of the highest maternal mortality risks in the world are faced by women in Nigeria. Globally, 1 in 6 maternal death occurs in Nigeria and each year approximately 50,000 women die from mostly preventable pregnancy-related complications (Lancet and World Bank, 2008). Men's involvement in maternal health has been observed as a promising strategy for promoting maternal health. According to (Cohen and Burger, 2000; Mullyay, Hindin and Becker, 2005) an important strategy in achieving women's empowerment is to get the husband/partner involved and persuade joint decision-making among couples which can lead to the reduction of maternal morbidity and mortality.

Primarily, men are responsible for making decisions in most families in developing countries; as a result, involving them in maternal health issues could lead to promotion of a better relationship between couples in the family and enhance maternal wellbeing (Mullick, Kunene and Wanjiru 2005). There will be positive impact on women's and children's health when there are changes and improvement in the way men are involved in reproductive health problems (Bustamante, 2004). There are several ways men could be involved in maternal health care which include; avoiding delays in seeking medical care, helping pregnant women to stay healthy, supporting contraceptive use by women, arranging for skilled care during delivery and helping after the baby is born (Joseph and Ezekiel, 2009). Evidence also shows that men can reduce unmet need for family planning, prevent unintended pregnancies, foster safe motherhood and practice responsible fatherhood (Drennan, 1998).

In USA, there has been increased in antenatal care attendance 1.5 times as a result of partner involvement in pregnancy (Martin, McNamara, Milot, Halle and Hair, 2007). Even in India, positive changes were found in knowledge, gender roles and decision-making as a result of maternity care model that encouraged husband's participation in their wives' antenatal and postnatal care (Varkey, Mishra, Das, Ottolenghi, Huntington, Adamchak, Khan and Homan, 2004). In addition, demographic and health surveys in five Latin American countries (Bolivia, Peru, Colombia, Haiti and Nicaragua) indicated that improved health outcome for children is associated with positive couple interaction (Heaton, 2008). Most culture, particularly in Africa consider all matter associated with pregnancy or childbirth as a female sphere; hence in many instances, men are not required to attend antenatal care clinic with their wives or be present during delivery (Mullick et al., 2005; Theuring, Mbezi, Luvanda, Jordan-Harder, Kunz and Harms, 2009).

Safe motherhood has been envisioned as a means of ensuring women's accessibility to needed care through antenatal programme in order to aid their safety and ideal health throughout pregnancy and childbirth (Price, 2002). This is a means of protecting the lives of women and enhancing the health of millions of others (Jatau, 2000). The purpose of Safe motherhood is to inhibit maternal and prenatal death and morbidity. It will also increase the quality and safety of women live through the adaptation of combination of health and non- health strategies. The scheme is achieved through a programme of inter-linked steps which strive to provide family planning services to prevent unwanted pregnancies; safe abortions (where abortion is legalized couple with efficient management and treatment of complication of unsafe abortions are accessible); prenatal and delivery care at the community level with quick access to first-referral services for complication and postpartum services, promotion of breastfeeding, immunization and nutrition services (Daly, Azefor and Nasah, 1993).

A major public health problem in the world is maternal mortality and providing safe motherhood with opportunity to necessary health care that include antenatal care, emergency, obstetric services, post-natal care is a requirement for decreasing maternal death. Men are principal stakeholders in Safe motherhood and can be possible hinderance to women's health care seeking conduct in pregnancy, delivery and post-partum period; hence their involvement is crucial for safe motherhood. Not many countries have instigated comprehensive programs that get across to men.



For instance, male involvement in reproductive health is poor in Cambodia (Naomi, 2014) while in Africa, the responsibility of men in maternal care is deputed (Mpembeni et al., 2007).

## **1.2 Statement of the problem**

Over the years, the issue of maternal health has been predominantly seen and treated as a purely feminine matter. Nigeria has been named among those with poor maternal health indicators in the world (Joseph et al., 2009; Federal Ministry of Health, 2003; Jose, 2010). The current maternal mortality ratio has increased to 814 deaths per 100,000 live births in Nigeria (CIA World fact book, 2018). North-East has the highest maternal mortality rate of 1,549 deaths per 100,000 live births in comparison to the South-West with 165 deaths per 100,000 live births (WHO, UNFPA, and UNICEF, 2015).

Nigeria is only 2% of the World population but yet account for 10% of the World maternal deaths in childbirth (WHO, 2006). Report has shown that more than 75% of maternal death is due to obstetric causes such as hemorrhage, unsafe abortion, sepsis, ruptured uterus and hypertensive diseases of pregnancy (Mpembeni and Killewo, 2007). The men are the major family decision maker, thus they singly take decision on their family health care (Consultative council on Obstetric & Paediatric Mortality and Morbidity, 2012).

Antenatal care attendance is poorly utilized in Nigeria (58%) in comparison with high attendance rate (98%) in developed countries (FMOH, 2008). One of the causes of maternal mortality is complications during and after pregnancy and child birth which is becoming alarming. A vast majority of this occurs in the developing country which is about 529,000 maternal mortalities yearly.

The hugely disproportionate representation of men, and their resulting influence among those responsible for the planning and provision of health care has had serious consequences for the health status of women and girls, particularly in developing countries (Taiwo et al., 2007). It has been assumed that men have no special role in reproductive health matters and services and mainly seen as women matter only. Whereas a major obstacle to a speedy fertility decline in Sub-Saharan Africa given the considerable authority and power vested on men as decision makers in the home and society has been observed to be the characteristic lack of male involvement in reproductive initiatives for instance in family planning (Drennon, 1998).

### **1.3 Justification of the study**

In most African countries, maternal health issues which include family planning, pregnancy and childbirth have long been regarded exclusively women's affairs. Although the health of mothers is determined by many factors including environmental factors and socio-economic status, one important and crucial factor that has been neglected over the years is the role of men as a determinant of health of mothers (Mullick et al., 2005).

Men are considered to be responsible for the large proportion of reproductive ill health suffered by their female partners. Non-availability of acceptable contraceptives, lack of services and lack of knowledge with quality of care prevent men from sharing the responsibility in reproductive health matters. Also, limited availability of scientific data and misinformation regarding male sexuality contribute to less involvement of men in reproductive health.

Community diagnosis in Sabo community showed that women present late at the primary health care because they needed to take permission from their husband. Those declined by their husband secretly hid their hospital card in the health facility as well some women went ahead to carry out family planning without the consent of the husband. This study, therefore, aim to assess the knowledge and level of involvement of men in maternal health care of their wives in Sabo. Data that will be generated from the study can be used to plan relevant educational and behavioural intervention.

### **1.4 Research Questions**

- i. What is the level of knowledge of maternal health care among male in Sabo community, Ibadan, Oyo state?
- ii. What are the areas of male's involvement in maternal health care of their wife(ves) in Sabo community, Ibadan, Oyo state?
- iii. What are perceptions of male on involvement in maternal healthcare of their wife(ves) in Sabo community, Ibadan, Oyo state?
- iv. What are the factors influencing male's involvement in maternal health care of their wife(ves) in Sabo community, Ibadan, Oyo state?

## 1.5 General objective

The general objective of this study was to investigate male's knowledge and involvement in maternal health care of their wife(ves) in Sabo community, Ibadan, Oyo state.

## 1.6 Specific objectives

The specific objectives were to:

- i. Assess the knowledge of maternal health care among male in Sabo community, Ibadan, Oyo state.
- ii. Determine the areas of male's involvement of men in maternal health care of their wife (ves) in Sabo community, Ibadan, Oyo state.
- iii. Determine perceptions of male on involvement in maternal healthcare of their wife (ves) in Sabo community, Ibadan, Oyo state
- iv. Identify the factors influencing men's involvement in maternal health care of their wife (ves) in Sabo community, Ibadan, Oyo state.

## 1.7 Research Hypotheses

The following are the null hypotheses for this study;

**H0<sub>1</sub>:** There is no significant association between educational status of men and knowledge of maternal health care of their wife(ves) in Sabo community, Ibadan, Oyo state

**H0<sub>2</sub>:** There is no significant association between age of men and level of involvement in maternal health care of their wife(ves) in Sabo community, Ibadan, Oyo state

**H0<sub>3</sub>:** There is no significant association between knowledge of maternal health and level of involvement in maternal health care of their wife(ves) in Sabo community, Ibadan, Oyo state

## CHAPTER TWO

### LITERATURE REVIEW

#### 2.1 CONCEPT OF MATERNAL HEALTH

Maternal health can be viewed as various programmes and facilities formulated for the intent of administering medical and social services for mothers. Such services comprise of prenatal, postnatal services and family planning (Healthy people, 2010). Many times, motherhood is a positive and desirable experience, for too many, it is affiliated with suffering, ill-health and even death (WHO, UNICEF, UNFPA and World Bank, 2013). Maternal Health care include the health care, aspects of family planning, preconception, prenatal and post-natal care in order to minimize maternal morbidity and mortality.

Preconception care comprises of enlightenment among women of reproductive age to lower risks factors that might cause damage to future pregnancy. The aim of prenatal care is to recognize any potential difficulty of pregnancy early, to avert them if possible and to direct women to appropriate specialist medical services as appropriate. Postnatal care matters include readjustment from childbirth, concerns about newborn care, breastfeeding, nutrition and family planning. Maternal health has become prominent as one of the most important issue that decides global and national wellbeing (Ladipo, 2010). This is because every individual, family and community is at some point closely engrossed in pregnancy and the success of childbirth (WHO, 2006). In spite of the honour conferred on women-hood and the gratitude of the birth of a new baby, pregnancy and childbirth is still regarded as unsafe journey in the developing countries (Ladipo, 2010; Galadanchi, 2009; Ibeh, 2008).

##### 2.1.1 Prevalence of Maternal Mortality

Risk for pregnancy-related illnesses, negative consequences after birth and the risk for maternal death (during pregnancy or childbirth) in sub-Saharan Africa is 175 times higher than in developed countries. A connection has been established between poverty, maternal health and outcomes for a child. Majority of the worldwide annual neonatal deaths has been accounted for neonatal mortality in developing countries (Filippi and Veronique, 2006).

Globally, an estimated 287,000 maternal deaths were observed in 2010, out of which 56% of these deaths were attributed to Sub-Saharan Africa (WHO, 2012). International dedication to reducing the maternal mortality rate (MMR) such as the safe motherhood initiative of 1987 and the Millennium Development Goals (MDG) of the 1990s have prompted a decrease of 47% of the global MMR between 1990 and 2010. Presently there has been universal attempt as incorporated in MDG 5, which calls for decreasing the MMR by 75% between 1990 and 2015 (WHO, 2012).

Globally, maternal mortality ratio deteriorated by 44% from 385 deaths to 216 deaths per 100, 000 live births, according to UN inter agency estimates from 1990 to 2015. This transcribe into a typically yearly rate depletion of 2.3%. While spectacular, this is less than half the 5.5% annual rate required to achieve the 75% reduction in maternal mortality targeted for 2015 in Millennium Development Goal 5. Factors credited with the decline in the MMR include; improved care during pregnancy and delivery, a decreased birth rate and greater education of women. 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.

### **2.1.2 Determinants of Maternal Health**

A woman's lifetime risk of dying as a consequence of pregnancy or childbirth is 1 in 39 in Sub-Saharan Africa, as compared to 1 in 4,700 in industrialized countries. A woman's chance of mortality or morbidity during pregnancy and childbirth is nearly linked to her economic and social status; the topographic distance of her home, and the norms and values of her culture i.e. the greater the chance of mortality when a woman is poor and not cared for by relatives. (United Nations Population Fund, 2012).

Four elements are essential to maternal death determinants. Firstly, prenatal care, it is recommended that expectant mothers should at least visit antenatal clinic four times to check and monitor the health of both the mother and unborn baby. Secondly, skilled birth attendance with emergency backup such as nurses, doctors and midwives who have the expertise to supervise normal deliveries and identify the inception of complications. Thirdly, emergency obstetric care to take care of the main causes of maternal mortality which are obstructed labour, hemorrhage, hypertensive disorders, unsafe abortion and sepsis. Lastly, postnatal care which is the six weeks

succeeding delivery. During this time bleeding, sepsis and hypertensive disorders can occur and newborns are extremely endangered in the instant following birth.

### **2.1.3 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, antenatal care attendance with wife, their presence in the labour room with wife during delivery, family planning and breast feeding (USAID, 2004). Educational interventions for pregnancy health have culturally been insufficient in addressing a woman's extent of influence within the household on health-related decisions particularly as compared with her husband. Observational studies have shown that educating men about the importance of health care for the family increase the promotion of some health seeking behaviour such as antenatal care and child immunizations and enhances communication and support by men to their female partners (Mullany et al., 2006; Lawoyin, 2007).

## **2.2 KNOWLEDGE ON MATERNAL HEALTH CARE**

A number of studies have emphasized the major role engaged by men in making decisions pertaining to maternal health issues and called for male involvement in maternal health care (Kululanga, Sundby, Malata and Chirwa, 2011). However, lack of knowledge of men on maternal health issues restricts access to life saving medical care. On the other hand, intervention studies have revealed that maternal health education intervention paying attention to both men and women have showed to expand knowledge in both men and women; escalate health seeking behaviour among pregnant women; increase awareness and use of family planning after six weeks of delivery, and also raise awareness of double protection for sexually transmitted infections (Kululanga et al., 2011). In a study conducted by (Olugbenga, Asekun, Adewole , Adeomi and Olarewaju, 2013) among 400 men living in Atelewo community in Osogbo, Osun State, the knowledge of the respondents towards maternal health care was found to be average.

According to a qualitative study conducted by (Sarah, Andrew and Padam, 2015) rural Nepal, it was discovered that although some husbands were well informed about aspects of pregnancy and childbirth, there were remarkable gaps. Many husbands were acquainted with some of the advantages of delivering in a health facility and expressed that they would propose their wives to

have an institutional delivery orchestrated by a qualified health worker. Also, some of the respondents clearly showed some awareness of possible obstetric complications such as obstructed labour. Nevertheless, generally the husbands' knowledge of the scope of danger signs in pregnancy, during delivery, and in the neonatal and postnatal periods was deficient. Studies have revealed that inadequate knowledge about maternal health care cause a notable opposition to effective male companion involvement (Mullany, 2006; Nanjala, 2012).

### **2.3 MALE'S INVOLVEMENT IN MATERNAL HEALTH CARE (MHC)**

Male involvement in MHC can be expressed as a process of social and behavioural change that is required of men to play more responsible functions in MHC with the aim of securing women's and children's wellbeing. Actually, the importance of direct male involvement in decreasing maternal death cannot be exaggerated. In reference to Millennium Development Goal 5 (MDG), an article in Frontlines, a monthly publication of the United States Agency for International Development (USAID) acclaimed that "reducing maternal mortality by 75% all through the world by 2015 will take the involvement of men in countries where it is most significant (USAID, 2010). Men's support in reproductive health results in improved understanding between husband and wife, it not only lowers unplanned pregnancies but also reduces maternal and child death rate that is connected with pregnancy and labor through preparation for obstetric predicament (Babalola & Adesegun, 2009).

It is crucial to note that the pre-requisite for improved male involvement in maternal health care services is for the providers to have in-depth knowledge and understanding of the men's health point of view, behavior and practices (Some, 2013). In spite of the fact that pregnancy is not an illness, it generates a lot of physical and emotional pressure on the mother. Both the husbands and other family relatives need to acknowledge and recognize the discomfort and fatigue that may occur to the pregnant woman as a result of pregnancy. The consciousness of the demands of pregnancy on the part of the husband and other family relations could lead into the obligatory support the pregnant woman requires from the family relations including the husband (Sapkota, Kobayashi, Kakehashi, Baral and Yoshida 2012). The essential components of the birth plan package include identification of danger signs, a plan for the place of delivery, a plan for a birth assistant, and saving money for transport or other expenses in case the need arises (UNAIDS 2012). Furthermore, in case of emergencies for birth preparedness, a possible blood donor and a

decision-maker need to be recognized. This is owing to the fact that complications such as hemorrhage are unforeseeable and tremendously devastating if prompt treatment is not procured. Necessary interventions in antenatal clinic encompass recognition and management of obstetric problems such as tetanus toxoid immunization, pre-eclampsia, intermittent preventive treatment for malaria during pregnancy, and identification and management of Infections including syphilis, HIV and other sexually transmitted infections (WHO, 2012). Antenatal care is also a suitable time to stimulate the use of skilled attendance at birth and healthy behavior such as planning for optimal pregnancy spacing, breastfeeding and early postnatal care

Globally, low male involvement in maternal health care services remains a problem to health care providers and policy makers. Since the Cairo International Conference on Population and Development, (ICPD) (1994), and the Beijing World Conference for Women (1995), a lot of emphasis has been to encourage male involvement in reproductive health including maternal health (WHO, 2007).

In South Africa, as in most other African countries, family planning, pregnancy and childbirth have long been regarded as exclusively women's affairs. Men generally do not accompany their partners to family planning, antenatal or postnatal care services and are not expected to attend the labour or birth of their children. However, male dominance socially and in sexual relations can put women at serious risk of unwanted pregnancy and infection; in pregnancy, male sexual behaviour can affect the health outcomes of both mother and baby.

Their lack of participation at family planning, antenatal and postnatal consultations means that they do not benefit from any information given by health providers, regarding the health of mother and baby, or about their role in it. In addition, men are rarely exposed to clinic reproductive health services as they tend to seek care for sexually transmitted infections (STIs) in the private sector, and condoms can be obtained from clinics without contact with providers. The issue of accessibility of reproductive health (RH) services to men in South Africa is a logistical and cultural problem. The exclusive use of services by women has, to a great extent, made RH services unfriendly for men. The involvement of men in maternal health emerged as a result of the numerous impact men have on almost all domain of life (Joseph et al., 2009; Isiugo, 2016).



The negative attitude of men towards maternal health predominantly in Africa has been markedly assigned to the practice of male influence, commonly called “patriarchy” (Joseph et al., 2009). Support and involvement of African men in MHC are essential for healthy maternal and child welfare considering the critical role they play in family decisions. According to (Green, 2001) social relationships dictate people’s ability to be in charge of their sexual and reproductive health, with salient implications not only for their health but also for other life choices. Some studies showed that many poor conditions are preventable if the pregnant woman have access to social and psychological support, besides high quality maternal and child health care, and their social network, mostly their partners (WHO Regional office for Europe, Copenhagen and Denmark, 2003).

In a qualitative study by Sarah Lewis, Andrew Lee, and Padam Simkhada in rural Nepal, it was reported that male involvement in maternal health and safe childbirth is complex and correspond to gradual and advance changes in attitudes taking place. Traditional beliefs are sustained which affect male involvement, that include the central role of women in the sphere of pregnancy and childbirth that cannot be disregarded. Therefore, husbands do have a role to play in maternity care. For instance, they may be the only person available when a woman goes into labour.

According to a study carried out by (Joshua, Robert and Derek, 2017) in Anomabo, Central Region Ghana among 100 adult male respondents whose partners were pregnant or had given birth within twelve months before the study. The results on male involvement in various MCH services revealed that 35% of participants attended antenatal clinic with their partners during pregnancy, 44% followed their partners to delivery while 20% followed their partners for postnatal care services. Men not only function as decision-makers for women and children’s access to health services, but also through abandon or abuse, men’s deeds can have a direct impact on the health of their spouses and children. It is rare to see husband at antenatal clinic in many communities and it is absurd to find men accompanying with their partners during antenatal and delivery (Dereje, Gizachew and Teka, 2016).

Several studies in low and middle-income countries have reported low male participation in maternal and child health matters (Mepham , Zondi , Mbuyazi , Mkhwanazi anm, d Newell, 2011;

Clouse, Schwartz, Van Rie, Bassett, Yende and Pettifor, 2014; Theuring , Mbezi and Luvanda, 2009; Nanjala and Wamalwa, 2012; Van den Berg, Brittain, Mercer, Peacocks, Stinson and Janson, 2015; Ministry of Health, Community Development, Gender, Elderly and Children, 2016).

## **2.4 MALE'S PERCEPTION ON INVOLVEMENT IN MATERNAL HEALTHCARE**

Maternal health care issues are mainly seen and treated as basically feminine matter. This is because women are the ones who get pregnant and give birth. Even though men play an important role in the safety of their female partner's pregnancy, their participation in maternal health care services has been found to be low (Mullick et al., 2005). Male involvement in maternal health care has been perceived as loss of women's right to make decisions concerning pregnancy issue; therefore, men do not want to intrude their territory (Onyango, Owoko and Oguttu, 2010). Men who experienced maternal death either as the death of friends or family members gave various reason for the problem. Some said that the death was due to spiritual powers and could have been prevented if the woman had been delivered by a traditional herbalist / doctor (Lawoyin, Olusheyi and Adewole, 2007).

Male involvement in the antenatal care (ANC) clearly goes against existing gender norms in many places in Sub-Saharan Africa. Reproductive health seeking was perceived by men as "women's work". Men recognized the antenatal clinic as women's domain, and the exposition and arrangement of the program as basically female oriented (Reece et al., 2010). Predictably, men had the notion that antenatal clinic activities fell outside their area of responsibility. Therefore, men perceived that attending the antenatal clinic would be "unmanly". Pregnancy, childbirth and care of the newborn were mainly regarded as activities to be conducted by the woman herself or by other women, particularly the mother-in-law, the wife's mother and the husband's sister. This gendered perception remarkably impacts the degree of the husband's involvement (Sarah et al., 2011).

## 2.5 FACTORS AFFECTING MALE'S INVOLVEMENT IN MATERNAL HEALTH CARE

Several studies indicated various ways in which men arbitrate and regulate women's access to health care services including men's decision-making authority (Tsui, Wasserheit and Haaga, 1997; Bloom, Tsui, Plotkin and Bassett, 2000; Murthy, Ramachandar and Pelto, 2002 ; Lawoyin , Lawoyin.C and Adewole, 2007; Danforth, Kruk, Rockers, Mbaruku and Galea, 2009 ; Joseph et al., 2009 ; Senarath and Gunawardena, 2009), their control over material resources including financial resources (Danforth, Kruk, Rockers, Mbaruku and Galea, 2009), poor level of fundamental knowledge in any of maternal and child health care affairs (Bloom et al., 2000; Murthy, Ramachandar and Pelto, 2002), and cultural barricade that pose partners in maternal health: Implications for reproductive health counseling in restrictions on women's movement and exclude men from taking part in women's health (Cham, 2005). In many cultures, men, older women and families make decisions to take contraceptives, when and where to seek treatment and the kind of services to use, whether to pay for skilled assistance or transportation to a hospital, that affect women's sexual and reproductive health and contribute to high occurrences of reproductive disease, morbidity and mortality (Heaton and Forste, 2008).

In Bangladesh, principally a patriarchal society, women's access to economic, social, politico-legal and healthcare institutions is mostly interceding by men. In the confine of the household and public domain, men influence women's sexuality, their choice of marriage partner, access to labour and other markets and their income and properties (Baden, Green, Goetz and Guhathakurta, 1994). This influences women's health and health-seeking behaviour in many ways, firstly, by regulating behaviour and decision-making power of husbands and elderly members (Barkat, Helali, Rahman, Majid and Bose, 1995; Afsana and Rashid, 2003; Chakraborty, Islam, Chowdhury, Bari and Akhter, 2003), secondly, through abandonment and not giving importance to low women's health matters (Freedman, 2001; Cook, Dickens and Fathalla, 2003) and finally, because of cultural view that regard morbidity during pregnancy a normal repercussion of pregnancy (Goodburn, Gaziand Chowdhury, 1995) . Other notable obstacles to male involvement in maternal health are social taint derived from belief of bad fate (awful happening linked with women's luck) connected with an unusual pregnancy or delivery; timidity and embarrassment at having to discuss women's matters openly (Leppard, 2000; Mullany, 2006; Shahjahan and Kabir, 2006).

According to (Joshua et al., 2017), it was revealed that 55% of the participants lived together with their partners, 80% of the participants lived less than 5km away from the health centre, while 61% perceived the MHC services offered at the health centre to be easily accessible. In addition, 93% of the participants highlighted that poor spousal communication, forbidding cultural norms (69%), work schedules (79%), unfavourable health policies (85%), financial problem (53%), attitudes of health workers (90%), long waiting time at health facility (83%), and gender roles of men (50%) affected their involvement in MHC. (Mullick et al., 2005) indicated that men hold on to their cultural view that a man may lose strength if he is available during the birth of his baby and for that reason men do not accompany women for maternal health services. Similar views have been reported in Kenya (Onyango et al.,2010).

### **2.5.1 Unfavourable Health Policies**

There was a notable association between unfavourable health policies and male involvement in MHC (Joshua et al., 2017). Green, 2001 observed that researchers and reproductive health service providers have been inclined to describe women's disadvantaged positions without men's roles. This has led to the case whereby many reproductive health programs organized to improve women reproductive health sees men as part of the problem and not part of the solution. Such health policies tackling maternal health issues focus majorly on women and children than men. This undermines the intention of men to escort their partners to assess MHC. The failure to include men in maternal health promotion, prevention, and care programs by policy makers, program planners, and implementers has had a serious influence on male involvement in the health of women (Green, 2001).

The effect of global interests in male involvement in enhancing access to and usage of the new-born, maternal and child health services, the Tanzania maternal and child health policy documents explained the demand for male involvement (MOHSW, 2015). In addition, couples are persuaded to attend clinics together as part of the antenatal care policy. Throughout antenatal care visits, health workers provide health education on the general care of the pregnant woman at home, danger signs during pregnancy, and discuss birth preparedness and complication readiness plans. Likewise, an essential component of the national policy on new-born, maternal and child health is male involvement in HIV counseling and testing (MOH, 2002).

### **2.5.2 Attitudes of health workers**

The attitudes of health workers at the health facility accounted for low male involvement in MHC in our study (Joshua et al., 2017). The study is consistent with a study conducted by (Byamugisha, Tumwine, Semiyaga and Tylleskar, 2010). They reported that unpleasant and disapproving language directed at Ugandan women from skilled health professionals was an obstacle to male participation. Harsh treatment of men by health providers discouraged them from returning or participating in prevention of mother-to-child transmission (PMTCT) of HIV activities. In Turkey, it was noted that health care workers were not supporting men who wanted to join in MHC services, and as such a lot of men who visited the clinic with their wives had to stop at the door of the clinic (Pile, Bumin, Ciloglu and Akin, 1999).

### **2.5.3 Availability**

The husbands' availability is another recorded rationale that hinders male involvement in maternal health and childbirth as this is especially associated with labour migration movements. Their absence limits the role that they play in their wife's pregnancy and childbirth, and enhances the magnitude of the role played by others, such as the mother or mother-in-law, at the time of delivery. In some instances, when the husband was available, other women or health workers were often not present and therefore the husband's presence was important as they were the only person available to assist with the delivery (Sarah et al., 2015). Furthermore, social and economic factors are related to family. Maternal mortality is caused when husbands are not available to provide money for care (Lawoyin et al., 2007; Nkuoh, Meyer and Nkfussai, 2010).

### **2.5.4 Cultural beliefs**

Cultural beliefs could also impede male involvement. These embrace the notion that birthing difficulties would be experienced if the husband was present during childbirth. Another tradition followed is postpartum seclusion, where physical contact has to be prevented from the postnatal woman between 3 and 7 days after delivery. This also involves constraints on food preparation. The extent to which this tradition was followed varied between households (Sarah et al., 2015).

In a study by (Onyago et al., 2010), it was revealed that the existing gender norms among cultures in western Kenya affect and determine the degree of male involvement in reproductive health.

Factors that were enumerated by the respondents to illustrate how men manifest these norms include; negative cultural practices, parenting practices pertaining to reproductive health, prevention and treatment of sexually transmitted infections (STIs), and accompanying/not accompanying female partners to the health facilities. In a study on perceptions on male involvement in pregnancy and childbirth in Tanzania, all the respondents described that the gender roles in the community were reinforced by the tradition of jando and unyago which is still being practiced. According to the tradition, boys and girls at the onset of puberty are taken individually to the bush or any suitable place and given training on their role as mothers and fathers. This tradition segregates the responsibilities of boys from that of girls. In addition, boys are informed not to get included in women's activities and vice versa. According to this tradition, pregnancy care, issues related to ANC, and childbirth were regarded as women affairs. For instance, attending clinics was classified as solely women's role. A man who was seen to accompany his wife to clinic was considered to be under the control of a woman, which was seen as disgraceful for men (Stephen and Apollonia, 2018).

### **Gender Norms**

Respondents identified some certain cultural practices in western Kenya influence male involvement in reproductive health. These encompass polygamy, naming of newborn children after relatives, fondness of children of a certain sex over the other, and socialization of male children. Participants affirmed that some of these practices are greatly rooted in culture and will take time to change. An instance was given of men who hail from families where polygamy has been practiced for generations. These men have no motivation to use family planning because of pressures within their culture which impose that a man should have many children. A woman who is in a polygamous marriage and desires to stop giving birth most often has to use her own creativity. In a conventional traditional practice in parts of western Kenya, direct relatives from both sides (e.g., mother in-law) will want the children to be named after certain relatives (dead or alive). This demand puts duress on women to deliver many children and makes men more unwillingly to be actively involved in family planning activities with their wives. The findings from a study on factors hindering husbands from participating in maternal health care in Malawi revealed nearly common agreement among women and men about the norms corresponding to maternal health care. Both men and women regarded pregnancy and childbirth as women's sphere.

The respondents conveyed that they have been brought with the belief that maternal health services are for women. Although the respondents reported that with the initiation of male involvement programme some men followed their spouses to antenatal clinic, but were swift to say that it was a prohibition for men to enter the labour and delivery room. Even during home deliveries, respondents highlighted that husbands are restricted near the birthing hut; only women are allowed to attend to the birthing women. Childbirth is regarded as women's affair culturally; men were distinguished as source of capital of the family (Sosten, Paul, Jack and Robert, 2015).

Male involvement in maternal and child health care related matters is comparatively new in Tanzania. Conventionally, pregnancy and childbirth have been examined to be women's matters and pregnant women were given assistance by their mother-in-laws, sisters, and other women relations during labour and birth (Kayombo, 1997). The findings of this study supports previous studies that indicated that traditional gender norms continue to restrain men's participation in pregnancy and childbirth related services (Falnes, Moland, Tylleskar, de Paoli, Msuya and Engebretsen, 2011; Ditekemena, Koole, Engmann, Matendo, Tshefu, Ryder, Colebunders, 2012; Reece, Hollub, Nangami and Lane, 2010; kandawile and Hendriks, 2018).

### **Parenting practices in relation to Reproductive Health**

In western Kenya, as in many parts of the country, childbirth and child rearing are traditionally women's responsibilities. The man in the family is not supposed to discuss matters of sexuality with his female children as part of his role as the head of the household. This cultural belief not only hinders men from canvassing issues of reproductive health; it also contributes to the general lack of male involvement in reproductive health. It was revealed that though most married men (especially the older generation) seldom discuss reproductive health matters with their wives and children, the younger generation is considered more open and can talk more freely about reproductive health.

### **2.5.5 Gender roles**

Generally, husbands do not participate in the hands-on delivery. Instead, when they are involved, their roles are largely secondary and supportive, and most notably had to do with providing and preparing food. This is partly due to the women's restricted access to the kitchen during the postpartum seclusion period and as such may be perceived to be of importance. The other women,

such as the mother-in-law, instead had the main role of assisting directly with the childbirth. Some of the primary tasks in the postnatal period that may be undertaken by the husbands included the cutting of the umbilical cord or providing the necessary instruments to do so. This depended on whether this was perceived to be a woman's role and who else was present. However, in many cases the woman herself cuts the cord. Other secondary tasks commonly undertaken by the men included massaging their wife during labour and washing the newborn afterwards. Of note, although some men described themselves as being present at the time of delivery, whilst they were physically present they tended not to actually participate in the delivery.

Men also accompanied their wives to health facilities, due to the need to be stretched, to provide financially, and as they perceived it to be an obligation as a husband. However, men were then expected to wait outside the delivery room. That said, at one health centre in a nearby town husbands were now being encouraged to enter the delivery room; as a health worker explained that witnessing the pain of childbirth could facilitate future family planning. It was also discovered that decision making varied between households, being undertaken by both husbands and the mother-in-law. Traditionally, the mother-in-law occupies the top position in the household.

However, decision making is increasingly no longer the exclusive of the mother-in-law. Although their decision making is dependent on their availability, husbands did make decisions in relation to seeking medical help, determining the place of birth, allocation of family resources including finances, and task allocation such as with regards to the domestic workload. In some cases, particularly in the absence of their husbands, the women made these decisions independently (Sarah et al., 2015). The socio-cultural components that have been discovered very much revolved around traditional gender role anticipations. Helping in household chores and attending clinics with spouse to clinics for check-ups or deliveries were embraced opportunities for a few men. Majority of the husbands expressed the view that roles for men and women are different. This issue triggered much contention amongst the respondents in the focus group discussions based on their religious and cultural beliefs. Whilst those in support of helping in household chores affirmed it would minimize women's burden and make the women and their unborn child healthy for safe delivery, others professed that it is culturally intolerable for a man to be cooking when the wife is around. They insisted that, where a woman is unable to work during pregnancy, female relations



need to come and stay with her or the woman has to go and stay with her parents for the mother to help her (Bassoumah and Kee Ling, 2017).

### **2.5.6 Education**

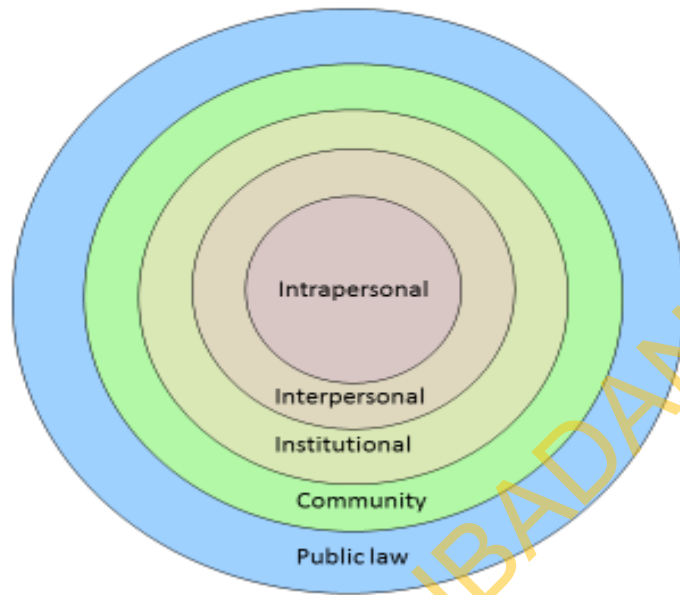
Many researchers have identified the fact that educational level and employment status of one's partner could have an effect on the level of male involvement in maternal health services (Amenu, Belachew and Araya, 2011; Baral, Lyons, Skinner and Van, 2010). Consequently, upper levels of education among pregnant women are linked with high levels of involvement of their male partners in MHC. 59% of respondents' partners had no education and this was found to be remarkably connected with male involvement in MHC services, particularly antenatal care and delivery (Joshua et al., 2017). This implied that perhaps uneducated women are less likely to canvass and involve men in decisions on maternal health matters than their more educated peers (Mullany, Hindi and Becker, 2004).

### **2.5.7 Gender Issues**

Women's ability to exercise their rights to reproduce health and to negotiate their access to health services is directly affected by the gender, social cultural and economic inequalities they face. It has been shown that reductions in maternal mortality are directly connected to girls' and women's educational opportunities. Over 40 million girls remain out of school worldwide (United Nations' Millennium Development Goals Report, 2007; Global campaign for Education, 2005). Girls and women are disempowered in multiple ways by not having right to education fulfillment, they miss out on important messages about health and sex and are less likely to become economically independent (Ghaida and Klasen, 2004). Control of finances and the decision making power 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 lives and that of their babies in pregnancy-related issues, while awaiting decision to be taken by such gatekeepers (FMOH, 2007; Lucas and Gills, 2003). 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 rate of birth in health facilities, low attendance of postnatal services, poor inborn immunization, inadequate child care practice and poor health seeking behaviour. This is mostly true in the Northern part of the country (FMOH, 2007).

## CONCEPTUAL FRAMEWORK

### Ecological Model



- **Intrapersonal factors:** Self-esteem, knowledge on maternal healthcare (MHC), perceptions on male involvement in MHC, perception of pregnancy support as a female role
- **Interpersonal factors:** Peer approve male involvement in MHC, family influence on men participation in MHC
- **Institutional factors:** Physical lay-out of clinics, Adequacy of health facilities, Adequacy of health personnel (Doctors and Nurses) to attend to pregnant women, Attitude of health worker, antenatal care services
- **Community factors:** Gender norms, cultural belief, values on male involvement in maternal health care
- **Public Policy:** Government policy on active male involvement in maternal healthcare

## CHAPTER THREE

### METHODOLOGY

#### 3.1 Study design

A cross-sectional descriptive study design was used for the study and a well-structured interviewer administered questionnaire

#### 3.2 Study Area

Sabo is a community in Ibadan North Local Government Area of Ibadan, Oyo state with predominantly Hausa dwellers. It is situated in ward 6 of Ibadan North Local Government, Oyo state. It is bounded on the North by Mokola road, West by Veterinary, South by Adamasingba stadium complex and East by Alaafia Hospital Dugbe road.

The population predominantly consists of people from the Northern region of the country. There are also other ethnic groups from different parts of the country and outside the country who came to reside in Sabo for commercial activities. The major commercial activities in the community are bureau de change who engages in currency exchange, Suya spot, Tailoring and Embroiding, Okada riding and Cafeterias. It has one Primary Health Centre and some other private hospitals as well as pharmacy stores. There are also filling stations and government schools such as Saint Gabriel Secondary School as well as private schools like Mercy day group of school. Sabo is a community dominated by Muslim but we still have Christians in the community. It has one central Mosque and two other mosques and different Islamic schools for both the men and women including children. We also have churches such as Baptist church and Zion day church.

The community is divided into different clusters which are according to their respective population. This includes;

**Table 3.1: Population of Sabo Community**

<b>Settlements</b>	<b>Total Population</b>
Sabo central	6,188
Turmu sawa	1,947
Gangare	1,638
Saint Lawrence	491
Sabo garage	1,542
Ghana	1,633
Oke esu	9,578
Ile ayo	1,223
Oro compound	941
Alafia hospital area	636
Cornoil area	742
Saint bridge area	428
Oke hausa	1,206
Magirika	1,993
Christus hospital area	628
<b>TOTAL</b>	<b>30,814</b>

Source: (National Population Commission, Oyo state, 2015)

### 3.3 Study population

The target study population consisted of married men that are resident in the community who consented to participate in the study

### 3.4 Inclusion criteria

The study included married men whose wife has had at least a child or currently pregnant who consented to participate in the study

### 3.5 Exclusion criteria

1. Men that were not married
2. Men whose wife did not have at least a child or not currently pregnant

### 3.6 Sample size

Sample size for this study was estimated using the formula for calculating single proportions by Abraham and Gahlinger. The estimated number of people in Sabo community is above 10,000. Therefore, the sample size formula was used as follows:

$$n = \frac{Z^2 pq}{d^2}$$

n = minimum sample size required

Z = standard normal deviation set at 1.96 normal interval corresponding to 95% confidence level

p = prevalence of male participation 32.1% (Iliyasu, Isa, Hadiza and Muktar, 2010)

d = degree of accuracy desired or maximum allowable difference from true proportion which is set at 5% (0.05)

$$n = \frac{(0.32 \times 0.68 \times 1.96^2)}{(0.05)^2} = 334$$

Non response rate (10%) = 367

### 3.7 Sampling technique

A multi stage sampling technique was employed in selecting married men in Sabo community in Ibadan North Local government area. The study sample was drawn from population of men resident in the five sub communities within Sabo community which are Sabo Gangare, Sabo Oke hausa, Sabo oke esu, Sabo Gana and Sabo central

**Stage one:** A stratified sampling technique was used to stratify the community into five strata that include; Sabo Gangare, Sabo Oke hausa, Sabo oke esu, Sabo Gana and Sabo central

**Stage two:** Proportionate sampling was used to determine the total number of respondents in each of the selected strata

**Stage three:** Systematic sampling technique was used to select respondents at an interval of two houses within the community. In a situation where there was more than one man in a particular house, random selection was used to select respondent. All married men that were willing to participate were recruited into the study. An estimated number of data to be calculated based on the sample size which was set as target was made known to the research assistants. The commercial activities which brought most of the men to the road side during the day was considered and participants were also recruited among them but in order to identify which of the strata of the community each participant by the road side came from, there was a question in the socio demographic status that stated which part of Sabo they live.

**Table 3.2: Proportionate Sampling of Respondents by their location**

Location	Total	Sample size
Sabo Gangare	3,016	$\frac{3,016}{30814} \times 367 = 36$ 30814
Sabo Oke hausa	3,827	$\frac{3,827}{30814} \times 367 = 46$ 30814
Sabo oke esu	11,742	$\frac{11,742}{30814} \times 367 = 140$ 30814
Sabo Gana	4,094	$\frac{4,094}{30814} \times 367 = 48$ 30814
Sabo central	8,135	$\frac{8,135}{30814} \times 367 = 97$ 30814

### **3.8 Instrument for data collection**

A semi-structured interviewer administered questionnaire was used for data collection. The questionnaire was in 5 sections: Section A covered socio-demographic status of respondents (age, educational level, occupation, religion, ethnicity); Section B covered respondents knowledge on maternal health care, Section C elicit information on area of involvement of men in maternal healthcare, Section D sought to elicit information on perceptions of men in involvement of maternal healthcare and Section E collected information on factors influencing men's involvement in maternal healthcare.

### **3.9 Validation of instrument**

Review of relevant literature was carried out. Research experts including the supervisor were consulted to ensure that the instrument measures what it intended to measure as well as a peer review was carried out. Two (2) Research assistants were trained and recruited

### **3.10 Reliability of instrument**

In order to ascertain the reliability of the instrument, 10% of the total study population was pretested at another Hausa community in Ojoo called Shasha. This is because it has similar socio-demographic and socio-economic characteristics as the study area. This provided a means for ascertaining the appropriateness of the questions for obtaining valid and reliable responses. Reliability co-efficient measure was carried out on the pre- tested questionnaire to know how reliable the instrument was. A co- efficient of 0.7-1.0 was considered reliable. All necessary adjustment and modifications was then made on the instrument before the actual data collection began.

### **3.11 Data collection procedure**

For the study, serially numbered interviewer administered questionnaire was used. The data was collected by the researcher and two (2) other research assistants who were trained prior to the time of data collection. Both the benefits and harm that may arise as a result of participating in the study was explained to the research participants. The informed consent form (attached to the questionnaire) was also distributed to the potential participants after they were given adequate



information about the study. Then, after the questionnaire was filled, the researcher checked for completeness and errors before leaving the field.

### **3.12 Data management and analysis**

The completed questionnaire was checked one after the other for the purpose of completeness and accuracy. Serial number was assigned to each questionnaire for easy identification, entry and analysis. The data was then coded and entered into the computer for analysis using both inferential and descriptive statistic with the aid of statistical package for Social Sciences (SPSS) version 20. Pearson Chi-square and Fishers exact tests at 0.5% level of significance were conducted to assess significant associations between the dependent and independent variables. Results were presented in prose, tables, charts and percentages.

Respondents' knowledge of maternal healthcare was measured on a 30-point knowledge scale. Knowledge score (KS) of  $<15$  was rated as poor knowledge, KS of  $15 \leq 22$  was considered fair and  $KS > 22$  was rated as good knowledge. Overall level of involvement was based on a 10-point scale and 75% of the overall score was taken as a cut off point for good involvement in maternal health care.

Respondent's perception on involvement in maternal health care was scored on a 10-point scale; appropriate response for each statement was scored 1 while the wrong was scored 0. The scores were added up to get each respondent's perception which was then categorized into negative and positive perception. Scores (0-7) was categorised as negative perception while scores  $>7$  was categorised as positive perception

### 3.13 Ethical considerations

Ethical approval was obtained from Oyo State Ministry of Health Ethical Review Committee who reviewed the proposal, questionnaire and consent form before providing clearance. Also permission was gotten from Head of the community.

**Informed consent:** Adequate information was provided to the respondents and having understood the study, consent form was given to the respondents before administering the questionnaire

**Confidentiality:** This was maintained by removing all identifiers of the respondents during data entry. All information provided will be kept confidential and will be strictly used for research purpose only.

**Voluntariness:** The decision to participate in the study was entirely voluntarily. The respondents had the right to choose to participate in the study or not without any consequence.

**Benefit:** There was no direct benefit but information provided can be used in advancing knowledge and science on the improvement of maternal health care

## CHAPTER FOUR

### RESULTS

This chapter presents the results of data collected for this study. The entire three hundred and sixty-seven (367) questionnaire administered to the respondents in Sabo community, which constituted the representative samples of married men in Sabo community were returned. Therefore, the analyses were based on three hundred and sixty-seven (367) returned questionnaires. The analyses were divided into five major sections to include: Socio demographics status of respondents, knowledge on maternal health care, men's involvement in maternal health care, perception on men's involvement in maternal health care and factors influencing men's involvement in maternal health care. The hypotheses that guided the execution of this study were tested in the last section of this chapter

#### 4.1 Socio demographic variable of Respondents

This section deals with the socio-demographic characteristics of the respondents in this study. This includes age, level of education, occupation, religion, ethnicity etc. The ages of the respondents ranged from 28 to 67 years with a mean age group of  $40.34 \pm 8.79$  having more (43.0%) of the respondents within the range of 28-37 years old. The respondents were grouped into three namely Christianity, Islamic and Traditional Religion. The distribution of respondents by religious affiliation showed that Islamic 364 (99.2%) was the dominant religion in the study location. This was followed by those who practiced Christianity Religion 3 (0.8%) while none practices Traditional Religion. Larger proportion 280 (76.3%) of the respondents practice monogamy family (table 4.1). Figure 4.4 shows the number of wives for each married men that indicated polygamous family. Few number 65 (17.7%) of the respondents have two wives, while minute number 1 (0.3%) of the respondents has nine wives (figure 4.4)

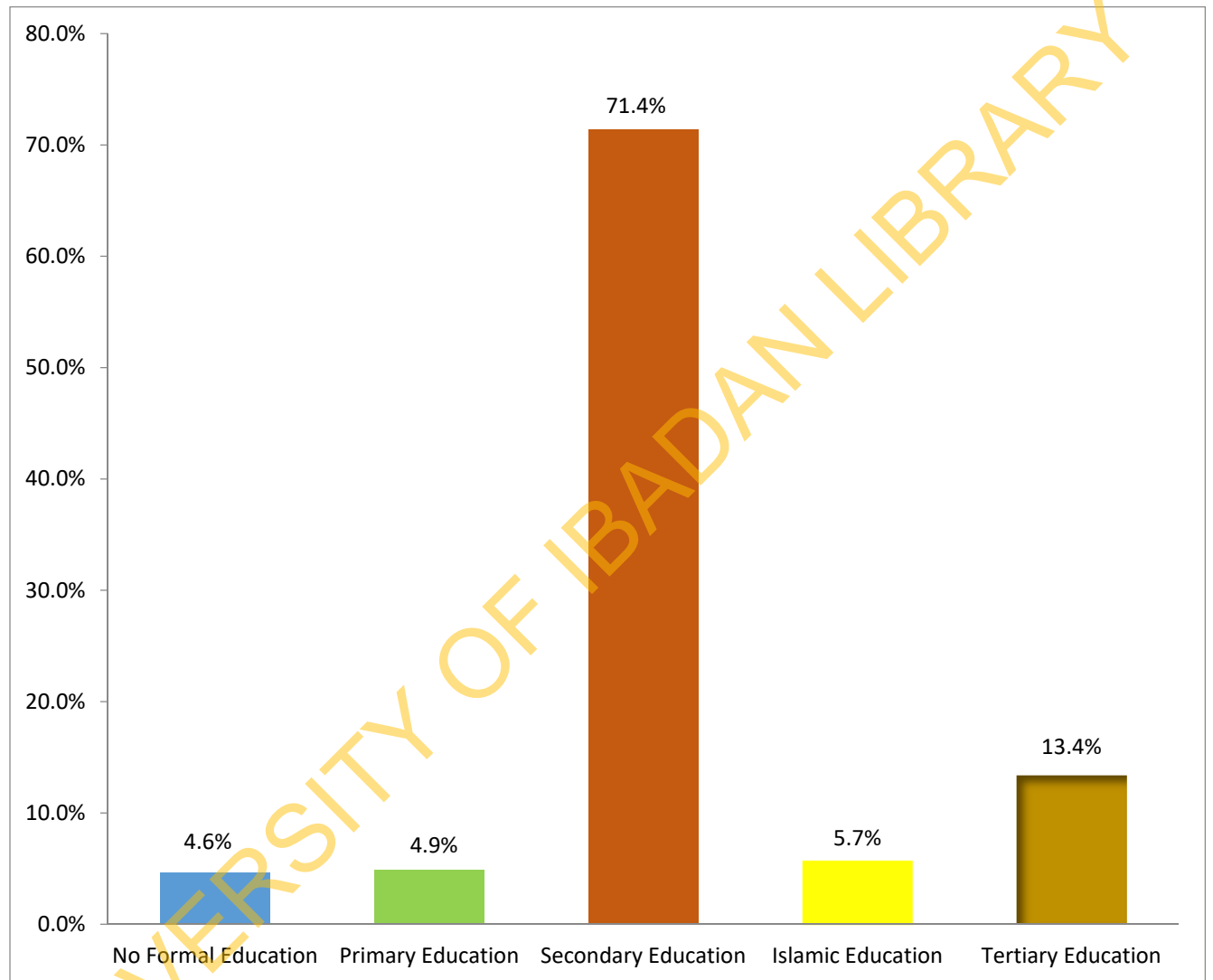
Largest number of the respondents indicates that they have secondary education 262 (71.4%). This was followed by those who indicated they have tertiary education 49 (13.4%). Respondents who indicated that they have Islamic education were 21 (5.7%) while 18 (4.9%) have primary education. The lowest number of respondent 17 (4.6%) indicated that they have no formal education (figure 4.2). On account of occupation, majority of the respondents 347 (94.6%) are self-

employed, 8 (2.2 %) are private sector worker, 8 (2.2%) are unemployed and 4(1.1%) are civil servants (figure 4.3). Highest proportions 356 (97%) of the respondents are Hausa. This is followed by 7 (1.9%) Respondents that are Yoruba 7 (0.5%), 1 (0.3%) and 1 (0.3%) are Fulani, Igbo and Nupe respectively (table 4.1). The highest number of children (25) was indicated by 0.3% of the respondents while 21.8% of the respondents reported having two (2) children (Table 4.1)

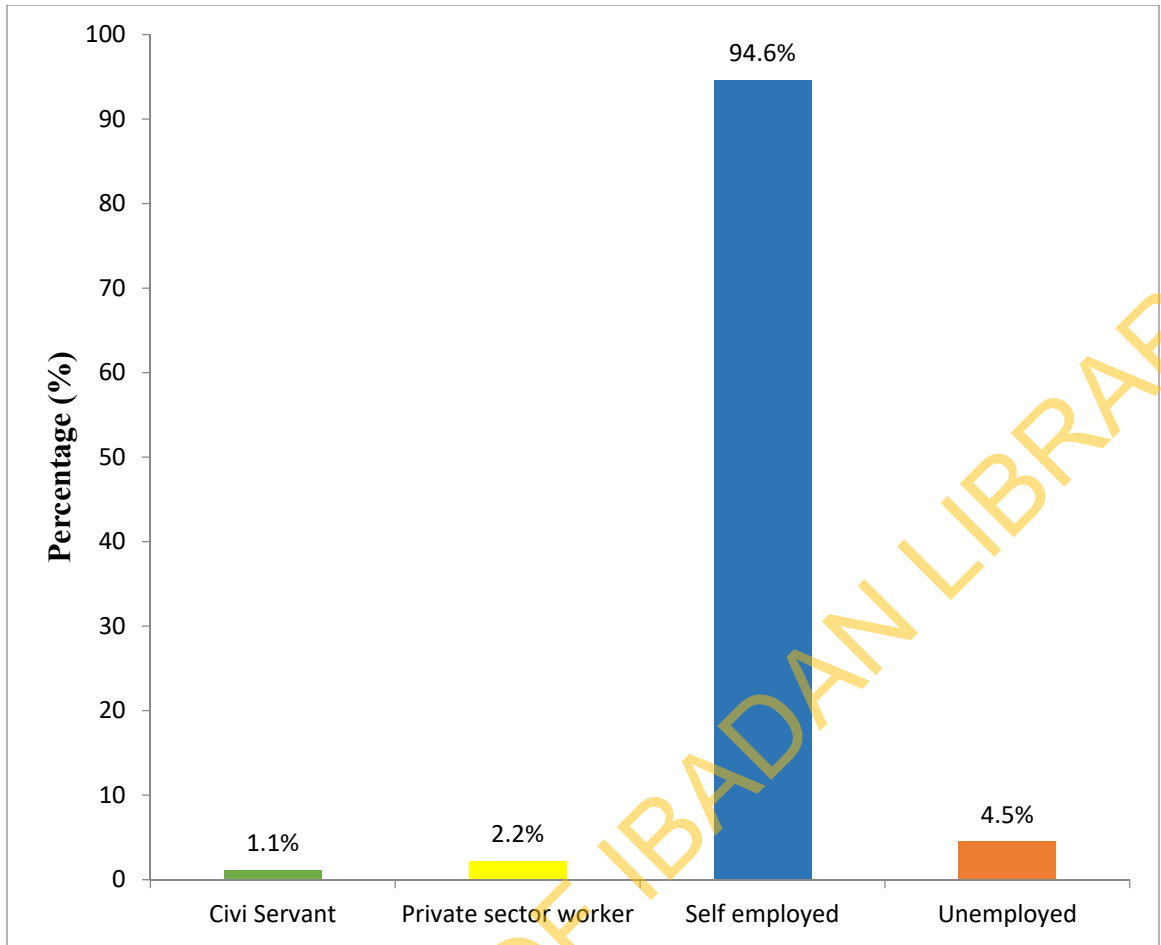
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**Table 4.1: Socio demographic variable of Respondents (N=367)**

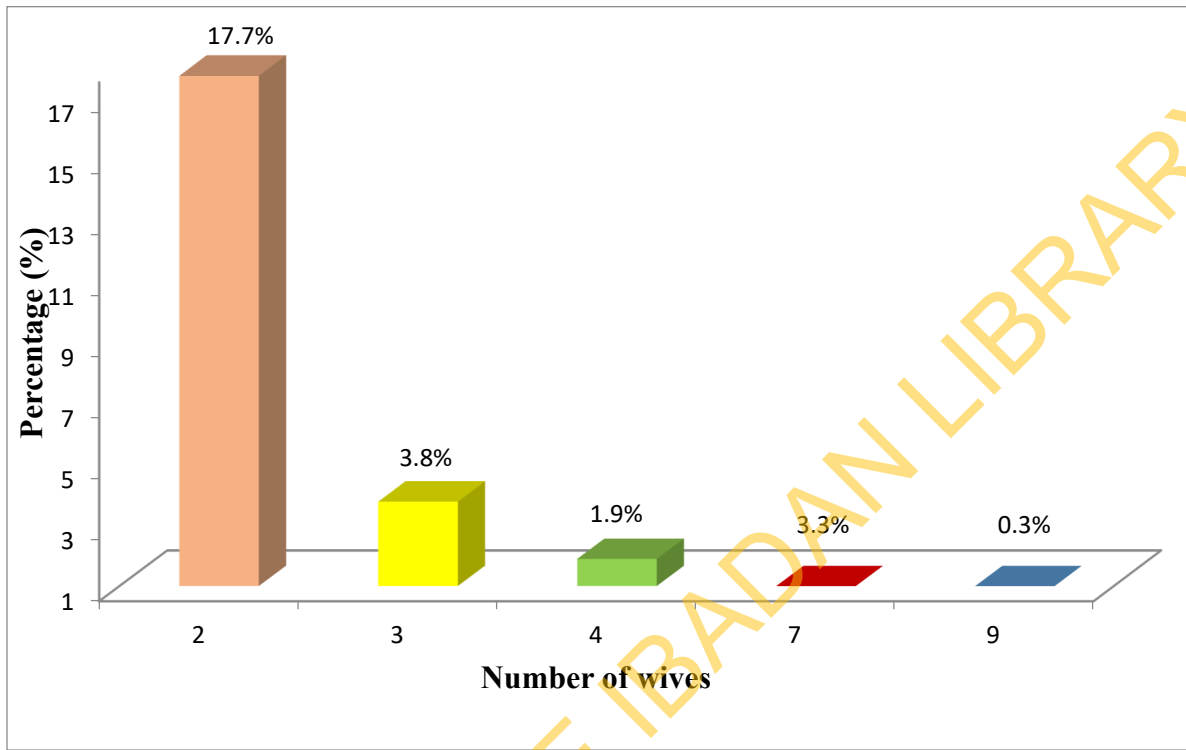
Socio demographics variables	Frequency	Percentage
<b>Age group</b>		
28-37	158	43.0
38-47	131	35.7
48-57	56	15.3
58-67	22	6.0
<b>Mean</b>	40.3±8.79	
<b>Number of Children</b>		
0-4	232	63.2
5-8	86	23.4
9-12	31	8.4
>12	18	4.9
<b>Type of Family</b>		
Monogamous	280	76.3
Polygamous	87	23.7
<b>Ethnicity</b>		
Hausa	356	97
Yoruba	7	1.9
Fulani	2	0.5
Igbo	1	0.3
Nupe	1	0.3
<b>Religion</b>		
Islamic	364	99.2
Christianity	3	0.8



**Figure 4.2: Respondents' Level of Education**



**Figure 4.3 Respondents' Occupation**



**Figure 4.4 Number of wives in each Polygamous family**



## 4.2 Respondents' Knowledge on Maternal Health Care

All the respondents 367 (100%) have the knowledge that women need special care during and after pregnancy. Almost all the Respondents 360(98.1%) reported to have heard about family planning. Many of those who are aware of family planning understood it to mean Child Spacing 305 (84.7%) and control of family size 44(12.2%), with few number 11(3.1%) of the respondents understanding it to mean preventing unwanted pregnancy. Among the respondents 265(72.2%) indicated birth control pills which is the most known contraceptives method, this is followed by withdrawal 264(71.9%), Injectable 260(70.8%) and male condom 246(67.0%).

The top three key danger signs in pregnancy recognized by the respondents are severe headache 346(94.3%), blurred vision 341(92.9%), and too weak to get out of bed 100 (27.2%). The least recognized key danger signs in pregnancy by the respondents are swollen heads/face 76(20.7%) and back pain 80(21.8%). The most recognized key danger signs during labour by the respondents are loss of consciousness 346(94.3%), high fever 342(93.2%), prolonged labour 340(92.6%), and vaginal bleeding 335(91.3%). All the key danger signs during postpartum were adequately identified by the respondents, this include severe abdominal pain 351(95.6%), severe headache 345(94.0%), offensive vaginal discharge 329(89.6%), swollen eyes with pus 294(80.1%) and fever 250(68.1%).

An appreciable number of respondents 323(88.0%) have heard about exclusive breastfeeding while few number of the respondents (12.0%) have not heard about it. Among those that have heard about exclusive breastfeeding, just a little above average 171(52.9%) respondents understood it to mean breast milk alone while 152(47.1%) respondents understood it to mean breast milk with little water. Just below average number 150(46.4%) of respondents were knowledgeable about the correct duration of exclusive breastfeeding. 31(9.6%) indicated less than 6 months, 150(46.4%) indicated 6 months only while 142(44.0%) indicated 6 months and above.

Respondents' knowledge of maternal healthcare was measured on a 30-point knowledge scale. Knowledge score (KS) of  $<15$  was rated as poor knowledge, KS of  $15 \leq 22$  was considered fair and  $KS > 22$  was rated as good knowledge. It was revealed that majority of the respondents 241(65.7%) had fair knowledge while far below average 109(29.7%) had good knowledge of maternal health care (table 4.8)

**Table 4.2: Respondents' Knowledge on Family planning**

<b>Variable</b>	<b>Frequency</b>	<b>Percentage</b>
<b>Ever heard of family planning (N=367)</b>		
Yes	360	98.1
No	7	1.9
<b>Meaning of family planning (n=360)</b>		
Child spacing	305	84.7
Control of family size	44	12.2
Prevent unwanted pregnancy	11	3.1

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**Table 4.3: Respondents' Knowledge on Contraceptive method**

<b>Contraceptive methods (N=367)</b>	<b>Frequency</b>	<b>Percentage</b>
Birth control pills	265	72.2
Withdrawal	264	71.9
Injectable	260	70.8
Male condom	246	67.0
Female condom	32	8.7

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**Table 4.4: Respondents' Knowledge on key danger signs in pregnancy**

<b>Key danger signs in pregnancy (N=367)</b>	<b>Frequency</b>	<b>Percentage</b>
Severe headache	346	94.3
Blurred vision	341	92.9
Too weak to get out of bed	100	27.2
Back pain	80	21.8
Swollen hands/face	76	20.7

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**Table 4.5: Respondents' Knowledge on Key danger signs during labour**

<b>Key danger signs during labour (N=367)</b>	<b>Frequency</b>	<b>Percentage</b>
Loss of consciousness	346	94.3
High fever	342	93.2
Prolonged labour	340	92.6
Vaginal bleeding	335	91.3
Water leak without pain	335	91.3
Vaginal bleeding	67	18.3

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**Table 4.6: Respondents' Knowledge on Key danger signs during postpartum**

<b>Key danger signs during postpartum (N=367)</b>	<b>Frequency</b>	<b>Percentage</b>
Severe abdominal pain	351	95.6
Severe headache	345	94.0
Offensive vaginal discharge	329	89.6
Swollen eyes with pus	294	80.1
Fever	250	68.1

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**Table 4.7: Respondents' Knowledge on Exclusive Breastfeeding**

<b>Variable</b>	<b>Frequency</b>	<b>Percentage</b>
<b>Ever heard about Exclusive Breastfeeding</b> <b>(N=367)</b>		
Yes	323	88.0
No	44	12.0
<b>Understanding of Exclusive Breastfeeding</b> <b>(n=323)</b>		
Breast milk alone	171	52.9
Breast milk with little water	152	47.1
<b>Duration of Exclusive Breastfeeding</b> <b>(n=323)</b>		
Less than 6 months	31	9.6
6 months only	150	46.4
6 months and above	142	44.0

**Table 4.8: Categorization of Respondent's knowledge on Maternal Health Care**

Level of knowledge	Frequency	Percentage (%)
Poor (<15)	17	4.6
Fair (15-22)	241	65.7
Good (22-30)	109	29.7
<b>Total</b>	<b>367</b>	<b>100</b>

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### 4.3 Involvement of Respondents in Maternal Health Care

Table 4.9 shows the Involvement of respondents in maternal health care. Few number of the respondents 73(19.9%) follow their wives to antenatal clinic. Almost three-quarter of the respondents 275(74.9%) help their wives with house chores during and after pregnancy. Majority of the respondents 327(89.9%) ensure their wives register at the antenatal clinic as soon as she is pregnant. Almost three-quarter of the respondents 268(73.0%) encourage other men to follow their wives to antenatal clinic. Majority of the respondents 258(70.3%) save money ahead of time of wife's delivery. Appreciable number 248 (67.3%) arrange for emergency transportation before the delivery of their wives. Just a little above average 204(55.6%) determine place of delivery for their wives. On the basis of decision concerning family planning, 142(38.7%) of the respondents reported to make joint decisions with wife on when to get pregnant, 136 (37.1%) make joint decisions with wife on the number of children while 168(45.8%) ensure child spacing by using contraceptive method.

Overall Involvement was based on a 10-point scale and 75% of the overall score was taken as a cut off point for good involvement in maternal health care. Far below average number of the respondents 126(22.3%) had a good involvement in maternal health care of their wives (table 4.10).

**Table 4.9: Involvement of Respondents in Maternal Health Care**

<b>Variable</b>	<b>Frequency</b>	<b>%</b>
Ensure wife register at ANC as soon as she is pregnant	327	89.1
Help wife with house chores during and after pregnancy	275	74.9
Encourage other men to follow their wives to ANC	268	73.0
Save money ahead of time of wife's delivery	258	70.3
Arrange for emergency transportation before wife deliver	248	67.6
Determine place of delivery for wife	204	55.6
Ensure child spacing by using contraceptives	168	45.8
Make joint decisions with wife on when to get pregnant	142	38.7
Make joint decisions with wife on the number of children	136	37.1
Follow wife to ANC	73	19.9

**Table 4.10: Overall Level of Involvement of Respondents in Maternal Health Care**

<b>Level of Involvement</b>	<b>Frequency</b>	<b>Percentage (%)</b>
Poor (0-7)	285	77.7
Good (8-10)	82	22.3
<b>Total</b>	<b>367</b>	<b>100</b>

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#### 4.4 Perception of Respondents on involvement in Maternal Health Care

Table 4.11 shows the perception of Respondents on involvement in maternal health care. Some of the respondents 247(67.3%) agreed that it is necessary for men to follow their wives to Antenatal clinic while 109(29.7%) disagreed with the statement. Above three-quarter of the respondents 279(76.0%) disagreed with the statement “It is not important for men to accompany their wives on the day of delivery because it is the duty of women”. Majority of the Respondents 350(95.4%) agreed that men that accompany their wife to antenatal clinic will have more information about danger signs during pregnancy and delivery, 6(1.6%) were undecided and 11(3.0%). Almost all the respondents 364(99.2%) agreed that men should ensure their wives takes adequate and required diet during and after pregnancy. About three-quarter 265(72.2%) disagreed that it is not the role of men to ensure that wife attend ANC care at least four times before delivery and 98(26.7%) agreed. Few number of Respondents 37(10.1%) had the wrong perception that pregnancy support is a female role while 324(88.3%) had the right perception. An appreciable number of Respondents 77(21.0%) had the wrong perception that presence of men at the time of delivery delays the baby, 14(3.8%) were undecided and 276 (75.2%) had the right perception. Majority of the respondents 348(94.8%) disagreed that men that attend antenatal with their wives are considered weak. Large number of Respondents 364(99.2%) were of the opinion that men should encourage their wives to practice exclusive breastfeeding while 49(13.4%) were undecided and the rest disagreed. About three tenths of the Respondents 107(29.2%) agreed that it is the role of mother only to ensure child complete immunization while 254(69.2%) disagreed.

Respondent’s perception on involvement in maternal health care was scored on a 10-point scale; appropriate response for each statement was scored 1 while the wrong was scored 0. The scores were added up to get each respondent’s perception which was then categorized into negative and positive perception. Scores <75% (0-7) was categorized as negative perception while scores >75% (8-10) was categorized as positive perception as shown in table 4.11. About three quarter of the respondents 315(73.8%) had positive perception on involvement in maternal health care.

**Table 4.11: Perception of Respondents on involvement in Maternal Health Care**

Variable	Agree (%)	Undecided (%)	Disagree (%)
Necessary for men to follow their wives to ANC	247(67.3)*	11(3.0)	109(29.7)
Not important for men to accompany their wives on the day of delivery because it is the duty of women only	79(21.5)	9(2.5)	279(76.0)*
Men that accompany their wife to antenatal clinic (ANC) will have more information about danger signs during pregnancy and delivery	350(95.4)*	6(1.6)	11(3.0)
Men should ensure their wives takes adequate and required diet during and after pregnancy	364(99.2)*		3(0.8)
It is not the role of men to ensure that wife attend ANC care at least four times before delivery	98(26.7)	4(1.1)	265(72.2)*
Presence of Men at the time of delivery delays the baby	77(21.0)	14(3.8)	276(75.2)*
Pregnancy support is a female role	37(10.1)	6(1.6)	324(88.3)*
Men that attend antenatal with their wives are considered weak	13(3.5)	6(1.6)	348(94.8)*
Men should encourage their wives to practice exclusive breastfeeding	303(82.6)*	49(13.4)	15(4.1)
It is the role of mother only to ensure child complete immunization	107(29.2)	6(1.6)	254(69.2)*

\*Correct response

**Table 4.12: Categorization of Respondent's perception on involvement in Maternal Health Care**

	<b>Frequency</b>	<b>Percentage</b>
Negative (0-7)	96	26.2
Positive (8-10)	271	73.8
<b>Total</b>	<b>367</b>	<b>100</b>

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#### 4.5 Factors influencing Respondents' involvement in Maternal Health Care

Table 4.13 shows the factors influencing respondents' involvement in maternal health care. When asked about the factors influencing the respondents' involvement in maternal health care of their wives, the most recognized among 301(82.0%) of the respondents is the belief that morbidity is a normal consequence during pregnancy. About three quarter of the respondents 276 (75.2%) indicated that they are too busy at work. About one- third of respondents 115(31.3%) specified Inadequate knowledge on maternal healthcare as one of the factors. Few number of the respondents 85(23.2%) pointed out Financial constraint. Presence of family/older children to take care of wife influences some number of respondents 107(29.2%) in involvement of maternal healthcare of their wives. A few number of respondents 37(10.1%) indicated Polygamy. Among the respondents 47(12.8%) were influenced by Health worker's attitude. About one-tenths of the respondents 32(8.7%) were controlled by Cultural constraint. About one-tenths of the respondents 27(7.4%) were persuaded by Peer influence. About one-fifths 61(16.6%) of the respondents indicated Unawareness of any health policy that encourages men to accompany their partners for antenatal care. Below average number of respondents 166(45.2%) identified Religious constraint on the use of contraceptive method while a small number of the respondents 42(11.4%) have the opinion that use of contraceptives encourages promiscuity. A small number of the respondents 17(4.6%) gave other reason that influence their involvement in maternal health care of their wives as activities of the clinic, usage of contraceptive by wife, concept of large family prevents use of contraceptives, wife strong enough to do house chores, future use of family planning, and belief that family planning is for those without enough money.

**Table 4.13: Factors influencing respondents' involvement in maternal health care**

<b>Variable</b>	<b>Frequency</b>	<b>%</b>
I believe that morbidity is a normal consequence during pregnancy	301	82.0
Too busy at work	276	75.2
Inadequate knowledge on maternal healthcare	115	31.3
Financial constraint	85	23.2
Presence of family/older children to take care of wife	107	29.2
Polygamy	37	10.1
Health worker's attitude	47	12.8
Cultural constraint	32	8.7
Peer influence	27	7.4
Unaware of any health policy that encourages men to accompany their partners for antenatal care	61	16.6
Religious constraint on the use of contraceptive method	166	45.2
Use of contraceptives encourages promiscuity	42	11.4
Others (Activities of the clinic, wife uses contraceptive, wife strong enough to do house chores, future use of family planning, family planning is for those without enough money, concept of large family prevent use of contraceptives)	17	4.6



**Table 4.14: Association between respondent's age, type of family and men who attend antenatal clinic with their wives**

		Follow wife to antenatal clinic		X <sup>2</sup>	Df	P-value
		Yes (%)	No (%)			
<b>Age</b>	28-37	35(22.0)	123(77.8)	1.776	3	0.620**
	38-47	25(19.1)	106(80.9)			
	48-57	8(14.3)	48(85.7)			
	58-67	5(22.7)	17(77.3)			
	<b>TOTAL</b>	<b>73(19.9)</b>	<b>294(80.1)</b>			
<b>Type of family</b>	Monogamy	57(20.4)	223(79.6)	1.61	1	0.688**
	Polygamy	16(18.4)	71(81.6)			
	<b>TOTAL</b>	<b>73(19.9)</b>	<b>294(80.1)</b>			

Not significant \*\*

**Table 4.15: Association between respondent's occupation, educational status and men who attend antenatal clinic with their wives**

		Follow wife to antenatal clinic		X <sup>2</sup>	Df	P-value
		Yes (%)	No (%)			
<b>Occupation</b>	Civil servant	3(75.0)	1(25.0)	9.269	3	0.010
	Private sector worker	3(37.5)	5(62.5)			
	Self employed	67(19.3)	280(80.7)			
	Unemployed	0(0.0)	8(100)			
	<b>TOTAL</b>	<b>73(19.9)</b>	<b>294(80.1)</b>			
<b>Educational status</b>	No formal education	1(5.9)	16(94.1)	54.409**		0.000*
	Primary education	9(50.0)	9(50.0)			
	Secondary school education	32(12.2)	230(87.8)			
	Islamic education	3(14.3)	18(85.7)			
	Tertiary education	28(57.1)	21(42.9)			
	<b>TOTAL</b>	<b>73(19.9)</b>	<b>294(80.1)</b>			

Significant \*

Fisher exact test \*\*

There is no significant association between socio-demographic status (age, type of family and occupation) and men that follow their wife to antenatal clinic but there is a significant association between educational status and men that follow their wife to antenatal clinic with p-value ( $< 0.005$ ) according to table 4.14 and 4.15.

There is no significant association between socio-demographic status (age, type of family, occupation and educational status) and level of knowledge of maternal health care according to table 4.16 and 4.17.

There is no significant association between socio-demographic status (age, type of family, occupation and educational status) and perception on male's involvement in maternal health care (table 4.18 and 4.19).

There is no significant association between socio-demographic status (age, type of family, occupation, and educational status) and male's involvement in maternal health care (table 4.20 and 4.21)

**Table 4.16: Association between respondents' age, type of family and level of knowledge of maternal health care**

		Level of Knowledge			Fisher Exact test value	P-value
		Poor (%)	Fair (%)	Good (%)		
<b>Age</b>	28-37	8(5.1)	102(64.6)	48(30.4)	1.812	0.945**
	38-47	7(5.3)	83(63.4)	41(31.3)		
	48-57	2(3.6)	40(71.4)	14(25.0)		
	58-67	0(0.0)	16(72.7)	6(27.3)		
	<b>TOTAL</b>	<b>17(4.6)</b>	<b>241(65.7)</b>	<b>109(29.7)</b>		
<b>Type of family</b>	Monogamy	12(4.3)	182(65.0)	86(30.7)	0.914	0.654**
	Polygamy	5(5.7)	59(67.8)	23(26.4)		
	<b>TOTAL</b>	<b>17(4.6)</b>	<b>241(65.7)</b>	<b>109(29.7)</b>		

Not significant \*\*

**Table 4.17: Association between respondents' occupation, educational status and level of knowledge of maternal health care**

		Level of Knowledge			Fisher exact test value	P-value
		Poor (%)	Fair (%)	Good (%)		
<b>Occupation</b>	Civil servant	1(25.0)	3(75.0)	0(0.0)	12.776	0.026**
	Private sector worker	1(12.5)	5(62.5)	2(25.0)		
	Self employed	14(4.0)	231(66.6)	102(24.9)		
	Unemployed	1(12.5)	2(25.0)	5(62.5)		
	<b>TOTAL</b>	<b>17(4.6)</b>	<b>241(65.7)</b>	<b>109(29.7)</b>		
<b>Educational status</b>	No formal education	0(0.0)	11(64.7)	6(35.3)	6.680	0.503**
	Primary education	2(11.1)	12(66.7)	4(22.2)		
	Secondary school education	10(3.8)	177(67.6)	75(28.6)		
	Islamic education	2(9.5)	11(52.4)	8(38.1)		
	Tertiary education	3(6.1)	30(61.2)	16(32.7)		
	<b>TOTAL</b>	<b>17(4.6)</b>	<b>241(65.7)</b>	<b>109(29.7)</b>		

Not significant \*\*

**Table 4.18: Association between respondents' age, type of family and perception on male's involvement in maternal health care of their wives**

		Perception		X <sup>2</sup>	Df	P-value
		Negative (%)	Positive (%)			
<b>Age</b>	28-37	49(31.0)	109(69.0)	6.619	3	0.085**
	38-47	24(18.3)	107(81.7)			
	48-57	17(30.4)	39(69.6)			
	58-67	6(27.3)	16(72.7)			
	<b>TOTAL</b>	<b>96(26.2)</b>	<b>271(73.8)</b>			
<b>Type of family</b>	Monogamy	74(26.4)	206(73.6)	0.045	1	0.832**
	Polygamy	22(25.3)	65(74.7)			
	<b>TOTAL</b>	<b>96(26.2)</b>	<b>271(73.8)</b>			

Not significant \*\*

**Table 4.19: Association between respondents' occupation, educational status and perception on male's involvement in maternal health care of their wives**

		Perception		X <sup>2</sup>	P-value
		Negative (%)	Positive (%)		
<b>Occupation</b>	Civil servant	2(50.0)	2(50.0)	4.379	0.160**
	Private sector worker	3(37.5)	5(62.5)		
	Self employed	87(25.1)	260(74.9)		
	Unemployed	4(50.0)	4(50.0)		
	<b>TOTAL</b>	<b>96(26.2)</b>	<b>271(73.8)</b>		
<b>Educational status</b>	No formal education	2(11.8)	15(88.2)	6.473	0.160**
	Primary education	7(38.9)	11(61.1)		
	Secondary school education	65(24.8)	197(75.2)		
	Islamic education	9(42.9)	12(57.1)		
	Tertiary education	13(26.5)	36(73.5)		
	<b>TOTAL</b>	<b>96(26.2)</b>	<b>271(73.8)</b>		

Not significant\*\*

**Table 4.20: Association between respondents' age, type of family and male's involvement in maternal health care of their wives**

		Level of involvement		Fisher exact test value	P-value
		Poor (%)	Good (%)		
<b>Age</b>	28-37	114(72.2)	44(27.8)	4.559	0.205**
	38-47	107(81.7)	24(18.3)		
	48-57	46(82.1)	10(17.9)		
	58-67	18(81.8)	4(18.2)		
	<b>TOTAL</b>	<b>285(77.7)</b>	<b>82(22.3)</b>		
<b>Type of family</b>	Monogamy	210(75.0)	70(25.0)	4.805	0.028**
	Polygamy	75(86.2)	12(13.8)		
	<b>TOTAL</b>	<b>285(77.7)</b>	<b>82(22.3)</b>		

Not significant \*\*



**Table 4.21: Association between respondents' occupation, educational status and male's involvement in maternal health care of their wives**

		Level of involvement		Fisher exact test value	P-value
		Poor (%)	Good (%)		
<b>Occupation</b>	Civil servant	3(75.0)	1(25.0)	3.856	0.241**
	Private sector worker	4(50.0)	4(50.0)		
	Self employed	271(78.1)	76(21.9)		
	Unemployed	7(87.5)	1(12.5)		
	<b>TOTAL</b>	<b>285(77.7)</b>	<b>82(22.3)</b>		
<b>Educational status</b>	No formal education	13(76.5)	4(23.5)	9.345	0.047**
	Primary education	13(72.2)	5(27.8)		
	Secondary school education	211(80.5)	51(19.5)		
	Islamic education	18(85.7)	3(14.3)		
	Tertiary education	30(61.2)	19(38.8)		
	<b>TOTAL</b>	<b>285(77.7)</b>	<b>82(22.3)</b>		

Not significant \*\*

## 4.6 Test of Hypotheses

### Hypothesis 1

**H0<sub>1</sub>:** There is no significant relationship between respondents' educational status and knowledge of maternal health care

Based on the results shown in table 4.17, P value is 0.503 which is more than 0.05; therefore, there is no significant relationship between respondents' educational status and knowledge of maternal health care. Hence we fail to reject the null hypothesis

### Hypothesis 2

**H0<sub>2</sub>:** There is no significant association between respondents' age and level of involvement in maternal health care

Since table 4.20 reveals that there is no significant association between respondents' age and level of involvement in maternal health care ( $p > 0.05$ ), therefore the null hypothesis is not rejected.

### Hypothesis 3

**H0<sub>3</sub>:** There is no significant association between respondents' knowledge and level of involvement in maternal health care

Table 4.22 shows that there is no significant relationship between respondents' knowledge and level of involvement in maternal health care ( $p > 0.05$ ), we fail to reject the null hypothesis. Therefore, there is no significant relationship between respondents' knowledge and level of involvement in maternal health care

**Table 4.22: Association between respondents' knowledge and level of involvement in Maternal Health Care**

Level of involvement	Knowledge			Fisher exact test value	P-value
	Poor (%)	Fair (%)	Good (%)		
Poor (0-7)	12(4.2)	194(68.1)	79(27.7)	3.483	0.177**
Good (8-10)	5(6.1)	47(57.3)	30(36.6)		
<b>TOTAL</b>	<b>17(4.6)</b>	<b>241(65.7)</b>	<b>109(29.7)</b>		

Not significant \*\*

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## CHAPTER FIVE

### DISCUSSION, CONCLUSION AND RECOMMENDATION

The following headlines will be discussed under this chapter; Socio demographics status of Respondent, Knowledge on Maternal Health Care, Involvement in Maternal Health Care, Perception on involvement in Maternal Health Care and Factors influencing respondent's involvement in maternal health care. This will further lead to implications of findings for health promotion and social policy, conclusion, recommendation and suggestions for further research.

#### 5.1 DISCUSSION

##### 5.1.1 Socio demographic status of Respondents

The demographic pattern shows that the predominant age group found was within the age groups of 28 to 37 years which is below average number of the respondents (43.0%); this implied that many men in Sabo community were still within their active reproductive years. This is similar to a study carried out in Atelewo community, Osogbo where majority of the respondents were found within their active reproductive years (Olugbenga et al., 2013). Almost all the respondents (99.2%) practice Islamic religion, this is expected since the study was carried out among Hausa community whose dominant religion is Islamic. Above average number of the respondents (76.3%) practice monogamy family as opposed to the belief that Hausa people are known to marrying many wives. The educational status of men in the community was observed to be below average considering 71.4% of them who had secondary school education. Similarly, only 69.2% of men were found to be literate (CIA world fact book 2015). Almost all the respondents are self-employed; this is attributed to the fact that the community is known for several commercial activities.

##### 5.1.2 Respondents' Knowledge on Maternal Health Care

The categorized knowledge of maternal healthcare revealed that majority of the respondents had fair knowledge while far below average number had good knowledge of maternal healthcare which is similar with a study by Olugbenga et al., 2013 where below average number of men had good knowledge of maternal healthcare. Also in a study on knowledge and perceptions of maternal health in Kaduna state by (Nuhu, Babayo, Hadiza, Farouk and Kelly, 2010), it was revealed that overall men had remarkably poor knowledge of maternal health because only 3% of men had a

good knowledge. There was a significant association between the respondents' level of education and their knowledge score ( $p=0.001$ ); knowledge of maternal health was higher among those with more education. This is in contrast with this study where there is no significant association between respondents' educational status and knowledge of maternal health care ( $p=0.590$ ) this could be attributed to the fact that majority of the respondents had secondary school education and so there is no way to ascertain the relationship between the respondents' knowledge and educational status.

All the respondents agreed that women need special care during and after pregnancy which collaborate a study by Olugbenga et al., 2013. The most poorly recognized key danger signs by the respondents are swollen hands/face, too weak to get out of bed and back pain during pregnancy and water leak without pain during labour. This commensurate a study by (August, Pembe, Mpembeni, Axemo and Darj, 2015) where swollen hands/face was recognized as obstetric danger sign during pregnancy by only 3% of the respondents.

### **5.1.3 Involvement of Respondents in Maternal Health Care**

This study revealed that far below average number of the respondents (34.3%) had a good involvement in maternal health care of their wives. This is similar to a study where the categorized involvement of men in maternal health care after scoring of the outcome variables indicated that far below average number of respondents had good involvement. The involvement of men in maternal health care was observed to be remarkably related with the respondents' age ( $p = 0.0001$ ) such that those older than 40 years, were more involved in maternal health care (Adenike et al., 2013) whereas in this study there was no significant association between respondents' age ( $p=0.205$ ) and level of involvement in maternal health care. Furthermore in developing countries such as Malawi, husband involvement in maternal health care was reported to be very low (Aarnio, Olsson, Chimbiri and Kulmala, 2009) as well as studies carried out in El Salvador (Iliyasu, Abubakar, Galadanci and Aliyu, 2010) and Greece (Carter and Speizer, 2005) revealed poor male involvement in antenatal care and labour; these studies revealed low levels of male participation (34%) in prenatal care, delivery and postnatal care attendance.

On account of decision on place of delivery, just a little above average number of the respondents determine place of delivery for their wives. Studies have shown different percentage of male involvement in choice of delivery site. For example, in Kenya, the Kenyan Demographic and

Health Survey (KDHS) 2008/2009 recorded that 73% of women either made their own decision, or a collective decision with regard to health care. In a study by (Wassie, Bekele, Ismael, Tariku, Heran, Getnet, Mitike, Adamu and Seifu, 2014) in Ethiopia, male involvement (90.4%) was observed to be high. A study by Dia, 2005 in Senegal indicated that husbands made 52% of the decisions on delivery site. A study in south western Uganda revealed that 56% of male partners were involved in deciding spouses' place of delivery (Kabakyenga, Ostergren, Turyakira and Pettersson, 2012). Nevertheless, in Nyandarua Kenya, 58.4% of the women interviewed had their place of delivery determined by their husbands (Wanjira, Mwangi, Mathenge, Mbugua and Ng'ang'a, 2011) while a study at Asembo Kenya observed that many of the women (87%) made decisions on delivery site on their own (Kwambai, Stephanie, Charles, Bobbie, Florence, Linda, Kayla and Feiko, 2013).

It was also observed that few numbers of the respondents make joint decision with their wives on when to get pregnant as well as the number of children. Other research has revealed that couples who agree about the number of children they want are more probably to use contraception and attain their reproductive goals than those who do not (Lalla, 1996). Persistently in Nigeria, less than 75% of men singly instigate discussions on issues such as when to achieve pregnancy, when to avoid pregnancy and the use of contraceptives (Cleland, Ndugwa and Zulu, 2011; Ijadunola, Abiona, Ijadunola, Afolabi, Esimai and Olaolorun, 2010). Whereas a little above average number of men in Ethiopia reported no discussion with their wives on issues corresponding to family planning use and understood it to be a natural process which does not require a discussion (Marius, Christine and Carine, 2014).

It was discovered that a small proportion of men followed their wife to antenatal clinic collaborating with a study by (Marius, Christine and Carine, 2014). Although, most respondents across Focus group discussion indicated that it was beneficial to follow their wives to antenatal clinic, to have access to direct information about the health of their wives and unborn babies. Some men have the belief that their wives either twist or conceal some information after clinic visits which was sometimes as a result of a deliberate act. An absence of trust meant they needed to get the information personally from the health worker. Some respondents also made mention of the fact they would be able to prompt their spouses to follow the doctors' instructions. However, one of the reasons given that prevent the men from accompanying their wives to antenatal clinic is as

a result of their belief that they are the head of household and provider and so their focal point is on economic activity which is more paramount for them to focus on at this time (Titus, Stephanie, Meghna, Charles, Bobbie, Florence, Linda, Kayla and Feiko, 2013).

Analysis showed that the socio-demographic factors influenced the men in accompanying the women to antenatal clinic. The age, type of marriage, education and occupation of the respondents had influence on the men to accompany the woman to attend the antenatal care (Sally and Mary, 2017). Whereas this study discovered that Age, Type of marriage, occupation had no influence on men to accompany their wife to antenatal clinic except Educational status with p-value ( $< 0.005$ ) which makes it statistically significant. Therefore, there is a significant association between educational status and men attending antenatal clinic with their wives. This implies that the higher the educational status the more the men accompany their wives to antenatal clinic.

A large number of the respondents help their wives with house chores during and after pregnancy. This contrast a study where below average numbers of the respondents help their wives in domestic household tasks during recent pregnancy (Dereje et al., 2016).

#### **5.1.4 Perception of Respondents on involvement in maternal health care**

Majority of the respondents had positive perception on involvement in maternal health care. Many number of the respondents agreed it is important for men to accompany their wives on the day of delivery. The perceptions and beliefs of some men about male involvement in maternal healthcare enthrall them in their involvement. In a study by (Bassoumah and Kee Ling, 2017) most of the respondents were of the opinion that any woman who had been involved in illicit love affairs would experience delayed labour would not have a safe delivery pending the time she admits. Consequently, accompanying wives to hospital was a particularly consequential restriction in patriarchal societies and children from extra marital pregnancies were not recognized as true blood of the family. As a result, men designate their sisters or mothers to following their wives to clinics in patriarchal societies which makes the relations of the husband to be present at the time of delivery to ascertain that the child was their blood, in the occurrence of any confession.

Many respondents disagreed that pregnancy support is a female role. The study is similar where there was an agreement that a man should welcome the idea of collaboration in pregnancy. The man is expected to demonstrate the responsibility by providing support and care for the woman

during pregnancy and childbirth if he was responsible for the pregnancy (Dan, Othman, Annetee, Michael, Scovia and Nelson, 2014). In contrast, many men revealed that primarily pregnancy support was commonly provided by other women. It was made clear that males were generally exempted from a supporting role, even as part of a couple. They mentioned that divulgence of pregnancy was seldom made known to them in the first instance, even though some men wish to be the first to be informed. Nearly all men disclosed that it is typical of women's choice to inform their co-wives, mothers in law, friends or trusted female neighbours before their spouses. In addition, some men were of the opinion that concealment or even non communication to their husband was commonly due to women's timidity in discussing female affairs or panic of the husbands' response to an unplanned pregnancy (Titus et al., 2013). Some men demonstrated their views that involvement and appearance of men during the delivery process is a western tradition that should not be embraced. Pregnancy and childbirth including care of the children in the family were viewed as women's responsibility. Men who accepted to bath their children, change their clothing and cuddled them were perceived as renegade by some men. Some men were of the view that very sick women should be cared by their fellow women and not men for privacy reason (Secka, 2010).

### **5.1.5 Factors influencing Respondents involvement in maternal health care**

When asked about the factors influencing the respondents' involvement in maternal health care of their wives, the most recognized among 301(82.0%) of the respondents is the belief that morbidity is a normal consequence during pregnancy.

A little above average number of the respondents indicated that they are too busy at work. Men's company and assistance for women to seek antenatal and delivery care was merited by most respondents but were commonly hindered by myriad of factors. Some men felt it is their responsibility to follow women to clinics and offer assistance when the need arise, but this was restrained by men's job responsibility. It was further revealed by men that if they are absence from work and available in the clinic together with their partners, this could leave their children without food because an hour absence from work will mean a struggle for the next day money. Most respondents reported having limited income and needed more hours of work to meet their survival (Secka, 2010; Matt and SSWH, 2017)



Some of the respondents specified inadequate knowledge on maternal healthcare as one of the factors which is similar to a study where some men agreed they needed education to increase their knowledge on pregnancy and childbirth (Dan et al., 2014). Men admitted that they lacked knowledge because their spouses did not inform them what they learnt from the clinics. One commented that women do not inform them what is being said at the clinic and do not bother to ask the men to follow them to the clinic, while another revealed that the women only talk about problems being detected at the clinic (Saiqa and Monica, 2005).

Below average number of respondents identified religious constraint on the use of contraceptive method. This is similar to a study which revealed that majority of the men do not practice family planning due to religious reasons. Making reference to various religious injunctions and traditions, they discussed that giving birth to many children is supported by Islam and is also essential for growth of Muslim Ummah (Ghulam, Syed, Wasqas, Safdar, Muhammed, Wajahat, Aftab and Erik, 2015).

A few number of respondents indicated Polygamy. Some men were of the view that polygamous men and women are being restrained by what was termed one rule is applicable to all, meaning once a husband has accepted to escort and support one of the wives he has to do the same for the other wives and which was considered tiresome (Secka, 2010). Some of the respondents gave other reasons that influence their involvement in maternal health care of their wives as activities of the clinic similar to a study where men disclosed that if the men followed their partners to the antenatal clinics, they normally stayed outside the clinics, as there was no space or seat for them, they were not given any particular attention on many occasions (Dan et al., 2014).

## **5.2 IMPLICATIONS OF FINDINGS FOR HEALTH PROMOTION AND EDUCATION**

The findings of the study have several implications for planning, development and implementation for health promotion and education on maternal health care programmes among men. It has been deduced from the study that knowledge has a direct influence on the perception and involvement in maternal care. Therefore, to improve the knowledge and involvement of men in maternal care, the following should be put in place:

### **Public enlightenment**

This could be organized as a town hall meeting where the men will be given adequate information on the importance of maternal health care and their role as their husbands in ensuring safe motherhood. Different information and education communication (IEC) materials such as posters, handbills, jingles and so on could be used in doing this. This will ensure the message is well driven home among the men. Also, meetings involving men gathering can be used. Mass media is also another very good platform for the dissemination of useful information. It has been observed that a very good number of men listen to radio and other mass media; hence such information could be disseminated through this platform thereby bringing about a change in the behavior of men towards maternal health care.

### **Training**

This will help fortify the men with the needed skills in taking care of their wives. Some men would have loved to assist their wives but due to lack of knowledge on what to do; they therefore refer their wives to their mothers or other female relatives. Men need to be trained on how to identify the danger signs in pregnancy, signs of labour and other things that are imperative to the health of the mother and child.

### **Policy formulation**

The importance and necessity of paternal leave for men have been overemphasized in ensuring the wellness of the mother and child. Men do not see the need to really get involve in preparing for the arrival of their bundle of joy in as much as they give money to the expectant mother to buy all that is needed. They only see it as females' thing therefore they face other things that will bring money. The government should formulate and implement a policy where fathers will be given at

least a month paternity leave to take care of the baby with their wife. This type of policy should be ensured it is effectively implemented as this will give men a sense of responsibility towards their wives and newborns.

### **5.3 CONCLUSION**

This study investigated the knowledge and level of involvement of men in maternal health care of their wives in Sabo community, Ibadan, Oyo state. The level of knowledge on maternal health care could be concluded to be poor. In spite of the positive perception of men towards involvement in maternal health care, majority of the men were not involved in maternal health care of their wives. Therefore, positive perception could not bring about the involvement of men in maternal health care of their wives.

Involvement of men in maternal health care include but not limited to helping wives with house chores during and after pregnancy, ensuring the registration of wife at ANC as soon as she is pregnant, following and encouraging other men to follow their wives to ANC, saving money ahead of the time of wife's delivery, arranging for emergency transportation before the wife's delivery, ensuring child spacing and practicing of exclusive breastfeeding.

However, some of the factors that hinder men from getting involved in maternal health care are too busy at work, wrong belief that morbidity is a normal consequence during pregnancy, polygamy, religious constraint on the use of contraceptive method, lack of knowledge on maternal health care and activities of the clinic among others. It is therefore imperative for men to be given adequate information on maternal health care, how they can effectively perform their role as men. This will help to avoid most of the factors highlighted.

This study therefore indicates that maternal health care knowledge, perception and involvement among men need to be improved to prevent the preventable deaths of mother and child during and after pregnancy. In addition, health workers, religious leaders, community leaders and other stakeholders will be needed to ensuring that the health of mother and child is given utmost attention.

## 5.4 RECOMMENDATIONS

Based on the findings from this study, the following recommendations were made to call on public and private attention to improve male's knowledge and involvement in maternal healthcare:

1. Men should be given adequate information on maternal health care so as to know what their roles are in maternal health care. This should be done through mass media, social media and other platforms where men can be reached.
2. Men should be trained on how to recognize key danger signs during pregnancy, labour and post-partum period and what to do in situations like these.
3. Further studies should be done on the expectations of women from their husbands during and after pregnancy.

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## APPENDIX I

Serial No -----

### QUESTIONNAIRE

#### **MALE'S KNOWLEDGE AND INVOLVEMENT IN MATERNAL HEALTH CARE OF THEIR WIVES IN SABO COMMUNITY, IBADAN NORTH LOCAL GOVERNMENT AREA, IBADAN, OYO STATE**

Good day sir, I am a Postgraduate student of Health Promotion and Education Department, Faculty of Public Health, College of Medicine, University of Ibadan. The aim of this study is to investigate on **Male's Knowledge and Involvement in maternal health care of their wives in Sabo community, Ibadan North Local Government area, Ibadan, Oyo state**. There are no wrong or right answers to the questions asked or statements made, what is desired of you is your honest answer. Please note that the completion of the questionnaire is entirely voluntary. All information provided will be kept confidential and will strictly be used for research purpose only. Information provided will be used in advancing knowledge and science on the improvement of maternal health care. Thanks for your cooperation.

I have read and understood the consent form and voluntarily agree to participate in the study by ticking the appropriate box below:

1. YES [ ]      2. NO [ ]

#### **SECTION A: SOCIO-DEMOGRAPHICS STATUS**

1. Age (as at last birthday) -----

2. Religion: 1. Christianity [ ]    2. Islamic [ ]    3. Traditional [ ]

3. Type of Family: 1. Monogamous [ ]    2. Polygamous [ ]

4. If Polygamous, how many wives? -----

5. Level of Education: 1. No formal Education [ ]    2. Primary Education [ ]

3. Secondary Education [ ] 4. Islamic Education [ ]

5. Tertiary Education [ ] 6. Others-----

6. Occupation: 1. Civil servant [ ] 2. Private sector worker [ ] 3. Self-employed [ ]

4. Unemployed [ ] 5. Others (please specify) .....

7. Ethnicity: 1. Yoruba [ ] 2. Igbo [ ] 3. Hausa [ ] 4. Others-----

8. Average daily income \_\_\_\_\_

9. Number of children \_\_\_\_\_

## **SECTION B: KNOWLEDGE ON MATERNAL HEALTH CARE**

10. Do women need special care during and after pregnancy? 1. Yes [ ] 2. No [ ]

11. Have you heard of family planning? 1. Yes [ ] 2. No [ ]

12. What is the meaning of family planning?

1. Control of family size [ ] 2. Child spacing [ ] 3. Prevent unwanted pregnancy [ ]

13. What are the contraceptive method(s) that you know? (Multiple response)

1. Male condom [ ] 2. Female condom [ ] 3. Injectable [ ]

4. Birth control pills [ ] 5. Intrauterine device (IUD) [ ] 6. Withdrawal [ ]

14. What are the key danger signs in pregnancy that you know? (Multiple response)

1. Blurred vision [ ] 2. Severe headache [ ] 3. Swollen hands/face [ ]

4. Back pain [ ] 5. Too weak to get out of bed [ ]

15. What are the key danger signs during labour that you know? (Multiple response)

1. High fever [ ] 2. Vaginal bleeding [ ] 3. Water leak without pain [ ]

4. Prolonged labour [ ]    5. Loss of consciousness [ ]

16. What are the key danger signs during postpartum that you know? (Multiple response)

1. Offensive vaginal discharge [ ]    2. Swollen eyes with pus [ ]    3. Fever [ ]

4. Severe abdominal pain [ ]    5. Severe headache [ ]

17. Have you heard about exclusive breastfeeding? 1. Yes [ ]    2. No [ ]

18. If yes, what do you understand by exclusive breastfeeding?

1. Breast milk alone [ ]    2. Breast milk with little water [ ]

19. What is the duration for exclusive breastfeeding?

1. Less than 6months [ ]    2. 6 months only [ ]    3. 6months and above [ ]

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## SECTION C: MALE'S INVOLVEMENT IN MATERNAL HEALTH CARE

**Instruction: Please indicate Yes/No to the following statements/questions to determine your area of involvement in maternal health care of your wife.**

S/N	Statements	Yes	No
20	Do you follow your wife to antenatal clinic?		
21	Do you help your wife to do some house chores during and after pregnancy?		
22	I make sure my wife register at antenatal clinic as soon as she is pregnant		
23	Do you encourage other men to follow their wives to antenatal clinic?		
24	I save money ahead of time before my wife go into delivery		
25	I arrange for emergency transport before the delivery of my wife		
26	I determine the place of delivery for my wife		
27	I make joint decisions with my wife on the number of children		
28	I make joint decisions with my wife on when to get pregnant		
29	I ensure child spacing by using contraceptive method		
30	Others (specify)		

**SECTION D: PERCEPTIONS ON MALE’S INVOLVEMENT IN MATERNAL HEALTHCARE**

**Instruction: Please indicate whether you agree/ disagree with the following statements to determine your perception on men’s involvement in maternal health care**

S/N	Statements	Agree	Undecided	Disagree
31	It is necessary for men to follow their wives to antenatal clinic			
32	It is not important for men to accompany their wives on the day of delivery because it is the duty of women only			
33	Men that accompany their wife to antenatal clinic (ANC) will have more information about danger signs during pregnancy and delivery			
34	Men should ensure their wives takes adequate and required diet during and after pregnancy			
35	It is not the role of men to ensure that wife attend ANC care at least four times before delivery			
36	Presence of Men at the time of delivery delays the baby			
37	Pregnancy support is a female role			
38	Men that attend antenatal with their wives are considered weak			
39	Men should encourage their wives to practice exclusive breastfeeding			
40	It is the role of mother only to ensure child complete immunization			

**SECTION E: FACTORS INFLUENCING MALE’S INVOLVEMENT IN MATERNAL HEALTH CARE**

**Instruction: Please indicate Yes/No to the following statements to identify factors that influence your involvement in maternal health care of your wife.**

S/N	Statements	Yes	No
41	I believe that morbidity is a normal consequence during pregnancy		
42	I am too busy at work		
43	I don't have adequate knowledge on maternal healthcare		
44	Financial constraint		
45	Presence of family/older children to take care of wife		
46	Polygamy		
47	Health worker's attitude		
48	Cultural constraint		
49	Peer influence		
50	I am unaware of any health policy that encourages men to accompany their partners for antenatal care		
51	Religious constraint on the use of contraceptive method		
52	Use of contraceptives encourages promiscuity		
53	Others (specify)		



4. Aikace-aikacen  5. Wasu (don Allah saka) .....

7. Ethnicity: 1. Yoruba  2. Igbo  3. Hausa  4. Wasu -----

8. Matsakaicin kudin shiga yau da kullum \_\_\_\_\_

9. Yawan yara \_\_\_\_\_

### **SASHE NA B: SANTA DA SANTA DA KUMA A KANKA**

10. Shin mata suna bukatar kulawa ta musamman a lokacin da bayan ciki? 1. Ee  2. Babu

11. Kun ji labarin shirin iyali? 1. Ee  2. Babu

12. Menene ma'anar tsarin iyali? 1. Gudanar da girman iyali  2. Tsarin yara  3. Tsayawa ciki maras so

13. Mene ne hanya (contra) da aka hana yin saba wa juna? (Mahimman amsa)

1. Kwangwadon kwari na mace  2. Jigidar yatsa na mace  3. Injectable

4. Kwayoyin maganin haihuwar haihuwa  5. Kwayoyin Intrauterine [IUD]  6. Sauya

14. Mene ne manyan alamun haɗari a cikin ciki da ka sani? (Mahimman amsa)

1. Balance mai ban tsoro  2. Cutar ciwon haushi  3. Fuskar hannu / fuska

4. Jin ciwon baya  5. Raunin rauni daga barin gado

15. Menene manyan alamun haɗari yayin aikin da ka sani? (Mahimman amsa)

1. Babban zazzabi  2. Cizon sauro  3. Rashin ruwa ba tare da jin zafi

4. Rashin ci gaba  5. Rashin sani

16. Mene ne manyan alamun haɗari a lokacin gidan rediyon da ka sani? (Mahimman amsa)

1. Cutar da bala'i mai cutarwa  2. Fuskoshin idanu da turawa  3. Fever



4. zafi mai zafi mai tsanani [] 5. Maganin ciwon kai []

17. Kun ji game da nono nono? 1. Ee [] 2. Babu []

18. Idan haka ne, me kuke fahimta ta hanyar nono nono?

1. madara madara kadai [] 2. madara madara da ruwa kadan []

19. Menene tsawon lokaci na nono nono?

1. Kasa da 6months [] 2. 6 watanni kawai [] 3. 6months da sama []

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**SASHE NA C: MUTANE DA MUTANE A CIKIN KUMA KUMA**

**Umurnin: Don Allah a nuna Ee / A'a ga wafannan maganganu / tambayoyin don sanin yankinku na hannu a kula da lafiyar mata na matar ku.**

S/N	Bayanai	Ee	A'a
20	Kuna bi matar ku zuwa asibitin antenatal?		
21	Kuna taimaka wa matar ku yin wasu ayyukan gida a lokacin da bayan ciki?		
22	Na tabbata cewa matata na rijista a asibitin antenatal a duk lokacin da ta kasance ciki		
23	Kuna karfafa wasu mutane su bi matan su zuwa asibitin antenatal?		
24	Na ajiye kudi kafin lokaci kafin matar ta shiga cikin aiki		
25	Na shirya izinin gaggawa kafin sadar da matata		
26	Na kayyade wurin aikawa ga matata		
27	Ina yin shawarwari tare da matata akan yawan yara		
28	Ina yin shawarwari tare da matata lokacin da zan yi ciki		
29	Na tabbatar da yaduwar yarinya ta hanyar amfani da hanyar hana kwayar cutar		
30	Wasu (saka)		

**SASHE NA D: TAMBAYOYIN MUTANE MUTANE A GASKIYAR GASKIYA**

**Umurnin: Don Allah a nuna ko kun yarda / saba da maganganun da suka biyo don sanin yadda kuka fahimci yadda maza ke shiga cikin kiwon lafiyar mata**

S/N	Bayanai	Amince	Ba a yi ba	Ba daidai ba
31	Wajibi ne maza su bi matan su zuwa asibitin antenatal			
32	Bai zama mahimmanci ga maza su bi matan su a ranar aikawa ba saboda aikin mata kawai			
33	Maza da ke bi da matar su zuwa asibitin daji (ANC) zasu sami farin bayani game da alamun hadari yayin tashin ciki da kuma bayarwa			
34	Maza ya kamata su tabbatar da matayensu suna daukar nauyin abincin da ake bukata a lokacin da bayan ciki			
35	Ba aikin namiji ba ne don tabbatar da cewa matar ta halarci kulawa ta ANC akalla sau huɗu kafin a bayarwa			
36	Gabatar da maza a lokacin jinkirin jinkirin jariri			
37	Turawa na ciki shine aikin mata			
38	Maza da ke halartar jima'i tare da matansu suna dauke da rauni			
39	Ya kamata maza su karfafa matansu suyi aikin nono			
40	Matsayi ne na mahaifi kawai don tabbatar da cikakken rigakafin yara			

**SASHE NA: KARANTA KASANCE DA KARANTA DA MUTANE A MUTANE A KUMA SANKA**

**Umurnin: Don Allah a nuna Ee / A'a zuwa ga wadannan maganganun don gano abubuwan da ke tasiri aikinka a kula da lafiyar mata na matarka.**

S/N	Bayanai	Ee	A'a
41	Na gaskanta cewa mummunan abu ne na al'ada a lokacin daukar ciki		
42	Ina aiki sosai a aikin		
43	Ba ni da cikakken ilmi game da kiwon lafiyar mata		
44	Ƙuntatawa ta kudi		
45	Gabatar da yara / yara masu tsufa don kulawa da matar		
46	Matar auren mata		
47	Ma'aikatan kiwon lafiya		
48	Ƙuntata al'adu		
49	Harkokin ɗan layi		
50	Ban san kowane tsarin kiwon lafiyar da ke karfafa maza don biyan abokan su don kulawa ba		
51	Ƙuntata addini a kan yin amfani da hanyar hana daukar ciki		
52	Yin amfani da maganin hana haihuwa yana karfafa lalata		
53	Wasu (saka)		

TELEGRAMS.....

TELEPHONE.....



**MINISTRY OF HEALTH**  
DEPARTMENT OF PLANNING, RESEARCH & STATISTICS DIVISION  
PRIVATE MAIL BAG NO. 5027, OYO STATE OF NIGERIA

Your Ref. No. ....  
All communications should be addressed to  
the Honorable Commissioner quoting  
Our Ref. No. AD 13/479/ 929

24<sup>th</sup> September, 2018

The Principal Investigator,  
College of Medicine,  
Department of Health Promotion and Education,  
University of Ibadan,  
Ibadan,  
Oyo State.

**Attention: Arewa Mopelola**


**ETHICS APPROVAL FOR THE IMPLEMENTATION  
OF YOUR RESEARCH PROPOSAL IN OYO STATE**

This is to acknowledge that your Research Proposal titled: "Knowledge and Men's Involvement in maternal Health Care of Their Wives in Sabo Community Ibadan, Oyo State" has been reviewed by the Oyo State Ethics Review Committee.

2. The committee has noted your compliance. In the light of this, I am pleased to convey to you the full approval by the committee for the implementation of the Research Proposal in Oyo State, Nigeria.

3. Please note that the National Code for Health Research Ethics requires you to comply with all institutional guidelines, rules and regulations, in line with this, the Committee will monitor closely and follow up the implementation of the research study. However, the Ministry of Health would like to have a copy of the results and conclusions of findings as this will help in policy making in the health sector.

4. Wishing you all the best.

  
Signature  
Dr. Abbas Gbojahan  
Director, Planning, Research & Statistics  
Secretary, Oyo State Research Ethics Review Committee

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