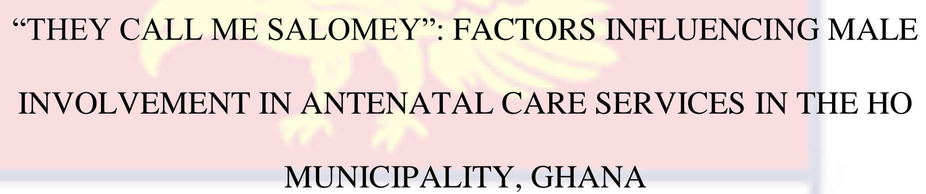
University of Cape Coast https://ir.ucc.edu.gh/xmlui

UNIVERSITY OF CAPE COAST



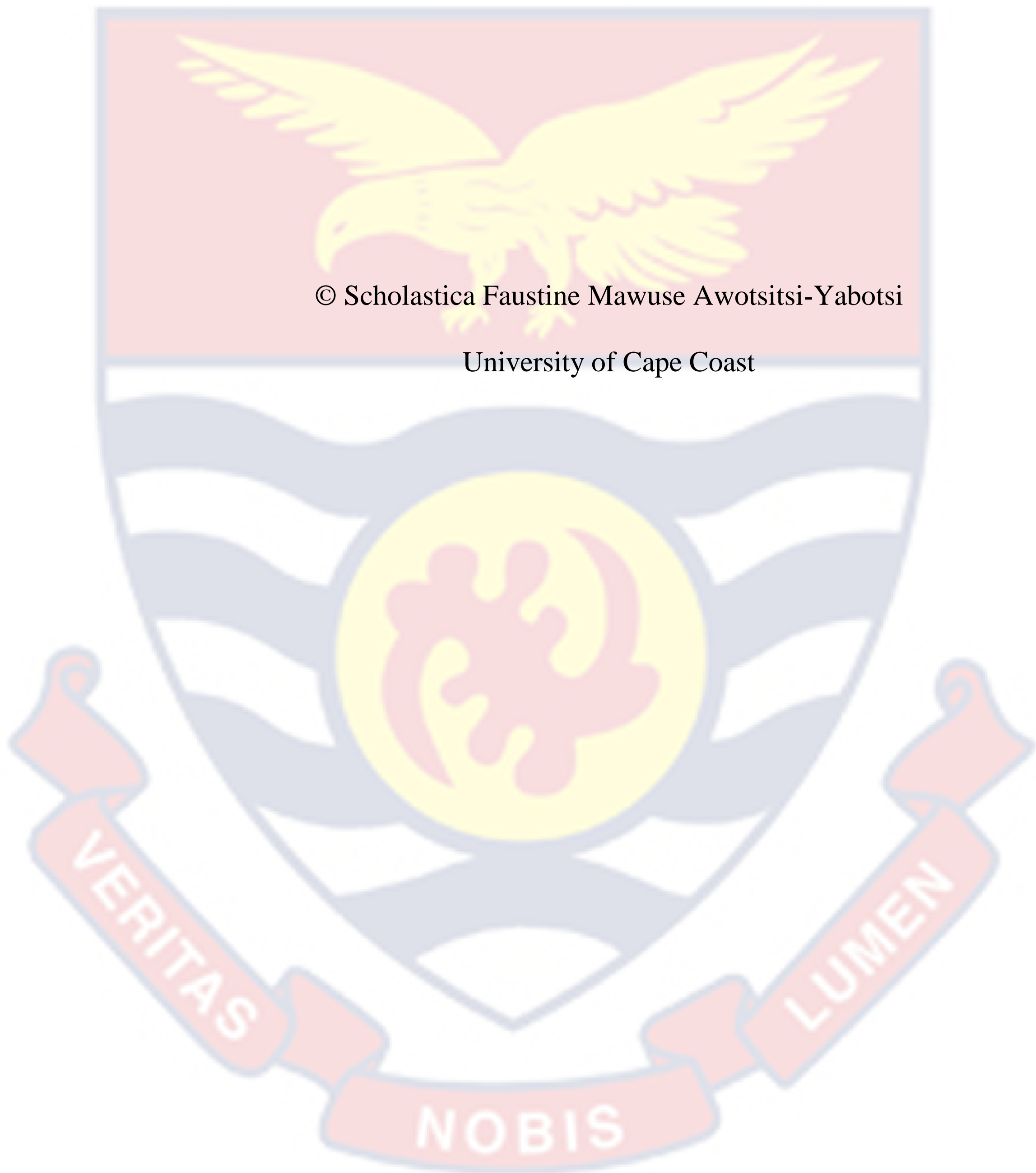
"THEY CALL ME SALOMEY": FACTORS INFLUENCING MALE INVOLVEMENT IN ANTENATAL CARE SERVICES IN THE HO MUNICIPALITY, GHANA

SCHOLASTICA FAUSTINE MAWUSE AWOTSITSI-YABOTSI

2024

Digitized by Sam Jonah Library

University of Cape Coast https://ir.ucc.edu.gh/xmlui



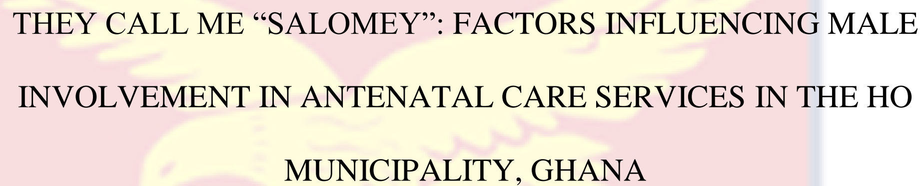
© Scholastica Faustine Mawuse Awotsitsi-Yabotsi

University of Cape Coast

Digitized by Sam Jonah Library

University of Cape Coast https://ir.ucc.edu.gh/xmlui

UNIVERSITY OF CAPE COAST



THEY CALL ME "SALOMEY": FACTORS INFLUENCING MALE INVOLVEMENT IN ANTENATAL CARE SERVICES IN THE HO MUNICIPALITY, GHANA

BY

SCHOLASTICA FAUSTINE MAWUSE AWOTSITSI-YABOTSI

Thesis submitted to the Department of Health, Physical Education and Recreation of the Faculty of Science and Technology Education, College of Education Studies, University of Cape Coast, in partial fulfilment of the requirements for the award of Master of Philosophy Degree in Health Promotion.

APRIL, 2024

Digitized by Sam Jonah Library

University of Cape Coast https://ir.ucc.edu.gh/xmlui

DECLARATION

Candidate's Declaration

I hereby declare that this thesis is the result of my own original research and that no part of it has been presented for another degree in this university or elsewhere.

Candidate's Signature: .... Date: ....

Name: Scholastica Faustine Mawuse Awotsitsi-Yabotsi

Supervisors' Declaration

We hereby declare that the preparation and presentation of the thesis were supervised in accordance with the guidelines on supervision of thesis laid down by the University of Cape Coast.

Principal Supervisor's Signature: .... Date: ....

Name: Dr. (Mrs.) Salome Amissah-Essel

Co Supervisor's Signature: .... Date: ....

Name: Prof. Thompson Mumuni

Digitized by Sam Jonah Library

University of Cape Coast https://ir.ucc.edu.gh/xmlui

ABSTRACT

The study was a qualitative study which adopted interpretive phenomenological design to explore the social and cultural factors influencing male partner involvement in antenatal care service. The study specifically examined the perception of men on their engagement in antenatal care, and explored how socio-cultural and facility-related factors affect the engagement of male partners in antenatal care. In addition, personal factors which influence men's engagement in prenatal care were determined. Interview guide was used to collect data from a total of twenty-three (23) respondents made up of an opinion leader, chief, elder and male partners who escorted their partners to antenatal care clinic. Purposeful and convenient sampling procedures were used to select participants for the study. Thematic content analysis was used to analyse the data. The findings revealed that male partners perceive that their involvement in antenatal care shows care to the woman, reduces her workload and makes her happy. Also, sociocultural factors which affect male partner involvement in antenatal care are stereotyping and erroneous societal perceptions. Again, attitude of staff at health facilities and inadequate space at these facilities are the key health-related factors which influence involvement of men in antenatal care. It was recommended that there should be increased education and sensitization on the importance of male involvement in antenatal care. Also, the Municipal Health Directorate of the Ho municipality must strengthen sensitization of all health workers to always put-up attitudes that are receptive and accommodative, especially, to men who accompany their partners to antenatal clinic.

Digitized by Sam Jonah Library

University of Cape Coast https://ir.ucc.edu.gh/xmlui

KEYWORDS

Male involvement

Maternal healthcare

Antenatal care

Ho Municipality

Ghana

Digitized by Sam Jonah Library

University of Cape Coast https://ir.ucc.edu.gh/xmlui

ACKNOWLEDGEMENT

God, and our Lord Jesus Christ with the guidance of the Holy Spirit deserves all the glory and praise, for His faithfulness and blessings. Without the Triune God, this work could not have come this far. It is grace and love.

My supervisor, Dr. Mrs. Salome Amissah-Essel, whose superb direction allowed me to develop this work in a distinctive style, deserves a great debt of thanks from me. I also thank all my lectures, administrative staff of the Department of Health, Physical Education and Recreation and my colleagues of 2018/2019 academic year throughout my years of study in this university (UCC).

Special thanks to my friends, Alfred Blay, Madams Evelyn Akofa Quashie and Mawusi Alordey for their support and encouragement.

Finally, to my dearest mother Madam Mercy Awusie, brother, Albert Adipah-Yabotsi for their prayers and encouragement throughout my years of study. In addition, to my loved ones, I appreciate your immeasurable contributions in my quest to climb the academic ladder.

While I share credit for this thesis with all of the persons indicated above, I am solely responsible to any errors, shortcomings or omissions in the dissertation.

Digitized by Sam Jonah Library

University of Cape Coast https://ir.ucc.edu.gh/xmlui

DEDICATION

To dedicated and caring men who accompany their spouses to Antenatal Care Services.

Digitized by Sam Jonah Library

TABLE OF CONTENTS

	Page
DECLARATION	ii
ABSTRACT	iii
KEYWORDS	iv
ACKNOWLEDGEMENT	v
DEDICATION	vi
TABLE OF CONTENTS	vii
LIST OF TABLES	xi
LIST OF FIGURES	xii
LIST OF ABBREVIATIONS	xiii
CHAPTER ONE: INTRODUCTION	
Background to the Study	1
Statement of the Problem	8
Purpose of the Study	10
Objectives of the Study	10
Significance of the Study	10
Delimitation of the Study	11
Definition of Terms	11
Organization of the Study	12
CHAPTER TWO: LITERATURE REVIEW	
Theoretical Framework of the Study	13
Social Cognitive Theory	14
Socio-Cultural Theory	18
Social Ecological Model	22

Digitized by Sam Jonah Library

University of Cape Coast https://ir.ucc.edu.gh/xmlui

The PEN-3 Cultural Model 27
Conceptual Base of the Study 34
Culture and Context of the Model 35
Male Perception of Antenatal Care Services (Perception) 35
Diverse Social Identities (Enablers) 37
Health Care Workers as Family Member 38
Role of Families (Nurturers) 41
Positive Aspects of Culture (the role of support systems) 42
The Role of Elders 43
Concept of Antenatal Care Services 44
Concept of Culture 48
Male Partner Involvement in Antenatal Care Services 52
Factors Affecting Male Partner's Participation in Antenatal Care Services 56
Health Facility Factors Influencing Male Partner Involvement in Antenatal Care Services 62
CHAPTER THREE: RESEARCH METHODS
Research Design 65
Study Area 66
Population 67
Sample and Sampling Procedures 68
Data Collection Instrument 69
Validation of the Instrument 70
Trustworthiness 70
Data Collection Procedures 71
Data Processing and Analysis 72

Digitized by Sam Jonah Library

University of Cape Coast https://ir.ucc.edu.gh/xmlui

Reflexivity 74

Ethical Issues 74

CHAPTER FOUR: RESULTS AND DISCUSSION

Background Characteristics of the Respondents 76

Results 78

Objective 1: Perception of men on male partner involvement in antenatal care services 78

Theme 1: Reduces wife's workload 78

Theme 2: Shows care 79

Theme 3: She is attended to early 79

Theme 4: To be in the known and assist 81

Theme 5: Makes wife happy 82

Theme 6: I also learn 83

Objective 2: Socio-cultural factors influencing male partner involvement in antenatal care services 84

Theme 1: Stereotyping 85

Objective 3: Health facility factors which influence male partner involvement in antenatal care services 92

Theme 1: Attitude of staff 92

Theme 2: Physical structure 97

Objective 4: Personal factors which influence male partner involvement in antenatal care services 98

Theme 1: Time constraints as a result of work 99

Theme 2: Lack of knowledge 100

Theme 3: Lack of respect for men by wives 101

Digitized by Sam Jonah Library

University of Cape Coast https://ir.ucc.edu.gh/xmlui

Discussion 102

CHAPTER FIVE: SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

Summary 110

Key findings 111

Conclusions 112

Recommendations 112

Suggestions for Future Research 113

REFERENCES 114

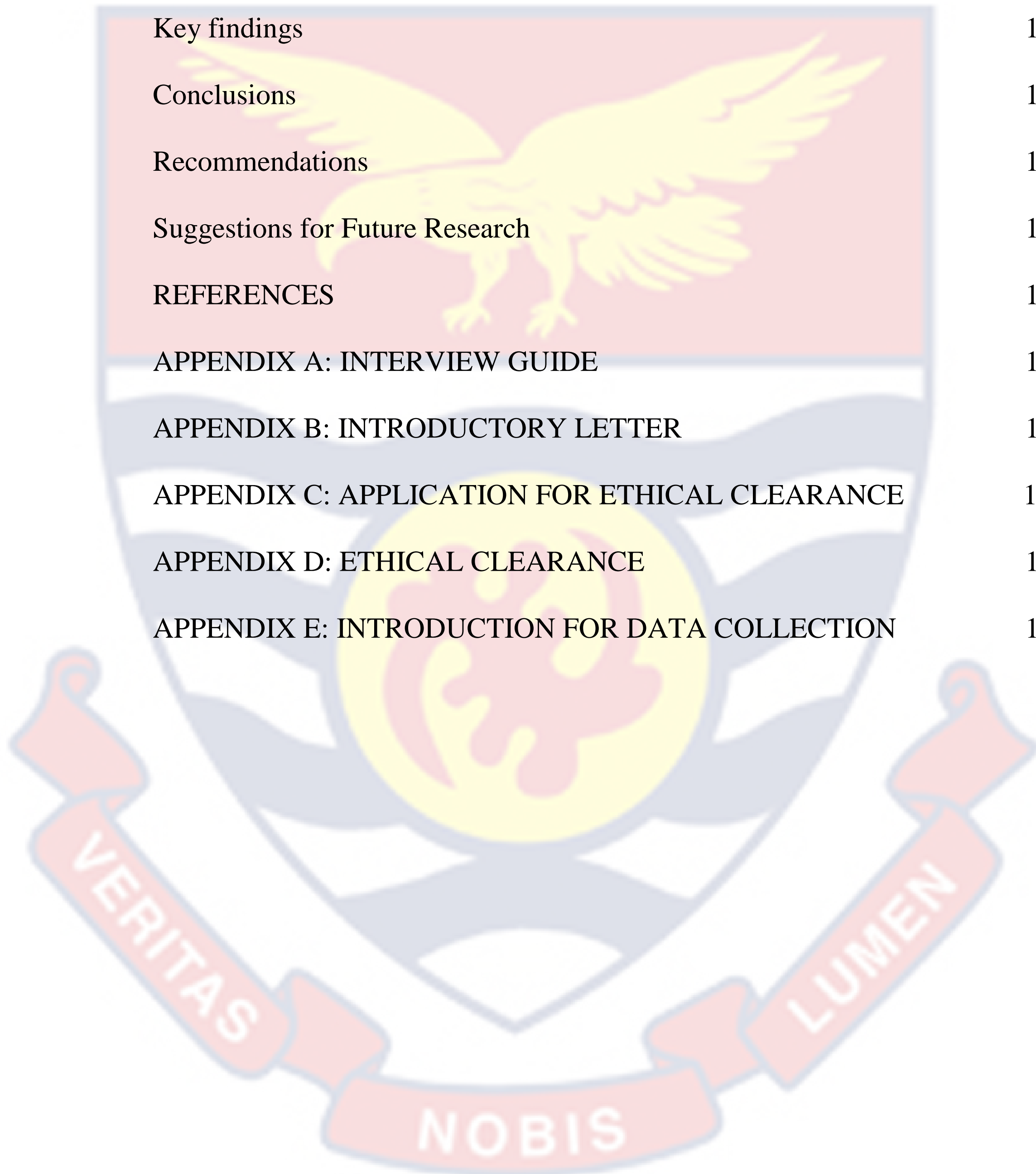
APPENDIX A: INTERVIEW GUIDE 131

APPENDIX B: INTRODUCTORY LETTER 134

APPENDIX C: APPLICATION FOR ETHICAL CLEARANCE 134

APPENDIX D: ETHICAL CLEARANCE 136

APPENDIX E: INTRODUCTION FOR DATA COLLECTION 137



Digitized by Sam Jonah Library

University of Cape Coast https://ir.ucc.edu.gh/xmlui

LIST OF TABLES

Table Page

1: WHO Antenatal Schedule..47

2: Background characteristics of respondents..77

Digitized by Sam Jonah Library

LIST OF FIGURES

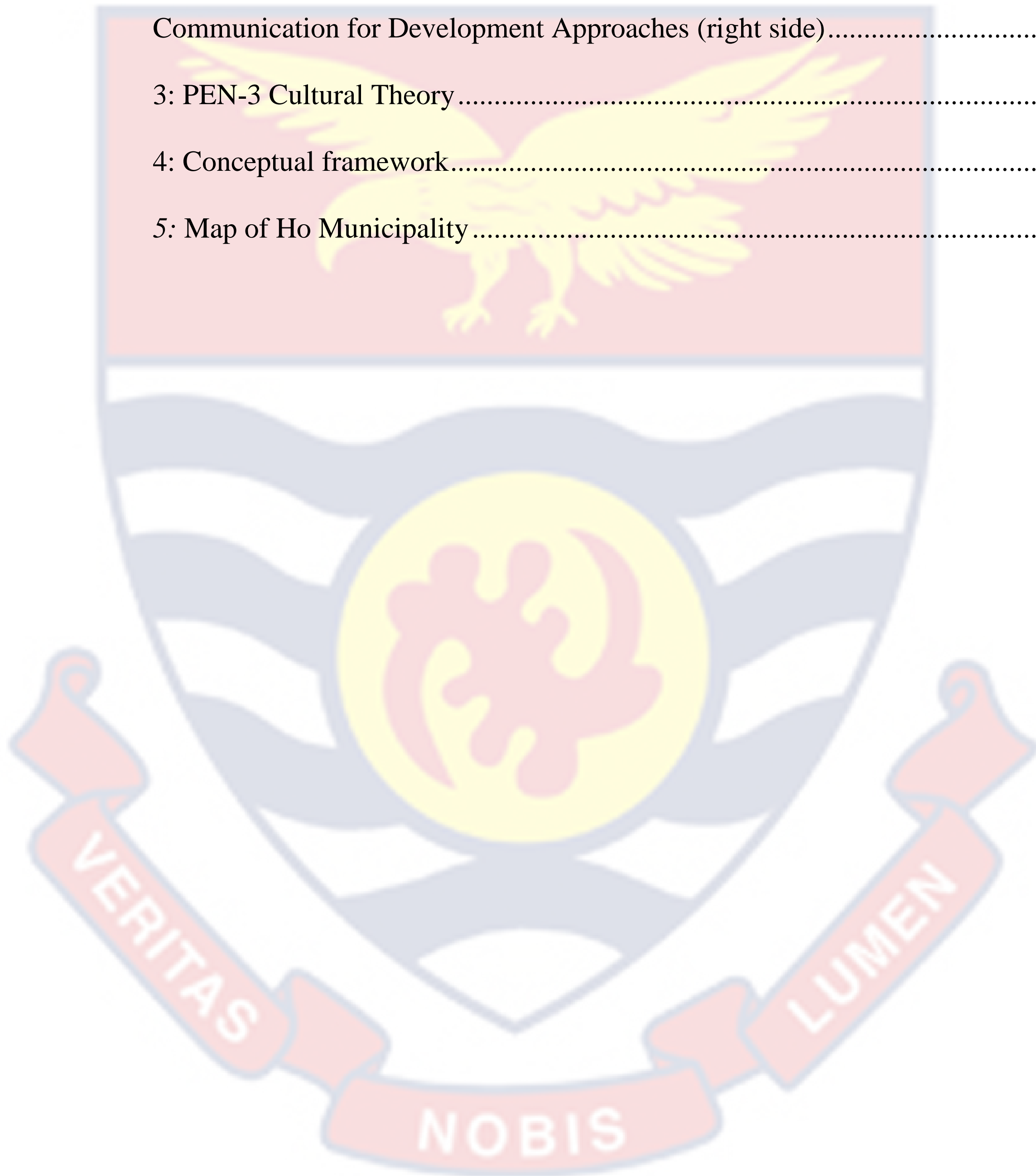


Figure Page

1: Socio-cultural theory of human learning 20

2: The Social Ecological Model (left side) and Corresponding

Communication for Development Approaches (right side)............................ 23

3: PEN-3 Cultural Theory 29

4: Conceptual framework.. 34

5: Map of Ho Municipality 67

Digitized by Sam Jonah Library

University of Cape Coast https://ir.ucc.edu.gh/xmlui

LIST OF ABBREVIATIONS

ANC	Antenatal Care
ICPD	International Conference on Population and Development
IPA	Interpretative Phenomenological Analysis
SCT	Social Cognitive Theory
SEM	Social Ecological Model
SSA	Sub-Saharan Africa
TBA	Traditional Birth Attendant
WHO	World Health Organization

Digitized by Sam Jonah Library

University of Cape Coast https://ir.ucc.edu.gh/xmlui

CHAPTER ONE

INTRODUCTION

Background to the Study

In traditional African societies, family resources and authority expended as often tilted in favour of men. Invariably, the views of men hold sway when it comes to gender relations within the home setting (Singh, Lample & Earnest, 2014). Most women, who are at the fringes of society, do not have the financial resources for the utilisation of medical services when necessary. Research evidence suggest that insight of men regarding antenatal health needs of women, play critical roles in terms of helping pregnant women access health care services (Singh et al., 2014). Moreover, showing love, care and concern in the form of accompanying their women to health facilities serve as a learning curve for men because, it gives them nuanced understanding regarding the complexities linked to issues pertaining maternal health (Matsuyama, 2002). In support of this claim, Amuzie et al. (2022) argues that "in reproductive health, the roles of men are threefold: men as clients, partners and agents of positive change" (pg. 2). The significance of male participation in reproductive health was further reiterated during the 1994 International Conference on Population and Development (ICPD).

Male participation therefore, is a critical element appropriate to maximizing quality antenatal care services within the health sector in the developing world. Research evidence (Singh et al., 2014) suggests that the Cairo Conference on Population and Development in 1994 became a defining moment regarding provision of reproductive health care across gender divide. Anecdotal evidence suggests that men to some extent make decisions

Digitized by Sam Jonah Library

University of Cape Coast https://ir.ucc.edu.gh/xmlui

regarding antenatal care services. Nevertheless, it is usually limited to issues such as family planning and other medical conditions that almost every human person becomes a victim from time to time. In effect, insights of men into the complexities closely linked to pregnancies and causal factors leading to maternal deaths is vital. This is significant because it would create awareness about the causes of maternal and child deaths and how it could be averted in many developing countries across the world.

However, the question that arises is the level of awareness regarding how males' complementary roles play in quality antenatal care services. Dzumbila-Namasasu (2010) has proven that men are aware of the hitches linked to pregnancies, delivery, postnatal and the consequences therein across differing sociocultural contexts within the West-African sub-region. Maternal and child health which are critical issues in any health delivery system has been overlooked. Evidence suggests that, empowering women to be able to assume control over their nutrition and reproductive health issues, should inform decision of policy makers decisions of policy makers (Mkandawire & Hendriks, 2018).

Over the years, several theories and models both in preventive and curative health interventions used to modify undesirable health behaviours. The central and most widely-used theoretical models in public health and health promotion comprised the social cognitive theory (SCT), socio-cultural theory, social system theory, social ecological model (SEM) and positive, existential and negative (PEN-3) model. The PEN-3 model examines cultural beliefs, values and the influences on their health seeking behaviours. Each

Digitized by Sam Jonah Library

domain comprises three individual concepts that explains the acronyms PEN-3 (Airhihenbuwa, 1995). The PEN-3 model is used to frame the current study.

Culture is explained as a set of common ideals, notions, meanings, and ideas that are sufficiently pervasive to affect a person's thinking, speaking, and behaviour (Kline, 2007). As a result, culture influences how people think about and behave in relation to their health, which in turn affects how they react to information about their health.

The engagement of men in issues concerning women's reproductive health has received emergent global attention (Dzumbila-Namasasu, 2010). The Cairo International Conference on Population and Development (ICPD) held in 1994 marked a new chapter in reproductive health. Nations were urged to promote comprehensive reproductive health. It stressed the necessity to offer both men and women comprehensive reproductive health care (Barker & Das, 2004; Dzumbila-Namasasu, 2010).

Antenatal care or prenatal care has to do with the routine, recommended medical and nursing treatment for women primarily during pregnancy. Antenatal care, which attempts to provide regular exams so that medical personnel can treat and prevent any health concerns during the period of the pregnancy, is an example of preventative care. Additionally, it intended to promote healthy lives for both mother and child (Aarnio, Olsson, Chimbiri & Kulmala, 2009). The World Health Organization (WHO) (2016) recommended prenatal care model: a minimum of four contacts with a midwife or a doctor during the period of pregnancy. This is key to every pregnant woman receiving information on obstetric emergencies and birth

Digitized by Sam Jonah Library

preparedness, a programme that required male partners' engagement in prenatal, natal and postnatal care services.

The availability and use of prenatal care services, however, are still insufficient in poor nations (Pafs, Musafili, Binder-Finnema, Klingberg-Allvin, Rulisa, & Essén, 2015). This may be explained by differences between recommended antenatal care and the care actually provided, accessibility and prior antenatal care experience, the educational qualification of the woman and her husband, social and economic status, including cultural factors, and so on (Kululanga, Sundby, Malata, & Chirwa, 2012).

Women will get medical information on physiology of the mother, biological changes during pregnancy, and nutrition for antenatal care, including prenatal supplements, during check-ups. Counselling on living healthy lifestyles also known to the expectant mothers. For example, an expectant mother would be educated on good nutrition, exercise, personal hygiene, use of prescribed or non-prescribed medicines and avoidance of alcohol use, cigarette smoking during pregnancy. Routine antenatal has contributed significantly to reducing maternal deaths, spontaneous loss of pregnancy, birth defects, low birth weight and other avoidable health complications of mother and child (Backstrom & Wahn, 2011).

The phrase "male involvement" is used to discuss males having knowledge of and participating in prenatal care activities, according to Mullick, Kunene, and Wanjiru (2005). Additionally, it implies that they collaborate as equal partners to support choices and initiatives that will result in improved health outcomes for both children and women. However, pregnancy and childbearing are considered completely as women's sole

Digitized by Sam Jonah Library

responsibility in sub-Saharan Africa. Allendorf (2007) indicated that, it is rare for husbands (male partners) in Africa to escort their wives (a woman) to the antenatal clinic. Moreover, in most cultures, the men possess the social, cultural and economic powers, and take great control over their wives. In addition, they choose the frequency and terms of sexual activity, the composition of their family, and whether or not their partner will make advantage of the available healthcare options.

In order to ensure decrease in maternal morbidity and mortality in Africa, it would be critical to involve male partners in health services concerning mothers and children (Allendorf, 2007). It is unclear, though, as to whether or not the engagement of men has any significance in maternal health outcomes (Yargawa, & Leonardi-Bee, 2015). However, Amosu, Adenike, Degun, Makinde and Babalola (2011) observed that non-engagement of male partners in the utilisation of health services aimed at improving the health and wellbeing of mothers and children could cause the utilisation of these health services, by some women, from unskilled persons thereby worsening the maternal health outcomes.

Interestingly, awareness is growing globally in getting male partners involved in reproductive health services to help curb the complications that occur in childbirth. Andersson et al. (2011) suggest men shared off those cultural values that scared them from carrying out their roles as partners in family life because their engagement in reproductive health is key to improve upon the reproductive healthcare and minimize obstetric complications. Babalola and Adesegun (2009) affirmed this that men's participation in activities aimed at improving the health of women leads to better

Digitized by Sam Jonah Library

understanding between the couples, and all information concerning reproductive health of the women thereby reducing obstetric emergencies.

The sociocultural practices of men, who are often the heads of families in Sub-Saharan Africa (SSA), go above and beyond to ensure the welfare of pregnant mothers throughout the prenatal care period (Lindsey, 2015). According to SSA research, women are more probable to utilise maternity care services when they are accompanied by their partners to the doctor (Wai, Shibanuma, Oo, Fillman, Saw, & Jimba, 2015).

However, it plainly goes against established gender conventions in sub-Saharan Africa for males to participate in prenatal care (Onyango, Owoko & Oguttu, 2010). Maternal health care is perceived as a “woman’s work” (Reece, Hollub, Nangami, & Lane, 2010) which limits men’s involvement. Fiol and O’Connor (2017) in support of this claim further and argued that issues like maternal health and male attitudes towards it, is the imposition of gender roles by a certain culture through mechanisms such as modelling, imitation, and the use of incentives and penalties A study by Kariuki and Seruwagi (2016) in Uganda revealed that most communities in Africa are culturally patriarchal and men are not allowed to take part in prenatal care programmes which explains the low participation regarding the antenatal care of the wives (Nanjala & Wamalwa, 2012).

Once more, data from the 2014 Demographic and Health Survey in Kenya showed a trend of declining prenatal care service commitment among men. Women’s health was seriously impacted by the inability of policymakers, programme planners, and implementers of maternal health services to engage males in maternal health promotion, preventive, and care

Digitized by Sam Jonah Library

programmes, which also hindered the effectiveness of all activities involving women (Stuckler, Feigl, Basu, & McKee, 2010).

In South Africa, pregnancy, childbirth, and family planning have always been considered as primarily female matters. According to cultural norms, men rarely visit the health facility with their spouses to access family planning, prenatal care, or postnatal services, nor do they attend the child's labour or birth (Wassie et al., 2014). Male sexual conduct in social interactions, however, can put women at considerable risk for unintended pregnancies and infections that can have an impact on the health of both the mother and the unborn child (Yazdkhasti, Pourreza, Pirak & Fatemeh, 2015).

Additionally, males are hardly ever exposed to reproductive health facilities, because they can easily obtain condoms from pharmacy stores even without coming into contact with health providers. Therefore, the issue of accessing reproductive health services to men, is said to be culturally a big problem in SSA (Reece et al., 2010). Also, the nature and environment of health delivery services by women has made reproductive health services unfriendly for men.

Anecdotal evidence regarding antenatal care attendance in government health facility in Ghana showed only women in attendance. In essence, the men seen at the antenatal care are either staff at the facility or very few 'brave' ones (the odds) who escorted their wives (partners) for antenatal care services (Umar & Bawa, 2015). A study conducted by Craymah, Oppongn and Tuoyire (2017) in the Central Region of Ghana (specifically, Anomabo) revealed low male participation (involvement) in maternal and child health care, with differences in proportion of men accompanying their wives to antenatal care

Digitized by Sam Jonah Library

(35%), delivery (44%) and postnatal services (20%). Similar results in a study in Kumasi metropolis of Ghana indicated that the involvement of male partners in antenatal care was very low (35%) while 65 percent of the men had never attended antenatal care with their wives or partners (Umar & Bawa, 2015). This is and driving force behind the current study, which aimed to investigate the socio-cultural variables impacting male partner engagement in prenatal care services in some hospitals within the Ho municipality of Ghana to enhance maternal health care and promote a healthy society.

Statement of the Problem

According to the WHO (2019), avoidable causes relating to pregnancy and childbirth led to the death of around 810 women every day in 2017. Most (94%) of these pregnancy and childbirth related deaths occur in low-resource settings, such as SSA and Southern Asia where about 254,000 maternal deaths were estimated to have occurred in 2017. The WHO (2019) again reported that maternal mortality is on the increase globally. About 295,000 women died during childbirth and pregnancy related complication in 2017 which is unacceptable; 'no woman should die while giving life'. Two-thirds (196,000) of these maternal fatalities occurred in SSA alone, and one-fifth (58,000) in Southern Asia.

Male partner engagement in child and maternal health services utilisation was found to be one of the strategies to reducing this menace or to improving health outcomes for women in developed nations (Yargawa & Leonardi-Bee, 2015). Contrary to reports from undeveloped nations, where there is little proof that having men present in delivery rooms has any good effects, evidence according to Yargawa and Leonardi-Bee suggest that male

Digitized by Sam Jonah Library

partner engagement is not a major determinant of childbirth complications in developed countries. Further evidence from meta-analyses conducted by Yargawa and Leonardi-Bee (2015) reveal that with increased male partner engagement in maternal health issues in developed countries, the number of complications during labour significantly decreased. It concluded that men's involvement in health services concerned with women's health appeared to have greater outcomes in developed countries, centrally, to that of developing countries where little evidence is reported.

Several studies (Craymah et al., 2017; Doe 2013; Olayemi, Bello, Aimakhu, Obajimi, Adekunle, 2009; Kululanga et al., 2012; Kariuki and Seruwagi, 2016; Yende, Van Rie, West, Bassett, & Schwartz, 2017; Demissie, Bulto & Terfassa, 2016) have attested to the facts that, facets of reproductive health such as antenatal and delivery are still not investigated. Besides, men's engagement in maternal healthcare services in sub-Saharan African countries including Ghana, remains very low (5% - 40%) (Umar & Bawa, 2015). Regardless of all these studies, most previous studies were on determinants of men's involvement in antenatal care services and this seem to be limited rigorous scientific investigation on social and cultural practices which affect the engagement of men in prenatal care services in Ghana; for example, (Umar & Bawa, 2015; Craymah et al., 2017).

Volta Regional Maternal Health Report within two years in 18 districts of the region revealed that Ho municipal was leading in the deaths of women with pregnancy related problems (37 deaths) (that is, 16 in 2018 and 21 in 2019). Some districts recorded no deaths, and others recorded one or two

Digitized by Sam Jonah Library

University of Cape Coast https://ir.ucc.edu.gh/xmlui

maternal deaths (Ghana Health Service, 2019). These figures are alarming; hence, the site - Ho Municipality is chosen for this study.

Purpose of the Study

The purpose of the study was to explore the socio-cultural factors influencing male partner involvement in antenatal care.

Objectives of the Study

The objectives seek to:

1. Describe the perception of men on male partner involvement in antenatal care services.
2. Assess the role socio-cultural factors play in male partner involvement in antenatal care services.
3. Determine health facility factors that influence male partner involvement in antenatal care services.
4. Ascertain the personal demographic factors influencing male partner involvement in antenatal care services.

Significance of the Study

Findings from this study would provide insights into the sociocultural factors influencing men's engagement in antenatal care. Thus, the findings may inform policy on the involvement of male partners in antenatal care services to enhance pregnant women's utilisation of antenatal services. This will contribute to the attainment of Sustainable Development Goals (SDG) 3.1 and 3.2. SDG 3.1 aims to, by 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births whereas goal 3.2 aims to end preventable deaths of newborns by 2030. In addition, the study will add to the body of knowledge on antennal service delivery and serve as a guide to

Digitized by Sam Jonah Library

University of Cape Coast https://ir.ucc.edu.gh/xmlui

developing other studies as well serve as, be a reference material for students and other researchers and policy makers.

Delimitation of the Study

The study was delimited to male partners who accompanied their wives to the antenatal clinic. Also, it was confined to selected health facilities in the Ho municipality.

Definition of Terms

The terms listed below have operational definitions.

Antenatal Care: expert care provided to the expectant mother before birth.

Antenatal Clinic: The location where consultations are held and prenatal profiling (blood tests, etc.) is performed by a laboratory technician.

Delivery: The act by which a pregnant woman gives birth.

Family Planning: deciding on a family's size and the intervals between children's births.

Immunization: One of the key interventions to prevent immunizable diseases form children. a strategy for increasing the body's resistance to certain illnesses by employing altered or eliminated microbes.

Involvement: Is to take part or to make someone take part in something.

Labour: The process by which a pregnant woman passes through to give birth.

Postpartum (Postnatal) Period: the first six weeks following the baby's birth.

Reproductive health decision making: that is, being aware on and making decisions as a couple regarding the woman's reproductive health including:

Digitized by Sam Jonah Library

University of Cape Coast https://ir.ucc.edu.gh/xmlui

sexual relations, pregnancy, delivery, postnatal care/breastfeeding, family planning services and the wellbeing of the baby.

Socio-cultural: These lifestyles, attitudes, values and norms customs characterised a society.

Organization of the Study

There are five chapters in this work. The study's introduction was the main focus of chapter one. It provided the research's historical context and emphasized the vacuum in the body of literature that made the investigation necessary. Chapter one also included the study's objectives, research questions, importance, and delimitations. Chapter two highlights the relevant or related literature on the subject matter. The third chapter addresses the research methods. In particular, chapter three elaborated on the research design, study area, population, sample, and sampling technique, data collecting instrument, and processes for data collection, processing, and analysis. In addition, ethical issues were discussed. In chapter four, the results of the study are presented and discussed whereas the last chapter, chapter five, provides a summary, conclusions and recommendations of the study. Also, suggestions are made for future studies in chapter five.

Digitized by Sam Jonah Library

CHAPTER TWO

LITERATURE REVIEW

The purpose of the study was to explore the socio-cultural factors which affect male partner involvement in antenatal cares services in the Ho municipality of Ghana and to find out their perception, beliefs, backgrounds and experiences on antenatal care services. In this chapter, relevant literature is reviewed as relates to the study in the following sub-headings:

1. Theoretical Framework
2. Conceptual Base of the study
3. Concept of Antenatal Services
4. Concept of culture
5. Male partner involvement in antenatal care services
6. Factors influencing male involvement in maternal health care services.

Theoretical Framework of the Study

Theories are created to interpret, predict, and analyse events as well as, usually, to challenge and expand our understanding while remaining within the parameters of fundamental limiting assumptions. They are important in every research and serve as the structure that holds or supports the ideas of a research study. They describe a research's course and firmly anchor it in theoretical contexts (Swanson & Chermack, 2013).

According to Grant and Osanloo (2014), the overarching goal of a theoretical framework is to provide more meaning to the findings of a research, to make them compatible with existing theoretical frameworks, and to guarantee their generalizability. By providing the research inquiry with both path and stimulus, they contribute to the stimulation of research and ensure the

Digitized by Sam Jonah Library

University of Cape Coast https://ir.ucc.edu.gh/xmlui

expansion of knowledge. According to Grant & Osanloo (2014), it is a research's "blueprint" or roadmap. The theories also improve a study's rigour and practicality (Adom, Adu-Gyamfi, Agyekum, Ayarkwa, Dwumah, Abass, & Obeng-Denteh, 2016). The specific theory or ideas regarding facets of human activity that are helpful in the understanding of occurrences are known as the theoretical framework. It is important to place this study in a context within theoretical and conceptual framework.

Social Cognitive Theory

Cognitive theory's founding father is Albert Bandura. In the 1960s, Social Learning Theory (SLT) was first developed into Social Cognitive Theory (SCT), which was later renamed Social Cognitive Learning Theory (SCLT) in 1986. It implies that "social interactions between individuals, their environment, and their conduct, which take place throughout learning, are dynamic and reciprocal" (Bandura, 1999, pg. 23). According to learning theories, the environment is actually the most important factor in development (Hoffman, 1993). What distinguishes SCT from alternative techniques is its emphasis on both internal and exterior social reinforcement. Bandura's Social Mental Hypothesis has impacted numerous areas of request: (Hoffman, 1993) Other fields include psychotherapy, education, health sciences, and social policy.

Muro and Jeffrey (2008) state that the social learning theory is being highlighted more frequently as an essential part of sustainable resource management and as a means of encouraging desirable behavioural change. The likelihood that we benefit from our interactions with others in a social setting is what supports this hypothesis. People independently adopt

Digitized by Sam Jonah Library

comparable behaviour by watching individuals around them. People often absorb and copy the methods of others after witnessing them in action, particularly when the observational experience is pleasurable or involves incentives associated with the observed activity.

Bandura (1977) defined imitation as the precise replication of observed motor actions. With many of its fundamental ideas being similar to those of classical learning theory, SLT is currently perhaps the most popular theory of learning and development. Because it considers attention, memory, and motivation, this theory links behaviourist learning theories and cognitive learning theories (Muro & Jeffrey 2008). However, Bandura believed that not all forms of learning could be explained by direct reinforcement. As a result, he incorporated a social component into his theory and claimed that people might pick up new behaviours and abilities by observing others. The elements of this theory include the following three general ideas for learning from one another: modelling, imitation, and observation (Newman & Newman 2007).

The social environment affects how people learn, act, and retain their behaviour, according to the social cognitive theory. The theory takes into account an individual's experiences, which influence whether a behaviour will be practiced. These experiences affect reinforcements, expectations, and expectancies, all of which have influences on a person's propensity to participate in a certain conduct as well as their reasons for doing so. By the mid-1980s, Bandura's research had taken on a broader focus, and his conclusions tended to provide a more thorough picture of how human cognition relates to social learning. The idea provides a framework for

Digitized by Sam Jonah Library

understanding, predicting, and changing human conduct, claim Green and Peil (2009).

Many behavioural theories used to the promotion of good health do not consider behaviour maintenance; instead, they concentrate on behaviour induction. This is regrettable since the major objective of public health is to sustain behaviour, not just to initiate it. Newman and Newman (2007), clarifying how people regulate and reinforce their conduct to create goal-directed behaviour that will be sustained over time is the objective of SCT.

There are five constructs of the SCT discussed as follows:

Reciprocal Determinism – The core idea of SCT is this. It describes the relationship between the individual, who is a unique entity with a range of learning experiences, the environment, which is the outside social context, and behaviour, which is the way that individual reacts to stimuli in order to accomplish objectives.

Behavioural Capability – This expresses a person's actual capacity to engage in a conduct by utilising the requisite knowledge and skills. To carry out a behaviour correctly, a person must be aware of both the what and the how of it. When people behave after observing the repercussions of their actions, the environment in which they live is altered.

Observational Learning – This asserts that people are able to watch and notice other people's behaviours then "model" that behaviour in order to carry it out themselves.

Reinforcements – This is a reference to the responses someone receives from within or outside of oneself that affect their decision to continue or quit

Digitized by Sam Jonah Library

engaging in a certain conduct. Reinforcements are self-initiated environmental cues that can be favourable or negative.

Expectations – This speaks to the expected outcomes and expectations of the person's behaviour are connected to their health. Before acting, people consider the repercussions of their choices, and the degree to which these expectations are met might affect the behaviour's effectiveness. Expectancies are subjective to the individual and, while they are based on prior experience, they are more focused on the value placed on the outcome.

Self-efficacy – This is a measurement of how much a person believes they can carry out a behaviour. Despite being included in other theories, self-efficacy is unique to SCT. According to Bandura (1977), self-efficacy is influenced by a person's particular traits, other personal characteristics, environmental factors (barriers and facilitators), and more.

The following are only a few of SCT's limitations. According to the hypothesis, people's surroundings will inevitably alter as a result of environmental changes. The concept is only loosely organised and is focused mostly on the dynamic interplay between people's behaviour and surroundings. It places a strong emphasis on the learning process while ignoring biological and physiological predispositions that may affect behaviour independent of past knowledge or expectations. The theory only refers to experience when discussing motivation or emotion (Bandura, 1977). The idea has a lot of potential applications and might be challenging to fully operationalize.

Digitized by Sam Jonah Library

Socio-Cultural Theory

Lev Vygotsky, a Soviet psychologist from the early 1900s, is the source of socio-cultural ideas, which convey a perspective on culture that sees it not just as a system passed down through generations but also as something that is continually being formed and reconstructed in particular local contexts. Socio-cultural perspectives investigate how social and cultural processes function as conduits for human action and cognition. Socio-cultural theories hold that the primary unit of examination for the study of human behaviour is activity, or cultural practices, in contrast to many psychological points of view that concentrate on human cognition and conduct at the individual level. This idea of activity provides an analytical framework that enables comprehension of the intricate interactions between the person and culture during development. Socio-cultural theories often include a number of major themes (Cole, 1998).

Firstly, changes in learning and development, throughout timescales of months and years, as well as historically and phylogenetically all happen simultaneously on several levels (side-to-side).

Secondly, cultural practices are a crucial area of study for comprehending developmental processes.

Thirdly, learning and development, which serve as mediators of psychological processes, are substantially influenced by cultural tools and artifacts, particularly ideational or symbolic artifacts.

Last but not least, social connections and social interaction processes are crucial to learning and development, and learning is defined by shifting relationships within these social interactions and the social environment.

Digitized by Sam Jonah Library

According to Vygotsky's sociocultural theory of learning, learning is a social process that develops in society or culture, much like human cognition. Vygotsky's theoretical framework is based on the central thesis that social contact is necessary for cognitive growth. Vygotsky asserts that learning takes place on two levels: first, through social interaction, and second, as it gets ingrained into the individual's mental framework. He said, "every function in the child's cultural development appears twice: first, on the social level, and later, on the individual level; first, between people (inter-psychological) and then inside the child (intra-psychological). This applies equally to voluntary attention, to logical memory, and to the formation of concepts. All the higher functions originate as actual relationships between individuals" (Vygotsky, 1978, p.57).

The second aspect of Vygotsky's theory is that the ability for cognitive development is restricted to a zone of proximal development (ZPD). Although the learner is capable of researching this area cognitively, help and social connections are still required for the student to realise their full potential (Briner, 1999). An instructor or more seasoned peer can offer the learner the support necessary for the student's comprehension of the various domains of knowledge or the development of difficult skills. Collaborative learning, discourse, modelling, and framework are strategies for fostering purposeful learning and enhancing learners' intellectual knowledge and capacities (Vygotsky, 1978).

Vygotsky also explained how problem-solving under adult supervision or in cooperation with more experienced peers might create the gap between the degree of projected development and the actual developmental level as

Digitized by Sam Jonah Library

measured by autonomous problem-solving. Fundamentally, it includes all of the knowledge and skills that a person can learn with guidance but has not yet mastered or is able to do on their own. Progressively, children are able to extend their zone of proximal development when given the chance to increase their knowledge and abilities, for instance by observing someone who is a little more advanced than they are (see Figure 1).

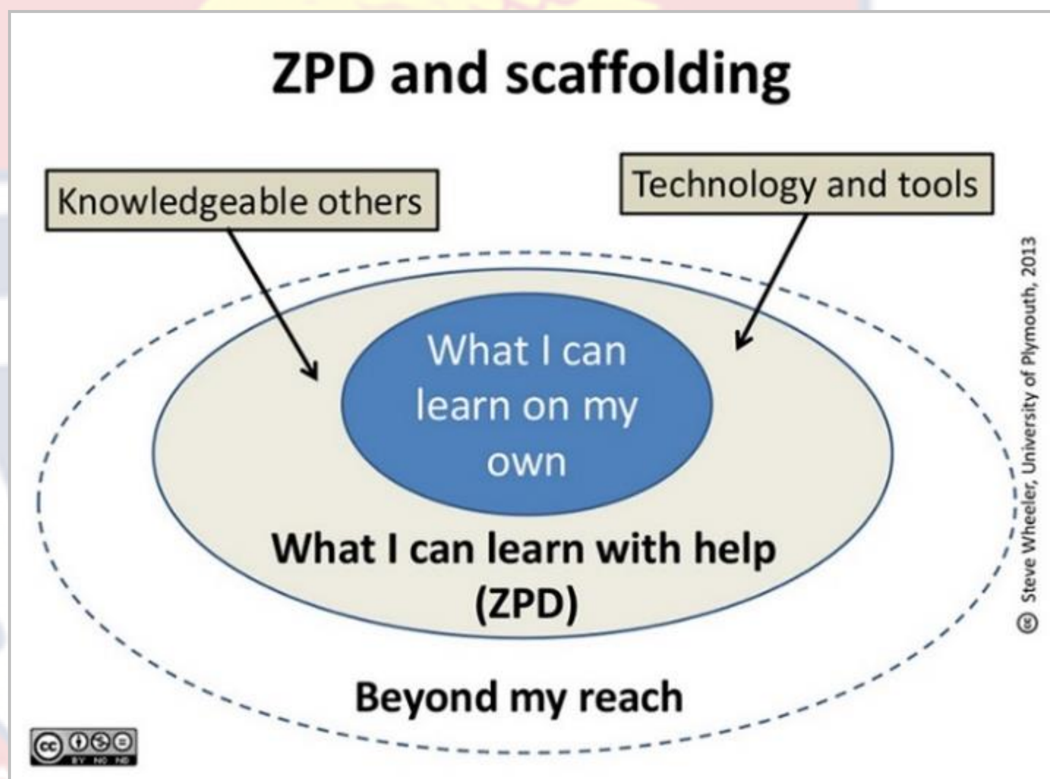


Figure 1: Socio-cultural theory of human learning
Source: Vygotsky’s (1978)

Apart from providing the kids with an opportunity to watch, Vygotsky's theory highlighted the importance of play in education. He suggested that parents and teachers apply this knowledge by providing children with lots of opportunities to play. According to Vygotsky's theory, children use play and imagination to understand their abilities and their

Digitized by Sam Jonah Library

understanding of the world around them (Vygotsky, 1978). He went on, "Some examples of play that can enhance learning are imaginary play, role-playing, games, and re-enactments of actual events. These activities support the development of abstract reasoning."

It is a theory applied to how children learn through various means. One fundamental tenet of the idea was that parents, carers, peers, and culture as a whole were responsible for the development of higher order functions via social interactions. He argues that, it is not prudent to understand development in a vacuum of the individual. Nevertheless, it is good to have an assessment of the social world that surrounds the individual's development. He added that earning be viewed as rooted within social contexts and occurring as individuals engage in interactions with people, objects, and environments during the course of their life. However, each culture provides what he refers to as "tools of intellectual adaptation." These tools provide children the ability to use their core cognitive abilities in a way that fits with the culture in which they live. For instance, whereas one culture could strongly emphasise memory strategies like taking notes, other cultures might prefer approaches like reminders or rote learning.

In applying the socio-cultural and cultural historical theory of Vygotsky to this present study of men's engagement in antenatal care services, the relevant aspects are used. These are: social interaction plays a major role in the development of cognition; knowledge is constructed by learners, learning situated in the activity context, culture and history in which the experience occurs.

Digitized by Sam Jonah Library

In addition, within the social constructivist domain, the individual are the acting agents as their life stories constructed through their unique experiences. Men involvements, therefore, in the care of their pregnant women and unborn children is a unique experience of social life (Vygotsky, 1978). The interactions between the male partners in the family and society provide the connections under the socio-cultural domain of Vygotsky's theory of learning. The community history, a country's burdens, and the political climate also create a link to the cultural and historical theory (Bronfenbrenner, 1977).

Social Ecological Model

The Social Ecological Model (Bronfenbrenner, 1977) provides guidance for developing efficient programmes by utilising social settings and helps in comprehending the factors affecting conduct. The social ecology model emphasised the various levels of effect (including individual, interpersonal, organisational, community, and public policy). The model holds that the social environment was responsible for changing behaviour. The social cognitive theory, which believes that creating an environment that is conducive to change is essential to making it easier for individuals to adopt healthy behaviours and lifestyles, is consistent with the principles and concepts of social ecological theory.

The ecological model is predicated on the idea that biological, behavioural, and environmental factors interact dynamically to affect patterns of health and well-being. Over the course of a person's lifetime, that of their family, and that of their society, this interaction occurs (Smedley & Syme, 2000). This model also presupposes that a person's sex, age, ethnicity, as well

Digitized by Sam Jonah Library

as social and economic inequalities influence health risks and resources both directly and indirectly by affecting the setting in which people function. The ecological model also helps to pinpoint numerous public health intervention points, from the microbiological to the environmental levels, so as to decrease the risks of illness, disability, and death and increase the likelihood of good health, mobility, and longevity (Maleku & Pillai, 2015).

There are five identifiable concepts in the social ecological theory believed to influence health behaviour. These includes; individual factors such as knowledge, attitudes and skills; interpersonal actors which is characterised by social network; organizational factors such as environment and ethos or philosophies; community factors including cultural values and norms; as well as public policy (Figure 2).

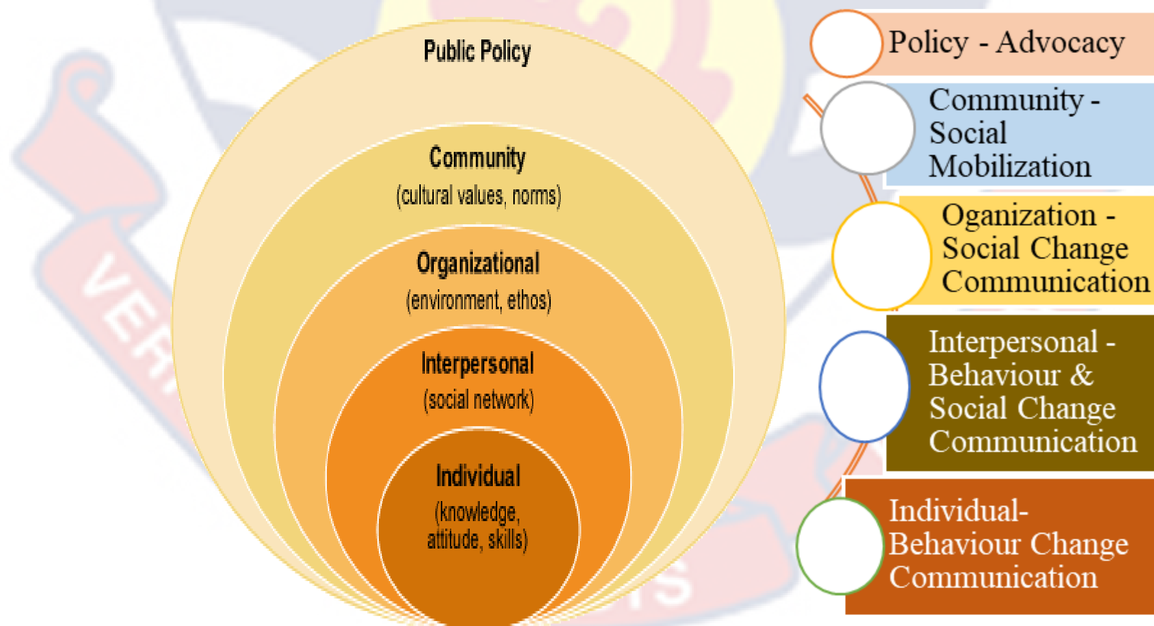


Figure 2: The Social Ecological Model (left side) and Corresponding Communication for Development Approaches (right side)

Source: Bronfenbrenner (1977)

Digitized by Sam Jonah Library

The Social Ecological Model (SEM), which is based on theory, is a framework for comprehending the intricate interactions between individual and environmental factors that influence behaviour. It also helps to identify organizational and behavioural vantage points and intermediaries for health promotion within organizations. "Individual, interpersonal, community, organizational, and policy/enabling environment" are the five hierarchical layers of the SEM (Figure 2). The SEM is a framework for comprehending the interactions between people and their environment at different levels of a social system. Public health promotion, preventive, and control strategies that are most successful combine interventions at all model levels.

Studies reviewed to explore the socio-ecological factors that influence male involvement in antenatal care in some selected health facilities in Ghana and beyond revealed that public policy, community, organisational, interpersonal and individual socio-demographic factors influence male involvements in antenatal care (Craymah et al., 2017; Sham-Una, 2016; Baines, 2017; Yende et al., 2017; Atuahene, Arde-Acquah, Atuahene, Adjuik, & Ganle, 2017).

Public Policy Factors

Public policies such granting of maternity leaves to pregnant women for medical check-ups not granted to the male in most working institutions. This, to some extent also influence men's engagement in antenatal care. Male partners need to have 'paternity' leave. This will enable men to take responsibility of escorting their wives and or women to access antenatal services. Additionally, studies have revealed that in order for the government to enact legislation requiring males to demonstrate financial and emotional

Digitized by Sam Jonah Library

responsibility for their unborn children and their pregnant partners, policy reform has to be advocated for (Yende et al., 2017; Atuahene et al., 2017).

Community Factors

The social and cultural factors that affect men's engagement in antenatal care include both public policy and community factors conceptualized by the SEM. These factors include the culture, values and norms. Antenatal care is usually for women since it is part of the maternal care process (Davis, Luchters & Holmes, 2012). Men are not usually exposed to clinics of reproductive health including antenatal care services. This is because they can easily obtain their health needs (for example, condoms) from pharmacies, having no contact with health providers. Therefore, the issue of accessing reproductive health services to men, is said to be culturally a big problem in SSA (Reece et al., 2010). In addition, the nature and environment of health delivery services by women has made reproductive health services unfriendly for men.

Organizational Factors

According to a study by Atuahene et al. (2017), the health facility, particularly the area where prenatal services are offered, needed to be improved with regards to space and seating provisions to comfortably fit all mothers and their spouses, as well as the addition of more doctors to help clients receive quick and high-quality services. The obstacles which challenge men's engagement include the attitude of healthcare providers and lengthy wait times (Craymah et al., 2017). These elements have an impact on men's participation in prenatal care.

Digitized by Sam Jonah Library

The SEM considers these factors as the social institutions with rules and regulations to operations affecting how well, maternal and child health services rendered to the individual or groups (thus the health facility in this case) effected. Naimoli, Perry, Townsend, Frymus and McCaffery (2015) believe that such factors, when addressed could positively enhance male involvement in antenatal care.

Interpersonal Factors

Interpersonal trust and training together were consistently strongly supported by social network data across research locations as essential determinants for dyad-level interactions. For instance, family, friends, classmates, co-workers, religious networks, conventions, and traditions can all have an impact on an individual's behaviour, as can formal and informal social networks and social support systems. According to research, inter-professional training that emphasizes building trust, gender sensitivity, and enhancing views of health worker intentions may be especially helpful at encouraging cooperation among varied community health professionals (Naimoli et al., 2015).

Individual Factors

The individual factors as opined by the SEM include individual characteristics such as demographic factors that influence behaviour change. Such demographic factors include age, sex, educational level, marital status, number of children, employment status and religion (Naimoli et al., 2015). These characteristics are believed to have influence on health behaviour such as male involvement in antenatal care. Anecdotally, a male with low level of

Digitized by Sam Jonah Library

University of Cape Coast https://ir.ucc.edu.gh/xmlui

education, for instance may not see the need to encourage his pregnant wife to go for antenatal care, not to talk of going with her.

The PEN-3 Cultural Model

The body of research examining how culture affects health has grown significantly over time (Airhihenbuwa, 2007; Airhihenbuwa & Liburd, 2006). This demonstrates the rising awareness of how culture affects health and the growing interest in doing research on it (Airhihenbuwa & Liburd, 2006; Airhihenbuwa & Webster, 2004). Culture is a key determinant in the reduction of health inequities, the improvement of health literacy, and in developing and implementing successful public health initiatives. This rise necessitates a thorough comprehension of the role that culture plays in health. A group's ideas, attitudes, and behaviour are shaped through interactions with and within their environment (Airhihenbuwa, 1999) and by their shared values, norms, and rules.

It is crucial to "appreciate that the forest is more important than the individual tree" when examining how culture affects a person's health (Airhihenbuwa 1999). In addition to understanding and appreciating the shapes of the individual trees, one may investigate the cultural context of the forest to learn more about the functions, connections, and interactions (good or negative) that occur among the trees. These cultural variables are essential for the effectiveness and sustainability of public health interventions.

In order to give culture a central position among factors influencing health behaviour in health promotion and disease preventive interventions, Airhihenbuwa (1989) created the PEN-3 cultural model. The ecological approach of this model allows it to identify the impacts of the person, family,

Digitized by Sam Jonah Library

community, and system on behaviour change (Airhihenbuwa, 1995; Airhihenbuwa, 1999).

It is a paradigm that has proven crucial to providing understanding of how cultural values affect one's health. The PEN-3 cultural model was created in response to what appeared to be the exclusion of culture from previous theories and models of health behaviour (Airhihenbuwa, 1990). According to Airhihenbuwa (1995), the PEN-3 cultural model places culture at the core of research on health beliefs, behaviours, and outcomes.

The approach also emphasises the importance of culture in the conception, execution, and assessment of effective public health interventions (Airhihenbuwa & Webster, 2004; Airhihenbuwa 1995, 2007). According to Airhihenbuwa (2007), culture plays the function of a connecting net through which individual perceptions and behaviours about health are moulded and well-defined. The creation of health beliefs that are repeated to reflect cultural notions is then based on these perceptions and behaviours.

The PEN-3 cultural model offers a structuring framework for integrating culture into the identification of health issues and the conceptualization of potential remedies (Airhihenbuwa 1995, 2007). Additionally, rather of concentrating solely on negative values, these solutions are constructed to promote and honour moral principles, which are more likely to endure (Iwelunmora, Newsome, and Airhihenbuwa, 2014).

Cultural identity, connections and expectations, and cultural empowerment are the three main tenets of the PEN-3 cultural paradigm. Domains of cultural identity: individual, neighbourhood, and extended family; perspectives, facilitators, and nurturers in the relationship and expectation

Digitized by Sam Jonah Library

domain; Domains of cultural empowerment: existential, negative, and positive (see Figure 3).

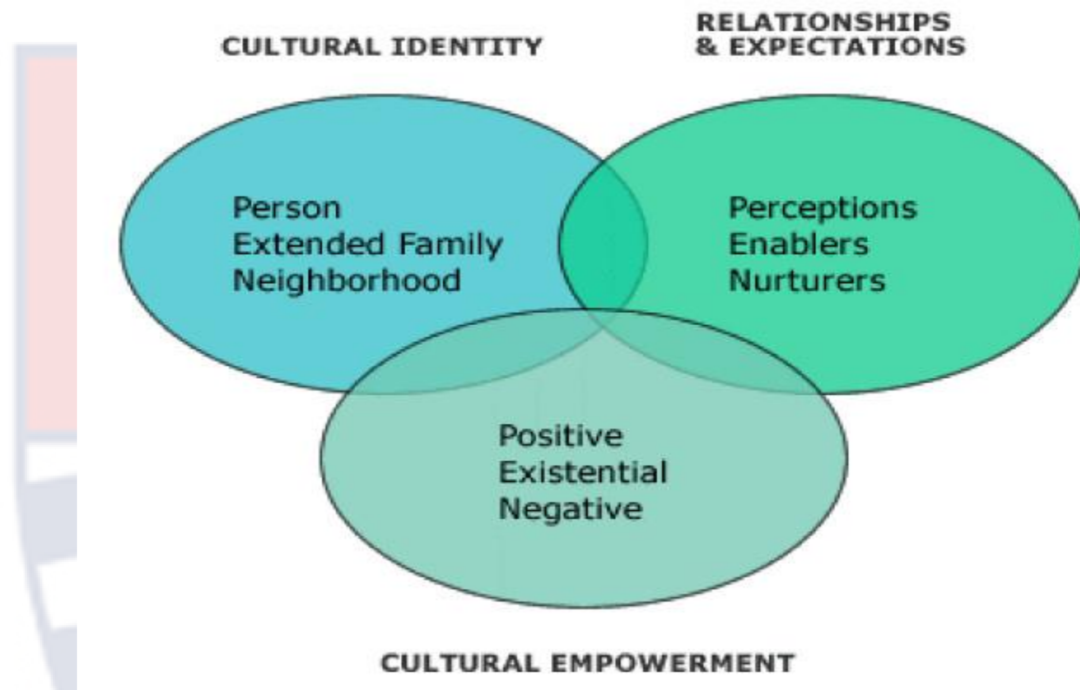


Figure 3: PEN-3 Cultural Theory

Source: Airhihenbuwa (1995)

The consequences of places of entry for health intervention are highlighted by the cultural identity domain. These occur on a personal level (for example, moms or healthcare providers), a family member's extended family (for example, grandparents), or localities (such as towns or villages). Perceptions or attitudes regarding health issues, societal or structural resources (e.g., healthcare services) that support or obstruct effective health-seeking behaviours, and the influence of family and relatives on decisions regarding the effective management of health problems are all included in the relationships and expectations domain.

Digitized by Sam Jonah Library

University of Cape Coast https://ir.ucc.edu.gh/xmlui

The "cultural empowerment domain" focuses on finding beneficial practises and values, emphasising existential values and beliefs that have no detrimental consequences on health, and then identifying harmful practises that serve as impediments. This allows for the exploration of health complications. Later, cultural practises and attitudes that have an impact on health are investigated, and proactive approaches to problems with health are promoted. Before addressing practises that are dangerous and have detrimental effects on health, those that are safe are first approved (Airhihenbuwa, 1989). As per Iwelunmora et al. (2014), the PEN-3 cultural model has been employed thus far to tackle problems associated with HIV, cancer, diabetes, hypertension, nutrition, HIV, smoking, and other ailments that necessitate cognizance of associated cultural contexts and behaviour.

A study of 45 studies that based on the PEN-3 model were of different cultural communities including; African-Americans, Chinese-Americans, Ghanaians, Hawaiians, Latinas, Mexican-Americans, Nigerians, and South Africans. The researchers found three themes across these studies including the role of culture and context, the role of families, and positive aspects of culture (Iwelunmor et al. 2014).

The PEN-3 model's second domain, "Relationships and Expectations," is dedicated to assessing how cultural variables affect health behaviour. Perceptions, Nurturers, and Enablers are rated according to their ability to either foster positive change, have an existential influence on behaviour (which is neither good nor negative but remains inherent to the culture of the persons and groups involved), or have a negative impact on conduct. The three

Digitized by Sam Jonah Library

dimensions in each domain is the researchers' focus of culture that relate to health.

Additionally, the first dimension of this domain (perceptions), has to do with indigenous, cultural beliefs, and values about a health problem of particular persons. For example, it is the believe of some that stillbirth, maternal and child deaths are caused by witchcraft. Aspects of the sociocultural environment that are commonly held yet difficult to observe are perceptions. In order to investigate the socio-cultural determinants affecting HIV disclosures, Iwelunmor, Sofolahan-Oladeinde, and Airhihenbuwa (2015) conducted focus group interviews with 27 male and PLWHA in South Africa. They discovered that the decision to conceal one's HIV status was impacted by participants' notions of masculine identity.

The second dimension (enablers) has to do with the resources that are provided by communities and societies for health. For example, health care systems and health workers. Airhihenbuwa, Okoror, Shefer, Brown, Iwelunmor, Smith and Shisana (2009) interviewed 453 South Africans to explore the role of culture in HIV stigma. They discovered that the health care system and community services were facilitators in how participants experienced stigma.

The third dimension (nurturers) focuses on traditions involving family and friends that outline health practices. Sofolahan-Oladeinde and Airhihenbuwa (2014) interviewed 15 women living with HIV and AIDS in Nigeria to understand male partners' support in making decisions about childbearing. Their findings highlighted the nurturing practices of different forms of male partner support.

Digitized by Sam Jonah Library

University of Cape Coast https://ir.ucc.edu.gh/xmlui

The PEN-3 has main areas of application: assessing cultural communities with health problems; implementing health programmes; and evaluating health campaign programmes (Airhihenbuwa et al., 2009; Iwelunmor et al., 2015). The assessment of cultural communities with a health problem has been the major area of application since the inception of the model. In assessing cultural communities with a health problem, researchers cross the “cultural empowerment domain (positive, existential, negative)” with the “connections and expectancies domain (perceptions, enablers, nurturers)” to focus on community members’ perspectives. This brings about the three-by-three, or nine-cell grid (Sofolahan-Oladeinde & Airhihenbuwa, 2014).

Researchers evaluate community members’ perceptions, enablers, and nurturers of a health problem using this grid (Airhihenbuwa et al., 2019; Airhihenbuwa & Webster, 2004). They look at community members’ existential perceptions, enablers, and nurturers of a health problem as well as their negative perceptions, enablers, and nurturers of a health problem.

It is not necessary for researchers to use all three domains and dimensions (Okoror, Belue, Zungu, Adam, & Airhihenbuwa, 2014; Mieh, Iwelunmor & Airhihenbuwa, 2013). Although PEN-3 used to implement and evaluate health programmes, it is rarely used in this way (Airhihenbuwa et al., 2009). An example is the use of PEN-3 to develop, implement, and evaluate a thirteen weeks nutrition educational programme to promote the diets, physical activities, and biomedical behaviours of 102 young African-American women. The intervention resulted in 45 percent of participants adopting dietary and biomedical behaviours (Kannan, Sparks, Webster, Krishnakumar, & Lumeng, 2010).

Digitized by Sam Jonah Library

University of Cape Coast https://ir.ucc.edu.gh/xmlui

The PEN-3 cultural model has many limitations. First, virtually all of the research examined used the PEN-3 model to create and interpret formative or qualitative data in response to culturally challenged processes of health behaviour. A few of the research assessed appeared to create the model's domains quantitatively (Iwelunmor et al., 2014).

Iwelunmor et al. (2014) further claimed that quantitative testing of the model's many domains would contribute to the body of data supporting the validity and efficacy of the PEN-3 model. The model's premise and foundation in addressing cultural aspects of health behaviour is supported by findings from qualitative research. Additionally, this research offers a method for unearthing detailed descriptions of the wide variety of complex variables that affect health behaviours at the individual, family, and community levels—whether they are good or bad. In contrast to previous initiatives that mostly concentrate on Western constructions of individual characteristics that impact health behaviours, it also represents a significant approach (Iwelunmor et al., 2014).

Transferability, or the degree to which the results from these qualitative researches may be applied in different contexts, is another restriction of the PEN-3 paradigm. Iwelunmor et al. (2014) concluded that "care should be used when applying the findings from the PEN-3 model to different contexts because cultural components of health behaviours that apply in one environment may differ from those that apply in another." Therefore, it is advised that PEN-3 always start with a qualitative research to fully understand the distinctiveness of each setting, culture, and community.

Digitized by Sam Jonah Library

Conceptual Base of the Study

The conceptual framework of the current study uses the 'Relationship and Expectation' domain (Perception, Enablers and Nurturers) of PEN-3 culture model on the impact culture has on health (Figure 4). It explores how this domain addresses health behaviours and health outcomes. The PEN-3 cultural model posits that public health and health promotion employ individual, or a person's health behaviour in his or her family and community, and the cultural setting that nourishes occur, to address the influence of culture on health beliefs, behaviours, and circumstances (Airhihenbuwa, 2007).

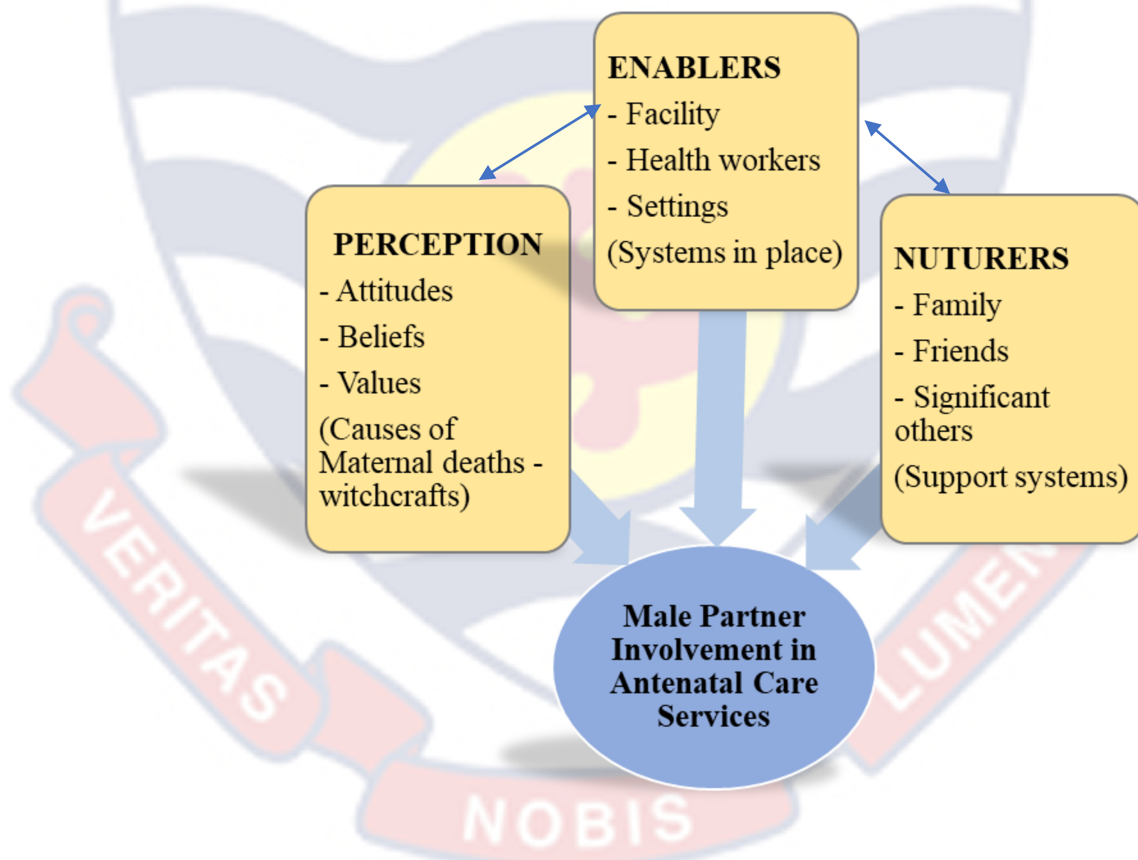


Figure 4: Conceptual framework

Source: Adapted from Airhihenbuwa (1995)

Digitized by Sam Jonah Library

University of Cape Coast https://ir.ucc.edu.gh/xmlui

Culture and Context of the Model

Studies using the PEN-3 model focus in various ways, the broader context of culture has on health practices. A study of individual in focus group interviews with 117 traditional leaders and 80 youths from the Botswanna, Lesotho, South Africa, and Swaziland to discovered indigenous cultural practices that influence sex-related norms. They discovered leaders debating the revival of ancient practises like chiefs' councils and rites of passage into adulthood as a method of fostering gender sensitivity and HIV/AIDS prevention in their communities (Green, Dlamini, D'errico, Ruark, & Duby, 2009).

Male Perception of Antenatal Care Services (Perception)

To investigate the cultural meanings of death and loss due to illness, Iwelunmor and Airhihenbuwa (2012) conducted focused group interviews with 110 South African women who were affected and infected by HIV and AIDS. The ladies discussed many cultural ramifications, including the idea that HIV is a death sentence and is just like any other sickness. The theme of culture and context points attention to cultural and historical factors such as customs, meanings, and taboos. A qualitative study in rural Tanzania by Vermeulen, Miltenburg, Barras, Maselle, van Elteren and van Roosmalen (2016) revealed that generally, men showed positive signs about their wives attending antenatal care clinics. While the majority of men identify advantages including illness prevention, evaluating their wife's and unborn child's health, and preparing for a safe birth, some men are unaware of what occurs during the delivery of prenatal care services.

Digitized by Sam Jonah Library

University of Cape Coast https://ir.ucc.edu.gh/xmlui

Even though generally, men appreciated Traditional Birth Attendants (TBAs) and often used both services, with antenatal care services at health facilities, the belief is that facility services are better equipped and healthcare workers have more expertise compared to the TBAs. Some husbands saw sending their wives to prenatal care as a normal duty, while others saw it as specialist treatment that was only necessary if issues arose (Vermeulen et al., 2016).

Additionally, several males claimed that during prenatal care visits, they overheard bad attitudes from healthcare professionals towards women that reflected mistreatment and disdain, fraud, protracted wait times, a lack of resources, and apathy towards their jobs (Vermeulen et al., 2016). Men stated that spouses often do not become engaged in pregnancy-related matters because they view it as being a "women only matter" when asked about their involvement in accompanying women to prenatal care. A respondent was quoted saying, "It is not part of our culture, it is western culture."

Once more, men described feeling uneasy while waiting outside a prenatal care clinic with their spouses. Another respondent was quoted lamenting that "Nowadays women are struggling to involve us, by asking to accompany them to the clinic. But even if you arrive there, you do not care and you may proceed with your own business (outside) instead of sitting with your wife and listening carefully to what it is being advised."

Furthermore, during focus group discussions, it was said that a lack of understanding of pregnancy and the risk factors associated with it resulted in a lack of understanding of the significance of their involvement in pregnancy-related difficulties. Men, for instance, failed to stress the importance of testing

Digitized by Sam Jonah Library

University of Cape Coast https://ir.ucc.edu.gh/xmlui

for HIV or that it was a significant reason for them to visit prenatal care. Men's resistance to attending prenatal care was influenced by misconceptions regarding HIV testing during antenatal care, which were linked to a lack of knowledge. The importance of men participating in antenatal care is emphasised by Vermeulen and colleagues (2016), who list the following benefits: they will hear the advice together, enabling them to work together during pregnancy; husbands will be less ignorant of the advice given by healthcare professionals, knowing that their wives' reduction in activities is not indicative of laziness; and HIV testing involves both of them.

The provision of preferential treatment for women visiting with their partners is another trend in government policy that encourages male presence during prenatal care. In spite of this effort, Tanzanian health institutions have a very low male attendance rate for prenatal treatment.

Diverse Social Identities (Enablers)

Another theme that furthers our understanding of the sociocultural factors that inform health is the impact of diverse social identities (e.g. religion). The PEN-3 studies show how social characteristics like race and gender affect health in African countries. Strong empathic links have been reported to form between female PLWHA and nurses thanks to gender concordance, particularly female-to-female relationships (Sofolahan, Airhihenbuwa, Makofane, & Mashaba, 2011; Sofolahan & Airhihenbuwa, 2013).

On the other side, it was discovered that gender imbalance between men and women stigmatises women and limits their ability to make healthy marital decisions. For instance, Williams and Amoateng (2012) concluded that

Digitized by Sam Jonah Library

University of Cape Coast https://ir.ucc.edu.gh/xmlui

"Ghanaian men's stigmatising ideas about women with cervical cancer and their lack of financial and spousal support for screening were challenges to cervical cancer prevention." Another instance is that female PLWHA in South Africa reported early difficulty in persuading their spouses to accept condom usage, according to Sofolahan and Airhihenbuwa (2013). Additionally, studies have also considered the impact of racial identity on gender health in Africa. For example, Brown, Belue, and Airhihenbuwa (2010) surveyed four hundred people from two communities in South Africa to quantify the influence of racial identity on HIV and AIDS stigma in South African families. They discovered that, compared to Coloured South African families, Black African families stigmatised family members who were living with HIV and AIDS more because of cultural or spiritual beliefs.

Petros, Airhihenbuwa, Simbayi, Ramlagan and Brown (2006) found the practice of HIV and AIDS in South Africa to be based on racial identity. They wrote, "South Africans from different racial backgrounds blame each other as either being the source of HIV or being responsible for spreading the disease" (pg. 70). They also found HIV and AIDS to be gender, homophobia, religion, and xenophobia based. A theme that discerned from applications of PEN-3 was the influence of diverse social identities (such as gender, race, and religion) on health behaviour and practices.

Health Care Workers as Family Member

Another theme found in applications of PEN-3 is the blurred role of the health care worker between that of a professional and a family member. For instance, according to Mieh et al. (2013), home-based caregiving (volunteers who helped family carers with PLWHA) is essential to African cultures. These

Digitized by Sam Jonah Library

University of Cape Coast https://ir.ucc.edu.gh/xmlui

volunteers had collective and communal identities that allowed them to fill the role of family for PLWHA who had been rejected by their biological families.

To learn more about how nurses care for PLWHA, Sofolahan et al. (2011) conducted focus group discussions with seventeen female nurses in Limpopo, South Africa. It was discovered that nurses had trouble separating their personal and professional lives. They wrote: "Nurses can identify with patients at work when they test HIV positive. This induces empathy, because each time a patient tests positive, it reminds you of your own family members who have and died of AIDS or those who you care for because they are HIV positive" (p. 5).

Participants in another research had expectations of healthcare professionals beyond policy requirements, according to the study's findings. The participants regarded caring and helpful health care professionals as positive, while unkind professionals were those who did not supply them with meals. Knowledge from applications of PEN-3 suggests the role of health care workers often blurred between that of a professional and an extended family member Okoror et al. (2014).

PEN-3 can inform the response to the recent Ebola crisis in West Africa. The use of the PEN-3 model requires the analyst begun by assessing the cultural community with a health problem. They expected to begin by generating viewpoints from community members of positive perceptions, enablers, and nurturers regarding the Ebola virus (e.g. cultural traditions where elders immediately isolate and monitor those suspected of infectious diseases). The results may contain ideas and knowledge that can be further exploited and

Digitized by Sam Jonah Library

University of Cape Coast https://ir.ucc.edu.gh/xmlui

harnessed when devising a campaign or intervention (Iwelunmor, Sofolahan-Oladeinde, & Airhihenbuwa, 2015).

The researcher generates existential perceptions, enablers, and nurturers from community members. These culturally unique beliefs, assets, and practices that have neither positive nor negative impacts on health. In addition, researchers generate negative perceptions, enablers, and nurturers of example, Ebola in the community. This provides the researcher with negative cultural factors surrounding the spread of the virus that need to change (e.g. burial traditions involving intimate contacts between the bereaved and the deceased).

After a thorough assessment, the analyst is encouraged to consult and collaborate with community members in developing solutions via campaigns and interventions (e.g. Ebola awareness, treatment, and prevention). These solutions should not only draw from and include the community, but they should also work to overcome cultural barriers to health while leveraging cultural assets (positive views, facilitators, and nurturers).

One initial consideration is the intervention point of entry. Initiatives, for example, may consider the entry points of mothers or grandmothers. Although women are the primary caretakers and the most engaged with health care systems, gender inequality and gender stigmatization may hamper their efforts. Initiatives may also consider the entry points of elders within families and within communities (e.g., religious and traditional leaders). Although these actors can play influential roles in family and community members' health decisions and practices, they may be distrustful of foreigners or

Digitized by Sam Jonah Library

University of Cape Coast https://ir.ucc.edu.gh/xmlui

outsiders and initially resistant to non-traditional health innovations and practices.

Initiatives can also consider the entry point of health care workers. PEN-3 research in African nations suggest health care workers play both strongly positive and negative roles in the health of community members. As such, carefully screen them before their participation in any intervention. The ideal health care worker would have a caring, supportive, and generous orientation. Such a worker believes he sick has an obligation to his community and regards patients and members of the community as extended family members.

Role of Families (Nurturers)

Another theme that Iwelunmor et al. (2014) found across applications of PEN-3 is the important role of families in the experience of health or illness and in the shaping of health decisions. Iwelunmor, Airhihenbuwa, Okoror, Brown and Belue (2006) again conducted focus group interviews with 204 participants in South Africa to examine the response by family systems to HIV and AIDS. They found family systems as sources of support (e.g. going with PLWHA to clinics and support groups), to be unique indigenous institutions (e.g. arranging family meetings to counsel members about HIV and AIDS), and sources of stress (e.g. rejecting members who disclosed their status).

Williams and Amoateng (2012) conducted focus group interviews with 29 men in Ghana on their beliefs and knowledge about cervical cancer and their willingness to encourage spousal cancer screening. They found most men were not aware of cervical cancer and held stigmatising beliefs about its risk factors (e.g. caused by female promiscuity and poor hygiene). They concluded

Digitized by Sam Jonah Library

University of Cape Coast https://ir.ucc.edu.gh/xmlui

that men's lack of awareness and support might inhibit their spouses' cervical cancer prevention. In another study, Iwelunmor, Zungu, and Airhihenbuwa (2010) conducted interviews with 54 women living with HIV and AIDS in South Africa to explore the role of "motherhood" in women's HIV status disclosures to their mothers.

Drawing on the notion of motherhood as a cultural construct, they found participants' motherhood roles predisposed disclosures and simultaneously created a dilemma that weakened their closeness with female family elders. The theme of role of families focuses on how communication in extended families and marriages shape members' health.

Positive Aspects of Culture (the role of support systems)

Iwelunmor et al. (2014) also found that applications of PEN-3 highlighted positive aspects of health practices that can further harnessed in campaigns and interventions. For example, Mieh et al. (2013) conducted focus group interviews with 41 female home-based caregivers for PLWHA in Limpopo, South Africa to examine their HIV and AIDS related perceptions. They discovered carers with thorough understanding of HIV and AIDS who were also reflecting on how they had changed from first stigmatising patients to supporting them.

In order to learn more about the experiences of 54 female PLWHA in South Africa, Okoror et al. (2014) also conducted seven focus group interviews with them. Patients spoke favourably about carer assistance and being able to consult with medical professionals without an appointment, among other experiences. Thirty-five female PLWHA participated in four further focus groups in South Africa to further study the variables impacting

Digitized by Sam Jonah Library

their sexual and reproductive choices around pregnancy. They found favourable opinions (e.g. HIV status acceptance empowering healthy choices).

Positive enablers (e.g. health care workers' attentiveness and supportiveness) and positive nurturers (e.g. marital partners supporting use of condoms and being faithful to partner) (Sofolahan & Airhihenbuwa, 2013). In addition to the three themes identified by Iwelunmor et al. (2014), applications of PEN-3 in African nations yielded additional knowledge that further highlights the contextual and socio-cultural factors that shape health. (The role of elders, the impact of diverse social identities, and the theme of health care workers as family members).

The Role of Elders

Elders found in communities and extended families are influential in shaping health decisions and practices. For example, Green et al. (2009) based their study of HIV prevention on traditional leaders (also referred to as "chiefs") in the countries of Botswanna, Lesotho, South Africa, and Swaziland. They argued that these leaders hold strong influence, particularly in rural communities, and their influence persists despite modernization and Westernization.

In another study, Iwelunmor et al. (2010) discovered that female elders in South African households often monitor and direct new mothers' childrearing practises as well as manage the pregnancy and delivery of younger family members. Petros et al. (2006), in their attempt to understanding HIV and AIDS practices (i.e. blaming and shaming) in broader South African society, turned to the local knowledge of key informants such as chiefs, traditional healers, and religious leaders. A theme from applications

Digitized by Sam Jonah Library

of PEN-3 is important to influence elders who lead extended families and communities in shaping members' health decisions and practices.

Concept of Antenatal Care Services

The regular medical and nursing care that is advised for women primarily during pregnancy is referred to as antenatal or prenatal care. Regular visits with a hospital or health facility to see a medical officer/practitioner throughout pregnancy allow women to get services essential to their health and the health of their unborn child. This is known as antenatal care. This care is given to expectant mothers by qualified medical professionals in order to provide the best possible health outcomes for the mother and the foetus. Thus, to safeguard both the mother's and the unborn child's health during pregnancy, continuous interaction with health professionals is necessary. To ensure happy pregnancies, all women should have access to high-quality prenatal care services. The pregnant women should experience respectful care throughout pregnancy to help protect baby and mother's health. Lastly, all pregnant women should have a minimum of eight encounters with qualified healthcare professionals during their pregnancy (WHO, 2016).

Antenatal care is a type of preventive care that promotes healthy lifestyles that are advantageous to both the mother and the unborn child. It does this by providing regular check-ups so that medical professionals can treat and prevent any health problems that may arise during the course of the pregnancy (Aarnio, Olsson, Chimbiri, & Kulmala, 2009). However, prenatal care facilities in impoverished countries continue to be underutilised and underprovided (Pafs et al., 2015). This may be explained by differences between recommended antenatal care and the care actually provided,

Digitized by Sam Jonah Library

accessibility and prior antenatal care experience, the education level of the woman and her partner, socioeconomic status, including socio-cultural factors, and the woman's and her partner's socioeconomic status (Kululanga et al., 2012).

Alkema, Chou, Hogan, Zhang, Moller, Gemmill, et al. (2015) report that about 303,000 women and adolescent girls died in 2015 due to pregnancy-related complications. In one year, 2.6 million babies were stillborn. Nearly all maternal fatalities (99%) and child deaths (98%) occurred in low- and middle-income countries. These maternal mortality may have been prevented if the adolescent girls and pregnant women had had access to high-quality prenatal care (WHO, 2016). According to Blencowe, Cousens, Jassir, Say, Chou, Mathers, … & Lawn (2016), untreated maternal infection, hypertension, and poor foetal development were the primary causes of 60% of the stillbirths (1.46 million) that occurred during the antepartum period.

The focused antenatal care (FANC) model, created in the 1990s, may be linked to more perinatal fatalities than other prenatal care models, according to recent research (Vogel, Habib, Souza, Gülmezoglu, Dowswell, Carroli et al., 2013). The pregnant lady and the healthcare professional have at least eight interactions throughout this time (WHO, 2016). According to a secondary study of the World Health Organization's (WHO) prenatal care experiment, a rise in stillbirths is more likely to be the cause of the rising perinatal death rate (Dowswell, Carroli, Duley, Gates, Gülmezoglu, Khan-Neelofur et al, 2015). The WHO's 2016 antenatal care recommendations were developed using the results of the secondary analysis and additional evidence. The recommendations provide countries with policy and programme

Digitized by Sam Jonah Library

considerations for adopting universal coverage and putting the recommendations into practice (Alkema et al., 2015; Blencowe et al., 2016; Dowswell et al., 2015; Vogel et al., 2013).

The WHO (2016) states that “the goal of the prenatal care model is to guarantee that pregnant women get respectful, personalised, person-centered care at each contact as well as efficient, integrated clinical practises (interventions and tests) at each contact.” A well-functioning healthcare system necessitates practitioners with strong clinical and interpersonal skills to provide timely and pertinent information as well as psychological and emotional support (Blencowe et al., 2016).

According to the available data, perinatal fatalities rise after just four prenatal care appointments and interactions (Vogel et al., 2013). The WHO suggests at least eight interactions, regardless of the nation where mother satisfaction has increased; one contact occurred in the first trimester, two encounters occurred in the second trimester, five contacts occurred in the third trimester (WHO, 2016) (see Table 1).

Digitized by Sam Jonah Library

Table 1: WHO Antenatal Schedule

WORLD HEALTH ORGANIZATION RECCOMMENDED ANC MODEL (2016)	
Contact	Period
First Trimester	
Contact 1	1 week up to 12 weeks
Second Trimester	
Contact 2	20 weeks
Contact 3	26 weeks
Third Trimester	
Contact 4	30 weeks
Contact 5	34 weeks
Contact 6	36 weeks
Contact 7	38 weeks
Contact 8	40 weeks
Return for delivery at 41 weeks if not given birth. NOTE: Intermittent preventive treatment of malaria in pregnancy should be started at ≥ 13 weeks.	

Source: WHO (2016)

The assumption of the WHO is, based on its unique core package of prenatal care services, each nation customises the new model for its situation (Dowswell et al., 2015). There is agreement on who provides prenatal care at each contact, where it is offered (system level of facility), how it is supplied (platforms), and how it is coordinated throughout all eight antenatal care contacts (WHO, 2016).

Digitized by Sam Jonah Library

The eight prenatal care contacts are to be operationalized in nations, continuity of care and health workforce issues are to be resolved, and communication and support for women are to be improved (WHO, 2016). Additionally, carrying case notes was always advised for pregnant women to enhance continuity, quality, and their pregnancy experience. In order to encourage healthy habits, distribute nutritional supplements that are recommended, and administer intermittent preventative therapy in pregnancy (IPTp) to avoid malaria, it is also advised to "task-shift" antenatal care services to a variety of cadres; nurses, midwives, lay health workers, and doctors. However, professional support interventions that help trained health professionals find and stay in distant and rural locations should be considered by policy makers (Blencowe et al., 2016; Vogel et al., 2013).

In regions with effective midwifery programmes, models of prenatal care led by midwives are advised. In addition, prenatal care packages that include home visits and family and community mobilisation are advocated, especially for mothers in rural and isolated areas. Home visits for prenatal care and community and household mobilisation are some of these approaches. (Alkema et al., 2015).

Concept of Culture

Airhihenbuwa (1999) defines culture as "shared values, norms, and codes that collectively shape a group's beliefs, norms, attitudes, and behaviour through interactions in and with the environment in which they live." Culture is also defined as "a system of associated values, concepts, meanings, and beliefs that are active enough to impact an individual's judgement, communication, and action."

Digitized by Sam Jonah Library

Individuals' attitudes and behaviours towards their health are influenced by their cultural background, which in turn affects how they react to health information. Culture is much more than just music, dancing, painting, and other forms of expression. Our worldview, which is crucial to how we comprehend who we are, where we have come from, and where we are going, is shaped by our culture. Everything about us, both inside and outside, defines and moulds who we are. Culture is regarded on numerous levels around the world. As one advances into the true core of culture, it might be advantageous to observe it from many perspectives (Bediako, 2006; Kwast, 1981).

According to Ngubane (2010), culture may be broken down into four categories: behaviour (what is done), values (what is right or ideal), beliefs (what is true), and worldview (what is actual). People might not always be aware of the wider picture that influences their everyday thoughts, feelings, and behaviours. The person feels that outside of the traditional African family and community, there is no room for self-determination. Mbiti (1969) writes, "Whatever happens to the individual happens to the whole group, and the whole group in affected by what happens to the individual. The individual will say, "I am, because we are, and since we are therefore, I am". This is a cardinal point in the understanding of the African view of man" (p. 109).

Culture serves as the virtually impenetrable adhesion that holds people together and provides them a feeling of continuity and identity. A circle with behaviours on one layer and worldview on the other is a good way to visualise culture. The uncertainty that individuals experience at the level of beliefs may be understood by considering worldviews as the foundation of every society

Digitized by Sam Jonah Library

(Ngubane, 2010). A person's worldview, which offers a set of ideas that are mirrored in their real values and actions, is referred to as their culture. When a new competing belief system, such as Christianity, is occasionally presented, the previous worldview continues to be uncontested and unaltered, and values and conduct reflect this, including how males see maternal health care (Magezi, 2007).

Ghana and other traditional African communities are patriarchal, with males regarded as the superior gender. According to Umar and Bawa (2015), women and children are supposed to submit to the authority of the man. The belief that respecting males as the patriarchs of families and as social leaders is a virtue underlies this attitude. This is motivated by the conviction and faith that males were chosen by God to be the community's and women's leaders. Men must thus be obeyed out of reverence for God (god) and ancestors who serve as an intermediary between God and mankind (Ngubane, 2010). Nyasani (1997) warns against not scrutinizing cultural beliefs and practices. According to the author, "Norms of culture were merely received but never subjected to the scrutiny of reason to establish their viability and practicability in the society. Maybe it is because of this lack of personal involvement and personal scrutiny that has tended to work to the disadvantage of the Africans, especially where they are faced with a critical situation of reckoning about their own destiny and even dignity" (Nyasani, 1997, pg. 63-69).

No matter what discipline background the term is based on, culture is usually accepted as the basis for health seeking behaviour (in general) and male partner involvement in antenatal care (specifically) and through which health for all, especially for women and children, must be defined and

Digitized by Sam Jonah Library

understood (Ngubane, 2010). Male engagement in women's reproductive health, according to Dzumbila-Namasasu (2010), has recently drawn attention on a worldwide scale, but it is still a difficulty and more study is needed.

According to Ongeso and Okoth (2012), men's engagement is a vital element in the optimisation of care provided for pregnant women. Umar and Bawa have indicated in their study that the level of men's participation in maternal health services was low (5% - 40%) (Umar & Bawa, 2015). In order to examine some of the fundamental sociocultural variables influencing men's engagement in maternal health concerns relevant to pregnancy and childbearing in rural areas in Gambia, Lowe (2017) undertook a qualitative research. Rural males and traditional birth attendants were the subjects of five focus group talks and six in-depth interviews in rural Gambia. The conversation focused on how men interact with their spouses throughout pregnancy and delivery as well as the challenges they encounter. The study's findings showed that gender roles and norms, which have been the cause of male engagement in prenatal care issues, are generally influencing social and cultural practises in Gambia.

Again, according to Lowe's (2017) study, traditional birth attendants and rural Gambian men reported that husbands' involvement in mothers' health is highly desirable but is influenced by a variety of factors, including the traditional conceptualization of pregnancy and delivery as the purview of women. Many men do not think that the tasks associated with being pregnant are worth their time and effort in comparison to other societal obligations.

Digitized by Sam Jonah Library

Male Partner Involvement in Antenatal Care Services

Various researches have been conducted to examine and describe the level or rate of male partner participation in antenatal services across the globe (Iliyasu, Abubakar, Galadanci & Aliyu, 2010; Sham-Una, 2016; Craymah et al., 2017; Kariuki & Seruwagi, 2016). This session therefore comprehensively reports related studies on the level of men's participation in antenatal services.

Globally, men's engagement in prenatal care was identified as one of the strategies in improving maternal health outcomes in developed countries (Yargawa & Leonardi-Bee, 2015). In Ghana, Craymah, Oppong and Tuoyire (2017) conducted a study with the aim of assessing the level of male participation in maternal health care services and the factors which determine it. The researcher employed Pearson chi-squared test and Fisher's exact test to determine the parameters related with male engagement in maternal health care services after randomly choosing 100 men with pregnant wives. According to the survey, only 35 percent, 44 percent, and 20 percent of men accompanied their partners to prenatal care, delivery, and postnatal care services, respectively, indicating that male engagement in mother and child health services is low.

Utilisation of prenatal care services is influenced by the social division of labour between men and women, particularly in terms of decision-making. Therefore, it is crucial that men comprehend and value the significance of receiving prenatal care in a medical facility because traditionally, maternal health issues, especially antenatal care services, are principally considered as entirely feminine issues in Ghana and other parts of Africa (Umar & Bawa, 2015). Men see reproductive health services as "women's work and space".

Digitized by Sam Jonah Library

The explanation and organisation of the programmes are essentially concerned with females hence, men perceived antenatal care activities as outside their area of responsibility and have conventionally excluded themselves from antenatal services (Reece, Hollub, Nangami, & Lane, 2010). This has confirmed the flawed conception that the process of pregnancy and childbirth processes are solely, women's responsibility (Iliyasu et al., 2010).

Mahiti, Mbekenga, Kiwara, Hurtig and Goicolea (2017) investigated male partners' perspectives on cultural traditions during postpartum care in rural Tanzania. According to the findings, older women played a major role in caring for postpartum moms and their infants, but males ultimately decided where to seek treatment. In addition, ancient customs separated males from their spouses for a period of time and required women to abstain from sexual activity during the postpartum period. However, cultural standards allowed males to have extramarital relationships. Men saw reproductive and child healthcare facilities as inhospitable to male partners, and local gender norms inhibited men from accompanying their spouses to seek treatments (Mahiti et al., 2017).

In a similar Tanzanian study, the degree of men's engagement in prenatal care and the variables affecting that involvement were ascertained by Gibore, Bali and Kibusi (2019). The findings demonstrated that men's participation in prenatal care was high (53.9%). Eighty-nine percent of respondents said they would seek prenatal care together. At least once, more than half (63.4%) of the respondents went to the prenatal clinic with their spouses. Fewer than a quarter (23.5%) of males felt comfortable talking to their partner's medical professionals about pregnancy-related concerns.

Digitized by Sam Jonah Library

Approximately 77.3% of participants offered their partners physical assistance when they were expecting. Occupation (AOR = 0.692), ethnicity (AOR = 1.495), religion (AOR = 1.826), waiting time (AOR = 1.444), knowledge of men's involvement in antenatal care (AOR = 3.077), and men's perception of the attitude of healthcare providers (AOR = 1.548) were factors influencing men's involvement in antenatal care (Gibore et al., 2019).

Similar to this, in Northern Uganda, Tweheyo, Konde-Lule, Tunwesigje and Sekandi (2010) found that whereas 65% of males accompanied their women for prenatal care, only 48% did so during deliveries. In Nepal, Mullany, Becker and Hindin (2007) found that 40% of husbands went with their wives for the first time to a prenatal appointment. A research conducted in Kenya in 2000 by Muia, Olenja, Kimani, and Leonard reported that only 13% of women receiving prenatal care were escorted by their spouses, which is in conflict with the findings of the present study.

Male partner prenatal engagement in Uganda continues to be minimal, despite linked favourable results for mother and child health, according to Kariuki and Seruwagi (2016). This study evaluated the proportion of male partners who regularly participate in prenatal care as well as the factors that influence male engagement in antenatal care in a sub-urban setting in Uganda. A mixed technique descriptive cross-sectional community-based survey was conducted. Using simple random sampling, 384 males between the ages of 18 and 49 whose wife had given birth to at least one kid under the age of two were chosen. The study's findings showed that "male involvement in prenatal care was extremely low (6%) and that this low level of involvement could be attributed to sociodemographic factors like education (p=0.000), marriage

Digitized by Sam Jonah Library

(p=0.001), and age (p=0.044), all of which were found to increase male involvement in prenatal care while lowering levels of male involvement were associated with lower income earnings (p=0.023)" (Kariuki & Seruwagi, 2016).

Again, living apart from one another while a woman is pregnant (OR=3.474, p=0.012), family members living with male partners and their spouses (OR=4.122, p=0.001), family members influencing a male partner's decision to seek antenatal care (OR=5.421, p=0.001), unplanned pregnancies (OR=8.935, p=0.001), peer influence (OR=3.614, p=0.036), and limited male involvement in choosing where spouses receive prenatal care (OR=4.245, p=0.009) all contributed to the inconsistent male partner's participation in antenatal care. Male participation in prenatal care was substantially correlated with health professional attitude, waiting time, and antenatal service costs (Kariuki & Seruwagi, 2016).

In order to determine the rate of men's engagement in prenatal clinics and the variables which affect their involvement in prenatal care in, Kumasi, Ghana, Sham-Una (2016) performed a quantitative study with a cross sessional design. Four hundred and ten males who are at least 18 years old, are partners of women who are now receiving prenatal care or have previously received postnatal care, were chosen at random to make up the sample size. The study discovered that male prenatal care attendance was extremely low (35%) and that 65% of the men participating had never gone to antenatal care with their wives or partners (Sham-Una, 2016).

Another study found that male participation in prenatal care services was low (5%–40%) and that sociodemographic factors such the level of

Digitized by Sam Jonah Library

education of partner, kind of marriage, living situation, and parity all had an impact. Additionally, barriers to male partners participating in prenatal care services included enabling/disenabling variables such distance to a health facility, the attitude of health staff, prohibitive cultural norms, unfavourable health policies, and gender roles (Umar & Bawa, 2015).

Male involvement in antenatal care services is therefore, an intervention by WHO to promote male partner involvement during pregnancy, labour and puerperium. It is a means employ males to support their spouses assessing health care throughout pregnancy to have healthy mother and baby at the end of the delivery (WHO, 2016).

Factors Affecting Male Partner's Participation in Antenatal Care Services

According to Rahman, Islam, Mostofa and Reza (2015), "males typically lack understanding about the true duties they should play during prenatal care and are unaware of what takes place in antenatal care clinics." Although men are aware of prenatal care, it doesn't seem like they comprehend the need of check-ups and a safe delivery for expectant moms. More males should participate in prenatal care services so that they may assist expecting mothers in a more informed and helpful way (Matiag'I, Mojola & Githae, 2013; Vermeulen et al., 2016).

Studies in Bangladesh, Tanzania, Ghana and Eastern Uganda (Story, Burgard, Lori, Taleb, Ali, and Hoque, 2012; Craymah et al., 2017; Umar & Bawa, 2015; Vermeulen et. al., 2016; Byamugisha, Tumwine, Semiyaga, & Tyllesk, 2010) found that male partners provided emotional and educational assistance to women who used professional delivery services. Women have

Digitized by Sam Jonah Library

difficulty utilising health care services because of the high expense of transportation and the facilities' remote location. Low male engagement in mother and child health care was reportedly caused by the attitude of the health staff at the hospital. This is in line with a research by Byamugisha et. al., (2010) that found male involvement was hindered by competent health professionals' insulting and abusive words aimed at Ugandan women. Men were deterred from returning to or taking part in PMTCT (prevention of mother-to-child transmission) of HIV activities by the harsh treatment they received from healthcare professionals.

According to a survey, males who wished to escort their spouses to maternal health services in Turkey were not given assistance by medical personnel. Because of this, many men who went to the clinic with their wives had to halt at the door or the entry to escape being verbally abused by the medical staff (Hussain, Khan, Ismail, ur Rehman, & Iftikhar, 2012). Due to men's fear of being verbally, emotionally, and occasionally physically abused, there is a very low level of male engagement in mother and child health (Hussain et al., 2012).

Mullany (2006) conducted a qualitative study in Nepal with the specific intention of identifying obstacles to male involvement in maternal health and investigating the perspectives of men, women, and clinicians towards encouraging male involvement in prenatal care and maternal health. Couples and experts in maternal health care were interviewed in-depth. The data indicate that the most significant impediments to male engagement in maternal health were a lack of information, social stigma, shyness/embarrassment, and employment commitments. Though providers

Digitized by Sam Jonah Library

University of Cape Coast https://ir.ucc.edu.gh/xmlui

anticipated some challenges, primarily in the form of hospital policy, manpower, and space constraints, they all concurred – and this agreement echoes the views of most pregnant women and their husbands – that the provision of couples-friendly maternal health services would enhance the standard of care and comprehension of health information given to expectant mothers (Mullany, 2006).

According to findings from past research, education level influences whether males participate in prenatal care (Byamugisha, Tumwine, Semiyaga, & Tylleskar, 2010). According to Byamugisha et. al., and other researchers, men with higher levels of education (secondary education and above) are more likely to participate in prenatal care than men with lower levels of education or no formal education (Byamugisha, Tumwine, Semiyaga, and Tylleskar 2010; Kakaire, Kaye, and Osinde, 2011; Craymah et al, 2017; & Umar & Bawa, 2015; Vermeulen et al, 2016). In contrast, a research in the Lang'ata district of Uganda looked at males in rural communities who had official jobs and found that more men were participating in certain prenatal care activities such as birth preparation. In that study, having a formal job for either partner was linked to consistent and predictable income, which was a key factor in determining male engagement. Increased motivation for pregnant partners to provide prenatal support comes from a reliable and consistent source of income (Becker, Fonseca-Becker, & Schenck-Yglesias, 2006; Beegle, Frankenberg, & Thomas, 2001).

The inclusion of men in prenatal care and men's knowledge were found to be directly related (Becker et. al., 2006). “Only 1.8 percent of males who could not name even one pregnancy hazard indicator reported being

Digitized by Sam Jonah Library

involved, as opposed to 47.4 percent of men who identified at least one danger sign." The study also discovered that "males who were highly knowledgeable about prenatal care helped their spouses with housework, as well as providing them with nourishment and emotional support" (Becker et. al., 2006).

Male participation in prenatal care was significantly influenced by community sensitization, sharing of educational materials with men, and creating a welcoming environment for them in health facilities (Mohlala, Gregson, & Boily, 2012). Mohlala and colleagues discovered that only 27.6% of individuals who escorted their wives to prenatal care had heard about male engagement from a health provider. Five percent more people had heard about the topic via friends, while the remaining eighty percent learned about it from radio and television programmes.

The enabling and disabling variables impacting male participation in prenatal care services were identified by Craymah et. al., (2017). Male participation in prenatal care was substantially correlated with the proximity of the health center (less than 5km: 40% vs farther than 5km: 15%) and the attitude of the health personnel (yes: 39% versus no: 0%) ($p<0.05$). Contrarily, unfavourable health policies, restrictive cultural norms, and gender roles were identified as the enabling/disenabling factors that were substantially ($p<0.05$) related with male engagement in maternal and child health (Craymah, et. al., 2017). Another study found that males were deterred from escorting their wives or partners to the prenatal clinics due to misconceptions regarding the facility's location and the services it offers (Umar & Bawa, 2015).

An index of seven proxy indicators was employed by Matiang'i, Mojola, and Githae (2013) in a cross-sectional study of 388 married men to

Digitized by Sam Jonah Library

describe men's participation in antenatal care. The index that was utilised to determine what factors contributed to male engagement in Kenya's affluent Lang'ata area. In comparison to scores below four, scores of four and above on the seven proxy measures showed greater participation. The seven indicators are: "two or more times accompanying spouse to antenatal care; knowledge of pregnancy information (knows signs of pregnancy complications - at least two-fourths of danger signs; knows the number of visits wife should make to antenatal care); husband was present during delivery; financial support (paid hospital bill, purchased food, saved for delivery, hired a home helper, purchased baby clothes); identification of the delivery site; and transportation arrangements." The study's findings showed that men made up 40% of the participants. High male prenatal care engagement was linked with higher education (OR=1.5, p<0.026), planned pregnancies (OR=0.60, p<0.001), high income (OR=0.51, p<0.001), combined couple counselling, and formalised marriages. According to the study's findings, males in Kenya were eager to participate in prenatal care activities, but there were no specific rules or regulations outlining how to do so (Matiang'i, et. al., 2013).

In Kenya, Ongolly and Bukachi (2019) employed mixed methods approach to investigate the hurdles to men's participation in the ANC and PNC. They discovered that, despite the hurdles, some males continue to participate in the ANC and PNC. The assumption that maternal health is primarily a woman's responsibility, as well as the availability of alternative traditional maternity services, were significant cultural hurdles. Men's job, limited income, and fees at ANC/PNC clinics posed considerable economic impediments. Key facility-based hurdles were a lack of services aimed at

Digitized by Sam Jonah Library

University of Cape Coast https://ir.ucc.edu.gh/xmlui

males, provider attitudes, non-invitation to the clinic, time spent at the clinic, and a lack of privacy.

Ditekemena, Koole, Engmann, Matendo, Tshefu, Ryder and Colebunders (2012) conducted a thorough investigation with an emphasis on HIV prevention of mother to child transmission (PMTCT) in sub-Saharan Africa to ascertain the factors that influence male partners' participation in MCH activities. Male participation in PMTCT services was shown to be correlated with three main factors: (1) Sociodemographic factors, like income and level of education; (2) Factors connected to health services, including number of hours worked, behaviour of providers, and space constraints for male partners; and (3) Sociologic factors, like gender norms and communication.

Aborigo, Reidpath, Oduro, and Allotey (2018) investigated the reasons behind men's aversion to taking a more proactive part in prenatal care, as well as their long-term effect in decision-making during crises. According to the report, as head of the household, males control finances and have the last say on where and when pregnant women seek medical treatment. Aside from that, they have no expectation of any additional role during prenatal care and hence think it superfluous to attend clinics with their spouses. There were differing perspectives on whether males should give any additional help to their pregnant women at home. Health professionals frequently thought that men offered little or no help to their partners. Although health professionals had helped to develop father support groups, there was no evidence of an impact on prenatal care (Aborigo, et al., 2018).

Digitized by Sam Jonah Library

In the Kassena Nankana Municipal of the Ubber East Region, Ghana, Kumbeni, Ziba, Alem, and Nborah (2019) performed a community-based cross-sectional study of 420 males to determine the determinants influencing male partner participation in prenatal care services. The study revealed that several factors were statistically significant in predicting male participation, including clinic distance, community acceptability, staff attitude, age, educational attainment, monthly income, living with a partner throughout pregnancy, and time spent at the clinics.

In Sekondi, Ghana, Annoon, Hormenu, Ahinkorah, Seidu, Ameyaw, & Sambah (2020) looked into how women saw the obstacles to men's membership in the ANC. The results showed that a high level of male engagement in ANC was reported by 70% of the participants. Compared to respondents whose partners were between the ages of 20 and 29, those whose partners were between the ages of 50 and 59 were less likely to indicate substantial male engagement in ANC. Compared to those who did not live with their spouses, those who did had a nearly two-fold higher likelihood of reporting substantial male engagement in ANC. In contrast to those who disagreed, participants who listed extended wait times at the medical facility as a factor influencing male engagement in ANC were less likely to report high levels of male involvement in ANC.

Health Facility Factors Influencing Male Partner Involvement in Antenatal Care Services

Nungari (2014) reported that the males were amazingly knowledgeable about the treatments provided and other activities conducted in the prenatal clinic. It was determined that male involvement in the prenatal clinic is

Digitized by Sam Jonah Library

influenced by social, cultural, and economic aspects as well as the services provided by health facilities. Nungari (2014) concluded that "the prenatal clinic area, in particular, needed to be improved in terms of size and seating arrangements to comfortably accommodate all women and their spouses." Once more, the clinic needs to hire more doctors to help customers receive prompt, high-quality care.

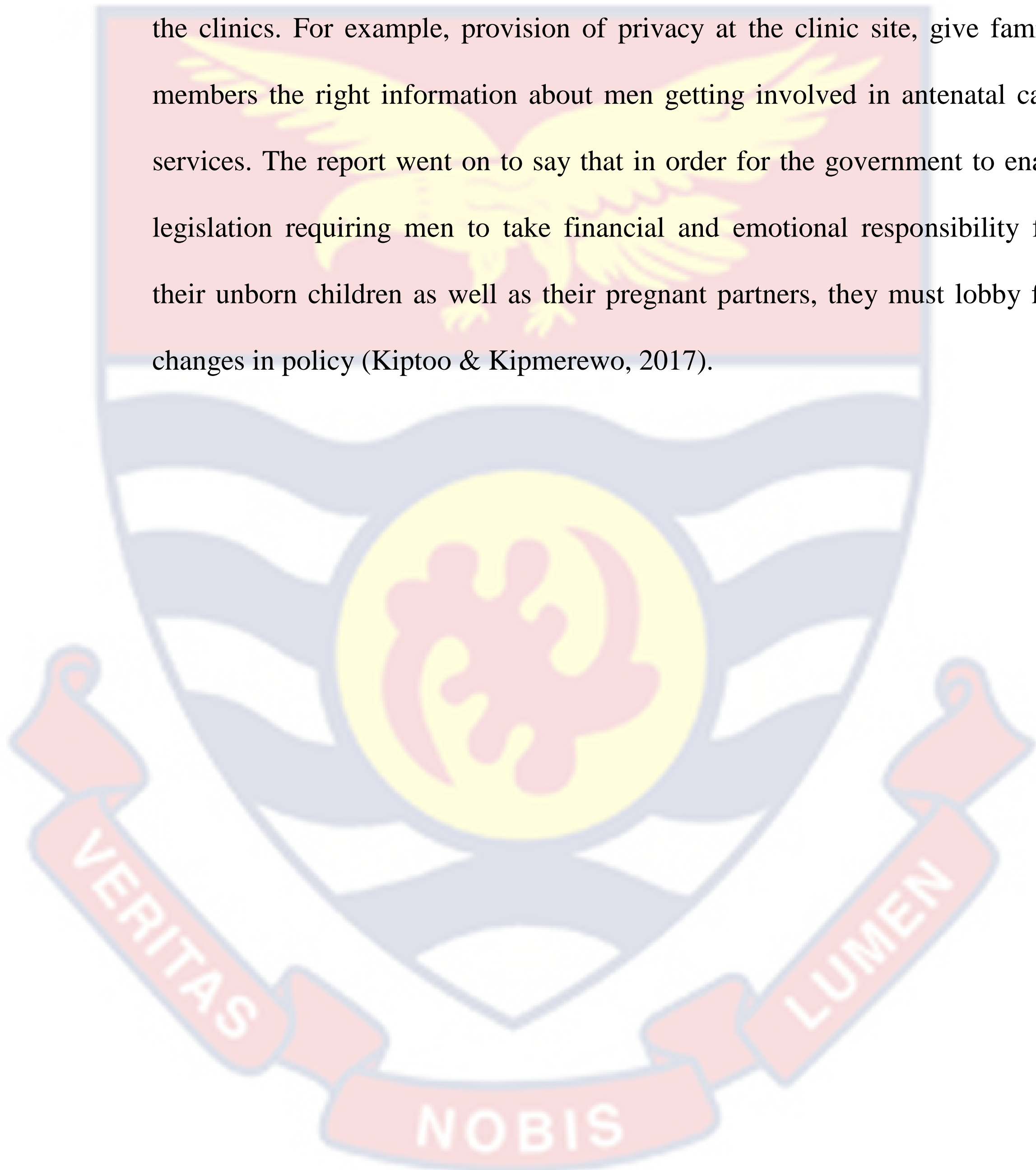
To better understand the variables influencing male engagement in reproductive health, Sharma and Khatri (2018) investigated gendered perceptions among educators and health professionals. In Bungamati, Lalitpur of a district in India, information was gathered through two focus group talks and seven key informant interviews. The study's findings revealed little male involvement in reproductive health, and participants noted a number of barriers to and difficulties with male prenatal care participation. The predominance of female healthcare professionals in many prenatal and maternal health clinics was one of these causes.

In a different research by Kiptoo and Kipmerewo (2017), males who came to the clinic with their spouses or partners were subjected to in-depth interviews to find out why they were there. The study's findings revealed that consumers were remarkably knowledgeable about the clinic's services and other activities. According to Kiptoo and Kipmerewo (2017), the factors which hindered men from involving in antenatal care include lack of education on maternal health issues on men getting involved in pregnancy and child health care, misinformation about the clinic settings and family or generation gap among family members. Religious factors, psychological factors as shyness, village life and social prestige of men, negative perceptions of the

Digitized by Sam Jonah Library

society were additional factors hindering men from escorting their wives or partners to seeking antenatal care services.

The study concluded that there was the need for the facility to improve upon their services to help attract the male partners of the pregnant women to the clinics. For example, provision of privacy at the clinic site, give family members the right information about men getting involved in antenatal care services. The report went on to say that in order for the government to enact legislation requiring men to take financial and emotional responsibility for their unborn children as well as their pregnant partners, they must lobby for changes in policy (Kiptoo & Kipmerewo, 2017).



Digitized by Sam Jonah Library

CHAPTER THREE

RESEARCH METHODS

The purpose of the study was to explore the socio-cultural factors influencing male partner involvement in antenatal care services in some selected health facilities in the Ho Municipality of the Volta Region of Ghana. This chapter describes the methods and procedures used in the study. Specifically, the chapter details the study design, study area, population, sampling procedure, data collection instrument, data collection procedure, and data processing and analysis. Ethical issues were also discussed in this chapter.

Research Design

This study used interpretative phenomenological design. According to Creswell (2013), phenomenology as an approach to qualitative research focuses on the shared values of lived experience within a particular group of people. According to Maxwell (2013), phenomenological approach attempts to extract the purest, uncorrupted from personal experiences. This approach to qualitative research seeks to describe accurately the lived experiences of people. It usually requires primary data and comprises in-depth interviews of participants who tell the story as it is lived (Ogah, 2013). Creswell, similarly, noted that in phenomenological studies, “interviews are conducted with a group of individuals who have first-hand information and or knowledge of an event, situation or experience.” The data collected is read, re-read, and like phrases and themes are grouped to form clusters of meaning (Creswell, 2013). This study used phenomenological enquiry because it focuses on the lived experiences of the individuals concerning their involvement in antenatal care.

Digitized by Sam Jonah Library

Study Area

A Legislative Instrument (L.I) 2074 of 2012 established Ho Municipal as one of the five (5) municipalities in the Volta Region. Agotime-Ziope and Ho West were formerly a part of the Ho District until they were split off from it in 2012. The capital of the Municipality is Ho, which also serves as the political and commercial hub of the Volta Region. Between latitudes $6^0$20'N and $6^0$55'N and longitudes $0^0$12'E and $0^0$53'E is where the Municipality is situated. The Republic of Togo to the east, the Adaklu and Agotime-Ziope districts to the south, the Ho West district to the north and west, and the Municipality to the south all share boundaries with the municipality (see Figure 1). According to the Ghana Statistical Service (2013), the municipality has a total land area of 2,361 square kilometres, which is 11.5 percent of the region's total land area of 20,570 square kilometres and 8.7 percent of Ghana's overall land area.

Of this population, roughly 21% are skilled workers in agriculture, forestry, and fishing, 26% are employed in service and sales, and 26% are employed in craft and allied trades. Employees in the public sector (managers, professionals, and technicians) make up the smallest percentage (15.8%). Agriculture is practised by as many as 68.6% of families in the municipality (Ghana Statistical Service, 2013). The main and minor seasons are the two wet seasons that the area endures. Every year, the minor season starts in July while the major season runs from March to June. Figure 5 is a map of the study area.

Digitized by Sam Jonah Library

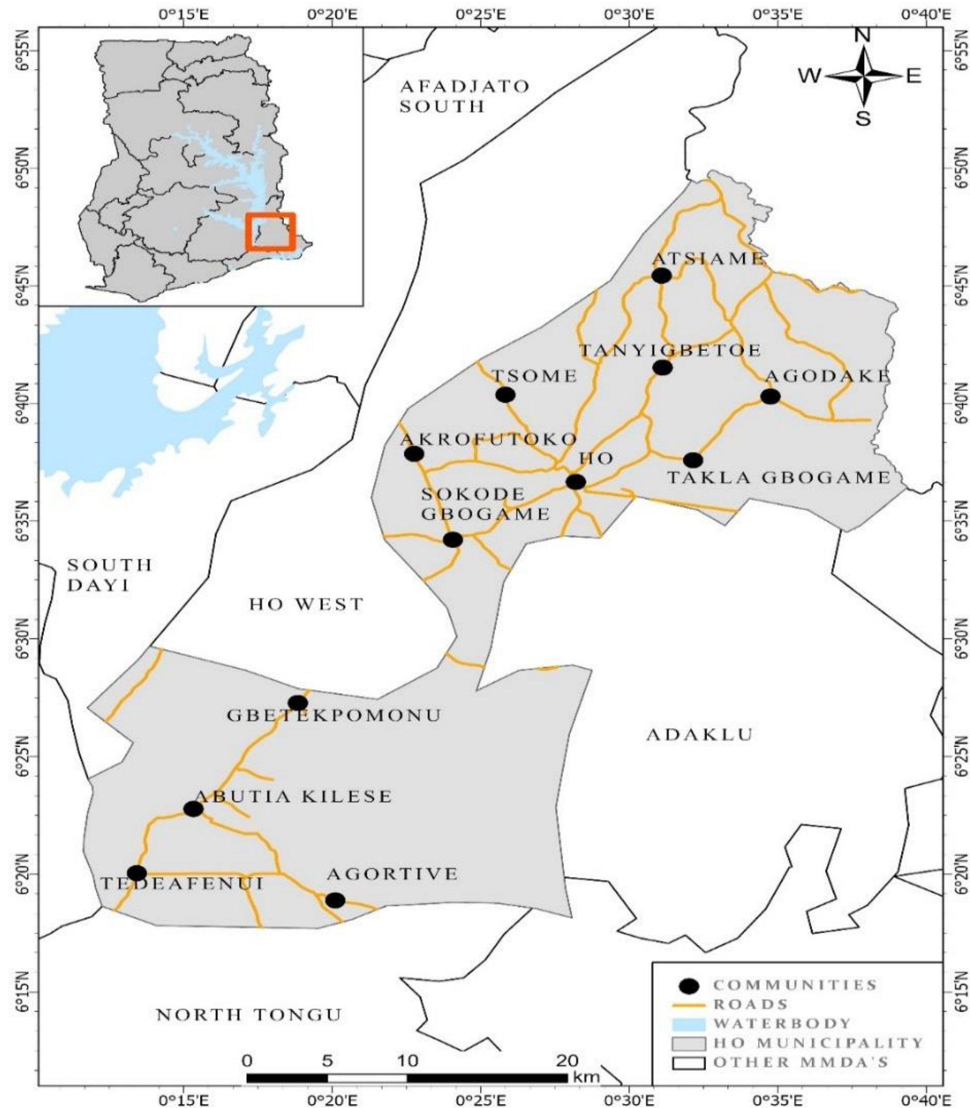


Figure 5: Map of Ho Municipality

Source: Ghana Statistical Service (2013)

Population

There are 177,281 people living in the Ho municipality, with females making up 52.7 percent of the population and males 47.3 percent. Urban areas are home to about 62 percent of the population. With just a tiny percentage of senior people (65 years and over), the Municipality's population is made up primarily of young people, who make up 31% of the total. The majority (72.7%) of the populace in the Ho municipality are indigenous Ewes and the

Digitized by Sam Jonah Library

University of Cape Coast https://ir.ucc.edu.gh/xmlui

language spoken is ‘Ewe-Gbe’ (Ewe language) or Ewe. There are also Ga (38.3%) and Asantes (12.1%) in the municipality (Ghana Statistical Service, 2013).

Male partners form the population for the study. They were selected from three hospitals in the municipality: a government hospital, a private hospital and one mission or church-based hospital. The study-addressed men whose wives or partners are pregnant six months preceding the study accidentally selected for the study. A chief, an elder and an opinion leader of Ho municipality were added to the men to enrich results. Male partners form the population for the study. They were selected from three hospitals in the municipality: a government hospital, a private hospital and one mission or church-based hospital. The study-addressed men whose wives or partners are pregnant six months preceding the study accidentally selected for the study. A chief, an elder and an opinion leader of Ho municipality were added to the men to enrich results.

Sample and Sampling Procedures

The data were collected until saturation was reached. That is, the sample size was determined by the information power. With the principle of saturation, selection of participants for the study ended when issues being reported by the participants become virtually the same, or when no new findings were being made from further interviews. In all, 23 participants were interviewed constituting 20 male partners who escorted their partners to the antenatal care clinic, a chief, an opinion leader and an elder.

Procedures for accidental and purposive sampling were both employed to choose research participants. A non-probability sampling technique called

Digitized by Sam Jonah Library

accidental sampling involves taking a sample from a population that is simple to reach or contact. Thus, where research participants are easily accessible to the researcher (Leiner, 2014). Sometimes, referred to as convenience sampling, accidental sampling "involves the selection of research participants based on their availability and willingness to participate in the study" (Dörnyei, 2007). This sampling technique is referred to as "accidental" since components may be included in the sample only because they are located close to where the researcher is gathering data (Patton, 2002).

Accidental sampling was used to select men (aged 18 years and above) in three health facilities of the Ho Municipality whose partners were pregnant six months preceding the study. This sampling procedure was used because the participants were contacted and interviewed as and when they came to the antenatal clinic. In addition, purposive sampling was used to select a chief, an elder and an opinion leader of Ho municipal. The selection of these persons was necessary to enrich or help obtain good and quality results on the socio-cultural dynamics of male partner involvement in antenatal care.

Data Collection Instrument

The instrument used to collect data for the study was an in-depth interview guide. The instrument was adapted from Dzumbila-Namasasu (2010). The instrument was sectioned into four parts (Section A–D). Section A elicited data on "the perception of men on male involvement in antenatal care." Section B gathered data on "socio-cultural factors influencing male involvement antenatal care" while Section C focused on "health facility related factors that influence male partner involvement in antenatal care." The

Digitized by Sam Jonah Library

University of Cape Coast https://ir.ucc.edu.gh/xmlui

last section, Section D, solicited data on “personal factors which influence male partner involvement in antenatal care.”

Validation of the Instrument

The degree to which an instrument measures what it is intended to measure is referred to as validity. The researcher’s supervisor from the Department of Health, Physical Education and Recreation (HPER) at the University of Cape Coast (UCC), who has in-depth experience on the topic of male engagement in prenatal care, submitted the instrument to a content validity analysis. All corrections made by the supervisor were incorporated into the instrument before its administration.

Trustworthiness

In their work on naturalistic enquiry, Lincoln and Guba (1985) asked “How can an inquirer persuade his or her audiences (including self) that the findings of an inquiry are worth paying attention to, worth taking account of?” (p. 290). They suggest the concept of ‘trustworthiness’ to address how to build trust in qualitative research. To ensure trustworthiness, the researcher conducted member checking to ascertain the genuineness of the transcripts. The transcripts of each interview were sent to the respondents to read through and confirm what they said during the interviews. They were at liberty to add to or subtract from the information they gave out during the interviews. For respondents who could not read and understand English, the audiotapes of the recorded interviews were play back to them.

Digitized by Sam Jonah Library

University of Cape Coast https://ir.ucc.edu.gh/xmlui

Data Collection Procedures

The data collection procedure was under three main stages namely clearance/permission seeking stage, research assistants training stage and the stage of data collection. These stages are described below.

In the first place, ethical approval was obtained from the Institutional Review Board, University of Cape Coast (UCC-IRB). An introductory letter was obtained from the Department of Health, Physical Education and Recreation (HPER) (Appendix B). The research proposal, together with a copy of the introductory letter, was submitted to the UCC-IRB. After review of the proposal, the UCC-IRB gave ethical clearance for the conduct of the study (Appendix D). Additionally, permission was sought and obtained from the Ho Municipal Health Directorate to enable the researcher conduct the study at the selected antenatal clinics in the municipality (Appendix E). Authorities of the selected facilities also gave their approval for conduct of the study.

The researcher by telephone contacted the chief of Ho municipality for a verbal permission. After, a visit was made to the palace to discuss the purpose of the study with the chief where a permission letter and consent form were sent. Appointment was then made to visit the palace later to conduct the interview. The opinion leader and elder were also contacted and interviewed in their homes.

Secondly, training was organised for the research assistant, who was a nurse knowledgeable about antenatal services. The training focused on ethical issues (such as participant's consent seeking, confidentiality and voluntary participation, and the rights of respondents regarding the study) and how best to conduct the interviews. The research assistant was chosen also because of

Digitized by Sam Jonah Library

his ability to understand and speak at least the Ewe and an Akan language to enable easy interactions with the participants who did not understand English. The data were collected within a period of four weeks after ethical clearance was obtained. The interviews were all performed in English, Ewe, or Twi (depending on whatever language the respondent could speak and comprehend the best) by the researcher or the trained field assistant. Digital recordings of the interviews were made using an audio recorder. Additionally, while conducting the interviews, handwritten notes were taken. In order to prevent the interview process from coming to a halt in the event that either the pen or the audio recorder malfunction during the interview, both the audio recorder and handwritten notes were used. Also, hand-written notes were taken to be able to capture non-verbal cues. Each interview took between 40-50 minutes, approximately, to complete.

In this era of COVID-19, safety protocols were observed. These included washing of hands with soap under running water or sanitizing hands with alcohol-based sanitiser, wearing of face mask and keeping appropriate physical distancing. These protocols were strictly adhered to so as to reduce the spread of the corona virus disease.

Data Processing and Analysis

The aim of the researcher was to present a story that considers culture, holistic outlook, contextualization, emic or etic perspective and multiple realities. An emic approach attempts to present the phenomenon from the viewpoint of the person or group studied (Ogah, 2013). Unlike the ethnographic studies where the researcher reflected the data, this study used a phenomenological or the emic approach to hear the voices of the men.

Digitized by Sam Jonah Library

University of Cape Coast https://ir.ucc.edu.gh/xmlui

The researcher or the field assistant manually entered the data obtained from the respondents. By concurrently listening to the audiotape and reading the transcripts, as well as grouping the transcripts into themes and using bracketing, interpretative phenomenological analysis (IPA) was used to verify the correctness of the transcripts (Smith, 2013). The IPA attempts to investigate in depth how people conceptualise the problems they confront and how they come to and defend their judgements. "It is concerned with an individual's personal perception or account of an event or state as opposed to attempting an objective record of the event or state itself. However, IPA recognises that access to this phenomenological space is dependent on the researcher's own conceptions which are required to make sense of that other personal world through a process of interpretative activity" (Smith, 2013, p.133).

The researcher read through the transcripts three times, each time getting a better sense of the overall themes and meanings that emerge and then identified initial codes that emerge from the data. These initial codes or themes were grouped into larger themes or categories. The researcher compared and contrasted themes that were found across cases, and created superordinate themes from them.

The developed topics (themes) served as the framework for the analysis. To support replies made to questions asked throughout the interview process, statements made by the respondents were provided as quotations. The participant's background characteristics were displayed in a frequency table.

Digitized by Sam Jonah Library

Reflexivity

Reflexivity, according to Olmos-Vega, Stalmeijer, Varpio and Kahlke (2023) is “a set of continuous, collaborative, and multifaceted practices through which researchers self-consciously critique, appraise, and evaluate how their subjectivity and context influence the research processes”. My experiences as a nurse and an educator coupled with my passion for women’s health influenced my interest in pursuing this research topic. Again, I was aware that when conducting the interviews with the male partners, I had to make an effort to maintain objectivity, putting aside my personal opinions, insights, and experiences in order to listen from the viewpoint of a researcher. However, I found it challenging to put aside my own experience and adopt an insider's perspective in order to be completely impartial. It is worth mentioning that my personal views influenced the way and manner in which the interviews were conducted, albeit does not compromise the quality of the data.

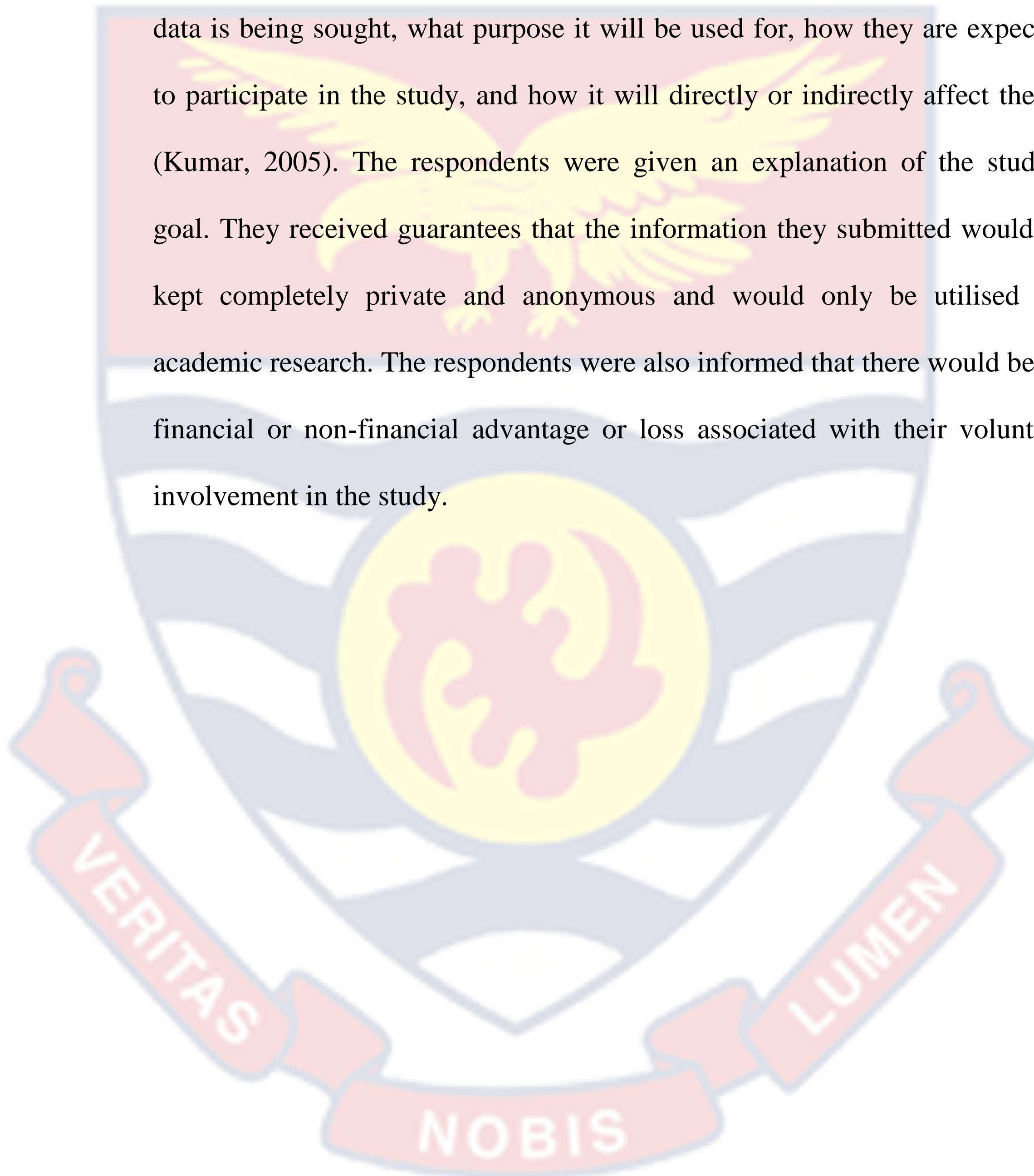
Ethical Issues

Research ethics is “a collection of moral standards that scientists’ (researchers’) acts are measured against” (Singleton, Straits, & Straits, 1998). Before the study began, ethical approval was acquired from the University of Cape Coast Institutional Review Board (UCC-IRB), with clearance ID - UCCIRB/CES/2020/53 (Appendix D). A letter of introduction was also received from the University of Cape Coast’s Department of Health, Physical Education, and Recreation (HPER). Furthermore, clearance and consent were sought from the Ho Municipal Health Directorate (Appendix E) as well as the

Digitized by Sam Jonah Library

authorities of the three chosen institutions to allow the researcher to perform the study.

Informed consent was obtained from the respondents, which means that they "were made fully aware of the type of data being sought, why the data is being sought, what purpose it will be used for, how they are expected to participate in the study, and how it will directly or indirectly affect them" (Kumar, 2005). The respondents were given an explanation of the study's goal. They received guarantees that the information they submitted would be kept completely private and anonymous and would only be utilised for academic research. The respondents were also informed that there would be no financial or non-financial advantage or loss associated with their voluntary involvement in the study.



Digitized by Sam Jonah Library

University of Cape Coast https://ir.ucc.edu.gh/xmlui

CHAPTER FOUR

RESULTS AND DISCUSSION

The study investigated the socio-cultural factors influencing men's engagement in antenatal care services. In this chapter, the results of the study are both presented and discussed. This was done based on the objectives of the study. Thus, the presentation and discussion of results are under the following headings: perception on male partner involvement in antenatal care, socio-cultural factors affecting male partner involvement in antenatal care, health facility factors influencing male partner involvement in antenatal care and personal factors which influence male partner involvement in antenatal care.

Background Characteristics of the Respondents

In all, twenty-three (23) men were interviewed. These were made up of one (1) chief, one (1) opinion leader, one (1) elder and twenty (20) male partners who accompanied their partners to access antenatal care services. Table 1 summarises the respondents' background information.

Digitized by Sam Jonah Library

Table 2: Background characteristics of respondents

Respondent	Age	Occupation	Status
Res. 1	56 years	RTD Teacher	Chief
Res. 2	72 years	Farmer	Elder
Res. 3	46 years	Teacher	Opinion leader
Res. 4	51 years	Farmer	Male partner
Res. 5	34 years	Trader	Male partner
Res. 6	34 years	Trader	Male partner
Res. 7	46 years	Farmer	Male partner
Res. 8	35 years	Teacher	Male partner
Res. 9	34 years	Mechanic	Male partner
Res. 10	37 years	Pharmacist	Male partner
Res. 11	35 years	Farmer	Male partner
Res. 12	36 years	Teacher	Male partner
Res. 13	37 years	Teacher	Male partner
Res. 14	34 years	Farmer	Male partner
Res. 15	31 years	Nurse	Male partner
Res. 16	35 years	Trader	Male partner
Res. 17	32 years	Mechanic	Male partner
Res. 18	47 years	Trader	Male partner
Res. 19	39 years	Farmer	Male partner
Res. 20	39 years	Security officer	Male partner
Res. 21	35 years	Banker	Male partner
Res. 22	33 years	Insurance	Male partner
Res. 23	34 years	Nurse	Male partner

Source: Fieldwork (2020)

Digitized by Sam Jonah Library

Results

Objective 1: Perception of men on male partner involvement in antenatal care services

The first objective of the study was to assess respondents' perception on male partner involvement in antenatal care services. Thus, the objective sought to find out what men think about their involvement in antenatal care services. The respondents expressed various perceptions about their involvement, as male partners, in antenatal care. Their responses can be grouped under six themes being: reduction of wife's workload, shows care, wife is attended to early at the antenatal clinic, helps the male partner to be in the known and assist, makes wife happy, and an opportunity to learn.

Theme 1: Reduces wife's workload

The respondents indicated that getting involved in issues concerning antenatal care as a male partner shows support for the woman (wife) and reduces her burden/workload. This was what a respondent 3 said; *"When we are both walking together like that, other people see and they are happy. Most women when they are pregnant, their husbands do not give them any support so carrying my wife to antenatal unit, it makes her work load to reduce and other women also learn from it"* (Respondent 3).

Some respondents explained that as they escort their partners to the health facility for prenatal care, they help the women with some basic things so as to lessen the burden on them. According to a respondent, *"At times she [referring to his wife] complains of lower abdominal pain and also waist pain and other things. That's why I even decided to carry the bag myself so that I will lessen the burden on her small"* (Respondent 5).

Digitized by Sam Jonah Library

Similarly, another respondent added, *"When she comes* [to the ANC clinic] *alone, she'll come back very tired. She doesn't come back home tired as I accompany her because most of the activities, moving up and down, I have to carry it out for her while she is relaxed"* (Respondent 10). He continued that, *"Maybe, when she's asked to go for drugs, I go for it. When she's asked to go and get anything, I do that"* (Respondent 13).

Theme 2: Shows care

Other respondents maintained that male partners' involvement in antenatal care shows care and concern about the wellbeing of the woman. In the words of a respondent, *"It's a beautiful thing and this act also makes everyone know that you, the man, takes care of the woman and that you are particular about her wellbeing"* (Respondent 7). Another respondent also said, *"It's good you bring your wife to antenatal because when you do that the woman will know that you are caring"* (Respondent 9).

In addition, a 36 years old male partner expressed a similar view and added that it shows your support for the pregnant woman and she would not feel that she is alone throughout the period of the pregnancy. According to him, *"If you get involved into her condition, she will not think that she is alone and I know the condition is for 9 months period so I must also be supporting her"* (Respondent 12).

Theme 3: She is attended to early

The respondents also expressed that involvement of male partner in antenatal care helps the woman to be attended to early. Thus, a pregnant woman does not spend a lot of time at the ANC clinic when her male partner accompanies her to the facility. According to a respondent, *"Anytime I*

Digitized by Sam Jonah Library

University of Cape Coast https://ir.ucc.edu.gh/xmlui

accompany her to the hospital and the nurses there, if they see us together, they attend to us quickly and the care is there" (Respondent 14).

A different respondent narrated that *"Normally when she comes alone, she doesn't return home early. The first day that I brought her here, I've seen that we went home early so that made me to bring her here again for us to go back early. The last time when we came, although people were here before we came, I realised that we just sat and the midwife called us that we should come and I asked the midwife that why? Is she not breaking any protocol? She said it's because I have accompanied my wife here. That's the rule that, if a man accompanies the wife, the wife has to be attended to early. That made me to be attended to so we went home early"* (Respondent 17).

A different respondent narrated that *"Normally when she comes alone, she doesn't return home early. The first day that I brought her here, I've seen that we went home early so that made me to bring her here again for us to go back early. The last time when we came, although people were here before we came, I realised that we just sat and the midwife called us that we should come and I asked the midwife that why? Is she not breaking any protocol? She said it's because I have accompanied my wife here. That's the rule that, if a man accompanies the wife, the wife has to be attended to early. That made me to be attended to so we went home early"* (Respondent 17).

Another respondent recounted a similar incident. *"When I came, I have seen that we were late because of my work but they just pointed at us that 'sister, sister come, come.' When she was going, I accompanied her to the place then the midwife said 'oh because you brought your husband that is why I have called you; have seen that people are here without their husband I*

Digitized by Sam Jonah Library

didn't call them but because you have brought your husband that is why I called you'" (Respondent 13).

Other respondents who expressed similar thoughts had these to say, adding that they heard it on the news. *"I've heard it over news that when we as men come with our wives, they will attend to our wife than any other person, those who refuse to come with their husbands. So, I thought of coming with my wife so that they will attend to us first so that we can go home and do our normal chores"* (Respondent 3).

"Last time I was hearing news and I overhead them saying that if we bring our wives to antenatal, they will treat us fast then we go home. Because normally, my wife doesn't come home early. Sometimes, when I come back from work, my wife is not at home to prepare me food. When we reached there [referring to ANC clinic], *although people were there before we reached there, they just called my wife from the crowd"* (Respondent 15).

Theme 4: To be in the known and assist

In addition, some of the respondents explained that when you get yourself involved in antenatal care services as a male partner, it helps you to be in the known of every situation so that you can assist (when necessary). This was what a respondent said; *"When you are in the house and you allow her to come herself, you'll be thinking whether she has reached, what is happening and all those kinds of thoughts will be running through your mind so it's better you accompany her yourself so that when something is going wrong you can also be in the known and assist. Suppose I allow her, you see as at now they have not even attended to her and I will be thinking over there but now that I am here with her, I can see what is going on"* (Respondent 4).

Digitized by Sam Jonah Library

Other respondents said they always want to be around not only to know what is going on but also to pay every money their wives will be asked to pay. According to a 46 years old male partner, *"At times, they also ask them to go to the labs and do certain tests so going with her, I will know what is going on. And if there is any payment since I am the man and I'm around, I will take that up"* (Male partner, 46 years). In the words of a different respondent, *"I won't be in the house and she'll call me that it's left with this amount, send me mobile money"* (Respondent 16).

Theme 5: Makes wife happy

Moreover, it became evident that male partner involvement in antenatal care services makes women happy. Thus, the respondents perceive that when they are involved in antenatal care services (especially, accompanying their wives/partners to the ANC clinic), it makes the women happy. According to a respondent, *"When you do all these* [helping the woman with chores], *you the man earn some respect and when you hold the hands of your wife and you go to the hospital together, it also makes the woman happy and she can say to herself that the man she married truly loves and cares for her"* (Respondent 1).

A different respondent added that, *"Since she* [referring to his wife] *got pregnant, she has always been happy. There was no day that she is sad because I always come with her to the ANC clinic"* (Respondent 18). Another person expressed a similar thought. *"She [referring to his wife] feels happy because she has realised that I've been with her throughout the day, accompanying her to the antenatal clinic"* (Respondent 21).

Digitized by Sam Jonah Library

University of Cape Coast https://ir.ucc.edu.gh/xmlui

Other male partners were of the opinion that their wives are proud of them for getting involved in antenatal care services. *"She feels proud that she wasn't left alone. She feels good anytime I come with her"* (Respondent 12). According to others, the women's happiness and pride is also because they have an owner for their pregnancy and the man accompanying them to the antenatal clinic is a testament. For instance, a respondent 23 had this to say; *"She is proud of me being with her at the hospital. Anytime we go together, it shows that she is not bringing the pregnancy from outside; this is the owner. So she is very proud"* (Respondent 23).

One respondent added that his wife, in addition to always praising him, goes to the extent of appreciating him with gifts for his involvement in her antenatal care. In his own words, *"Always, she has been praising me. Three days ago, for instance, she went to the road side and was coming and bought me canned malt as an appreciation so I can see that she feels good about that"* (Respondent 19).

Theme 6: I also learn

Again, other respondents indicated that accompanying their wives to the antenatal clinic is an opportunity for them to also learn. Thus, it is not only the pregnant women who are educated when they visit the antenatal clinic but the men also. According to a respondent who accompanied his wife to the antenatal clinic, *"I also learn a lot. Things like the benefits of the routine drugs that they've been giving her, the iron, the blood level increases and all those things. And also, there's this particular medicine that they said when she's taking it, there will not be any deformity. So, I learn, the diet ... they counsel us on nutrition and all those things. The food she should take; the*

Digitized by Sam Jonah Library

University of Cape Coast https://ir.ucc.edu.gh/xmlui

lifestyle, what she should not be doing. Alcohol intake; we were counselled that she should not be taking alcohol because it's not good for her condition. So, I benefit a lot" (Respondent 12).

A different respondent added, *"Me, myself the explanations they are giving especially about how a pregnant woman should eat and the food that will help her, at the same time help the baby; me too I need it so as they are hammering on those things, I'm also picking it. Something that will help you to get energy and also the body will be equipped to fight infection and all those things. So, me myself as hard-working man, I have to be getting those things so that falling sick will be minimized. And if the woman is also not falling sick, I don't think I will waste much money"* (Respondent 19).

According to another respondent, the reason why he always accompanies his wife to the antenatal clinic is that *"I also want to have some ideas about the processes that go on at the antenatal clinic. Also, to know the equipment used in attending to the pregnant women, what is being done as well as the advises being given them when they visit and when you the man you are present, you also hear about these advises given her to remind her on it on daily basis"* (Respondent 6).

Objective 2: Socio-cultural factors influencing male partner involvement in antenatal care services

This objective sought to explore the social and cultural factors which affect men's engagement in antenatal care. Actually a few of the respondents maintained that there are no social or cultural factors which influence male partner involvement in antenatal care services. According to them, if men are unable to involve themselves in antenatal care services, it is as a result of

Digitized by Sam Jonah Library

reasons other than socio-cultural reasons. These were some of the things they said. *"It's not a problem or a taboo or norms that a man should not accompany the woman to the clinic"* (Respondent 3). *"There are no taboos here that prevents men from accompanying their wives to the clinic for antenatal care services. There are men who do send their wives and there are men who also do not like to send their wives but me personally, it's because of my unavailability that I do not accompany her but if I get the chance to do so, I accompany her so there are no norms or taboos preventing us from doing so"* (Respondent 1).

Nevertheless, most of the respondents mentioned various social or cultural factors which influence the involvement of male partners in antenatal services. Their responses can be themed into two. These are stereotyping and erroneous societal perceptions.

Theme 1: Stereotyping

The findings show that society sometimes has a stereotypical labelling for men who get involved in antenatal services particularly, accompanying their wives to the antenatal clinic. One respondent expressed, *"Today when you do that* [referring to escorting your wife to the hospital] *they call you salomey you see, so as am doing this some people will give me bad names"* (Respondent 4). Another person explained that name calling happens because society consider it abnormal for men to be escorting their partners to the hospital. He said, *"They do* [call you names] *because in our society, people see you to be weak, or it's not normal"* (Respondent 6).

Another respondent lamented, *"The society in general, especially where I am coming from, when they see men going to the hospital with their*

Digitized by Sam Jonah Library

University of Cape Coast https://ir.ucc.edu.gh/xmlui

wives (antenatal and other things), they will be somewhere laughing at you. They will be laughing at you that 'Bɛma wɛi diɛ wa to oo' which means this man doesn't know what he is doing as if you are wasting your time on the lady. Then they sometimes also say that 'oh wɛi diɛ odidi kwa, odidi kwa' usually you are in the house eating, yours is to just carry ladies' bag to antenatal clinic. In fact, it causes me to be discouraged. If I don't strengthen myself, it will end up causing me to stop going with her" (Respondent 7). Another respondent lamented, *"The society in general, especially where I am coming from, when they see men going to the hospital with their wives (antenatal and other things), they will be somewhere laughing at you. They will be laughing at you that 'Bɛma wɛi diɛ wa to oo' which means this man doesn't know what he is doing as if you are wasting your time on the lady. Then they sometimes also say that 'oh wɛi diɛ odidi kwa, odidi kwa' usually you are in the house eating, yours is to just carry ladies' bag to antenatal clinic. In fact, it causes me to be discouraged. If I don't strengthen myself, it will end up causing me to stop going with her"* (Respondent 7).

In the words of another respondent, *"When your wife is pregnant and you are trying to be taking care of her, they think maybe she has juju you or something. So, you will be a laughing stock for some of them because as if the person has juju you or she has prepared something for you. They call you salomey"* (Respondent 13). When asked what 'salomey' means, he continued, *"they said if a woman overpowers you, that is what they call salomey. She is controlling you … a woman is controlling you because normally if she is walking, you carried her bag"* (Respondent 13).

Digitized by Sam Jonah Library

University of Cape Coast https://ir.ucc.edu.gh/xmlui

Some of the respondents also indicated that society sees men who help their wives as lazy, not having anything to do or have been overpowered by their wives. According to a male partner, *"We are in a compound house, when at times I want to assist her doing maybe washing, or cooking when she is tired, my colleague will be telling me that is it that I don't have anything to do"* (Respondent 6). He added that *"They see you to be a lazy man because the time you're supposed to go out and look for money, you're there helping your wife"* (Respondent 6).

Some of the respondents however pointed out that they disregard the insults and name-calling whenever they are helping their partners or escorting them to access antenatal care services. According to a respondent, *"If someone laughs at you, you don't mind the person, go ahead and do whatever you are doing"* (Respondent 4).

Another respondent explained, *"At times they will say that when you are following the woman, then it means the woman has juju you or has overpower you and all those things. But, this is health; if I allow this woman to go alone and my wife fall on the way, now that people will come and tell me and I will be running from wherever I am to go and support her. So, it's better I be with her. So those things, I don't take them into consideration. And some of the ladies in the village, they are doing that as a matter of jealousy because they don't get it so they want to discourage you so that you will all come to square one. So, it's better I be with her. So those things, I don't take them into consideration. And some of the ladies in the village, they are doing that as a matter of jealousy because they don't get it so they want to discourage you so that you will all come to square one"* (Respondent 19).

Digitized by Sam Jonah Library

Another respondent explained, *"At times they will say that when you are following the woman, then it means the woman has juju you or has overpower you and all those things. But, this is health; if I allow this woman to go alone and my wife fall on the way, now that people will come and tell me and I will be running from wherever I am to go and support her. So, it's better I be with her. So those things, I don't take them into consideration. And some of the ladies in the village, they are doing that as a matter of jealousy because they don't get it so they want to discourage you so that you will all come to square one. So, it's better I be with her. So those things, I don't take them into consideration. And some of the ladies in the village, they are doing that as a matter of jealousy because they don't get it so they want to discourage you so that you will all come to square one"* (Respondent 19).

According to some of the respondents, they see helping their pregnant partners as their responsibility therefore the mockery and name calling cannot make them neglect their responsibility. A Respondent 13 indicated, *"A lot of people make comments which are not encouraging and pleasing but I understand my role as a man and I need to assist my wife during this very critical period that she needs me the more"* (Respondent 13). Another respondent added, *"I don't see it* [referring to the name calling] *like it's something that will deprive me from doing my job"* (Respondent 16).

Some of the men said they disregard the name calling because there are positive examples in society. One respondent said that growing up, his father used to help his mother that is why he is doing same. According to another, he has a neighbour who also helps his wife. This was what they said; *"There is one teacher closer to us. That man is also well educated and he is teaching but*

Digitized by Sam Jonah Library

he also does what I am doing [referring to helping his wife]" (Respondent 20). *"I see it* [helping his wife] *to be normal because my dad used to do that to my mom"* (Respondent 9). Another man added that he educates the people who make mockery of him. *"Sometimes, they call me salomey and all those things. But I don't mind. If I get opportunity, I do educate them that it's not the way they perceive it but rather, I'm giving support to the lady"* (Respondent 12).

Theme 2: Erroneous societal perceptions

It was also evident that negative societal perceptions influence the involvement of male partners in antenatal care services. From the findings of the study, these negative societal perceptions can be sub-themed into three (3) being; antenatal care not the responsibility of men, not the usual practice, and an interference.

Subtheme 1: Not the responsibility of men

The findings reveal that some men do not consider it their responsibility to escort their partners to antenatal clinic. Society's expectation is for men to provide the financial needs of their pregnant partners, they hinted. In the words of a respondent, *"Men are not supposed to take their wives to the hospital. Their responsibility is to provide the financial and other material needs of the women"* (Respondent 4).

Similarly, another respondent expressed, *"The responsibility of the man is to prepare himself by providing her with money to buy the medicines she needs… The man, as head of the house, is responsible to provide food for the family so that she could get varieties of food to eat. When she is due for delivery and the time is getting nearer, she will be given a list of items to be purchased and it is the man that provides the money, sees to it that these*

Digitized by Sam Jonah Library

things are purchased and readily available to be used anytime she is due to deliver her baby" (Respondent 2).

An opinion leader, expressing a similar view, had this to say; *"Some men they don't even want to accompany their wives because they see it as the duty of the woman to go for antenatal alone so if the woman cannot go alone then that is her problem"* (Respondent 3).

In the words of another respondent, *"Our greatest responsibility as men towards our pregnant wives is to provide them with money"* (Respondent 14). He was, however, quick to add that *"In instances where the woman is not strong enough during pregnancy and therefore cannot perform certain house chores, then it is the responsibility of the man to do so"* (Respondent 14).

Some other men simply do not see the need for male partners to accompany their wives to access antenatal care services. One respondent indicated, *"Oh I don't have that leisure time to go to the clinic. If there were to be complications, fine but since there was none, I don't see why I should accompany her. A pregnant woman visits the clinic for antenatal so she could go through the necessary processes for the wellbeing of the baby and herself so if she is not having any complications, there is no need going with her ... So, I will say, antenatal does not mean that the man should necessarily come with the wife but rather if the woman is facing some problems or complications, the man can accompany her if she cannot go alone"* (Respondent 2).

Subtheme 2: Not usual

Additionally, it was found that men are not used to the practice of visiting the hospital with their partners for antenatal care services. According

Digitized by Sam Jonah Library

one respondent, when women are pregnant, they only visit traditional birth attendants for guidance and they do that alone (not together with their partners). This was what he said; *"Our forefathers during their time didn't have so much hospitals however the elderly women those days, God has given them so much wisdom and knowledge that some of them are birth attendants who help women to put to birth so when our mothers get pregnant and are ready to put to birth or facing any problems, our fathers only direct them to see the birth attendants and speak to them. So that is what they do and some of them when they go, the birth attendant only lays her hands on or under the belly and is able to determine if she is due for delivery or not. So, it's not usual for men to accompany their wives to antenatal"* (Respondent 1).

Another respondent added that growing up, he never saw any example of a man escorting his wife to the antenatal clinic. *"Where I grew, I've not seen my dad or any of my relatives who are males; they've never taken their wives to the antenatal clinic before"* (Respondent 12).

Subtheme 3: An interference

Also, it was unravelled that some men erroneously consider it an interference to visit the antenatal clinic with their pregnant partners. Indicating that visiting the hospital for antenatal care is an interference, this was what a respondent said; *"Some women feel that the men are interfering in their affairs too much such that anywhere they are going the man wants to be there with them therefore feel uncomfortable. I know of a woman who told me that anytime she is going out with her husband, she tells him to take the lead ahead of her so she will follow soon just because she doesn't want to walk alongside with him"* (Respondent 3).

Digitized by Sam Jonah Library

Objective 3: Health facility factors which influence male partner involvement in antenatal care services

In addition to socio-cultural factors, the study also explored the facility-related factors which influence male partner involvement in antenatal care services. Particularly, the facility related factors which influences male partners' decision to escort their partners to antenatal clinic were determined. Two themes emerged out of a thematic content analysis concerning the health facility factors influencing male partners' involvement in accessing antenatal care services. These are attitude of staff and physical structure of health facility.

Theme 1: Attitude of staff

Attitude of staff emerged as a significant health facility related factor which affect male partner involvement in antenatal care. The result is, however, ambivalent. While some respondents applaud the attitudes of health staff and consider it encouraging, others describe their attitudes as bad and discouraging. For example, one respondent indicated that *"They* [referring to health staff] *don't react badly towards me, no. They receive me whenever I visit them, they welcome me, they give me good reception and everything. In fact, I will score them hundred percent (100%)"* (Respondent 23).

He went on to explain that *"I have noticed that they are really working hard. They take proper care of women and our wives who visit the clinic. For me in particular, I do visit the clinic and even at times, I come earlier to make arrangements for my wife who will be visiting the clinic. I inform them to take care of her as well as attend to her and immediately my wife comes to the hospital and I call her she tells me that the nurses are already attending to her*

Digitized by Sam Jonah Library

even when there are a lot of people (patients) there before she arrives" (Respondent 23). Similarly, a different respondent added that *"When we go, in fact, they welcome us in a nice way. Their reception for us is so nice so all the time when my wife is going, I feel like going with her because of their warm reception they have been giving to us and they also render good care for her, especially when we went the other day and even today. When we arrived today, they just mentioned her name 'oh aunty charity, you are welcome.' That alone expresses some relationship between me and them"* (Respondent 7). Another respondent who feels the health staff are doing a good job had this to say; *"When you visit the hospital, they* [the staff] *offer seats or a place for them* [the pregnant women] *to sit and relax. The nurses then arrange them accordingly, based on the time you arrived by mentioning your names. They arrange them in queues for them to attend to those who arrived first in that orderly manner. This is what they do to ensure there is order. Also, I noticed that when they come to the hospital, the nurses take care of them, do not shout at them and all these are signs that show they are doing their work well and when people visit, they are satisfied with their work without anyone getting angry but rather going home happy and satisfied"* (Respondent 6).

This was what other respondents said; *"For the midwives, I've not had any issue with any of them and the one who is always attending to my wife is very good. She is very supportive. Sometimes, she even calls my wife in the house to check on her and see how she is doing. So, for that one, they are okay"* (Respondent 18). *"I could see that since I started bringing my wife here, even if there is queue, they call me first; and the way they talk to me, they respect my wife and all those things. I could see that they are really*

Digitized by Sam Jonah Library

working" (Respondent 21). He continued, *"Nobody is perfect. But they are really working. The way they talk to us; the health talk that they give; one-on-one communication and all those things, I really like it. No time wasting. The moment I come, they call me"* (Respondent 21).

This was what other respondents said; *"For the midwives, I've not had any issue with any of them and the one who is always attending to my wife is very good. She is very supportive. Sometimes, she even calls my wife in the house to check on her and see how she is doing. So, for that one, they are okay"* (Respondent 18). *"I could see that since I started bringing my wife here, even if there is queue, they call me first; and the way they talk to me, they respect my wife and all those things. I could see that they are really working"* (Respondent 11). He continued, *"Nobody is perfect. But they are really working. The way they talk to us; the health talk that they give; one-on-one communication and all those things, I really like it. No time wasting. The moment I come, they call me"* (Respondent 11).

Some respondents indicated that the treatment from health staff is good when they visit the hospital with their partners but cannot tell how their partners are treated when they visit alone. According to a respondent, *"The treatment is good. Anytime I accompany her to the hospital and the nurses see us together, they attend to us quickly and the care is good… I'll say when am with my wife, the treatment is very different. I don't know when am not with her but anytime we come the treatment is very different and perfect, yes"* (Respondent 14).

In a similar vein, a different respondent added, *"When I am there with my wife, the doctors and nurses attend to us on time. They also respect us but*

Digitized by Sam Jonah Library

instances where I do not go with my wife, my wife end up coming late. But the day I go there with my wife they attend to us on time" (Respondent 7).

As indicated earlier, not all respondents consider the attitude of health staff as encouraging. In addition to those who said the treatment differs depending on whether or not the male partner attends the hospital with the wife, some respondents indicated that some health staff are not friendly. A respondent lamented, *"Some nurses are friendly, others too are not. Because this morning, something happened after the OPD. The first OPD where we have the folder, the man in charge directed me and I was a bit confused so I met one of the nurses and wanted to get a clear direction from her but the way she threw me off, I had to go back and ask so I just left her then went back again the second time before I got the clear direction to this place"* (Respondent 18). Another narrated an incidence lambasting the attitude of health staff. This was what he said; *"Yesterday for instance, we were at Peki Government Hospital and the olden system has been changed. Now after buying the folder, they transfer everything onto the computer so there is no need to go and give your card to the nurse. They didn't tell me this so I was going to give the card to the nurse and come and see, as if I have never been to a hospital. But this is not a good process, if something has been changed you just direct the person, this is what you have to do. So, it's something that is creating problems in the whole. Even the big teaching hospitals, Korle Bu, Komfo Anokye, the situation there is even more than here oooo. Oh, the situation is worse than here so the doctors and nurses have to go for meeting so as to do something about it"* (Respondent 4).

Digitized by Sam Jonah Library

Some respondents indicated that the staff at the antenatal clinic sometimes ridicule and even insult the pregnant women. In the words of a male partner, *"The midwives some of them are good but the last time I came, I met one she was insulting a pregnant woman; insulting her that she is smelling. Meanwhile, the person was coming from a nearby village and doesn't have money. We had to shout on her that she should stop. Meanwhile, the person was coming from a nearby village and doesn't have money. We had to shout on her that she should stop"* (Respondent 10). *"The midwives some of them are good but the last time I came, I met one she was insulting a pregnant woman; insulting her that she is smelling. Meanwhile, the person was coming from a nearby village and doesn't have money. We had to shout on her that she should stop. Meanwhile, the person was coming from a nearby village and doesn't have money. We had to shout on her that she should stop"* (Respondent 10).

Another respondent narrated his ordeal. *"I had an experience with one midwife here which I didn't like. She was asking us questions and I didn't understand the question and she was laughing which is not really comfortable with me. Because I believe when you ask a question and the person didn't really understand the question, you are supposed to make it clearer to the person who is going to answer the question so he could give you a clearer answer but laughing at me makes me look so stupid"* (Respondent 13). He went on to recommend that *"There should be more education on the midwife-patient or nurse-client relationship. The relationship should be a little cordial or more cordial so that we can also feel comfortable to tell them exactly our*

Digitized by Sam Jonah Library

problems so they can also provide the adequate solutions to our problems then we can all have a very good, healthy society" (Respondent 13).

Theme 2: Physical structure

In addition to attitude of staff, the study also found that the physical structure of health facilities affects the involvement of men in antenatal care. Specifically, it was unravelled that inadequate space at the health facilities affects whether male partners accompanied their pregnant spouses (partners) to the antenatal clinic. One man indicated that *"Looking at the population or the size, the accommodation is not enough. Some people will love to come but when they come, I'm afraid, maybe they cannot accommodate us with our wives. Because of that, some men decide not to come at all. So, I think the accommodation should be expanded"* (Respondent 23).

Another added that *"The facility is too small. Normally when you come the women are there plenty. They will be in queue about fifty people and the unit where the antenatal mothers too are is not spacious. Some of them we don't know where they are coming from but when they come, they are overcrowded"* (Respondent 7).

Other respondents also expressed similar view concerning the inadequacy of infrastructure and recommended that the facilities should be expanded. According to them, if the environment is improved and made more conducive, more men will visit the facilities with their partners. This was what a respondent said; *"I think the facility lacks structures but I must also commend the nurses, they are doing very well. The little space that they have, they are trying; they are doing their best. But if the government can also do something about the structures, it will even help we the clients and the nurses.*

Digitized by Sam Jonah Library

Or if the government can expand the facility for them, I think it will help a lot" (Respondent 12).

In the words of another respondent, *"The whole environment is not bad but the structure is not in shape; old, dilapidated structure. At least, it needs some few touches. Expansion needs to come. Because, if you look at this place, the whole place is congested and people are finding it very difficult to pass by. We need expansion. And when it is expanded and there's comfort, I believe the men will feel more comfortable to come"* (Respondent 18).

In similar light, a different respondent added, *"It* [referring to the space at the clinic] *is too small. Because sometimes, there are too many pregnant women here and the whole place is congested. The place is not airy. Sometimes, because there is not space, I have to stand and she will have to sit. So, if the place is more conducive, I believe a lot more men will continue coming"* (Respondent 10).

Some of the respondents, on the other hand, indicated that the space is adequate. *"The space is good because this place is not chocked whereby if you want to get up and go out, you have nowhere to pass. It's not like that. They arranged everything and the chairs; if it's not your turn, where you will be and if it is your turn, the you move. And if you are coming here, there is nothing like fear or panic. They themselves are welcoming; I like them"* (Respondent 19).

Objective 4: Personal factors which influence male partner involvement in antenatal care services

The last objective of the study was to determine which personal factors influence male partner involvement in antenatal care. Three themes emerged

Digitized by Sam Jonah Library

after a thematic content analysis. These are time constraints as a result of work, ignorance and lack of respect for men by their partners.

Theme 1: Time constraints as a result of work

Time constraints because of work featured prominently among the personal factors which affect male partners' involvement in antenatal care services. Majority of the respondents indicated that men are not able to accompany their partners to the hospital for antenatal care services because their works do not allow them the time to do so. In the words of one respondent, *"There is no problem accompanying your wife to the antenatal clinic just that sometimes the work will not permit us to do that"* (Respondent 14). According to a different respondent, *"She* [referring to his partner] *told me about today's visit however I explained to her that I will come but since I am part of those taking the temperatures at work, I could not"* (Respondent 23). In the words of other respondents, *"I will be there but because of my job, it's not always that I am at home but when I'm at home, I do"* (Respondent 17). *"The only thing is my business. The mobile money is not the only thing I do so if my customers call me ... that's the only thing that prevents me from accompanying her to the antenatal clinic"* (Respondent 16).

Other respondents indicated that even though their work is a deterrent, anytime they do not have any serious work doing, they attend the hospital with their partners. Some men also ask for permission at work to enable them escort their partners to the hospital. For example, these were what some respondents said; *"When I don't have any serious work on the farm, I bring her"* (Respondent 4). *"Me myself I am a mechanic so my job does not allow me to*

Digitized by Sam Jonah Library

always be at home so when I get the time, I accompany my wife going to the clinic" (Respondent 17).

Another respondent explained, *"Sometimes my work too deters me but days that she goes now has been scheduled on monthly basis. At first, they told them that they should be coming every time but now they go on monthly basis. On the days that she is supposed to visit the hospital for antenatal care, I ask for permission from my boss at work to attend to my wife too"* (Respondent 7). An opinion leader expressed similar views. He elaborated that *"It is because sometimes I am not available and will be occupied at work. At times, you will go with her but would have to leave early to go and attend to duties at work. Also, mostly, the time given to her to visit the clinic for antenatal may not be favourable to you the man because you may have scheduled that time for a meeting. So, if it is necessary she needs to go together with someone, then I have to call in someone to accompany her. So, unavailability takes the major part of the reason why a man is unable to accompany the wife to the clinic for antenatal"* (Respondent 3).

Theme 2: Lack of knowledge

Another personal factor found to be influencing male partner involvement in antenatal care was ignorance about the fact that men are supposed to escort their partners to the health facility for antenatal care services. Some of the respondents (mainly the chief and opinion leaders) indicated that they are unaware of the existence of this policy. In the words of a respondent, *"Those times that my wife was bearing children, when she visits the clinic for antenatal, I never accompanied her because we were never*

Digitized by Sam Jonah Library

asked to do so. There was nothing like that for a man to accompany the wife to antenatal so I was not privy to anything like that" (Respondent 2).

Another expressed a similar position that *"Nothing prevented me and as I said earlier, they only give the dates to the pregnant woman to visit the clinic for antenatal. They never said that the man should accompany her to the clinic"* (Respondent 3).

In the view of another respondent, *"Our fathers had no idea about antenatal so they don't accompany their wives to the hospital for antenatal."* (Respondent 1). When questioned about his awareness about the policy that men must accompany their partners to access antenatal care services, this was what he said, *"Umm, if I tell you I heard about such policies, I may be lying to you however the law or policy I heard about is the family planning. When you say there is a law that the man has to accompany the wife to antenatal care till she delivers the baby, that I know nothing about"* (Respondent 1). These are clear indication that lack of knowledge about antenatal care and the policy that men must escort their partners to access antenatal care services is among the reasons explaining male partner non-involvement in antenatal care.

Theme 3: Lack of respect for men by wives

Finally, lack of respect for husbands was identified as a factor which influence men's involvement in antenatal care. Some respondents indicated their reluctance to accompany their wives to the hospital for antenatal care services because their wives do not respect them. According to them, the women are not even able to ask their husbands to escort them to the hospital knowing that they do not show any respect to the men. For example, one respondent explained that *"Some women do not respect their men so they are*

Digitized by Sam Jonah Library

not able to ask the men to accompany them to antenatal." He continued, *"When you respect me as a man, I will gladly do anything for you. So, one of the hindrances is the lack of respect that is not accorded to men"* (Respondent 1).

Discussion

This study showed that restrictive cultural norms and gender roles affect men's participation in prenatal care. Stereotyping (name calling) and unacceptability by the communities for men to accompany their partners to antenatal care influenced male participation in antenatal care. According to Mkandawire and Hendriks (2018), regardless of whether males participated in maternity care, sociocultural ideas about inequity and stereotyping with regard to gender roles and duties persisted. A similar finding shows that men who help with household chores are subjected to mockery and social stigma within the neighbourhood and so acts as a deterrent for male involvement in antenatal care (Lowe, 2017; Mullany, 2006). Perhaps, traditional cultural norms regarding marital roles especially in traditional settings could be the explanation (Kumbeni et al., 2019).

The results of this study are in line with previous research suggesting that men's engagement in maternal and child health is still hampered by socially created gender stereotypes. Pregnancy is traditionally a woman's domain, according to Kululanga et al. (2012) and Aarnio, Olsson, Chimbiri and Kulmala (2009), and males do not believe that they should be engaged.

Men frequently believe that women should be in charge of matters pertaining to pregnancy and maternal health. For instance, it has been claimed that males refuse to accompany women to maternity health care because they

Digitized by Sam Jonah Library

still adhere to the cultural ideal that a man will lose “strength” if he is there during the birth of his child (Mullick, Kunene, & Wanjiru, 2005; Onyango, Owoko & Ogutta, 2010). Also, in a focused group discussion, “men reported that they were hindered from participating in antenatal care as, per their culture, maternal health issues were considered the women’s domain and therefore they saw no reason to meddle in women’s issues” (Ongolly & Bukachi, 2019).

It was also found that men did not find escorting their partners for antenatal care as their duty. This finding is in line with a previous study by Kumbeni et. al., (2019), where it was found that men may not be directly involved in escorting their partners for antenatal care but may be involved in antenatal care activities at the household and community level. Mkandawire and Hendriks (2018) explain that “some men are gradually becoming active in nutrition activities relating to maternal and child health, which is another domain which was previously associated with women.” These ongoing discussions suggest that programmes and policies to encourage men’s involvement should move beyond escort to antenatal care and include other factors to engage them in the process.

Although a number of the perceptions indicated stereotyping and considered antenatal care visits as not the responsibilities of men, some also considered that there were no socio-cultural barriers in male involvement in antenatal care. This finding is substantiated by Doe (2013) where it was identified that there are no taboos that prohibit male involvement but concerns about how they will be perceived by relatives and other people as assisting their partners. In another study by Annoon et al. (2020), it was found that male

Digitized by Sam Jonah Library

partners will be seen as being controlled by the partner when they escort them to antenatal care. Such negative perceptions towards men have been found to negatively affect their participation in antenatal care services (Ditekemena et. al., 2012). The outcome is consistent with Nanjala and Wamalwa's (2012) research, which found that respondents believed that if they were seen accompanying their spouses to a medical institution, people would think they were under their wives' control.

Attitude of staff as well as the physical structure at the health facilities emerged as health facility factors which influenced male partner involvement in antenatal care. This finding is in line with the findings of Kumnei et. al., (2019) who emphasised that friendly staff attitudes encourage men to escort their partners and vice versa. Similarly, Craymah et al. (2017) found that the attitudes of health workers at the health facility accounted for low male involvement in antenatal care.

Again, the study is consistent with other past studies (Byamugisha, Tumwine, Semiyaga, & Tylleskär, 2010; Vermeulen et. al., 2016). For instance, Byamugisha et. al., noted that "male involvement was hindered by trained health professionals' harsh and critical language directed towards women. Men were further deterred from returning or taking part in prenatal care activities by the harsh treatment they received from healthcare professionals." According to Vermeulen et. al., (2016), some men may have felt unwelcome at prenatal care because of the attitude of some healthcare professionals towards men who come to appointments with their wives.

In a quantitative study by Gibore et al. (2019), attitude of staff came out strongly as a factor determining male partner involvement in antenatal

Digitized by Sam Jonah Library

care. Unexpectedly, the study found a link between men's perceptions of healthcare professionals' attitudes towards men who accompany their spouses to prenatal care and the extent of men's engagement in prenatal care. Compared to men who had a negative opinion, men who thought providers had a favourable attitude had lower probabilities of being involved (Gibore et. al., 2019). The results were interpreted in terms of men's protective tendencies towards their relationships, wherein those who had a negative impression could accompany their partners as a method of shielding them from providers with a negative attitude.

Additionally, Ongolly and Bukachi (2019) discovered that healthcare workers at the prenatal care clinic have a poor attitude towards men. According to several of the participants in that study, the healthcare professionals occasionally forbade them from entering the clinic rooms with their spouses and asked them socially awkward and unpleasant questions. According to Ongolly and Bukachi's research, men's participation in prenatal care was significantly hampered by the clinic's lack of services specifically geared towards them. Men who went to the clinics with their partners eventually just sat and waited. The most they could do was join their spouses in the waiting room or counselling room, but even then, the medical staff only actively engaged their couples, leaving the other patients feeling excluded.

Kumbeni et. al., (2019) similarly found, in Ghana, that male participation in prenatal care was less likely as a result of the unfavourable attitudes of the health care workers and the delays that men experienced during their visits. Men are more likely to accompany their spouses to prenatal care clinics when the staff is friendly. The study reported as follows: "men

Digitized by Sam Jonah Library

University of Cape Coast https://ir.ucc.edu.gh/xmlui

who assessed the attitude of healthcare workers as unfriendly were less likely to be involved in antenatal care compared with those who assessed the attitude of healthcare workers as friendly." In fact, such men (ie, those who consider the attitude of healthcare workers as unfriendly), compared with those who feel otherwise, were about 60 percent less likely to be involved in antenatal care (Kumbeni et. al., 2019). According to Kumbeni and colleagues, "males prefer to avoid returning to the prenatal care clinics when they encounter unpleasant staff members, which has an impact on their participation in pregnancy services."

This study found that inadequate space at health facilities is among the health facility related factors which affect male partner involvement in antenatal care. Inadequate space at health facilities is usually accompanied with long queues and long waiting times. In a study by Ditekemena et. al., (2012), it was similarly reported that "lack of space to accommodate male partners in antenatal care clinics was a barrier to male involvement in antenatal care." Other previous studies (Mullany, 2006; Nungari, 2014; Vermeulen, et. al., 2016) reported findings which are consistent with this result.

For instance, Nungari (2014) found that "there was a need for health facilities, particularly the antenatal clinic area, to improve in terms of space and sitting arrangements to comfortably accommodate all pregnant women and their spouses." The study focused on the factors influencing male participation in antenatal care. Thus, there is the need for expansion of health infrastructure to accommodate couples as they go for antenatal care services together.

Digitized by Sam Jonah Library

The finding however contrasts those of Sharma and Khatri (2018) who reported that physical structure was not a barrier to male partner involvement in antenatal care. "Dominance of female as health care providers in many antenatal and maternal health clinics was the major factor influencing male partner participation in antenatal care," according to Sharma and Khatri (2018).

The study also reveals that some personal factors such as constraint because of work played key roles in men's involvement in antenatal care. This result supports other studies' findings that the degree of male engagement in maternal health care may be influenced by a partner's work position (Aborigo et al, 2018; Craymah et al., 2017). Men are less likely to accompany their partners to antenatal care clinics if they feel that the time spent there is taking longer than they anticipated (Aborigo et al., 2018; Tweheyo, Konde-Lule, Tumwesigye & Sekandi, 2010).

Also, according to Gibore et al. (2019), occupation is a statistically significant determinant of male partner involvement in antenatal care. Gibore et. al., reported that men who were employed were about 30 percent less likely to be involved in antenatal care. Ongolly and Bukachi (2019) similarly reported from that men were hindered from participating in antenatal care by the nature of their work. The study revealed that majority of men are not able to actively participate in antenatal care because their work made it impossible for them. According to Ongolly and Bukachi, "the majority of them were farmers, self-employed individuals, and temporary employees with extremely low wages who found it extremely challenging to carve out enough time to accompany their partners to the clinic for prenatal care appointments."

Digitized by Sam Jonah Library

University of Cape Coast https://ir.ucc.edu.gh/xmlui

This result, however, contravenes the findings of Matiang'i, Mojola and Githae (2013). In that study, it was reported that educational and income levels, but not occupation status, had a significant influence on male partner involvement in antenatal care. In a similar vein, Mullany (2006) discovered that male partners' participation in prenatal care did not seem to be significantly hampered by work commitments or job duties.

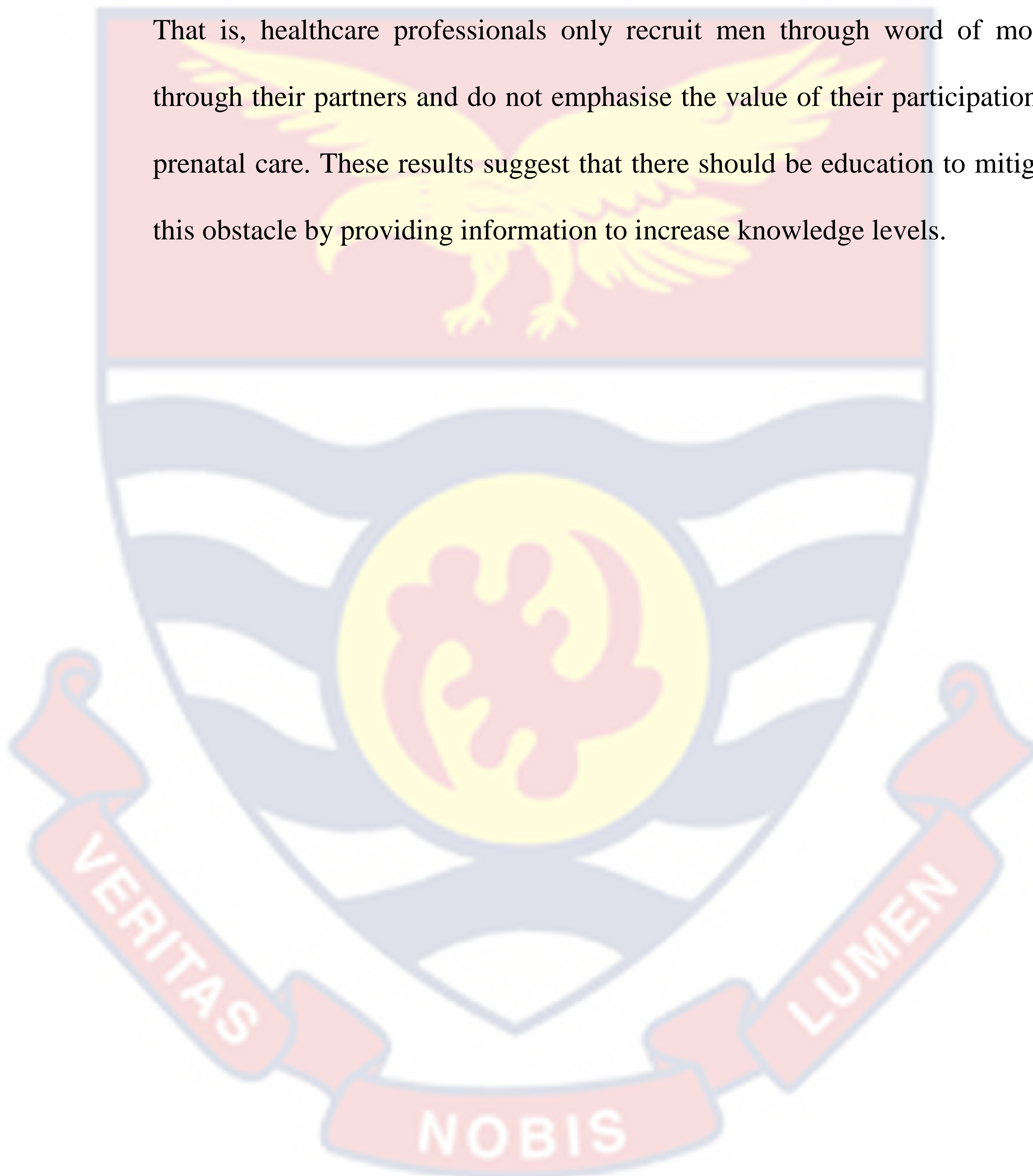
Craymah et. al. (2017) discovered in another study that males who were working were more likely to participate in prenatal care. They clarify that unemployment is a sign of financial inaccessibility to healthcare facilities, which contributes to poor male prenatal care participation. According to Kumbeni et. al., (2019), men who work in the private sector are less likely to participate in prenatal care than those who are jobless, whereas men who work in the public sector are more likely to do so. However, it should be noted that this result was not statistically significant.

Overall, occupation plays a significant role in predicting male participation in antenatal care because, "in the majority of African cultures, men are the main breadwinners in their families and would rather spend their time working to support their families than waiting for long periods of time at clinics where they are typically not present" (Mahiti et al., 2017). As a result, their lack of dedication at the clinics influences how they engage in prenatal treatment.

It was also shown that ignorance affected the engagement of the male spouse in prenatal care. Mullany (2006) found that although spouses' interest in and attempts to promote pregnancy health were quite high, a key barrier to being involved in a good way appeared to be a lack of understanding.

Digitized by Sam Jonah Library

Vermeulen et. al., (2016) reported similar findings. They claim that one of the biggest obstacles to male partners participating in prenatal care is their ignorance of the significance of their engagement. This, according to Ongolly and Bukachi (2019), is a result of the undervaluation of male participation. That is, healthcare professionals only recruit men through word of mouth through their partners and do not emphasise the value of their participation in prenatal care. These results suggest that there should be education to mitigate this obstacle by providing information to increase knowledge levels.


VERITAS NOBIS LUMEN

Digitized by Sam Jonah Library

University of Cape Coast https://ir.ucc.edu.gh/xmlui

CHAPTER FIVE

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

The study explored the socio-cultural factors influencing male partner involvement in antenatal care services. This chapter presents the summary of the findings of the study. Based on the findings, conclusions are also drawn in this chapter. In addition, recommendations are made based on the findings of the study as well as suggestions for future studies.

Summary

The study was a qualitative study which adopted a interpretative phenomenological design to investigate the socio-cultural factors influencing male partner involvement in antenatal care service. The study specifically assessed the perception of men on male partner involvement in antenatal care, and explored how socio-cultural and health facility factors influence male partner involvement in antenatal care. In addition, personal factors which influence male partner involvement in antenatal care were determined.

Interview guide was used to collect data from a total of twenty-three (23) respondents made up of an opinion leader, chief, elder and male partners who escorted their partners to antenatal care clinic. Purposeful and convenient sampling procedures were used to select participants for the study. The opinion leader, chief and elder were purposefully selected while the male partners were selected conveniently. Thematic content analysis was used to analyse the data. Quotations from the respondents were used to support the views they raised on the various issues. Statements of the respondents were presented as quotes to substantiate responses given to questions posed during the interview process.

Digitized by Sam Jonah Library

University of Cape Coast https://ir.ucc.edu.gh/xmlui

Key findings

1. The findings reveal that male partner involvement in antenatal care shows care to the woman, reduces her burden and makes her happy. In addition, it keeps the men in the known always and gives them opportunity to also learn.
2. It was also evident that society sometimes has a stereotypical labelling for men who accompany their wives for antenatal care visits. These men are called names and described as lazy.
3. In addition, erroneous societal perceptions influence male partner involvement in antenatal care utilisation. Particularly, some men believe that it is not the responsibility of men to be involved in antenatal care, and doing so is an interference.
4. Attitude of healthcare workers was identified as a significant determinant of male partner involvement in antenatal care. Some respondents applauded the attitudes of health staff and consider it encouraging, while others describe their attitudes as bad and discouraging.
5. Again, it was unravelled that inadequate space at the health facilities affects male partners' involvement in antenatal care. Specifically, inadequate space at the health facilities affects whether male partners accompanied their pregnant partners to the antenatal clinic.
6. Time constraints as a result of work featured prominently among the personal factors which affect male partners' involvement in antenatal care services. Thus, it was found that because of the demands of work,

Digitized by Sam Jonah Library

male partners are not able to accompany their wives to access antenatal care services.

7. Ignorance that men are supposed to escort their partners to the health facility for antenatal care services was another personal factor found to be influencing male partner involvement in antenatal care.

Conclusions

Based on the findings of the study, the following are concluded.

1. Male partners perceive that their involvement in antenatal care shows care to the woman, reduces her workload and makes her happy.
2. Sociocultural factors which affect male partner involvement in antenatal care are stereotyping and erroneous societal perceptions. Some male partners do not consider it their responsibility to be involved in antenatal services.
3. Attitude of staff at health facilities and inadequate space at these facilities are the key health-related factors which influence involvement of men in antenatal care.
4. The involvement of male partners in antenatal services utilisation is also affected by personal factors (like time constraints as a result of work demands).

Recommendations

Based on the findings of the study, the following recommendations are made:

1. Health workers should sensitize men to translate their perception (that their involvement in antenatal care shows care to the woman and reduces her workload) into action.

Digitized by Sam Jonah Library

2. Health workers should increase education and sensitization on the importance of male involvement in antenatal care so that men who are not aware and those who do not consider it their responsibility will be informed. This will also help to erase stereotypes concerning male partners' involvement in antenatal care.
3. The Municipal Health Directorate of the Ho municipality must strengthen sensitization of all health workers to always put-up attitudes that are receptive and accommodative, especially, to men who accompany their partners to antenatal clinic.
4. There should be National Policy for employers to permit men to be absent from work on days their partners attend antenatal clinic.

Suggestions for Future Research

1. Future studies could explore how men, who are involved in antenatal care, cope with or respond to stereotypes.
2. There could also be a quantitative study to determine the statistical significance of employment to male partner involvement in antenatal care.
3. Future studies could also explore the issue (male partner involvement in antenatal care) from the perspective of women.

Digitized by Sam Jonah Library

References

Aarnio, P., Olsson, P., Chimbiri, A., & Kulmala, T. (2009). Male involvement in antenatal HIV counseling and testing: exploring men's perceptions in rural Malawi. *AIDS Care, 21*(12), 1537-1546.

Aborigo, R. A., Reidpath, D. D., Oduro, A. R., & Allotey, P. (2018). Male involvement in maternal health: perspectives of opinion leaders. *BMC Pregnancy and Childbirth, 18*(1), 1-10.

Adom, D., Adu-Gyamfi, S., Agyekum, K., Ayarkwa, J., Dwumah, P., Abass, K., & Obeng-Denteh, W. (2016). Theoretical and conceptual framework: Mandatory ingredients of a quality research. *Journal of Education and Human Development, 5*(3), 158-172.

Airhihenbuwa, C. O. (1989). Perspectives on AIDS in Africa: strategies for prevention and control. *AIDS Education and Prevention 1*(1), 57-69.

Airhihenbuwa, C. O. (1990). A conceptual model for culturally appropriate health education programs in developing countries. *International Quarterly of Community Health Education, 11*(1), 53-62.

Airhihenbuwa, C. O. (1995). *Health and culture: Beyond the Western paradigm*. Thousand Oaks, CA: Sage Publications.

Airhihenbuwa, C. O. (1999). Of culture and multiverse: Renouncing the universal truth in health. *Journal of Health Education, 30*(5), 267-273.

Airhihenbuwa, C. O. (2007). SOPHE Presidential Address on being comfortable with being uncomfortable: Centering an Africanist vision in our gateway to global health. *Health Education & Behaviour, 34*(1), 31-42.

Digitized by Sam Jonah Library

Airhihenbuwa, C. O., & Liburd, L. (2006). Eliminating health disparities in the African American population: the interface of culture, gender, and power. *Health Education & Behaviour, 33*(4), 488-501.

Airhihenbuwa, C. O., & Webster, J. D. (2004). Culture and African contexts of HIV/AIDS prevention, care and support. *Sahara Journal of Social Aspects of HIV/AIDS, 1*(1), 4-13.

Airhihenbuwa, C., Okoror, T., Shefer, T., Brown, D., Iwelunmor, J., Smith, E. & Shisana, O. (2009). Stigma, culture, and HIV and AIDS in the Western Cape, South Africa: An application of the PEN-3 cultural model for community-based research. *Journal of Black Psychology, 35*(4), 407-432.

Alkema, L., Chou, D., Hogan, D., Zhang, S., Moller, A. B., Gemmill, A., ... & Inter, U. N. (2015). Global, regional, and national levels and trends in maternal mortality between 1990 and 2015, with scenario-based projections to 2030: a systematic analysis by the UN Maternal Mortality Estimation Inter-Agency Group. *The Lancet, 387*(10017), 462-474.

Allendorf, K. (2007). Do women's land rights promote empowerment and child health in Nepal? *World Development, 35*(11), 1975-1988.

Amosu, A. M., Degun, A. M., Makinde, C. M., Thomas, A., & Babalola, A. (2011). An assessment of specific knowledge and attitude of healthcare providers towards people living with HIV/AIDS in Ibadan, Nigeria. *Annals of Biological Research, 2*(2), 255-264.

Digitized by Sam Jonah Library

Amuzie, C. I., Nwamoh, U. N., Ukegbu, A., Umeokonkwo, C. D., Azuogu, B. N., Agbo, U. O., & Balogun, M. S. (2022). Determinants of male involvement in family planning services in Abia State, Southeast Nigeria. *Contraception and Reproductive Medicine*, *7*(1), 1-9.

Andersson, N., Omer, K., Caldwell, D., Dambam, M. M., Maikudi, A. Y., Effiong, B., ... & Hamel, C. (2011). Male responsibility and maternal morbidity: a cross-sectional study in two Nigerian states. *BMC Health Services Research, 11*(2), 1-11.

Annoon, Y., Hormenu, T., Ahinkorah, B. O., Seidu, A. A., Ameyaw, E. K., & Sambah, F. (2020). Perception of pregnant women on barriers to male involvement in antenatal care in Sekondi, Ghana. *Heliyon, 6*(7), e04434.

Atuahene, M. D., Arde-Acquah, S., Atuahene, N. F., Adjuik, M., & Ganle, J. K. (2017). Inclusion of men in maternal and safe motherhood services in inner-city communities in Ghana: Evidence from a descriptive cross-sectional survey. *BMC Pregnancy and Childbirth, 17*(1), 419.

Babalola, S., & Adesegun, F. (2009). Determinants of use of maternal health services in Nigeria-looking beyond individual and household factors. *BMC Pregnancy and Childbirth, 9*(1), 1-13.

Backstrom, C., & Wahn, E. H. (2011). Support during labour: first-time fathers' descriptions of requested and received support during the birth of their child. *Midwifery*, *27*(1), 67-73.

Baines, E. (2017). *Buried in the heart: Women, complex victimhood and the war in northern Uganda*. Cambridge University Press.

Digitized by Sam Jonah Library

Bandura, A. (1977). Self-efficacy: toward a unifying theory of behavioural change. *Psychological Review, 84*(2), 191.

Bandura, A. (1999). Social cognitive theory: An agentic perspective. *Asian Journal of Social Psychology, 2*(1), 21-41.

Barker, G., & Das, A. (2004). Men and sexual and reproductive health: the social revolution. *International Journal of Men's Health, 3*(3), 147-53.

Becker, S., Fonseca-Becker, F., & Schenck-Yglesias, C. (2006). Husbands' and wives' reports of women's decision-making power in Western Guatemala and their effects on preventive health behaviours. *Social Science & Medicine*, *62*(9), 2313-2326.

Bediako, K. (2006). Scripture as the interpreter of culture and tradition. *Africa Bible Commentary*, 3-4.

Beegle, K., Frankenberg, E., & Thomas, D. (2001). Bargaining power within couples and use of prenatal and delivery care in Indonesia. *Studies in Family Planning*, *32*(2), 130-146.

Blencowe, H., Cousens, S., Jassir, F. B., Say, L., Chou, D., Mathers, C., … & Lawn, J. E. (2016). National, regional, and worldwide estimates of stillbirth rates in, with trends from 2000: A systematic analysis. *Lancet 4*(2), 98–108.

Briner, R. B. (1999). The neglect and importance of emotion at work. *European Journal of Work and Organizational Psychology, 8*(3), 323-346.

Bronfenbrenner, U. (1977). Lewinian space and ecological substance. *Journal of Social Issues, 33*(4), 199-212.

Digitized by Sam Jonah Library

Brown, D. C., Belue, R., & Airhihenbuwa, C. O. (2010). HIV and AIDS-related stigma in the context of family support and race in South Africa. *Ethnicity & Health*, *15*(5), 441-458.

Byamugisha, R., Tumwine, J. K., Semiyaga, N., & Tylleskär, T. (2010). Determinants of male involvement in the prevention of mother-to-child transmission of HIV programme in Eastern Uganda: A cross-sectional survey. *Reproductive Health, 7*(1), 1-9.

Cole, M. (1998). *Cultural psychology: A once and future discipline.* Cambridge: Harvard University Press.

Craymah, J. P., Oppong, R. K., & Tuoyire, D. A. (2017). Male involvement in maternal health care at Anomabo, central region, Ghana. *International Journal of Reproductive Medicine*. doi.org/10.1155/2017/2929013

Creswell, J. W. (2013). *Qualitative inquiry & research design: Choosing among the five approaches*. Thousand Oaks, CA: SAGE Publications.

Davis, J., Luchters, S. & Holmes, W. (2012). *Men and maternal and newborn health: benefits, harms, challenges and potential strategies for engaging men.* Melbourne: Compass: Women's and Children's Health Knowledge Hub.

Demissie, D. B., Bulto, G. A., & Terfassa, T. G. (2016). Involvement of male in antenatal care, birth preparedness and complication readiness and associated factors in Ambo town, Ethiopia. *Journal of Health, Medicine and Nursing*, *27*(5), 14-23.

Doe, R. D. (2013). *Male partner involvement in maternity care in Ablekuma South District, Accra, Ghana* (Master's thesis, University of Ghana). Available at https://ugspace.ug.edu.gh/handle/123456789/5898

Digitized by Sam Jonah Library

Ditekemena, J., Koole, O., Engmann, C., Matendo, R., Tshefu, A., Ryder, R., & Colebunders, R. (2012). Determinants of male involvement in maternal and child health services in sub-Saharan Africa: A review. *Reproductive Health, 9*(1), 1-8.

Dörnyei, Z. (2007). *Research methods in applied linguistics*. New York: Oxford University Press.

Dowswell, T., Carroli, G., Duley, L., Gates, S., Gülmezoglu, A. M., Khan, Neelofur, D., et al. (2015). *Alternative versus standard packages of antenatal care for low-risk pregnancy*. The Cochrane Library. Doi: https://10.1002/14651858.CD000934.pub3

Dzumbila-Namasasu, J. (2010). *Socio-cultural factors influencing male involvement in reproductive health during pregnancy, childbirth and the postnatal period in rural districts of Malawi* (Doctoral thesis, Edith Cowan University). Available at https://ro.ecu.edu.au/theses/373

Fiol, M., & O'Connor, E. (2017). Unlearning established organizational routines – Part I. *The Learning Organization, 24*(1), 13-29.

Ghana Health Service (2019). *Annual maternal health report. Ho Volta Region, Ghana.* Available at https://www.moh.gov.gh/wp-content/uploads/2017/09/2016-Annual-Report.pdf

Ghana Statistical Service. (2013). *2010 Population and Housing Census: District Analytic Report – Ho Municipality*. Accra: Ghana Statistical Service.

Gibore, N. S., Bali, T. A., & Kibusi, S. M. (2019). Factors influencing men's involvement in antenatal care services: a cross-sectional study in a low resource setting, Central Tanzania. *Reproductive health*, *16*, 1-10.

Digitized by Sam Jonah Library

Grant, C., & Osanloo, A. (2014). Understanding, selecting, and integrating a theoretical framework in dissertation research: Creating the blueprint for your house. *Administrative Issues Journal: Education, Practice, and Research, 4*(2), 12-26.

Green, E. C., Dlamini, C., D'Errico, N. C., Ruark, A., & Duby, Z. (2009). Mobilising indigenous resources for anthropologically designed HIV-prevention and behaviour-change interventions in southern Africa. *African Journal of AIDS Research*, *8*(4), 389-400.

Green, M., & Piel, J. A. (2009). *Theories of human development: A comparative approach* (2nd Ed.): Prentice-Hall, Inc.

Hoffman, L. W. (1993). *Hoffman Developmental psychology today*: McGraw-Hill Companies.

Hussain, H., Khan, A. A., Ismail, T., ur Rehman, Z., & Iftikhar, B. (2012). The role of effective communication between couples about contraceptive use. *Journal of Medical Sciences*, *20*(1), 19-21.

Iliyasu, Z., Abubakar, I. S., Galadanci, H. S., & Aliyu, M. H. (2010). Birth preparedness, complication readiness and fathers' participation in maternity care in a northern Nigerian community. *African Journal of Reproductive Health*, *14*(1), 21-32.

Iwelunmor, J. & Airhihenbuwa, C. (2012). Why culture matters in reducing the burden of NCDs and CDs in Africa. *Commonwealth Health Partnerships, 2012,* 107-111.

Iwelunmor, J., Airhihenbuwa, C. O., Okoror, T. A., Brown, D. C., & BeLue, R. (2008). Family systems and HIV/AIDS in South Africa. *International Quarterly of Community Health Education*, *27*(4), 321.

Digitized by Sam Jonah Library

Iwelunmor, J., Newsome, V., & Airhihenbuwa, C. O. (2014). Framing the impact of culture on health: A systematic review of the PEN-3 cultural model and its application in public health research and interventions. *Ethnicity & Health, 19*(1), 20-46.

Iwelunmor, J., Sofolahan-Oladeinde, Y., & Airhihenbuwa, C. O. (2015). Sociocultural factors influencing HIV disclosure among men in South Africa. *American Journal of Men's Health, 9*(3), 193-200.

Iwelunmor, J., Zungu, N., & Airhihenbuwa, C. O. (2010). Rethinking HIV/AIDS disclosure among women within the context of motherhood in South Africa. *American Journal of Public Health*, *100*(8), 1393-1399.

Kakaire, O., Kaye, D. K., & Osinde, M. O. (2011). Male involvement in birth preparedness and complication readiness for emergency obstetric referrals in rural Uganda. *Reproductive Health*, *8*(12), 1-7.

Kannan, S., Sparks, A. V., Webster, J. D., Krishnakumar, A., & Lumeng, J. (2010). Healthy Eating and Harambee: Curriculum development for a culturally-centered bio-medically oriented nutrition education program to reach African American women of childbearing age. *Maternal and Child Health Journal, 14*(4), 535-547.

Kariuki, K. F., & Seruwagi, G. K. (2016). Determinants of male partner involvement in antenatal care in Wakiso District, Uganda. *British Journal of Medicine and Medical Research*, *18*(7), 1-5.

Kiptoo, S. J. & Kipmerewo, M. (2017). Male partner involvement in antenatal care services in Mumias East and West sub-counties, Kakamega County, Kenya. *Journal of Nursing and Health Science, 6*(4), 37–46.

Digitized by Sam Jonah Library

Kline, S. (2007). The morality and politics of consumer religion: How consumer religion fuels the culture wars in the United States. *The Journal of Religion and Popular Culture*, *17*(1), 2-2.

Kululanga, L. I., Sundby, J., Chirwa, E., Malata, A., & Maluwa, A. (2012). Barriers to husbands' involvement in maternal health care in a rural setting in Malawi: A qualitative study. *Journal of Research in Nursing and Midwifery, 1*(1), 1-10.

Kumar, R. (2005). *Research Methodology: A step-by-step guide for beginners* (2nd Ed.). London: SAGE Publications Ltd.

Kumbeni, M. T., Ziba, F. A., Alem, J. N., & Nborah, S. A. (2019). Factors Influencing Male Involvement in Antenatal Care in the Kassena Nankana Municipal in the Upper East Region, Ghana. *European Scientific Journal, 15*(21), 3-19.

Kwast, L. E. (1981). Understanding culture. *Perspectives on the world Christian movement*, 397-399.

Leiner, D. J. (2014). *Convenience samples and respondent pools*. Thousand Oaks, CA: Sage Publications.

Lincoln, Y., & Guba, E. G. (1985). *Naturalistic inquiry.* Beverly Hills, CA: Sage.

Lindsey, L. L. (2015). *Gender roles: A sociological perspective*. Oxfordshire: Routledge.

Lowe, M. (2017). Social and cultural barriers to husbands' involvement in maternal health in rural Gambia. *The Pan African Medical Journal, 27,* 255-261.

Digitized by Sam Jonah Library

Magezi, V. (2007). Pastoral counselling: Towards a diagnostic and interpretational approach in Africa. *In die Skriflig, 41*(4), 655-672.

Mahiti, R. G., Mbekenga, C. K., Kiwara, D. A., Hurtig, A. K., & Goicolea, I. (2017). Perceptions about the cultural practices of male partners during postpartum care in rural Tanzania: A qualitative study. *Global Health Action, 10*(1), 1361184.

Maleku, A., & Pillai, V. K. (2015). Antenatal Care in Nepal: A Socioecological Perspective. *Health Care for Women International, 37*(4), 496-515.

Matiang'i, M., Mojola, A., & Githae, M. (2013). Male involvement in antenatal care redefined: A cross-sectional survey of married men in Lang'ata district, Kenya. *African Journal of Midwifery and Women's Health, 7*(3), 117-122.

Matsuyama, K. (2002). The rise of mass consumption societies. *Journal of Political Economy, 110*(5), 1035-1070.

Maxwell, J. A. (2013). *Qualitative research design: An interactive approach*. Thousand Oaks, CA: SAGE Publications.

Mbiti, J. (1969). *African philosophy and religion.* Nairobi: East African Educational Publishers.

Mieh, T. M., Iwelunmor, J., & Airhihenbuwa, C. O. (2013). Home-based caregiving for people living with HIV/AIDS in South Africa. *Journal of Health Care for the Poor and Underserved, 24*(2), 697-705.

Mkandawire, E., & Hendriks, S. L. (2018). A qualitative analysis of men's involvement in maternal and child health as a policy intervention in rural Central Malawi. *BMC Pregnancy and Childbirth, 18*(1), 1-12.

Digitized by Sam Jonah Library

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

Mullany, B. C., Becker, S., & Hindin, M. J. (2007). The impact of including husbands in antenatal health education services on maternal health practices in urban Nepal: results from a randomized controlled trial. *Health Education Research*, *22*(2), 166-176.

Mullick, S., Kunene, B., & Wanjiru, M. (2005). Involving men in maternity care: health service delivery issues. *Agenda Special Focus, 6,* 124-135.

Muro, M., & Jeffrey, P. (2008). A critical review of the theory and application of social learning in participatory natural resource management processes. *Journal of Environmental Planning and Management, 51*(3), 325-344.

Naimoli, J. F., Perry, H. B., Townsend, J. W., Frymus, D. E., & McCaffery, J. A. (2015). Strategic partnering to improve community health worker programming and performance: features of a community-health system integrated approach. *Human Resources for Health*, *13*(1), 1-13.

Nanjala, M., & Wamalwa, D. (2012). Determinants of male partner involvement in promoting deliveries by skilled attendants in Busia, Kenya. *Global Journal of Health Science, 4*(2), 60.

Newman, B. M., & Newman, P. R. (2007). *Theories of human development.* Mahwah, NJ: Lawrence Erlbaum Associates.

Ngubane, S. J. (2010). *Gender roles in the African culture: implications for the spread of HIV/AIDS*. (Master's thesis, University of Stellenbosch). Available at http://scholar.sun.ac.za/handle/10019.1/4195

Digitized by Sam Jonah Library

Nungari, G. M. (2014). *Factors influencing male participation in antenatal care in Kenya: a case of Kenyatta National Hospital, Nairobi, Kenya* (Master's thesis, University of Nairobi). Available at http://erepository.uonbi.ac.ke/handle/11295/74173

Nyasani, J. M. (1997). *The African psyche*. Nairobi: University of Nairobi and theological Printing Press Ltd.

Ogah, J. K. (2013). *Decision making in the research process: Companion to students and beginning researchers*. Accra: Adwinsa Publications Ltd.

Okoror, T. A., BeLue, R., Zungu, N., Adam, A. M., & Airhihenbuwa, C. O. (2014). HIV positive women's perceptions of stigma in health care settings in Western Cape, South Africa. *Health Care for Women International, 35*(1), 27-49.

Olayemi, O., Bello, F. A., Aimakhu, C. O., Obajimi, G. O., & Adekunle, A. O. (2009). Male participation in pregnancy and delivery in Nigeria: a survey of antenatal attendees. *Journal of Biosocial Science*, *41*(4), 493-503.

Olmos-Vega, F. M., Stalmeijer, R. E., Varpio, L., & Kahlke, R. (2023). A practical guide to reflexivity in qualitative research: AMEE Guide No. 149. *Medical teacher*, *45*(3), 241-251.

Ongeso, A., & Okoth, B. (2018). Factors influencing male involvement in antenatal care among clients attending antenatal clinic: a case of Kenyatta National Hospital, Kenya. *International Journal of Advanced Research, 6*(5), 72-82.

Digitized by Sam Jonah Library

Ongolly, F. K., & Bukachi, S. A. (2019). Barriers to men's involvement in antenatal and postnatal care in Butula, western Kenya. *African Journal of Primary Health Care & Family Medicine, 11*(1), 1-7.

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

Påfs, J., Musafili, A., Binder-Finnema, P., Klingberg-Allvin, M., Rulisa, S., & Essén, B. (2015). 'They would never receive you without a husband': paradoxical barriers to antenatal care scale-up in Rwanda. *Midwifery, 31*(12), 1149-1156.

Patton, M. Q. (2002.). *Qualitative research and evaluation methods*. Thousand Oaks, CA: Sage Publications.

Petros, G., Airhihenbuwa, C. O., Simbayi, L., Ramlagan, S., & Brown, B. (2006). HIV/AIDS and 'othering'in South Africa: The blame goes on. *Culture, Health & Sexuality*, *8*(1), 67-77.

Rahman, M., Islam, M. T., Mostofa, M. G., & Reza, M. S. (2015). Men's role in women's antenatal health status: evidence from rural Rajshahi, Bangladesh. *Asia Pacific Journal of Public Health*, *27*(2), 1182-1192.

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

Sham-Una, U. (2016). *Factors influencing male participation in antenatal care in the Kumasi Metropolis, Ghana* (Doctoral dissertation). Available at http://dspace.knust.edu.gh/handle/123456789/8781

Digitized by Sam Jonah Library

Sharma, S., & Khatri, A. (2018). Factors influencing male participation in reproductive health: A qualitative study. *Journal of Multidisciplinary Healthcare, 11*(1), 601-608.

Singh, D., Lample, M., & Earnest, J. (2014). The involvement of men in maternal health care: cross-sectional, pilot case studies from Maligita and Kibibi, Uganda. *Reproductive Health, 11*(1), 1-8.

Singleton, R. A., Straits, B. C. & Straits, M. M. (1998). *Approaches to social research* (2nd Ed.). New York: Oxford University Press.

Smedley, B. D., & Syme, S. L. (2000). Public health and safety in context: Lessons from community-level theory on social capital. In *Promoting health: Intervention strategies from social and behavioral research*. National Academies Press (US). https://www.ncbi.nlm.nih.gov/books/NBK222839/pdf/Bookshelf_NBK222839.pdf

Smith, J. A. (2013). *Interpretative phenomenological analysis. Qualitative psychology: A practical guide to research methods*. London: Sage Publications.

Sofolahan, Y. A., & Airhihenbuwa, C. O. (2013). Cultural expectations and reproductive desires: experiences of South African women living with HIV/AIDS (WLHA). *Health Care for Women International*, *34*(3-4), 263-280.

Sofolahan, Y., Airhihenbuwa, C., Makofane, D., & Mashaba, E. (2011). "I Have Lost Sexual Interest…" – Challenges of Balancing Personal and Professional Lives among Nurses Caring for People Living with HIV and AIDS in Limpopo, South Africa. *International Quarterly of Community Health Education*, *31*(2), 155-169.

Digitized by Sam Jonah Library

Sofolahan-Oladeinde, Y., & Airhihenbuwa, C. O. (2014). “He Doesn’t Love Me Less. He Loves Me More”: Perceptions of Women Living With HIV/AIDS of Partner Support in Childbearing Decision-Making. *Health Care for Women International, 35*(7-9), 937-953.

Stuckler, D., Feigl, A. B., Basu, S., & McKee, M. (2010). *The political economy of universal health coverage. Background paper for the global symposium on health systems research* (Vol. 2010). Geneva: World Health Organization.

Swanson, R. A., & Chermack, T. J. (2013). *Theory building in applied disciplines*. Oakland, CA: Berrett-Koehler Publishers.

Tweheyo, R., Konde-Lule, J., Tumwesigye, N. M., & Sekandi, J. N. (2010). Male partner attendance of skilled antenatal care in peri-urban Gulu district, Northern Uganda. *BMC Pregnancy and Childbirth, 10*(1), 1-9.

Umar, A. S., & Bawa, S. B. (2015). Antenatal care services utilization in Yobe State, Nigeria: Examining predictors and barriers. *International Journal of MCH and AIDS, 4*(1), 35.

Vermeulen, E., Miltenburg, A. S., Barras, J., Maselle, N., Van Elteren, M., & Van Roosmalen, J. (2016). Opportunities for male involvement during pregnancy in Magu district, rural Tanzania. *BMC Pregnancy and Childbirth, 16*(1), 1-9.

Vogel, J. P., Habib, N. A., Souza, J. P., Gülmezoglu, A. M., Dowswell, T., Carroli, G., ... & Oladapo, O. T. (2013). Antenatal care packages with reduced visits and perinatal mortality: A secondary analysis of the WHO Antenatal Care Trial. *Reproductive Health, 10*(1), 1-7.

Digitized by Sam Jonah Library

Vygotsky, L. S. (1978). *Mind in society: The development of higher psychological processes*. Cambridge, MA: Harvard University Press.

Wai, K. M., Shibanuma, A., Oo, N. N., Fillman, T. J., Saw, Y. M., & Jimba, M. (2015). Are husbands involving in their spouses' utilization of maternal care services? A cross-sectional study in Yangon, Myanmar. *PloS one, 10*(12), e0144135.

Wassie, L., Bekele, A., Ismael, A., Tariku, N., Heran, A., Getnet, M., ... & Seifu, H. (2014). Magnitude and factors that affect males' involvement in deciding partners' place of delivery in Tiyo District of Oromia Region, Ethiopia. *Ethiopian Journal of Health Development, 28*, 6-13.

Williams, M. S., & Amoateng, P. (2012). Knowledge and beliefs about cervical cancer screening among men in Kumasi, Ghana. *Ghana Medical Journal*, *46*(3), 147-151.

World Health Organisation. (2016). *Recommendations of antenatal care services.* Geneva: World Health Organisation. Available at https://www.who.int/publications/i/item/9789241549912

World Health Organisation. (2019). *Maternal mortality fact sheet*. Geneva: World Health Organisation. Available at http://www.who.int/mediacentre/factsheets/fs348/en/index.html.

Yargawa, J., & Leonardi-Bee, J. (2015). Male involvement and maternal health outcomes: systematic review and meta-analysis. *Journal of Epidemiology and Community Health, 69*(6), 604-612.

Digitized by Sam Jonah Library

Yazdkhasti, M., Pourreza, A., Pirak, A., & Fatemeh, A. B. (2015). Unintended pregnancy and its adverse social and economic consequences on health system: a narrative review article. *Iranian Journal of Public Health*, *44*(1), 12-21.

Yende, N., Van Rie, A., West, N. S., Bassett, J., & Schwartz, S. R. (2017). Acceptability and preferences among men and women for male involvement in antenatal care. *Journal of Pregnancy, 2017*. https://doi.org/10.1155/2017/4758017

Digitized by Sam Jonah Library

University of Cape Coast https://ir.ucc.edu.gh/xmlui

APPENDIX A: INTERVIEW GUIDE

UNIVERSITY OF CAPE COAST

COLLEGE OF EDUCATION STUDIES

FACULTY OF SCIENCE AND TECHNOLOGY EDUCATION

DEPARTMENT OF HEALTH, PHYSICAL EDUCATION AND RECREATION

TOPIC: SOCIO-CULTURAL FACTORS INFLUENCING MALE INVOLVEMENT IN ANTENATAL CARE SERVICES

Date…………………………………………………………………………………

Village……………………………………………… District……………………

Name of moderator……………………………………………………………

Language of discussion………………………………………………………

Start time…………………………… End time………………………

SECTION A: PERCEPTION OF MALE PARTNER INVOLVEMENT IN ANTENATAL CARE SERVICES

1. How do you understand antenatal care services?
2. Why do you see this antenatal care as beneficial?
3. Why did you accompany your partner to the clinic?
4. What informed your decision to get involved in antenatal care activities with your wife or partner?
5. As a husband or partner, do you think antenatal care has any benefits for your woman, why?
6. How does your wife or partner respond to your involvement in antenatal care activities?

Digitized by Sam Jonah Library

7. How do you feel about these reactions?
8. What do you consider if any, as motivating factors to you being involved in antenatal care services?
9. What are your thoughts about men involving themselves in antenatal care services?
10. What are your roles or the roles of men during pregnancy and childbirth care?

SECTION B: SOCIO-CULTURAL FACTORS INFLUENCING MALE PARTNER INVOLVEMENT IN ANTENATAL CARE

11. How does your community see men assisting their pregnant women?
12. Are there cultural taboos preventing men from accompanying their partners?

    Probe: which cultural taboos prevent men from accompanying their partners to antenatal care services?
13. How has your beliefs influenced your decisions concerning women's health behaviour?
14. Are there cultural obstacles to male involvement during pregnancy care?

    Probe for social, financial, policy and facility related factors and attitude of healthcare providers.
15. In what ways do you to think these obstacles could be overcome?
16. How do you see your partner or wife when making decisions about her reproductive health?

Digitized by Sam Jonah Library

University of Cape Coast https://ir.ucc.edu.gh/xmlui

SECTION C: HEALTH FACILITY FACTORS INFLUENCING MALE PARTNER INVOLVEMENT IN ANC

17. How do you see the physical environment at antenatal care clinics?
18. Does the physical environment encourage you to accompany your partner to antenatal care?
19. How do you see the social environment when you accompany your wife or partner to antenatal care?

SECTION D: DEMOGRAPHIC OR PERSONAL FACTORS WHICH INFLUENCE MALE PARTNER INVOLVEMENT IN ANC

20. Tell me about yourself, and why here personally to decide to involve yourself in antenatal care services?
21. What sort of strategies do you often employ in escorting your wife or partner to antenatal care and childbirth care services?
22. As a husband or partner, have you experienced any benefits of your decision to accompany your wife/partner for antenatal care services?
23. Tell me any challenges you have encountered socially and culturally as a husband or partner in the course of accompanying your wife or partner to antenatal care services. (How do you see these and feel? Tell me more about that).
24. Tell me the kind of strategic or steps you often take to deal with these challenges? (How useful has any of these strategies been, in dealing with the challenges? Tell me more about that).
25. Are there any comments on the subject you will like to add?

THANK YOU VERY MUCH

Digitized by Sam Jonah Library

APPENDIX B: INTRODUCTORY LETTER

UNIVERSITY OF CAPE COAST
COLLEGE OF EDUCATION STUDIES
FACULTY OF SCIENCE AND TECHNOLOGY EDUCATION
DEPARTMENT OF HEALTH, PHYSICAL EDUCATION & RECREATION

TELEPHONE: +233 - (0)206610931 / (0)543021384 / (0)268392819

TELEX: 2552, UCC, GH.

Our Ref: **ET/MHE/18/0010**

EMAIL: **hper@ucc.edu.gh**

Cables & Telegrams:
UNIVERSITY, CAPE COAST

18th May, 2020.

The Chairman
Institutional Review Board
University of Cape Coast
Cape Coast

INTRODUCTORY LETTER: SCHOLASTICA AWOTSITSI-YABOTSI (ET/MHE/18/0010)

The above named person is a student of the Department of Health, Physical Education and Recreation of the University of Cape Coast. She is pursuing a Master of Philosophy degree in Health Education. In partial fulfilment of the requirements for the programme, she is conducting a research for her thesis titled **"Hear Them: Socio-Cultural Factors Influencing Male Involvement in Antenatal Care Services."**

She has defended her thesis proposal and has passed. I therefore kindly request that she is granted ethical clearance to enable her conduct the research.

Counting on your usual co-operation.

Thank you.

Dr. Daniel Apaak
(HEAD)

Digitized by Sam Jonah Library

APPENDIX C: APPLICATION FOR ETHICAL CLEARANCE

University of Cape Coast
College of Educational Studies
Faculty of Science and Technology Education
Department of Health, Physical Education and Recreation
6th April, 2020

The Chairperson
Institutional Review Board (IRB)
University of Cape Coast

Thro':
The Head
Department of Health, Physical Education and Recreation
University of Cape Coast

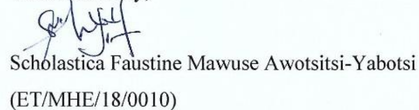
Dear Sir/Madam,

APPLICATION TO FILL RIB FORM FOR ETHICAL CLEARANCE TO CONDUCT RESEARCH

I would be very glad if you could grantme, the permission to fill the ethical clearance form to enable me conduct my research work.I have successfully defended my proposalon the topic: **Socio-cultural Factors Influencing Male Involvement in Antenatal Care Services in the Ho Municipalityin the Volta Region, Ghana.**

I hope my request would be given the needed attention.
Thank you very much.

Yours faithfully,



Scholastica Faustine Mawuse Awotsitsi-Yabotsi
(ET/MHE/18/0010)

Digitized by Sam Jonah Library

University of Cape Coast https://ir.ucc.edu.gh/xmlui

APPENDIX D: ETHICAL CLEARANCE

UNIVERSITY OF CAPE COAST

INSTITUTIONAL REVIEW BOARD SECRETARIAT

TEL: 0558093143 / 0508878309/ 0244207814
E-MAIL: irb@ucc.edu.gh
C/O Directorate of Research, Innovation and Consultancy

OUR REF: UCC/IRB/A/2016/779
YOUR REF:
OMB NO: 0990-0279
IORG #: IORG0009096

5TH AUGUST, 2020

Scholastica Faustine Mawuse Awostsitsi-Yabotsi
Department of Health, Physical Education and Recreation
University of Cape Coast

Dear Awostsitsi-Yabotsi,

ETHICAL CLEARANCE – ID (UCCIRB/CES/2020/53)

The University of Cape Coast Institutional Review Board (UCCIRB) has granted **Provisional Approval** for the implementation of your research protocol **Hear them: Socio-Cultural Factors Influencing Male Involvement in Antenatal Care Services in the Ho Municipality.** This approval is valid from 5th August, 2020 to 4th August, 2021. You may apply for a renewal subject to submission of all the required documents that will be prescribed by the UCCIRB.

Please note that any modification to the project must be submitted to the UCCIRB for review and approval before its implementation. You are required to submit periodic review of the protocol to the Board and a final full review to the UCCIRB on completion of the research. The UCCIRB may observe or cause to be observed procedures and records of the research during and after implementation.

You are also required to report all serious adverse events related to this study to the UCCIRB within seven days verbally and fourteen days in writing.

Always quote the protocol identification number in all future correspondence with us in relation to this protocol.

Yours faithfully,

Samuel Asiedu Owusu, PhD
UCCIRB Administrator

ADMINISTRATOR
INSTITUTIONAL REVIEW BOARD
UNIVERSITY OF CAPE COAST

Digitized by Sam Jonah Library

APPENDIX E: INTRODUCTION FOR DATA COLLECTION

In case of the reply the number and the date
of this letter should be quoted

My Ref. No. GHS/HMHD/HASS/61
Your Ref. No....................

Municipal Health Directorate
GHANA HEALTH SERVICE
P.O. BOX 118,
HO, V/R.
Tel. (03620-26919)

hmhd.ho@gmail.com

Our **Ghs Core Values**

- **PEOPLE-CENTRED**
- **PROFESSIONALISM**
- **TEAM WORK**
- **INNOVATION/EXCELLENCE**
- **DISCIPLINE**
- **INTEGRITY**

AUGUST 19, 2020

INTRODUCTION FOR DATA COLLECTION
REV. SR. SCHOLASTICCA F. M. AWOTSITSI-YABOTSI

This is to introduce to you the above mentioned student of University of Cape Coast who is in the municipality to collect data on her research protocol **Hear them: Socio-Culture Factors Influencing Male Involvement in Antenatal Care Services in the Ho Municipality.**

She has been granted Ethical Clearance to carry out this exercise by the institution.

Kindly provide her with the necessary assistance in this regard.

I count on your usual cooperation.

Attached is her Ethical Clearance for your perusal

Thank you.

MS. VICTORIA KPELLY
AG. MUN. DIR. OF HEALTH SERVICES
HO

Distrubution:

- **The Medical Superintendent, Ho Municipal Hospital - Ho**
- **The Medical Superintendent, Royal Hospital - Ho**
- **The Medical Superintendent, Ho Polyclinic - Ho**
- **The Administrator, Mater Ecclesiae Hospital - Sokode-Gbogame**

Digitized by Sam Jonah Library