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The "Pregnant Man"; A Strategy Towards Husbands' Contribution To Maternal And Child Health Risk Reduction In Rural Ghana

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Abstract

This study aims at ensuring that husbands take active role in assisting their pregnant wives obtain maximum support to reduce maternal, neonatal and child health risk in Ghana. A community based cross-sectional study was conducted among households targeting husbands with wives who had at least one child of less than one year of age or pregnant at the time of the study. A sample size of 398 respondents was determined using single population proportion formula using a probability-based simple random sampling (lottery) method and asystematic random sampling technique in line with NCPH (2011)formula. The study revealed that men in Ghana are less likely than women to engage in MCH services across the pregnancy period, resulting in poorer prenatal care outcomes and dissatisfaction from the women.Health care facilities have achieved limited spousal attendance at ANC and immediate post-natal care and treatment coverage with barriers including confidentiality concerns, distance to the facility, inconvenient hours, and perceptions that facilities provide women-centered services. Other barriers to male engagement include peer negativity against the practice, poverty, and feelings of compromised masculinity associated with seeking health care with wife during pregnancy.Community-based education and husband to husband peer education interventions (particularly home and mobile) have high acceptability and reach more men than health care facility-based approaches for effective and efficient men involvement in MCH services. Community-based interventions should be tailored to the needs of men to maximize uptake, including flexible hours, multiple follow-up visits, and convenient and private access to

care. In conclusion, based on the findings of this study, more research is needed on male-centered approaches to increase men's engagement in MCH services, particularly earlier in wife's pregnancy.The current state of evidence strongly suggests that community-based educate-and-sanction strategies can reduce the gender disparity in MCH services and attendance by husbands by achieving higher levels of spousal engagement in and support of wives during both ANC and PNC services.

***Key words**: pregnant man, active, role, husbands, maternal and child health, risk reduction*

Introduction

The *pregnant man*! Is a concept developed by the authors to explore the strategic options available to propel husbands play key roles in maternal and child health risk reduction in rural communities of the Upper East region of Ghana. It is also an opportunity to drum home the idea that when one's wife is pregnant, the man is also pregnant. This is an idea to push men to support their pregnant wives to seek maternal care progressively to reduce risk and enhance safe delivery at the health facilities.

Husbands participation and active involvement in the pregnancy related activities of their wives may be described as the various ways in which husbands can relate to the reproductive health challenges and activities including reproductive rights and reproductive behaviour of their wives and women in general that are adopted scientifically to ensure renewed health and safe delivery of healthy babies by all pregnant women. The considered attention placed on maternal health outcomes dates back to the Millennium Goals development period as the 5th Millennium Goal, which ended in 2015. In 2010, the MOH/GHS and development partners developed an MDG5 Acceleration Framework (MAF). The MAF showed that additional investment focusing on skilled attendance at birth, emergency obstetric care and family planning would accelerate Ghana's move towards achieving MDG5 and also contribute significantly to the attainment of MDG 4 target (MOH, 2014). This move by the MOH/GHS partners was in the right direction, but lacked clarity as to approach needed to tackle the issue head long. The Cairo International Conference on Population Development in 1994 was among the first international declarations advocated for the active inclusion and shared responsibility of men in reproductive programmes (United Nations Department of Public Information, 1995). Men impact women's reproductive health through their role as partners, fathers and healthcare workers(Singh, Lample & Earnest, 2014).However, men involvement in gendered issues relating to pregnancy and child birth has been highly

problematic in many parts of the world (Lewis, et al., 2015, Mullany, 2006, Dolan & Coe, 2011). According to Lewis et al (2015), men get frustrated in their involvement in maternal health issues due to their inadequate knowledge regarding complications and danger signs during pregnancy and delivery. In the traditional milieu, the involvement of husbands in their wives' pregnancy and delivery journey is frowned upon. Theman is often seen to be an aggressive and oppressive person who finds it unusual to mingle in areas regarded as highly sensitive and provocative (Mumtaz & Salway, 2009; Lewis et al, 2015).

The loss of a love one or a long awaited child at birth can be extremely unbearable. In some traditional areas in Ghana, notably the Talensis in the Upper East region of Ghana view the circumstances surrounding a stillbirth, neonatal and maternal death in eschatological perspective, the belief that the anger of the gods has been vehemently visited on the family, the pain of which can be stressful to recount. Often times the husband is at cross roads and is tempted to seek consultation with the gods at the soothsayer to investigate the cause of death and appease the gods to avoid future occurrences (Azongo, Wombeogo & Yakong, 2015). Husbands' role in the health and safe delivery of pregnant wives cannot be underestimated by any standard. Yet, the process of propelling husbands in particular to contribute to the reduction of risk of morbidity and mortality of their wives has been handled nonchalantly, with no sense of urgency in it, highlighting missed opportunities in maternal and child health care, to say the least. The World Health Organisation (2016) describes the global efforts being made to reduce maternal and newborn deaths as "a far cry from reality". Despite a plethora of projects and initiatives to halt preventable maternal and newborn deaths, the problem still persists. The persistence is largely due to the inadequate and inappropriate inclusion and participation of husbands, who by law in many parts of Ghana, particularly the northern sector of Ghana, the statutory legal owners of wives and children. It is not just enough to invite husbands to hand out meetings and shows. The practical ways by which they can concretely contribute to make sure their wives are in good health and deliver healthy babies, must be pursued locally and nationally to ensure maternal and child health risk reduction.

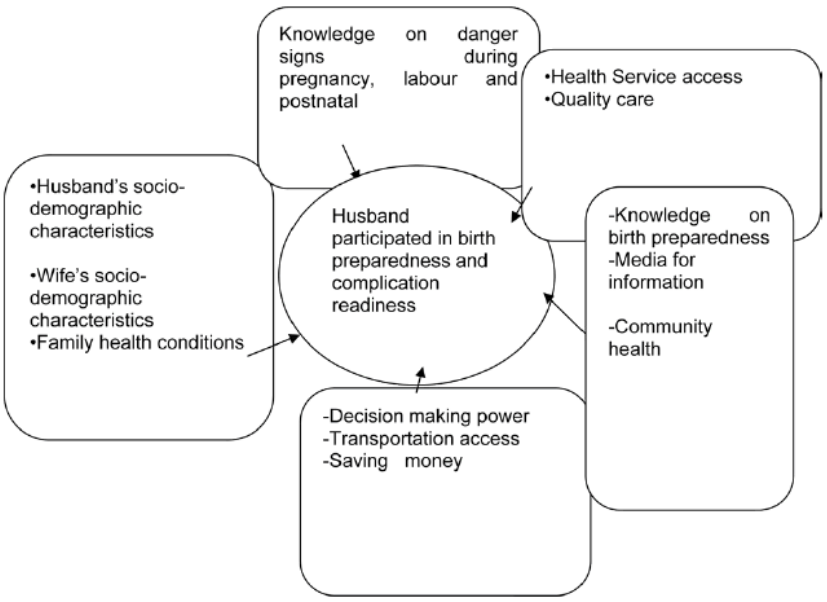
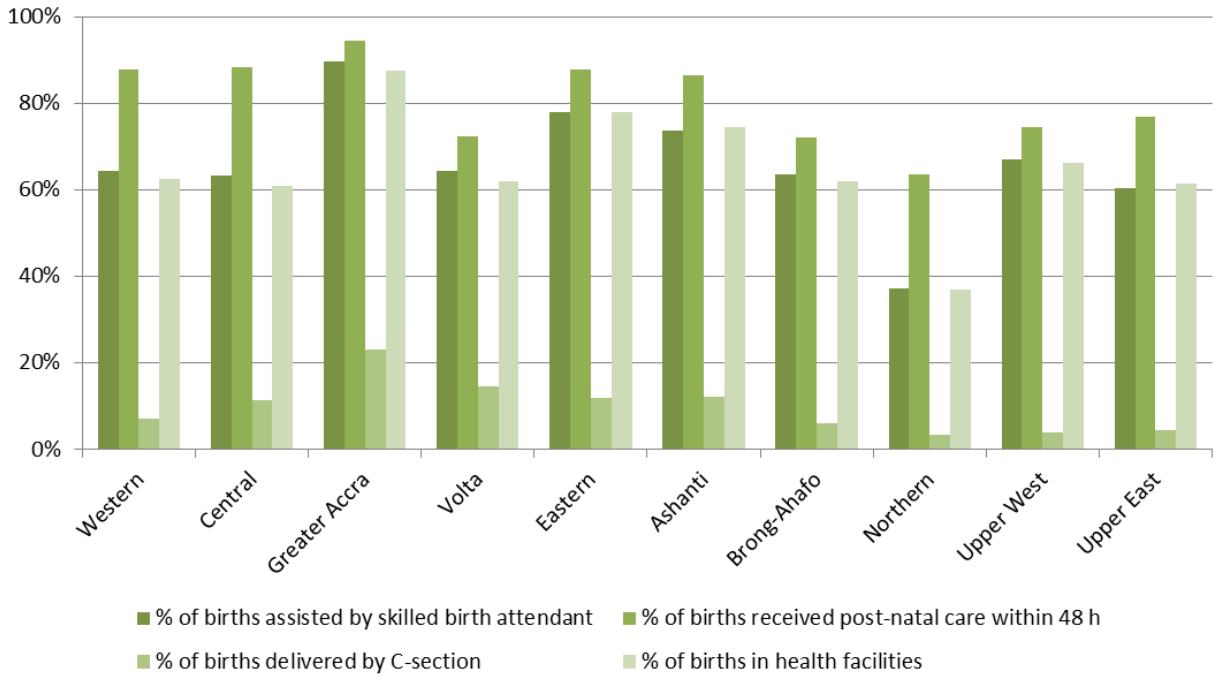


Figure 1: Conceptual frame on birth preparedness and complication readiness among husbands. (Adapted from JHPIEGO tools and indicators in Maternal & Neonatal Health, 2004).

The face of maternal mortality figures in Ghana continues to highlight the significant level of maternal and child health risk pervading in Ghana. Despite significant gains made in reducing maternal and child mortality in Ghana before the end of the MDGs in 2015, the rate of progress was not sufficient to achieve any of the health related Millennium Development Goals (MDGs). For instance, with respect to child health, under-5 mortality rate improved from 122 per 1,000 live births in 1990 to 60 per 1,000 live births in 2014 but this was inadequate compared to the MDG target of 40 per 1,000 live births (Ministry of Health, 2014). Similarly, infant mortality declined from 57 to 41 per 1,000 live births between 1994 and 2014 but was short of the target of 22 deaths per 1,000 live births (UNPC & UNDP, 2015; Ministry of Health, 2014). Also, neonatal mortality declined from 49 to 29 per 1,000 live births over the same period; but equally fell short of the target of 16 deaths per 1,000 live births (Minsitry of Health, 2014). In respect of maternal health, the situation is no different. The rate of reduction in institutional maternal mortality ratio from 216 per 100,000 live births in 1990 to 144 per 100,000 live births in 2014 was not enough to meet the global target of 54 per 100,000 live births in 2015 (UNPC & UNDP, 2015). Between 2013 and 2014 institutional maternalmortality rates were 143.8/100,000 live births in 2014 as compared to 153/100,000 live births in 2013 in Ghana. The maternal mortality figures of 319/100,000 live births in 2015 shows

that Ghana is not doing much progress (UNDP Information, 2016). A cursory look at the intervention coverage on MNCH risk reduction in Ghana as shown below speaks volumes of the task ahead.

Fig. 2 intervention coverage across continuum of care by geographical areas in Ghana



Source: Multiple indicator cluster survey (MICS, 2011)

The Ghana Health Service, for instance, the MICS (2011) has shown that significant percentage was clogged at Upper East region to increase maternal and child survival, yet since 2012 up to date, the region has been recording significant maternal deaths (Upper East Regional Health 2016 Annual report, 2017).

Studies (Yargawa & Leonardi-Bee, 2014)have shown statistical significant beneficial impacts of male active involvement on maternal health through reduced odds of maternal depression, improved utilisation of maternal health services (relating to skill birth attendance (SBA)

and postnatal care) and decreased likelihood of childbirth complications.

The research problem

The involvement of husbands in maternal and child health in Ghana has been a key healthcare nugget up till now. The Ghana Health Services (2014) and healthcare stakeholders have done extensive promotion for pregnant women to imbibe MCH care messages such as early attendance to ANC and PNC services at the health facility, skilled deliveries and proper and good nutrition for both mother and child. However, the husbands of these pregnant women have not featured much in any of such MCH care messages apart from encouraging the women to lobby their husbands for financial and related support. Literature (Ghana Health Service, 2014; Yargawa & Leonardi-Bee, 2014) has discovered that men's involvement in the affairs relating to active involvement at MCH services rendered to their wives and the benefits there of, have not really been a structured activity of healthcare providers and health promoters in Ghana.

Despite the efforts of the Ghana Health Service by adopting several pragmatic ways to enhance maternal health and reduce risk of mortality, this has not received nationwide coverage. For instance, the MICS (2011) has shown that significant percentage was clogged at Upper East region to increase maternal and child survival, yet since 2012 up to date, the region has been recording significant maternal deaths (Upper East Regional Health 2016 Annual review report, 2017). Theimport of this is that there is high urgency to explore alternate newer ways or enhance ways previously not thought of as important to ensure that maternal health risk is reduced significantly in the Upper East region in particular and Ghana in general.

Husbands in rural Ghana are the chief decision-makers, determining their wives' access to maternal health services and influencing their health outcomes. Therefore there is need to collectively determine the various strategic options that will propel and encourage husbands to play significant roles to ensure that maternal and child health risk reduction in rural Ghana becomes a reality. Hence, this study seeks to find ways and means at addressing this obvious, yet silent opportunity towards reduction of maternal and child health risk in Ghana.

Objectives

Goal: To ensure that husbands take active role in assisting their pregnant wives obtain maximum support to reduce maternal, neonatal and child health risk in Ghana

Specific objectives

1. To determine the difference in husbands contribution to MNCH risk reduction and husbands who do not
2. To find out the barriers militating against husbands' contribution to MNCH risk reduction in the Upper East region
3. To describe the various activities and actions husbands adopt to contribute to MNCH risk reduction in Upper East region
4. To find out the relation of husbands' contribution to wives' pregnancy, child birth and child health risk reduction in the Upper East region

Methods

Study area and period

The study was conducted from April 2016 to March 2017 in selected communities in the Upper East region of Ghana. According to the 2010 population census report, the Upper East region has 1,046,545 people, with 506,405 males and 540,140 being females. The region consists of 13 political districts which have at least a hospital either, private, quasi-governmental or governmental and several health centres and CHPS compounds. All of health facilities are providing maternal and child healthcare. Out of the 13 districts in the region, 5 of them have interventions in at least 2 and at most 3 communities, under the auspices of PARDA, an NGO based in the Upper East region. Ten communities in four districts participated in this study.

Study design and population

The term 'husbands contribution' is subjective and manifold. The basic criterion used for identifying husbands in this study was men being in marital unions with women according to (legal, religious or traditional)prescriptions of marriage. However, being a husband does not necessarily translate into the fact that every husband contributes to MNCH risk reduction. Hence three broad categories were considered as indicating husbands contribution:

- Active participation in maternal health services and care (husband's attendance of antenatal care (ANC); husband's presence at delivery room; and husband's support/help to wife during pregnancy, delivery or at post-partum) and how these activities contribute to risk reduction;
- Financial support given for pregnancy-related and childbirth-related expenses to ensure active utilisation of related health services to ensure survival;
- Shared decision-making powers on maternal health issues with wife.

A community based cross-sectional study was conducted among households targeting husbands with wives who had at least one child of less than one year of age or pregnant at the time of the study.

Excluded were potential respondents who accompanied or supported their pregnant girlfriends or children born out of wedlock adolescent pregnancies. In the traditional understanding of marriage, such categories of spouses have no socially acceptable standard to be husband and wife.

Those husbands equally excluded from the study were; all husbands who were not staying together with their wives during pregnancy and birth of the child and those who were critically ill.

Sample size and sampling technique

The sample of 398 husbands was determined using single population proportion formula with 95% level of confidence, 5% margin of error and 21% of husbands estimated to have participated in birth preparedness (United Nations Population Fund, 2004). Since population size was 3526, which is less than 10,000, sample size was adjusted using correction formula, 1.5 design effects and 10% non-response rate. From a total 5 operational districts in the Upper East region, 4 of them were selected by a probability-based simple random sampling (lottery) method. For each selected district, the sample size was allocated proportionally according to number of health facilities participating in MNCH interventions by PARDA. The sampling frame was formed by conducting a census to register all households of husbands with wives having less than one year of age child or still pregnant.

Finally husbands were selected by systematic random sampling technique in which the sampling interval was determined for each household and starting point was selected randomly using the NCPH (2011)formula :

$i = N/n$; where i is the interval number, from which every *ith* house on a section of the community, startingfrom x, where x is some randomly chosen number by rolling a dice. The sampling interval, i, is then calculated by dividing the total number of husbands (N) who fell within the inclusion criteria in the "community" by the sample size needed (n). To determine the starting point to pick the desired sample, the researcher used the dice selector technique. A dice is thrown to get the starting point and if it rolls a 9, then counting starts at the 9th house from the entrance at the right hand side first. Every *ith* house was then surveyed. To avoid bias, the researchers set some rules before starting the survey to maintain consistency in their sampling strategy. The "Survey target first only

houses on the right side of the community section and then turning to the left hand side and not the other way round or any other way".

Data collection and analysis

Both qualitative and quantitative methods were used in the data gathering process. The qualitative data process was in line with THOMPSON & BARRETT (1997, p.60) suggestive approach to qualitative data analysis, known as Summary Oral Reflective Analysis (SORA), which main aim is to retain the context of qualitative data, as this "facilitates actually 'hearing' what the data have to say rather than splicing them into arbitrary units before searching for topics, themes or meanings". The import of this approach in this research is to accentuate the impressions and emotions of the respondents as felt and observed for interpretation and inferences.

Structured questionnaire was prepared in English and administered by indigenes of the selected communities to selected husbands who fell within the inclusion criteria. The questionnaires were checked for completeness, coded and entered into SPSS version 21 software package for cleaning and analysis. Mean and standard deviation determined for continuous variables, and categorical variables were summarized by frequency distributions and percentage. Crude & adjusted odds ratio were used to control the possible confounding variables.

Ethical considerations

The study protocol was reviewed and approved by Health Research Ethics Review Committee of the University for Development Studies School of Allied Health Sciences. Verbal permission to undertake the study was obtained from the district health directorate and the midwives of selected health centres, the Assembly men and women and chiefs of selected communities. In addition, verbal consent was equally obtained from the study participants and data collection was done confidentially.

Results

Demographic information

S/N	Gender	Number	Frequency (%)
1.	Male	194	50
2.	Female	194	50
	Total	**398**	**100**

Table 1 Number according to gender

A total of 398 persons were interviewed comprising 50% males and 50% females hereby referred to as husbands and wives either pregnant or nursing children below 1 year of age during the period of study.

S/N	District/communities	Gender of persons selected	Number	Frequency (%) of gender total
1.	Talensi	Male	60	15.08
		Female	60	15.08
		Sub-Total	**120**	**30.16**
2.	Bolgatanga Municipality	Male	52	13.06
		Female	52	13.06
		Sub-Total	**104**	**26.12**
3.	Nabdam	Male	39	9.80
		Female	39	9.80
		Sub-Total	**78**	**19.60**
4.	Navrongo East Municipality	Male	48	12.06
		Female	48	12.06
		Sub-Total	**96**	**24.12**
		GRAND TOTAL	**398**	**100.00**

Table 2 Number according to district and community

Variables	*Frequency*	*Percentage (%)*
HUSBANDS		
Age in years		
18-29	84	43.30

Variables	*Frequency*	*Percentage (%)*
HUSBANDS		
30-39	65	33.51
40-49	30	15.46
≥50	15	7.73
Ethnicity (Both)		
Talensi	120	30.16
Frafra	104	26.12
Nabdam	78	19.06
Kasena	96	24.12
Religion (both)		
Christian	100	25.12
Muslim	35	8.80
Traditional	263	66.08
Husband's education		

Variables	*Frequency*	*Percentage (%)*
HUSBANDS		
Illiterate	140	72.16
Read and write	30	15.46
Formal education	24	12.37
Husband's occupation		
Farmer	130	67.01
Employed	42	21.65
Self-business	22	11.34
Monthly income in Ghana Cedis		
<100	110	56.70
100-500	65	33.50
>500	19	9.80
WIFE		
Age in years		
<20	120	61.85

Variables	*Frequency*	*Percentage (%)*
HUSBANDS		
20-34	54	27.84
35-49	20	10.31
Wife's education		
Illiterate	132	68.04
Read and write	52	26.80
Formal education	10	5.16
Wife's occupation		
Farmer	110	56.70
Employed	11	5.67
Self-business	73	37.63
Monthly income in Ghana Cedis		
<100	100	51.54
100-500	84	43.30
>500	10	5.16

Table 3 Socio-Demographic characteristics of respondents in Upper East region, Ghana, May, 2017 (N=398).

S/N	Variables	Frequency	Percentage (%)
	Husbands		
1.	Provide nutritious dietary foods (beans, meat, millet, maize, yam, sweet potatoes, tomatoes, etc.)	190	97.01
2.	Provide a platform for family discussions	100	51.54
3.	Accompany wife to hospital always	30	15.46
4.	Accompany wife to hospital or health facility sometimes	45	23.19
5.	Provide money to meet personal needs	38	19.58
6.	Prepare for the delivery of child by providing baby essential needs (warm clothing, diapers, baby powders and lotions, cords, etc.)	18	9.27
7.	Provide transportation for wife whenever she is to attend ANC/PNC	65	33.50
8.	Provide money for transport	47	24.22
9.	Make sure wife's opinion counts in all decision making	25	11.34
10.	Encourages wife to perform minimal exercises	15	7.73
11.	Reduces workload of wife in household chores	10	5.15
12.	Create peaceful environment to build confidence and love	85	43.81
13.	Direct wife to appropriate health facility for skilled delivery	68	35.05

14.	Make sure wife attends ANC within the first 2 months of pregnancy	35	18.04
	Wives		
15.	Provide nutritious dietary foods (beans, meat, millet, maize, yam, sweet potatoes, tomatoes, etc.)	85	43.81
16.	Provide a platform for family discussions	56	28.86
17.	Accompany wife to hospital always	18	9.27
18.	Accompany wife to hospital or health facility sometimes	25	11.34
19.	Provide money to meet personal needs	40	20.61
20.	Prepare for the delivery of child by providing baby essential needs (warm clothing, diapers, baby powders and lotions, cords, etc.)	10	5.15
21.	Provide transportation for wife whenever she is to attend ANC/PNC	55	28.35
22.	Provide money for transport	35	18.04
23.	Make sure wife's opinion counts in all decision making	15	7.73
24.	Encourages wife to perform minimal exercises	5	2.57
25.	Reduces workload of wife in household chores	8	4.12
26.	Create peaceful environment to build confidence and love	65	33.50
27.	Direct wife to appropriate health facility for skilled delivery	45	23.19

28.	Make sure wife attends ANC within the first 2 months of pregnancy	20	10.30

Table 4 Husbands' and wives' opinions on husbands contribution to MNCH risk reduction

Table 4 depicts an intersection of opinions and respondents could choose as many as was applicable. Thus, the frequency of choice was not regulated.

S/N	Variable	Frequency	Percentage (%)
1.	Do not know much about risk of pregnancy	38	9.54
2.	No enough time with wife	57	14.32
3.	Delays at health facility	55	13.81
4.	Attitude of health workers	46	11.56
5.	No enough money	30	7.54
6.	Wife is too troublesome	25	6.29
7.	Not a man's role to engage in women's reproductive issues	36	9.04
8.	Fear and intimidation from peers	32	8.04
9.	Not enough information and motivation to do so	15	3.77
10.	For traditional and cultural reasons	35	8.79
11.	Workload	13	3.26
12.	Family pressure	16	4.03
		398	**100.00**

Table 5 Barriers to husbands involvement in MCH risk reduction in the Upper East region (n=398)

Qualitative data

Interviewer: Do you accompany your wife to the health facility when she is pregnant?

Respondent 1: I don't do that unless she is too sick to go by herself. If she has to go for check up on the pregnancy, must I be there too?(Individual interviewee, 2017)

Respondent 2*: Yes, from time to time I accompany her to the clinic. I used to do that on regular bases when the NGO brought a programme to include us in their work with the pregnant women. It was very good. I enjoyed the talks and the dramas on how to support wives during pregnancy and the roles we men must play to make sure our wives deliver safely and our children also survive. They even asked us to make sure our pregnant wives attend the clinic for regular check-ups without fail. We are trying our best now. You know, this has never been part of a man's work to just accompany your wife to the clinic because she is pregnant.*

Interviewer: How often do you do that?

Respondent 1*: during her pregnancy I went with her once to the clinic*

Respondent 2*: I think it is up to 3 times. I would have been there more than that except that I was very busy at work.*

Interviewer: Why is it that husbands find it a task accompanying their wives to the health facility during pregnancy on regular bases?

Respondent 1*: You know we husbands are not women; this is a woman's job. Our work is to make sure that nothing bad happens to them throughout the pregnancy by working hard to get them food and consulting the gods to aid them and all the family members spiritually. This is important, so that if the child is born, it will not be attacked by witches and bad people (FGD at Namoaligo Community, 2017).*

Respondent 2*: Sir, if you often walk with your wife, people will think your wife has bewitched you and turned you to a small boy or a maid. Also, some of the women are so difficult that they want everything, especially if the midwife's says so. The demands are so much and we do not have enough resources to meet all of them. Life is tough, you know! We men must go to the farm and make sure we have food at home and at the same time we have to make sure that nothing bad happens to the woman and the unborn child. We cannot be doing all these and at the same time accompany the woman to the health facility always. However, we shall try and see how much time we can set aside to support them. It is not easy to carry a pregnancy to term. We must be grateful to our wives and mothers (FGD at Duusi Community, 2017).*

Interviewer: What are some of the difficulties or barriers militating against husbands when there is need for their wives to visit the health facility?

Respondent 1*: People may laugh at you; insult you and call you names like, (man-woman, a foolish man, or bewitched man by wife, etc.).; traditional taboos, cultural inappropriateness, work pressure, excessive demands from wives, the midwife's insistence on providing her needs by the husband, poor financial stand, etc. are critical barriers to husbands to be with their wives at the health facility.*

Interviewer: What can be done to increase husbands desire to support their pregnant wives for healthcare services?

Respondent 1: *A lot can be done in this matter. One way is for the chief to make an announcement and ask all husbands to accompany their pregnant wives to the clinic. Another way is to make some laws so that all those men who refuse can be punished. Also, you people can initiate some award to entice the men to come. Those who accompany their wives could be awarded. This will pull those who are not doing so to begin and eventually, the concept will become a norm with time.*

Respondent 2: I think if there is mass education on the importance and the benefits of men doing so that could help. After all, the man needs a healthy baby and safety of the wife.

Interviewer: Should it be made compulsory for men to see it as a key duty to support their wives at all times during and throughout pregnancy?

Respondent 1: *The Government can pass a law and compel all men whose wives are pregnant to comply or be punished. Also, the chiefs can do that and make sure all men with pregnant wives pay a fine if they fail to accompany them to the clinic or fail to meet their needs as directed by the midwife*

Respondent 2:*My brother, if it is made compulsory the better. As for us men, it will be difficult and perhaps almost unthinkable for men to do that voluntarily or see it as a core duty as the pregnant women do. If they are compelled, knowing that some punishment will follow on failure to do so, they will do it even quickly and that can help the women as well. Some of the men will go out on their motorbikes or bicycles leaving the pregnant woman to walk alone to the health facility. If it is compulsory, the men will have to carry their pregnant wives to the health facility on regular ANC attendance. This will help*

alleviate some difficulties the pregnant women face on daily bases

Interviewer: How often do you engage your wife in discussing about her pregnancy and what she needs before the birth of the child?

Respondent 1: *Hahahaa! This is a new teaching! How do I just be discussing with my wife about her pregnancy when she has not complained that she is sick or something is wrong with the pregnancy? It does not happen*

Respondent 2*: It is not a usual practice though, but I think it is a good thing to do. I have never done so, anyway, but it is not out of place. I shall give it a trial since it is not tabooed in our community to do so.*

Interviewer: Do usually discuss, plan and implement decisions together with your wife?

Respondent 1*: Yes, sometimes and not all decisions that we men discuss with women. Depending on what is to be discussed, we do so from time to time. When it comes to implementation, we men do that.*

Respondent 2*: Yes we do that often, discussing with our wives, especially when it has something do with the children. In any case the men provide everything that is planned and because of that some of us would go ahead and execute our plans without the women.*

Discussion

The findings revealed equal gender segregation (50% male & 50% female) of total respondents of 398. These respondents were sampled from four of five districts participating in the maternal and child project under PARDA in the Upper East region of Ghana. Though the gender divide had equal numbers, there was a variation in the ages of both male and female respondents. 43.3% of the males were aged between 18 and 29, as compared to 61.8% females of less than or equal to 20 years. These statistics signify that many more young people marry in their teens, which has a tendency for low school attendance and increase in population at a faster interval. It also may be a key reason why the findings revealed significant poverty levels among couples in the study areas as being one of the key hindrances to male active involvement in MNCH in solidarity with their pregnant wives. The findings show significantly low monthly income level variations for husbands. As indicated on table 3 showing the Socio-Demographic characteristics of respondents in Upper East region, only 9.8% of male respondents earned above GHC500.00 per month and majority of them (56.7%) monthly earnings fell below

GHC100.00. This finding signifies the levels of poverty among the husbands. The occupations of husbands as shown on table 3 above also indicate that majority (67%) of them, earned income from peasant farming. Thus, their inability to cater for all the needs of the family in terms of feeding and other extra and intra family expenses from the same farm produce.

The level of education of the respondents had a bearing on their acceptability of the messages on MNCH by health workers. The study statistics indicate a huge percentage illiterate rate across the gender divide among the respondents. 77.2% of husbands were illiterates and only 12.4% of the wives had formal education. Education has an influencing effect on the ability to appreciate health issues and practice them. Where the illiteracy rate is high as seen in this study, there could be a high possibility of non-compliance on MCH advice and men's reluctance to engage actively in MNCH activities towards maternal and child health risk reduction. This is also an indication that the study area has a youthful illiterate population which is likely to perpetuate the future if government does not whip up interest in the young parents to encourage their children to go to school.

Maternal health care is a key indicator for health intervention in Ghana.A skilled delivery care services during childbirth is the most critical intervention for improving maternal health. However, maternal mortality in Ghana remains high despite several efforts and interventions such as free maternal health care policy by the government of Ghana and development partners. A large number of women die annually due to pregnancy-related complications, which are considered to be preventable or at least reducible through supervised or skilled delivery services.

Many barriers(ignorance, poverty, spousal refusal and attitude of health workers, among other) prevent women from seeking medical care in general when needed. Understanding these factors is critical to improve the accessibility and utilization of medical care during pregnancy and childbirth. For instance, some male partners (33.7%) and female partners (43.8%) believed that participating together in antenatal care was important, especially in maintaining trust, peaceand planning together as couples. A few men (15.5%) and even fewer females (9.3%) reported regular participation of men in antenatal care (ANC) visits as a means of ensuring an overall health of the family. However, several obstacles hindered most men's ability to participate in ANC: respondents reported being unaware of ANC appointments many said they were "too busy" (18.09%) or financially constrained (7.5%) to attend. ANC operational hours also restricted how often working male

partners could accompany their wives (13.81%). A few male partners posited that men within their communities were also apprehensive about attending ANC clinics because of the perception that participating in ANC would force men into being victimizers of women caprices. Men's fear for being labeled as "victimizers" in situations of discordancy and described their fears of being abandoned by their female partners due to perceived infidelity. Amidst these fears and obstacles to ANC visit participation, many men chose to use their pregnant partner's behaviour as an excuse for their unwillingness or inability to maintain their MCH involvement status. In other instances, men said that they staunchly refused to accompany their wives to clinic, using Nabdam culture as a rationale for avoiding the 'effeminate' act of clinic attendance. Indeed, many echoed the notion that the ANC clinic was no place for a man and accompanying spouses was a sign of male weakness.

Men, generally, do not accompany their partners to family planning, antenatal or postnatal care services and would not be expected to attend the labour or birth of their child. Traditionally, couples and providers alike have considered family planning (FP), ANC attendance or just accompanying a pregnant woman to the health centre a woman's issue. Not only do women want their male partners to be more actively involved, but also men themselves are more interested (23.19 %) than previously believed in accompanying their wives to the health facility when the need arises.

The husbands' availability is another reported determinant that restricts husbands' involvement in maternal health and childbirth. This is particularly associated with labour issues. During a focus group discussion, some respondents contended that their husbands could not be with them at the health centres each time they had to attend ANC because of work on the farm or at the market. This statement confirms a verbalization by a male respondent who said

We men must go to the farm and make sure we have food at home and at the same time we have to make sure that nothing bad happens to the woman and the unborn child. We cannot be doing all these and at the same time accompany the woman to the health facility always. However, we shall try and see how much time we can set aside to support them. It is not easy to carry a pregnancy to term. We must be grateful to our wives and mothers (FGD at Duusi Community, 2017).

The men consider their labour issues and even the spiritual dimensions of life as supportive ways for their pregnant wives more important than being with them at

the health facility. In as much the husbands appreciate the physiological challenges involved in pregnancy, their understanding of risk reduction or avoidance is highly contingent on the intervention of the gods rather than man. This perception of consultation of the gods, as means of avoiding risk learns credence to literature (Azongo, Wombeogo & Yakong, 2015).

In addition, confidence and determination to deliver a healthy baby can form strong pillars for the expectant mother to endure the physiological challenges of pregnancy and labour. When pregnant women utilize obstetric education appropriately, they are able to go through the process smoothly there by reducing significantly some associated risk.

Persistentwives demands and continuous request for husband accompaniment to health facility are precursors to husbands' refusals to be involved in pregnant wife's clinic attendance issues. Besides, low family income as well as traditional and cultural developmental idiosyncrasies and high societal behaviour problems can be risk factors related to less positive husband – pregnant wife health facility attendance cordiality.

The study also found that mother's education and optimism were personal resources which served as protective factors to husband objective functioning in wife accompaniment to the health facility for pregnancy check-ups.

These finding suggests that education and high family income are important variables in reducing the burden of women loneliness at health facilities, dependency on husbands for support during pregnancy and maintenance of high level resilience.

Conclusions/recommendations

This study aimed at finding out the factors that influence husbands' involvement in maternal and child health risk reduction in the UER of Ghana. This was to illicit categorical information and facts that would enable policy-makers to have a clear understanding of husbands' role in MCH risk reduction and how stakeholders in health can commit more resources to advocate for appropriate changes to health service provision in order to prevent maternal and infant health risk and mortality in Ghana.

The study came out with the following recommendations:

The Ghana Health Service and various health stakeholders will develop a maternal and child health risk assessment and monitoring programme (MCHRAMP) to

build tentative data for planning and implementation of outcomes of maternal and child health risk reduction in Ghana.

Regional Health Directorate, District Assembly, NGOs and other development partners, stakeholders and policy-makers in health should, in a collaborative effort design strategies for health education, to intensify and promote husbands roles and responsibilities in minimizing MNCH risk in Ghana.

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