

Assessment of Factors that affect male partner involvement in emergency obstetric care in Fortportal Regional referral hospital

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ABSTRACT

Male partner involvement has been recognized as a key factor in improving maternal health and reducing maternal mortality in settings where men play key roles in decision making in the household. Male partner involvement is one of the strategies that can be used to accelerate the decline in maternal mortality and improve maternal health. The objective of this study was to determine the level of male partner involvement in emergency obstetric care and/or came from home in labour and identify factors that influenced their involvement. A cross-sectional survey using interviewer-administered structured questionnaire was conducted among 150 women aged 18 years. Male involvement was measured using a composite measure of 5 key points. Pearson Chi-Square was used to test association between the various factors and the level of male involvement and logistic regression analysis was carried out to determine the influence of these factors on the level of male involvement. The mean age of participants was 32.9 years (SD=8.2). Overall, 26.4% had high level of involvement, 55.2% had moderate level of involvement and 18.4% had low level of involvement. The period with the highest proportion of high male involvement was during labour and delivery. Younger age (18-25years vs. 26-35years: OR=0.28, 95%CI: 0.12, 0.66) and the couple living with other family members negatively impacted on the level of male involvement. On the other hand, higher level of education (Tertiary: OR=40.57, 95%CI- 3.16, 520.32; Senior Secondary: OR=7.73, 95% CI- 1.61, 37.15) and the couple living together (OR= 13.12, 95%CI 6.86, 25.08) had a positive influence on the level of male involvement. Healthcare institution barriers to male partner involvement included poor staff attitudes, restrictions on male access to labour and delivery rooms and unwelcoming health facility environment. Male involvement in emergency obstetric care and/or came from home in labour was not optimal. Improving male-friendliness of health facilities in terms of infrastructure, organization of services and staff attitudes and education of the community especially men to sensitize them against the negative attitudes towards male participation in maternity care can improve male involvement. The Hospital Management Team in collaboration with the community leaders should organize educational campaigns within the communities to educate community members especially the men, on the importance and benefits of male involvement in maternal health care. Such campaigns can also address negative sociocultural norms and attitudes. The hospital should restructure the maternal health clinics to make them more male friendly. Adequate space and privacy must be provided. Given the sociocultural diversity in the country, more research should be encouraged in this important area to enable the design of culturally appropriate and sensitive male friendly services throughout the country.

Keywords: Maternal mortality, male partner, emergency, obstetric care and Fortportal Hospital

INTRODUCTION

Male involvement in maternal health care has been described as a process of social and behavioral change that is needed for men to play more responsible roles in maternal health care with the purpose of ensuring women's and children's wellbeing

[1]. The concept of male involvement in maternal health is now being advocated as an essential element of World Health Organization(WHO) initiative for making pregnancy safer [2].The impetus for the initiative was as a result of the 1994

International Conference on Population and Development (ICPD) held in Cairo, Egypt, which urges that special efforts should be made to emphasize men's shared responsibility and promote their active involvement in responsible parenthood, sexual and reproductive behavior including family planning; prenatal, maternal and child health; prevention of sexually transmitted diseases, including HIV; prevention of unwanted and high-risk pregnancies; shared control and contribution of family income, children's education, health and nutrition; recognition and promotion of the equal value of children of both sexes [3][4-8].

In Uganda, male attendance in MCH is a fairly new research field. The available estimates depict a low attendance (3.4%) but are based on health facility information systems that monitor male attendance in the prevention of mother to child transmission (PMTCT) programs [4]. In the study that investigated male involvement in birth preparedness and complication readiness for emergency obstetric referrals in rural Uganda [5], found that men who were knowledgeable of ANC services, obtained health information from a health worker and whose spouses utilized skilled delivery at last pregnancy were more likely

to accompany their spouses at ANC, unlike those who wanted to have more child remand lived more than 5 km from the health facility. Perceived benefits of attending ANC were: HIV screening, monitoring foetal growth, and identifying complications during pregnancy.

In [6], found that educated men were more likely to accompany their spouse to antenatal clinics and also identified the main barriers for male involvement in the PMTCT of HIV programme in eastern Uganda. The barriers included health system, socio economic, and cultural factors. The fact that men were not catered for in the clinic setup, the rudeness of service providers, poverty and delivery being seen as women's affairs were hindering factors. A similar study in Tanzania found that male partners lack of knowledge of complications associated with delivery, cultural beliefs, high fees charged for deliveries at health facilities, and "uncooperative" health workers were major contributing factors to low male partner involvement in child birth activities [7] [9-11]. This study aimed to assess factors that influence male partner involvement in emergency obstetric care in Fort portal regional referral hospital.

METHODOLOGY

Research Design

A facility based descriptive cross-sectional study design was used and was quantitative in nature.

Study setting

The study was conducted, at Fort portal regional referral hospital (FRRH) in western Uganda, Kabarole district. It's the regional referral hospital for districts of Kabarole, Bundibugyo, Kamwenge, Kasese, Ntoroko, and Kyenjojo. According to the 2014 census data, the hospital serves the population of 469,236 people. The hospital has a bed capacity of about 300 beds. FRRH offers both general and specialized services and is a teaching hospital.

Study Population

The study populations included men 18 years and above whose wives were in labor at Fortportal regional referral hospital during time of study.

Sample Size Calculation

The sample size required for the study was calculated based on the formula by Kish to estimate a single population proportions [8].

$$N = \frac{Z^2 p(1-p)}{\delta^2}$$

Where;

N = estimated sample size

P = anticipated male involvement in maternal health care. [9] found it at 10%. So, P = 0.1

Z = standard normal variation ant 95% confidence (1.96)

δ = margin of error (5%)

The calculated sample size was,

$$\frac{1.96^2 \times 0.1(1-0.1)}{0.05^2} = 138.$$

Plus 10% non-response rate, total was 150.

Inclusion Criteria

The study included women who came from home in labor or those who had emergency obstetric condition.

Exclusion Criteria

A woman whose labor started from the hospital and those who did not have emergency obstetric condition.

Sampling Technique

The researcher used consecutive enrolment sampling where the respondents meeting the inclusion criteria were interviewed in order in which they were identified until the total sample size was reached.

Data Collection techniques

The researcher used different approaches of data collection that were guided by specific objectives. Interview guided questionnaire were used. Those who meet the criteria and consented for the study were interviewed face to face by the researcher.

Data analysis

Completed questionnaires was checked for completeness then entered in

The mean age of the participants was 32.9 (SD: 8.2) with a range of 18 - 57years. The average number of children per participant was 2.4 (SD: 1.2) with a range of 1 - 9. Majority (107) of the participants

Microsoft Excel 2016. Was cleaned for errors and exported to Statistical Package for Social Scientists (SPSS) version 21.0 for analysis.

Ethical Issues

The researcher sought a letter of introduction from the faculty dean that introduce her to the hospital administrator. Permission to collect data was sought from the hospital director of Fortportal regional referral hospital.

Confidentiality was assured to all respondents before they were interviewed. The respondents were only included in the study after understanding the purpose of the study and consented to take part. The study was voluntary, and the respondents deserved the right to withdraw at any time of wish.

RESULTS

representing 71.3% were married, more than half of the respondents (90) representing 60% had primary level of education, 80 (53.3%) were not employed, while 123 (82%) were Christians.

Table 1: A Table representing the age of respondents.

AGE(YEARS)	FREQUENCY	PERCENTAGE (%)
18 - 25	86	57.3
26 - 35	29	19.2
36 - 40	8	5.3
>40	27	18.2

Majority of Participants were in the age range of 18-25-year group with the highest proportion (54.7%) of low male involvement. The lowest proportion (5.3%) was among the 36-40-year group. The odds

of having a high level of involvement among the younger age group (18-25) were 0.28 times that of the 26-35-year group. (OR =0.28, 95% CI: 0.12, 0.66).

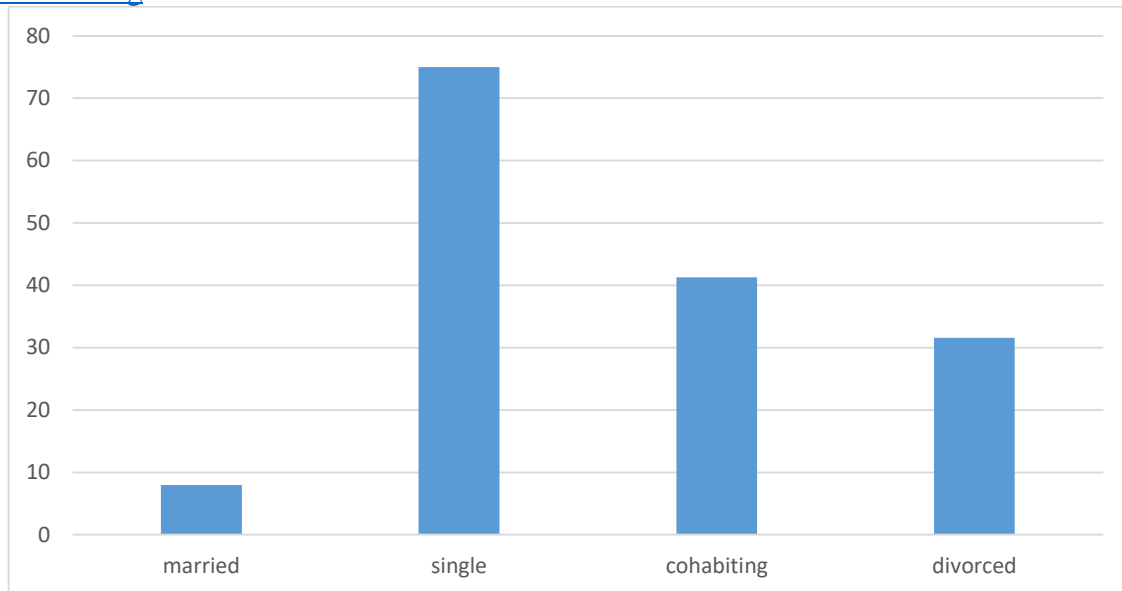


Figure 2: A bar graph showing the marital status of the respondents.

Participants who were single had the highest proportion (75%) of men with low involvement; followed by those who were cohabiting (41.3%) and those who were separated/divorced (31.6%).

Those who were married had the lowest proportion of participants with low male involvement (8.0%) and the highest level of male involvement (34.1%).

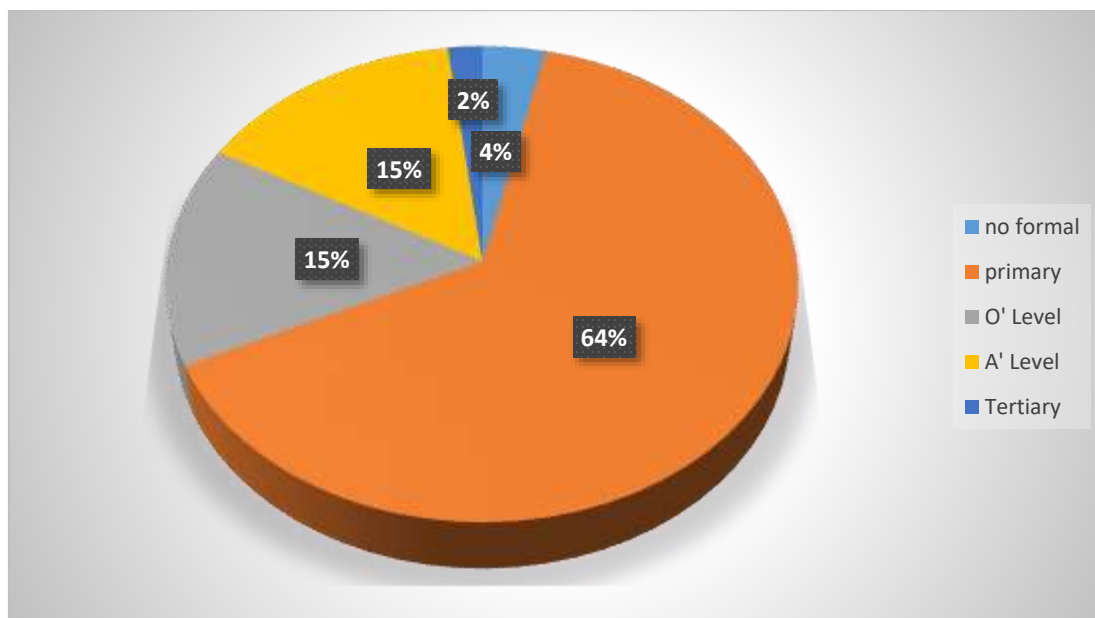


Figure 3: A pie chart showing the education level of the respondents.

Those with primary education had the highest proportion of low male involvement (64%) and those who had completed tertiary level education had the lowest proportion of low male involvement

(2%). Those who had completed Junior or senior secondary school showed similar proportions of low male involvement (15% and 15% respectively). The proportion with high level of involvement was highest

(54.4%) among those who had completed tertiary education. The odds of having high level of involvement were 40.57, 7.73 and 6.62 times that of no formal education for tertiary, and secondary education

respectively. (Tertiary - 95% CI: 3.16, 520.32; Senior secondary - 95% CI: 1.61, 37.15; Junior secondary - 95% CI: 1.35, 32.41).

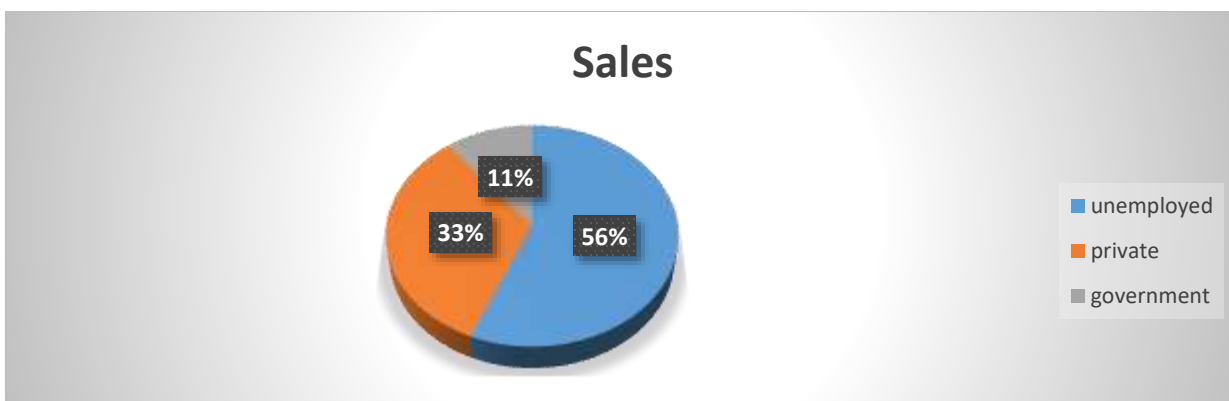


Figure 4: A pie chart showing the occupation level of the respondents.

Those who were unemployed had the highest proportion (56.3%) of low male involvement. Both employed and the self-employed had similar proportions of low level of male involvement, 13.0% and 15.6% respectively. But the civil servants had a

slightly higher proportion of high male involvement (35.2%) compared with the self-employed (22.9%). Men in the focus group discussion gave a link between employment and income and the extent of involvement:

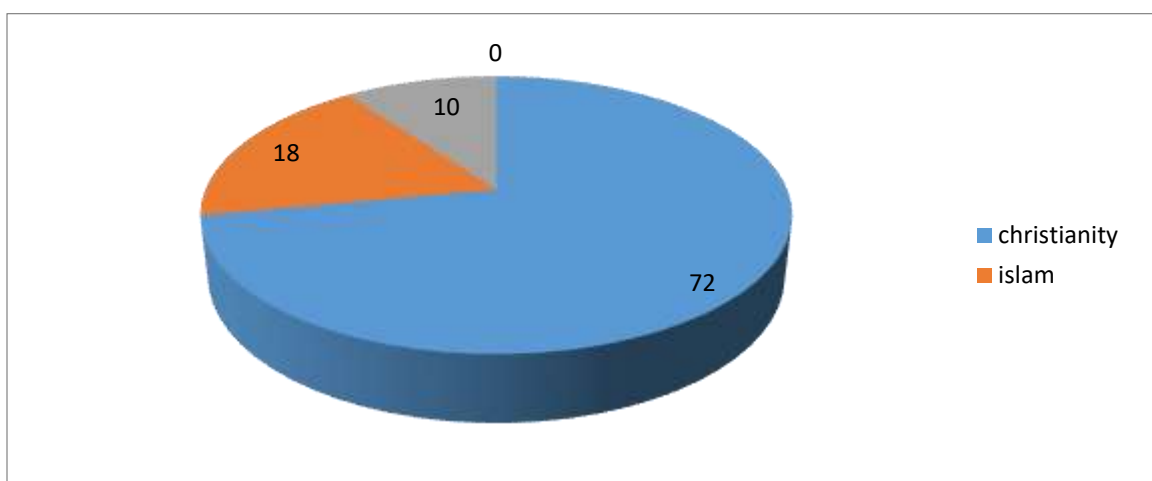


Figure 5: a pie chart representing religion of respondents.

Majority of the respondent whose men were involved were Christians (82%) followed by Islam who had 18% and those with other

religion (10%) with least percentage of male involvement.

Table 2: Table representing respondents' number of children.

NUMBER OF CHILDREN	FREQUENCY	PERCENTAGE (%)
1	18	12
2-3	104	69.3
4+	28	18.7

Majority of the respondents whose men were involved included those with children 2 to 3 with the highest percentage (69.3%)

and the least were those with one child (12%).

Table 3: Proportion of participants who performed each of the four key activities used in the measurement of male involvement in Obstetric care (N=150)

ACTIVITY	Participation	
	Yes (%)	No (%)
The man accompanies partner to health facility during ANC	59 (39.3%)	91(60.7%)
The man discusses maternal issues with partner	129 (86%)	21 (14%)
The man discusses maternal issues with a health care provider during labor	55 (36.7%)	95 (63.3%)
The man provides financial and physical support	150 (100%)	0(0%)
The man is involved in planning for emergency, delivery and postpartum care	115 (76.7%)	35(23.3%)

The level of male involvement in Emergency obstetric care was as follows: 55 (36.7%) had high level of involvement; 84

(56.0%) had moderate level of involvement and 11 (7.3%) had low level of involvement as shown in figure 1.

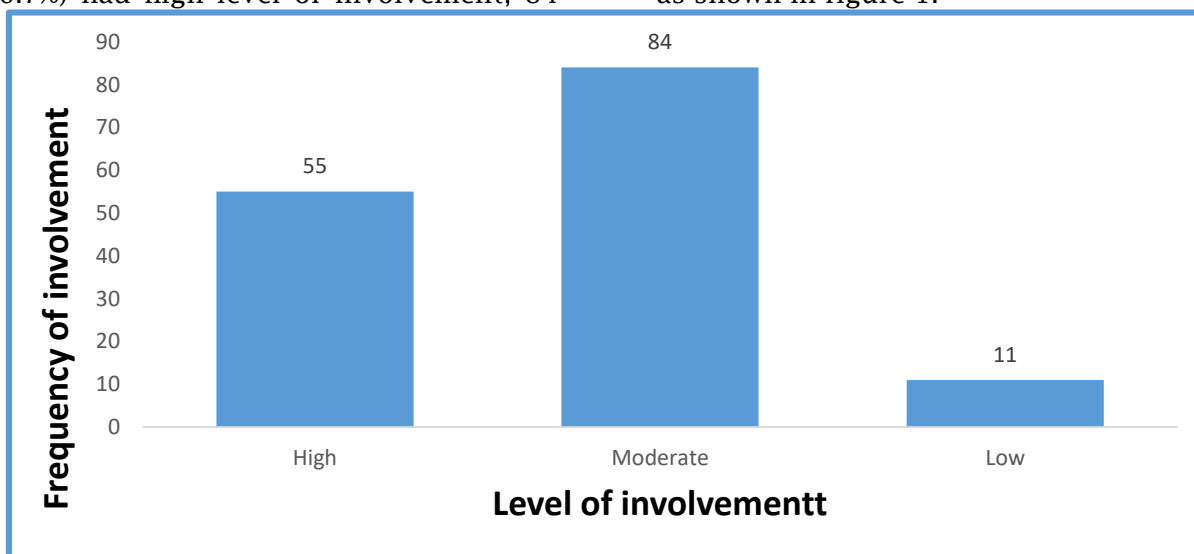


Figure 6: Level of involvement in emergency obstetric care (N=150)

A significant association was found between the level of male involvement and age, marital status, educational level

completed occupation, religion and the number of children.

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

Variable	Male involvement			Chi- Square	P-Value	
	Low	Moderate	High			
Age (years)	18 - 25	54.7%	40.0%	5.3%	90.36	<0.0001
	26 - 35	13.8%	58.6%	27.6%		
	36 - 40	5.3%	60.0%	34.7%		
	Above 40	6.0%	56.7%	37.3%		
Marital status	Married	8.0%	57.9%	34.1%	102.84	<0.0001
	Separated/divorced	31.6%	55.2%	13.2%		
	Cohabiting	41.3%	54.0%	4.7%		
Education level	Single	75.0%	20.0%	5.0%	49.32	<0.0001
	Below primary	57.1%	42.9%	0.0%		
	Primary	25.0%	67.9%	7.1%		
	Secondary	18.6%	55.4%	26.0%		
occupation	Tertiary	1.8%	43.9%	54.4%	47.40	<0.0001
	Employed	13.0%	51.9%	35.2%		
	Self-employed	15.6%	61.5%	22.9%		
Religion	Unemployed	55.0%	35.0%	10.0%	16.42	0.012
	Christianity	17.1%	53.4%	29.5%		
Number Of children	Islam	18.8%	65.2%	15.9%	54.43	<0.0001
	1	40.2%	47.7%	12.1%		
	2-3	11.0%	56.4%	32.6%		
	4+	9.1%	77.3%	13.6%		

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

Those who were unemployed had the highest proportion (55.0%) of low male involvement. Both employed and the self-employed had similar proportions of low level of male involvement, 13.0% and 15.6% respectively. But the civil servants had a slightly higher proportion of high male involvement (35.2%) compared with the self-employed (22.9%). Men in the focus group discussion gave a link between employment and income and the extent of involvement:

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

Those with 2 to 3 children had the highest proportion (32.6%) of high-level involvement. Those having their first child and those who had 4 or more children had 12.1% and 13.6% of high-level involvement respectively.

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

Socio-demographic Characteristics	Odds Ratio	P-value	95% Confidence Interval
Age			
18 - 25years	0.28	0.00	0.12-0.66
36 - 40years	2.39	0.18	0.66-8.62
Above 40years	1.96	0.35	0.48-7.98
26 - 35years*	1.00		
Marital status			
Married	2.73	0.06	0.97-7.67
Single	0.34	0.18	0.07-1.65
Cohabiting	0.76	0.65	0.24-2.45
Separated/Divorced*	1.00		
Educational level completed			
Primary	2.82	0.24	0.50-15.77
Secondary	7.73	0.01	1.61-37.15
Tertiary	40.57	0.00	3.16-520.32
No formal education*	1.00		
Occupation			
Unemployed	0.66	0.44	0.22-1.92
Self-employed	2.06	0.09	0.90-4.70
Civil/Public servant*	1.00		
Religion			
Christianity	15.17	0.00	2.55-90.21
Islam	17.34	0.00	2.48-121.45
Number of children			
1 Child	0.87	0.74	0.39-1.95
4 or more Children	0.82	0.86	0.10-6.49
2 - 3 Children*	1.00		

*Reference category

From the pregnancy period through the labour and delivery to the postnatal period, the proportion of men who lived together with their partners decreased from 348 (82.9%) through 308 (73.3%) to 235 (56.0%). In all the three aspects of maternity care, there was significant association between the couple living together and the level of male involvement ($P < 0.001$). During the antenatal period, 44.4% of men who did not live with their partners had low male involvement while only 5.6% had high

level of involvement. This was similar to those who did not live with their partners during the postnatal period, 47.0% of them had low level of male involvement while only 6.5% had high level of involvement. For those who lived with their partners during the labour and delivery time, only 2.6% had low level of involvement but 47.7% had high level of involvement. During antenatal care, living together increased the likelihood of high male involvement (OR=13.12, 95% CI: 6.86, 25.08). During

labour and delivery and the postnatal care, not living together reduced the likelihood of having high male involvement (labour and delivery- OR= 0.10, 95%CI: 0.04, 0.24; postnatal care- OR=0.13, 95% CI: 0.08, 0.22) Having other family members living with the couple had a significant association with the level of male involvement (P=0.037). Not living with other family members increased the likelihood of high male involvement (OR=2.37, 95% CI: 1.20, 4.67). The specific family member who lived with the couple however did not have any significant association with the level of male involvement (P=0.164).

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

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

Men being involved in the decision making on where their partners had antenatal care also had a significant association with the level of involvement (P<0.0001). Those who were involved in the decision making on where their partners had antenatal care had only a proportion of 1.8% having low level of male involvement. For those who were not involved in the decision making, 33.3%

had low level of male involvement. The odds of having high level of male involvement when the man was involved in the decision making on where the partner had antenatal care was 27.40 times that of cases where the men were not involved (OR=27.4, 95%CI: 10.58, 70.94).

A man's level of involvement was also significantly associated with his desire to be present with his partner in the labour and delivery room (P=0.006) and who he thinks must be present in the labour and delivery room with the laboring woman (P < 0.0001). The proportion of those who desired to be present who had high level of involvement was 40.5% compared with 25.0% of those who did not wish to be present. Those who thought the husband was the person who should be present in the labour and delivery room had the lowest proportion of low male involvement (1.5%) and the highest proportion of high male involvement (53.7%). They were also the ones who desired most to be present at the labour ward (85.3%). When a man felt that other family members should be present in the labour ward and not him, he was less likely to have a high level of involvement (the woman's mother- OR= 0.09, 95% CI: 0.03, 0.33; the man's mother- OR=0.10, 95% CI: 0.03, 0.39). Table 5 shows the sociocultural factors influencing male involvement in emergency obstetric care.

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

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

The likelihood of a man accompanying the partner more than once was significantly associated with his assessment of staff attitude and the time spent at the health facility per visit (P=0.001). Of those who found the staff to be unfriendly, 98.1% accompanied their partners once and 1.9% accompanied them 2 or more times. More than half (54.8%) of those who found the staff to be friendly accompanied their partners two or more times. Of those who assessed the time spent at the health facility to be too long, 93.3% accompanied their partners once and 6.3% did so two or more times. Over half (52.6%) of those who assessed the times to be reasonable accompanied their partners two or more times. Eighty-Three per cent (83%) of those who accompanied their spouses more than

once were those who found the time spent at the facility to be reasonable. The odds of accompanying the partner not more than once when the staff attitude is assessed to be friendly is 0.027 times the odds when it is assessed to be unfriendly. (OR= 0.027, 95% CI: 0.003, 0.224). The odds of accompanying the partner not more than once when the time spent at the facility per visit is assessed to reasonable is 0.13 times the odds when it is assessed to be too long. (OR= 0.126, 95% CI: 0.032, 0.500). Table 6 shows the health facility factors associated with the frequency with which the men visited the health facilities with their partners. Members of both the male and female focus group discussions had a lot to say about the health facilities:

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

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

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

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

On multivariate logistic regression, the factors that remained significantly associated with the level of male

involvement in maternity care were as shown in Table 8.

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

VARIABLE	Adjusted Odds			
	Ratio	[95% Conf.	Interval]	P-value
Age				
18-25yrs	0.92	0.38	2.23	0.851
36-40yrs	2.71	1.08	6.81	0.034
41 and above	3.71	1.28	10.79	0.016
26-35yrs	1.00			
Marital status				
Married	0.12	0.03	0.45	0.001
Single	0.14	0.02	1.05	0.055
Cohabiting	0.12	0.03	0.48	0.003
Separated/Divorced	1.00			
Educational level				
Primary	3.04	0.50	18.67	0.23
Junior Secondary	12.69	2.28	70.72	0.004
Senior Secondary	7.93	1.44	43.86	0.018
Tertiary	52.31	5.47	500.41	0.001
No formal education	1.00			
Occupation				
Unemployed	0.77	0.25	2.41	0.652
Self employed	1.28	0.63	2.60	0.488
Civil/Public Servant	1.00			
Number of children				
2-3 children	1.67	0.78	3.60	0.187
4 or more children	0.83	0.16	4.47	0.833
1 child	1.00			
Living together				
Couple living together	9.18	3.38	24.89	0.000
Couple not living together	1.00			
Planned or unplanned pregnancy				
Planned pregnancy	2.27	1.11	4.61	0.024
Unplanned pregnancy	1.00			
Involvement in decision on place of antenatal care				
Involved	4.76	2.57	8.82	0.000
Not involved	1.00			

DISCUSSION

The study found majority of the men being moderately involved in the emergency obstetric care of their partners with about 1 in 4 (26.4%) being highly involved and 1 in 5 having low level of involvement. The

proportion of high-level involvement was similar to findings in a study by [10] in Mozambique, who found 26.0% of the participants to have a high male involvement. This difference in results

could be attributed to difference in study setting.

The presence of support persons is known to greatly affect women's satisfaction with maternity care and enhances better birth outcome. [11] in their study on the assessment of the effect of psycho-social support during childbirth in multi-Centre study in upcountry areas of Uganda, found that women who did not have company during labour and delivery were five times more likely to deliver by caesarean section, had longer duration of the active phase of labour and higher pain scores. Male partners formed the highest proportion of companions in their study [12-18]

In cases where there is need for referral in emergency situations, the availability of the male partner will greatly facilitate such transfers. This is because in our local setting, relatives are sometimes called upon to help in the arrangement of transport and other logistics in emergency situations. [5] affirm a similar situation in their study in Uganda and found delays occurring during referrals to include unavailability of transport, failure to meet transport cost and the absence of someone to accompany the referred patient. Male partners being present can reduce these delays. The role of the promptness with which these things are done in reducing maternal morbidity and mortality cannot be overemphasized [19-22] [5]

The proportion of participants having discussions on their partner's maternal health issues with their health providers was also found to be low in this study. This was to be expected given the low proportion who accompanied their partners to the health facilities. Such discussions are crucial in equipping the male partners to offer appropriate, adequate and effective support to their female partners. The other key points of male involvement, that is, offering support and planning for emergencies will not be effective if the men do not have the right information. When men lack knowledge on maternal health issues, it limits what they can do. [12] in a study in Mulago hospital, Uganda, had some men expressing their frustration about not knowing what actions to take because of their low knowledge of maternal issues.

All the men provided physical and financial support in one form or the other. Most of them indicated financial support which is similar to findings by [13] who found 97% of the men providing financial support to their spouses to attend ANC in Tanzania. In a study in Rakai, 64.7% of the participants indicated that financial support was all that was required of the man [9] [23-25].

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

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

The younger age group (18-25years) were found to be less likely to be highly involved. These younger ones are more likely to be unmarried, students or employed and the pregnancies are more likely to be unplanned. This may account for their low level of involvement. [14] in Busia study did not find any significant association between age and male involvement.

Those who were formally married are more likely to be involved in their partner/s maternity care. Such men feel a sense of responsibility towards their partners and so provide support and show more interest in what goes on in their pregnancy. [1] found the men who were formally married to be more likely to attend antenatal clinic with their partners compared with those who were not formally married.

In this study, higher levels of education were found to be associated with higher levels of male involvement in maternity care. [5] found similar association. [14] also found a significant association between level of education and the level of involvement. This association may be mediated by their high income-earning potential. They may therefore be able to patronize private health facilities where men are more welcome to participate in their partner's maternity care [26-28][14]

They may also have better access to information concerning pregnancy outside the health facility, for example via the internet. Education may also enable them to discard negative cultural norms and attitudes.

Employment also seems to be associated with the level of involvement. The unemployed were less likely to be involved in their partner's maternity care. One would have expected that the unemployed will have more time on their hands to accompany their partners and to help with household chores among others. The underlining cause for this finding may be the lack of funds. Some men in the focus-group discussion lamented how sometimes, financial difficulties served as a deterrent to accompanying their partners for fear of being embarrassed by their inability to pay fees and other expenses. [14] in a study in Busia, Kenya, found fees charged at the health facilities to be one contributing factor to low male involvement in childbirth activities.

The socio-cultural practice which had a significant effect on the level of male involvement was the practice of pregnant women moving in with either their own

The level of male involvement in emergency obstetric care in this study was not optimal. A man's involvement was influenced by varied factors which may relate to the man (socio-demographic factors), the community (sociocultural factors) and the

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mothers or partner's mother especially around the labour, delivery and postpartum period. When the women move in with these older women who are presumed to be more experienced in pregnancy issues, the men relinquish some of their responsibilities to them. [15], in her study in Sub Saharan Africa, found that although men are more likely to advise their pregnant partners to see healthcare providers when there are problems, these older relatives are more likely to tell them what to do. This may lead to poor maternal and birth outcomes if such pieces of advice are not the right ones. [16] found similar roles played by mothers or mothers-in-law who took pride in their ability to accomplish feats without medical intervention. Occasionally, such relocation implied a change from a higher-level health facility to a low-level health facility without comprehensive emergency obstetric care which may in itself contribute to poor maternal birth outcome [29-31] [16].

In [17], it was found major shifts in hospital policy as an important first step in introducing couple-friendly maternity services.

CONCLUSION

health facility and health care providers. There is need for concerted effort from all these stakeholders if success will be achieved in improving male involvement in maternity care.

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