Global Scientific JOURNALS

GSJ: Volume 8, Issue 3, March 2020, Online: ISSN 2320-9186
www.globalscientificjournal.com

PERCEPTION OF UNIVERSITY OF IBADAN POSTGRADUATE STUDENTS ABOUT THE INFLUENCE OF MALE INVOLVEMENT IN PERINATAL CARE ON THE PROMOTION OF MATERNAL AND CHILD HEALTH

BY

BERTHRAN CONFIDENCE C.

MATRIC NO: 190972

DEPARTMENT OF NURSING,

COLLEGE OF MEDICINE,

UNIVERSITY OF IBADAN,

IBADAN, OYO STATE

IN PARTIAL FULFILMENT OF THE REQUIREMENT FOR BACHELOR

OF NURSING SCIENCE (BNSc)

CERTIFICATION

This is to certify that this project title, **"Perception of University of Ibadan Postgraduate Students about the Influence of Male Involvement in Perinatal Care on the Promotion of Maternal and Child Health"**was carried out by **BERTHRAN Confidence C. 190972**

---------- ----------

ODETOLA TITLAYO D. (RN, PhD, FWACN) Date/Signature

Supervisor

ABSTRACT

INTRODUCTION: Male involvement is associated with improved maternal health outcomes in developing countries, but studies have shown that its implementation is poor in Nigeria. Thus, the need to analyse various perceptions about male partner involvement in perinatal care.

METHODS: A descriptive study, using a cluster sampling technique to draw the sample for this study. Self-structured questionnaires were used in the collection of data from 240 postgraduates of the University of Ibadan

RESULTS: Results from this study portrayed male involvement as the involvement of male partners in joint decision making, provision of financial support, as well as having concern for his reproductive health. The respondents reported that effective male involvement in perinatal care would result in beneficial maternal and child health, as it reduces unhealthy maternal behaviour, provides emotional and financial support, and also ensure better maternal and child health outcomes. Perceived factors that could influence effective implementation of male involvement in perinatal careincluded long waiting time at the facility, behaviour and approach of the health workers, and the financial or employment status of the man. In this study, there was no significant relationship between gender and the level of knowledge about perinatal care (P-value = 0.890); the relationship between marital status and the perceived concept of male involvement was also not statistically significant (P-value = 0.272).

CONCLUSION: These findings suggests that the promotion of effective male involvement in perinatal care will require active involvement of the community members and stakeholders; training of health care providers on communication skills; involvement of the social media; development of supportive national policies; and the use of incentives and disincentives by hospital facilities.

Keywords: Male involvement, Perinatal care, Maternal health, Child health, Perception.

DEDICATION

I dedicate this work to God Almighty, to my parents, Late Pastor and Mrs. Obi Berthran C. and my lovely siblings.

ACKNOWLEDGEMENT

To God be the glory, honour, adoration for the successful completion of this work. My sincere appreciation goes to God for his mercy, love, and immeasurable kindness over my life.

To the Head of Department, Prof. Prisca O. Adejumo, who has indeed been a mother, I really appreciate you ma'am. God will continue to protect you and your family.

My sincere appreciation goes to Dr. Odetola Titilayo Dorothy, my ever supportive, smart and meticulous supervisor. She has been most wonderful. Thank you so much for your direction, correction and your motivation to complete this work. God almighty will bless you abundantly, ma'am.

A big thank you also to Mrs. Abiono for her supportive effort in the completion of this project. God bless you ma'am. And to all the lecturers in the department of nursing, university of Ibadan, I say a big thank you, for all your efforts in shaping me to becoming who I am both academically and socially.

To my parents of inestimable value Pastor and Mrs. Obi Berthran C., I really appreciate you for your love, care, encouragements and financial provision over my life and in my studies. God almighty will continue to prosper the works of your hands and preserve you.

Lastly, to my siblings, classmates and all the members of Deeper Life Campus Fellowship, Awo Mount Zion Centre, I say thank you all. Especially those who were of tremendous help to me during my data collection, God bless you richly.

TABLE OF CONTENT

CHAPTER THREE – RESEARCH METHODOLOGY

CHAPTER FOUR-RESULTS

LIST OF TABLES

Table: **Page No.:**

CHAPTER ONE: INTRODUCTION

1.1 BACKGROUND OF STUDY

Perinatal care, which involves the care of the mother and fetus before, during and after delivery; is an important aspect of care needed in promoting maternal and child health. The health of both the mother and the child is of national importance as they form a part of the vulnerable population. As part of the World Health Organization (WHO) initiative in ensuring health for all, primary health centres were developed with one of the aims being promotion of maternal and child health.

Male involvement, sometimes referred to as partner involvement is a global call to having the male partners participate in the care of their woman and child. According to United Nations report of the international Conference on population and development, cited in Kululanga, Chirwa, and Sundby (2012), male involvement in maternal health care has been described as a process of social and behavioural change that is needed for men to play more responsible roles in maternal health care with the purpose of ensuring women's and children's wellbeing.

According to Kiwanuka (2015), '… male involvement in reproductive and maternal health care has shown incredible impacts on the health outcomes of women and newborns.' Due to the decision making ability peculiar to the male gender in the family, it is therefore important to involve them in the health care matters of both the mother and the children. Studies have shown better health outcomes when the males are involved in perinatal care. Kiwanaka (2015), also added that 'male involvement in antenatal care (ANC) can reduce the risk of mother-to-child transmission of HIV and infant mortality by more than 40 percent.'

Over the years, measures to promote and encourage male involvement in perinatal care have been on going and the importance of involving men in reproductive, maternal and child health programs is increasingly recognized globally (Davis, Vyankandondera, Luchters, Simon, and Holmes 2016). Promotion of maternal and child health is of key relevance to reducing maternal and child mortality/morbidity, and ensuring positive health outcomes. Studies have shown that the involvement of males in the care of mothers from the antenatal to the postnatal period, have a great influence on the health of both the mother and the child. … Increasing male involvement in maternal health care-seeking are both viewed as important strategies to reduce preventable maternal morbidity and mortality (Jennings, Na, Cherewick, Hindin, Mullany, and Ahmed, 2014).

Male involvement in various health practices is recognized as an important factor in improving maternal and child health outcomes (Dumbaugh, Tawiah-Agyemang, Manu, Asbroek, Kirkwood, and Hill 2014). Despite the importance of male involvement to the reproductive health of the mother and positive wellbeing of the child, the practice of male involvement is still limited. While the benefits of male involvement have been acknowledged, there continues to be a challenge in creating a space for and engaging men in maternal health (Singh, Lample, and Earnest 2014).

Knowledge and perception of both male and female individuals about the involvement of male partner in perinatal care is vital so as to determine the current beliefs of this group of individuals, and to know the necessary steps to take to combat misbeliefs and encourage positive beliefs. In a study carried out by Onchong'a, Were, and Osero (2016), it showed that negative perception of male partners involved in reproductive health issues posed a challenge to male partner involvement. Onchong'a et al (2016) also cited a similar study carried out in Asembo Kenya, which stated that, some men view male involvement in delivery issues as less important compared to striving for the economic wellbeing of the family. Women on the other hand, perceiving childbirth as a women affair that does not require male partner involvement as seen in a study by Kululanga et al (2012), can be a contributing factor to low male partner involvement.

Positive perception about male involvement in perinatal care can be a contributing factor to promoting male involvement in pregnancy and improving maternal and child health outcomes. Positive view about male involvement was seen in the study by Kululanga et al (2012), as male partner involvement was viewed as an act of love and care. These have shown that the perceptions and views of individuals concerning male partner involvement have a part to play in its practices and at the long run, the health outcome of both mother and child.

The concept of male involvement especially in the care of both mother and child is sometimes not fully understood by the male party, that's why Yargawa, and Leonardi-Bee (2015) in their study, as a means of conclusion, suggested that 'effective awareness campaigns promoting male involvement should be organized so that men can be aware of their roles and specific ways to get involved maternal needs.' Studying the perception of individuals in the society as regards the participation of males in perinatal care will thus aid in providing a basis for assessing the level of knowledge of such individuals concerning male involvement in perinatal care, and also provide room for necessary intervention to increase their knowledge and even practice.

1.2 STATEMENT OF PROBLEM

The involvement of males in maternal and child health care is vital in ensuring their good health and it's a promising strategy for promoting maternal health (Adenike, Asekun-Olarinmoye, Adewole, Adeomi and Olarewaju, 2013). Male involvement is associated with improved maternal health outcomes in developing countries (Yargawa et al., 2015). Because of its relevance, this concept of male involvement in maternal health is being advocated as an essential element of World Health Organization (WHO) initiative for making pregnancy safer (Kulunga et al., 2012)

Despite the importance of male involvement in maternal and child health, most African countries have regarded maternal health issues particularly family planning and childbirth as a woman's affair only (Mfuh, Lukong, Olokoba, and Zubema, 2016). Adenike, Asekun-Olarinmoye, Adewole, Adeomi, and Olarewaju (2013), in their study on male involvement in Nigeria also, stated that male involvement is crucial, but "…their participation is poorly demonstrated. …and their involvement in the health care of their wives is low" This has shown a poor state of male involvement in maternal and child health care in our country.

With the poor level of male involvement in Nigeria, and the pressing desire to reducing infant and maternal mortality rate in the country, there is a need to obtain more data about this concept of male involvement; and according to Yahaya (2002), cited by Mfuh et al., (2016), …there is paucity of data on men's views with regard to maternal health." Despite the important role of men in maternal health, studies exploring male involvement in maternal health care and factors that influence their participation are limited (Craymah, Oppong and Tuoyire, 2017).

So therefore, this study will attempt to provide the views of scholastic adult intellectuals, about this concept of male involvement and its influence on maternal and child health, so as to provide a baseline data which will aid in developing measures for improving the poor state of male involvement in Nigeria and Africa at large.

1.3 OBJECTIVES/AIM OF THE STUDY:

The broad aim of this study is to assess the perception of University of Ibadan postgraduate students about the influence of male involvement in perinatal care on the promotion of maternal and child health.

The specific aim is to:

1. Identify perceptions about the concept of male involvement
2. Assess for knowledge about perinatal care services
3. Determine the factors influencing effective implementation of male involvement in perinatal care
4. Explore the concept of positive maternal and child health and determine the influence of male involvement in perinatal on the promotion of maternal and child health
5. Obtain possible suggestions for improving male involvement in perinatal care services.

1.4 RESEARCH QUESTIONS

1. What is male involvement?
2. What is the concept of perinatal care?
3. What are the factors influencing effective implementation of male involvement in perinatal care?
4. What is positive maternal and child health?
5. What influence does male involvement in perinatal care has on the promotion of maternal and child health?
6. What are the possible suggestions for improving male involvement in perinatal care services?

1.5 SIGNIFICANCE OF THE STUDY:

Male partner involvement, an important phenomenon in the promotion of maternal and child health outcomes, is practised poorly in our society. Over the years, various strategies have been introduced to improve male involvement in maternal and child health and even reproductive health at large, and based on the guidelines for facilitating male involvement in Reproductive health by Justus, Hanna, Nangombe (2016), there is a need to analyze various perceptions about male partner involvement in reproductive health. This study is carried out to determine the various perceptions about male involvement in care of mother and child through the perinatal period.

This study will provide information about the societal view concerning male involvement. Which in turn will aid relevant bodies and policy makers in knowing exactly how the people view male partner involvement and also the right steps and measure to employ that will be effective in implementing and practising male participation in maternal and child health care services within the nation.

Maternal and child health care, which is of great concern to both nurses and midwives, is affected by the level and nature of male participation. With the aid of this study, further information on how the participation of males in perinatal care services will aid in promoting maternal and child health can be assessed. Also, health care professionals who are interested in this variable of study, can also use relevant data provided by the study as baseline information to back up their research.

As a nurse researcher, this study will also expose me to this issue of global interest (male partner participation in maternal and child health care service), and increase my level of knowledge about the phenomenon. This will in turn make me a better agent in the promotion of male involvement in perinatal care services in my county, and in the long run, increase maternal and child health outcomes.

1.6 SCOPE OF THE STUDY:

The study is intended to be carried out among university of Ibadan postgraduate student. Basically, the two postgraduate halls of residence within the university will be used. They are:

1. Abdusalam Abubakar Hall
2. Tafawa Balewa Hall

Both male and female participants will be used in the study.

1.7 HYPOTHESIS

1. **N_0:** There is no relationship between gender and the level ofknowledge about perinatal and maternal care services.
2. **N_0:**There is no relationship between marital status and the perceived concept of male involvement.
3. **N_0:**There is no relationship between socio-economic status (employed, unemployed, self employed) and the perceived factors that influence effective implementation of male involvement in perinatal care.

CHAPTER TWO: LITERATURE REVIEW

2.1 CONCEPT OF MALE INVOLVEMENT

Understanding the differential meanings of male involvement to men, women and health care providers may lead to better predictions of future male participation (Kululanga, Chirwa, and Sundby, 2012). According to MEDICAM, male involvement involves, encouraging men to become more involved and supportive of women's needs, choices, and rights in sexual and reproductive health; and addressing men's own sexual and reproductive health needs and behavior. The involvement of men in maternal health is a new concept being adopted by the International community at the conference on Population and Development (ICPD) in Cairo, 1994, after tracing the remote causes of maternal mortality to cultural factors, chief of which is patriarchy (Okeke, Oluwuo, and Azi 2016).

Male involvement is a term that indicates not just the presence of a male figure in maternal and child health care activities, but also his total involvement in the care. According to ICPD male involvement in maternal health care has been described as a process of social and behavioural change that is needed for men to play more responsible roles in maternal health care with the purpose of ensuring the wellbeing of women and children (Mfuh, Lukong, Olokoba, and Zubema, 2016).

In a study by Stanback and Shattuc (2015), they stated that communication is central to the definition of male involvement. Yargawa and Leonardi-Bee (2015), on the other hand defined male involvement as “an all-encompassing term which refers to the various ways in which men relate to reproductive health problems and programmes, reproductive rights and reproductive behaviour”. They also considered it as an important intervention for improving maternal health.

Three broad categories were considered by Yargawa et al. (2015) as indicating male involvement:

- 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);
- Financial support given for pregnancy-related and childbirth-related expenses;
- Shared decision-making powers on maternal health with wife.

This categorization by Yargawa et al. (2015), tend to reflect the basic aspect of care involved in maternal and child health services, with emphasis that the male partner (husband) should

participate adequately at every stage. In a study by Comrie-Thomson, Tokhi, Ampt, Portela,Chersich, Khanna and Luchters (2015), male involvement was defined broadly as strategies to increase the involvement of men. This definition provides a direct illustration of the literal sense of the term 'male involvement'.

The concept of male involvement has been used in different ways in relation to the health service the researcher is concerned about, ranging from family planning, management of STIs, pregnancy, delivery, etc. Regardless of the area of focus in the definition of the concept of male involvement, the following should be embedded in the concept of male involvement:

- A male partner
- An active and adequate participant in all aspect of maternal and child health care needs and decisions
- An effective concern about his reproductive health care needs.

Based on the above component, male involvement can be referred to as **an active and adequate participation of a male partner in all aspect of maternal and child health care needs and decisions, with effective concern about his own reproductive health needs.**

2.2 CONCEPT OF PERINATAL CARE

Perinatal care is defined by Reference.MD, as the care of women and a fetus or newborn given before, during, and after delivery from the 28th week of gestation through the 7th day after delivery. Previously, perinatal period was seen as the interval between the time in which a couple decide to conceive and one year after birth. But currently, the perinatal period commences at 22 completed weeks (154 days) of gestation and ends seven completed days after birth (WHO, 2018).

According to the Guidelines for Perinatal Care (7^{th} edition), by the American Academy of Pediatrics (AAP) and the American College of Obstetricians and Gynecologists (ACOG), a regionalized system of perinatal care with integrated delivery of services should address the care received by the mother before pregnancy and during pregnancy, the management of labor and delivery, postpartum care, and neonatal care. The care rendered to a woman during the perinatal period is an essential one, as it encompasses so many aspects of her reproductive life.

Perinatal care services should be such that it meets the need of the woman from the point in which she is ready for conception up until after conception. Although this is not in sync with the definition of the postnatal period by WHO, "integrated perinatal care programs can be

extended to encompass preconception evaluation and early pregnancy risk assessment in both ambulatory and hospital-based settings" (AAP and ACOG, 2012).

Provision of efficient perinatal care services, should be carried out by trained personnel. Perinatal medical care providers include obstetricians, gynecologists, pediatricians, nurses/midwives, laboratory scientists, and skilled birth attendants (especially in primary health care centers). In addition, we have personnel known as Laborists and Hospitalists. "Laborist" most commonly refers to an obstetrician–gynecologist who is employed by a hospital or physician group and whose primary role is to care for laboring patients and to manage obstetric emergencies. The term "hospitalist" refers to physicians whose primary professional focus is the general medical care of hospitalized patients (AAP and ACOG, 2012).s

Antenatal, intranatal and even postnatal care are part of the perinatal care services. In a study by Worku, Yalew and Afework (2013), they found out from their participants that at the time of antenatal care, some women received important services (percentage of users in bracket) like blood pressure checkup (79%), urine testing (35%) tetanus immunization (45%), iron supplementation (64%), birth preparedness counseling (51%), saving money for possible complication (45.2%), and HIV testing (71%). Weight monitoring and diagnostics investigations like ultrasound scan, are also components of some of the services received during antenatal care. According to WHO (2002), some vital test during pregnancy include; blood pressure, urinalysis, weight, fundal height, abdominal palpation, pelvimetry, fetal heart/fetal movements, blood tests, rhesus, and ultrasound scans.

Components of services provided to a woman during delivery should involve: general health assessment, blood pressure & other vital signs, per vaginal examination, abdominal examination, auscultation of fetal heartbeat, control bleeding by drugs, information on progress of labor, ensuring comfort of mother, providing care for the baby, measure and record baby weight, give vaccine for baby, advise about breast feeding and advise on infant care (Worku et al. 2013). WHO (2002) added that labour and birth intervention could include; pain relief in labour, companionship in labour, common interventions used in many labours, Caesarean section, psychological adjustments to labour and birth, skin-to-skin contact with the newborn and early breastfeeding.

Accroding to MoHSW (Ministry of Health and Social Welfare, Tanzania) cited in August, Pembe, Mpembeni, Axemo andDarj (2016), during ANC, the health worker is supposed to discussbirth preparedness and complication readiness (BP/CR)with the couple, as well as general care of the pregnantwoman at home.

Postnatal care is one of the most important maternal health-care services for not only prevention of impairment and disabilities but also reduction of maternal mortality (Adenike, Asekun-Olarinmoye, Adewole, Adeomi, and Olarewaju, 2013). According to WHO (2002), postpartum care of the mother entails: breastfeeding, postnatal exercises, psychological adjustments to marriage and life with a new baby, sexuality during pregnancy and after birth, and working after childbirth. Postpartum care of the baby involves: care of the baby/equipment needed, coping with crying babies, stimulating the baby, baby's developmental milestones, and immunization for babies. This were stated by WHO as topics to be treated in its journal on Essential Antenatal, Perinatal and Postpartum Care.

Thegoal of the ANC package is to prepare for birth andparenthood as well as prevent, detect, alleviate, or managethe three types of health problems during pregnancy thataffect mothers and babies:

• complications of pregnancy itself

• pre-existing conditions that worsen during pregnancy

• effects of unhealthy lifestyles(Ornella, Seipati, Patricia and Stephen - Opportunities for Africa's Newborns).

ANC provides women and their families withappropriate information and advice for a healthypregnancy, safe childbirth, and postnatal recovery,including care of the newborn, promotion of early,exclusive breastfeeding, and assistance with deciding onfuture pregnancies in order to improve pregnancyoutcomes (Ornella et al. - Opportunities for Africa's Newborns).

ANC improves the survival and health of babies directly by reducing stillbirths and neonatal deaths and indirectly by providing an entry point for health contacts with the woman at a key point in the continuum of care (Ornella et al. - Opportunities for Africa's Newborns).

Perinatal Care Task Force, Venice, 1998 drew the Values and Principles of Perinatal Care; it entails:

- Care for normal pregnancy and birth should be demedicalized
- Care should be based on the use of appropriate technology
- Care should be regionalized
- Care should be evidence-based
- Care should be multidisciplinary

- Care should be holistic
- Care should be family-centred
- Care should be culturally appropriate
- Care should involve women in decision-making (World Health Organization, 2003).

2.3 FACTORS INFLUENCING EFFECTIVE IMPLEMENTATION OF MALE INVOLVEMENT IN PERINATAL CARE

Worldwide, male attendance of skilled ANC and deliverycare remains a challenge to safe motherhood (Tweheyo, Konde-Lule, Tumwesigye, Sekandi, 2010).The care given to the woman and child throughout the perinatal period is very important and it is of great relevance in the reduction of maternal and child health. Despite this fact, various factors have influenced how well male get involved in perinatal care. In a study by Tweheyo et al. (2010), the main factors identified by the respondents in thesurvey as barriers to attendance of ANC were lack of transportation, long waiting time and long walking distance to a health facility. Perceiving the walking distance to the health facility as long (greater than one-hour walk or greater than 5 km) was a prominent barrier and associated with reduced male attendance of ANC.

Men's involvement in reproductive health is crucial, though their participation has been poorly demonstrated and the factors responsible for this include culture, religion, ignorance and socio-economic factors (Adenike, et al. 2013). According to a study by Kiptoo, Mutai and Kipmerewo (2016), it was found out that the male partners age, education and occupation was a significant factor on male partners being involved in the decision on where the wife attended antenatal clinic (ANC).

According to Kiptoo et al. (2016), men with education and are employed provide support [to their wives] compared to those who have no education and are unemployed; thus, indicating the influence of education and social economic status on male involvement. Tweheyo et al. (2010) added that factorsassociated with higher male attendance in ANC were attainmentof secondary or higher level educationand perception of foetal monitoringas being a benefit of attendance. Furthermore, when the man is unemployed, the unemployment nature may make the male partner not to involve himself in maternity care services during perinatal period (Kiptoo et al. 2016).Tweheyo et al. (2010) found from the results of their study that male partner's education was not significantlyassociated with attendance of ANC.

A study by Adenike, et al. (2013) illustrated that the knowledge and attitude of their respondents towards maternal health care was average, and their involvement in the health care

of their wives was low; …"and limited knowledge of male partners about maternal health issues has been reported to be a significant barrier to their attendance" in the perinatal care of their wives(Tweheyo et al. 2010). In a study by Okeke, Oluwuo, Azi (2016); they found out that the knowledge made available to men concerning female reproduction was limited. Kaye et al. (2014) also added that in setting where they even make few attempts to give information to men about their partners' condition, the information given was perceived as inadequate by the males. As such, they were unable to communicate effectively with women candidly (Okeke et al. 2016).

According to a study by Tweheyo et al. (2010), they also found out that the attendance Rate of men during ANC was about 3 times higher among male partners that could identify at least three services offered at ANC compared to those identifying two or less services. This is implying the role knowledge of perinatal services plays in influencing male involvement in perinatal care services.

Onchong'a, Were and Osero (2016) also added that studies have shown that lack of knowledge about maternal health pose a significant challenge to positive male partner involvement. The level of knowledge of men about maternal care through the perinatal period could be a factor that could negatively affect male participation in perinatal services. Additionally, men who hold both the economic and decision-making power, are not knowledgeable about complications that can occur during pregnancy and childbirth… and this can make an impact on women's health when a need arises to take quick actions in seeking expert care (August, et al. 2016)

Tweheyo et al. (2010), on the other hand, found out in their study that ANC attendance was significantly lower if the source of health information were community campaigns whereas, obtaining health information from a facility health worker was positively associated with male partner attendance of ANC with their spouses.

Family separation and possible crises could also pose a significant barrier to effective participation of males in perinatal care. According to Kaye, Kakaire, Nakimuli, Osinde, Mbalinda and Kakande (2014), the perceived major deterrents to men's involvement during childbirth were personal factors (such as unhealthy couple relationship). When there is mutual understanding in the home, there will be physical intimacy, and "husband and wife living together will influence pregnant woman's decision to seek antenatal care (ANC). It could also be attributed to the fact that they are staying together hence can remind or escort the wife to the ANC clinic" (Kiptoo et al. 2016).

Other factors that could influence male participation in perinatal care is cultural and traditional beliefs. According to Onchong'a et al. (2016), negative perception of male partners involved in reproductive health (RH) activities posed a challenge to male partner involvement. A study by Kiptoo et al. (2016) showed that there were assumptions and beliefs that husbands' presence during labour was mostly restricted by cultural and traditional beliefs, such as the belief that men became sick and swollen when witnessing their spouse deliver. The fear of being perceived as a jealous husband following his wife around was stated by Onchong'a et al. (2016) as one of the reasons for lack of involvement in ANC services.

In a study in Malawi, it was found that women considered childbirth as a preserve for women only Onchong'a et al. (2016). Mfuh et al. (2016) also added that in most African countries, maternal health issues particularly family planning, pregnancy and childbirth have been long regarded as a woman`s affair only; this could also have a tangible influence on how males participate in the perinatal care of both mother and child.

Lowe and Lowe (2017), in their study on Social and cultural barriers to husbands' involvement in maternal health in rural, Gambia, stated that a good part of participants' description of the social and cultural factors affecting husbands' involvement in maternal health include: (a) the general perception associated with pregnancy and delivery as women's domain, (b) husbands' competing job responsibilities, (c) rivalry among co-wives, and (d) fear of mockery.

According to Kaye et al. (2014), the perceived major deterrents to men's involvement during childbirth were … unclear roles (not knowing what the health care system expected of them, lack of information on what to expect, not knowing their role or not wanting the new responsibilities). Even though male involvement is widelyrecognized that there is limited research on the role ofmale involvement during pregnancy (Tweheyo et al. 2010). Kaye et al. (2014) also found out in their study that participants expressed sentiments that they were excluded from what was going on, particularly from the decision-making process regarding the care given to their patients and the hospital environment, the behavior and language of the health care providers appeared to increase the participants' feeling of alienation.

In a study by Kululanga et al. (2012) the feeling of being ignored by the health care providers was expressed by participants, as they were not allowed in the examination room even in facilities where privacy was guaranteed. As such, the men lingered outside the clinic waiting for their wives, which could be a discouraging influence to their participation. Kiptoo et al. (2016) were of the opinion that restricted access offered to men who want to provide support to their wives during labour and delivery by health care providers, can influence the rate at which

males get involved in the care of their wives."This stems from the fact that these health systems do not make provision for, neither do they recognise – if they do recognised, they underestimate – the active role that male partners could play in the reproductive health of their partners. As result, male partners feel excluded" (Amukugo, Neshuku and Julia, 2016)

In a study by Tweheyo et al. (2010), the attendancerate of participants was significantly higher if the spouse's last deliverytook place in a health facility compared to those wherethe last delivery occurred either at home or at a traditionalbirth attendant's place… or if the male was religiously/traditionallymarried compared to consensual marital unions.

Mfuh et al. (2016), provided a comprehensive view on factors that could influence male involvement in perinatal care - the commonest reason stated by men for not participating in maternal health care include; religious/cultural factor, health system factor, attitude of health workers, long waiting time, financial constraint and ignorance of the need for them to participate.

2.4 CONCEPT OF POSITIVE MATERNAL AND CHILD HEALTH

According to Lucas and Gilles, (2003), maternal health refers to the broad apparent and currently accepted means of providing and promoting, preventive, curative and rehabilitative health care for mothers (Mfuh et al. 2016). Maternal health according to Adenike et al. (2016) refers to health of women during pregnancy, childbirth and postpartum period and it is a very important component of reproductive health.

In a study by Mfuh et al. (2016), maternal health care services were referred to as antenatal care, delivery and postnatal care, with the definition according to WHO (2006) being given as the health of a woman during pregnancy, childbirth and post-partum period. These health services include: preconception care, antenatal care (ANC), prevention of mother-to-child transmission (PMTCT) of HIV, safe delivery (intrapartum care), postnatal care (PNC), and emergency obstetric care/management of obstetric complications.

According to Wikipedia (2018), maternal health is the health of women during pregnancy, childbirth, and the postpartum period. It encompasses the health care dimensions of family planning, preconception, prenatal, and postnatal care in order to ensure a positive and fulfilling experience in most cases and reduce maternal morbidity and mortality in other cases. howMED (2015) defined maternal and child health to be a promotive, preventive, curative & rehabilitation health care for mothers and children.

Okeke et al. (2016) stated in their study that, maternal health care services comprise of a wide range of health services given to the mother before pregnancy, during pregnancy, labour and after delivery. It may also include services to prevent Mother-to-Child transmission of HIV (PMTCT) emergency obstetric care/management of obstetric complications.

According to USAID (2013), the specific objectives of Maternal and Child Health (MCH) care focuses on the reduction of maternal, perinatal, infant and childhood mortality and morbidity and the promotion of reproductive health and the physical and psychosocial development of the child and adolescent within the family.

USAID's new Maternal and Child Health (MCH) Program comprises of five major components. These components are:

1) family planning and reproductive health services;

2) maternal, newborn, and child health services;

3) health communications;

4) health commodities and supplies; and

5) health systems strengthening. (USAID, 2013)

2.5 INFLUENCE OF MALE INVOLVEMENT IN PERINATAL CARE ON THE PROMOTION OF MATERNAL AND CHILD HEALTH

Good care during pregnancy is important for the health of the mother and the development of the unbornbaby (Ornella et al. - Opportunities for Africa's Newborns).The involvement of men in maternal health is a new concept being adopted by the International community at the conference on Population and Development (ICPD) in Cairo, 1994, after tracing the remote causes of maternal mortality to cultural factors, chief of which is patriarchy (Okeke et al. 2016). According to Kaye et al. (2014), Men's involvement during pregnancy and childbirth plays a vital role in the safety of their female partners' pregnancy and childbirth, by ensuring access to care and provision ofemotional and financial support and guarantying women's access to reproductive health services in general.

According to Nansubuga and Ayiga (2015), the importance of male involvement in maternal health is two-fold - First, men are partners or husbands of the women (UNFPA 2007) and are

affected by maternal outcomes. Secondly, men's role in maternal health arises from a socio-economic and cultural dimension.

According to Becker and Robinson (1998) and Bustamante-Forest and Giarratano (2004), changing and improving the way men are involved in reproductive health problems can have a positive impact on women's, men's and children's health (Mfuh et al. 2016). Involvement of males in reproductive health is an important step in reducing maternal and newborn deaths… (Onchong'a et al. 2016). Kaye et al. (2014) also added that male involvement reduces negative maternal health behaviors, risk of preterm birth, low birth weight, fetal growth restriction and infant mortality.

Alio, Lewis, Scarborough, Harris, and Fiscella (2013), believed that the primary benefits of having a father or male partner involved during pregnancy were the reduction of maternal stress levels and the encouragement of positive maternal behaviors, which in turn will improve both her health outcome and that of her child. In addition, men's presence and their participation at the health facilities during antenatal care visit of their wives will help boost the morale of their wives and also bring about a greater sense of commitment of both parents to having healthy mothers and babies (Adenike et al. 2016). Men's involvement promotes safety of their female partners' pregnancy and childbirth by ensuring access to care and provision of emotional and financial support and more birth preparedness (Onchong'a et al. 2016).

Male involvement is an important avenue for giving men information so they can support healthy behaviours and health care seeking for children, such as exclusive breastfeeding and childhood immunization (Davis, Vyankandondera, Luchters, Simon and Holmes 2016); which will aid in promoting the child health.Men have also been encouraged to attend ANC visits, as they can obtain information regarding the pregnancy (August et al. 2016). Thaddeus and Maine; Aparajita observed that when men possess this kind of information related to pregnancy and knowledge of danger signs, they stress the importance of their wives delivering in a health facility (August et al. 2016).

According to Adenike et al. (2016), family planning is one of the essential interventions in improving maternal health … and men have roles to play in family planning. When these roles are performed effectively, they further aid in the improvement of maternal and child health. Men being critical partners for the improvement of maternal health and reduction of maternal mortality can be clearly demonstrated in the area of antenatal care (ANC) of which their social, emotional and economical inputs cannot be underestimated (Adenike et al. 2016).

Men's involvement in antenatal clinics results in positive maternal and child health outcomes as it increases women's attendance of antenatal clinics, compliance with breastfeeding, family planning and the uptake of Prevention of Mother-to-Child-Transmission of HIV/AIDS (Mkandawire and Hendriks, 2018); and their involvement during pregnancy and childbirth plays a vital role in the safety of their female partners' pregnancy and childbirth, by ensuring access to care and provision of emotional and financial support and guarantying women's access to reproductive health services in general (Kaye et al. 2014).

Male partners are to be their spouse's companion during the delivery process. According to a study by Hofmeyr, Nikodem, Wolman, Chalmers, and Kramer (1991), companionship had a striking, effect on the way that the participants reported experiencing labour (WHO, 2002). In a study conducted by Chalmers and Wolman on Social support in labour, ninety percent of mothers concluded that the father's presence increased the meaning of the labour and delivery experience, and all mothers and fathers felt that the shared experience had strengthened their relationship. The male partner performs certain psychological roles that promote the wellbeing of both mother and child during labour. Thaddeus and Maine added that involving men can contribute to preventing delays in seekingor reaching care (August et al. 2016).

Evidence also shows that men can prevent unintended pregnancies, reduce unmet need for family planning (FP), foster safe motherhood and practice responsible fatherhood (Mfuh et al. 2016). With the involvement of men in perinatal health initiatives, which have been aimed at improving the health of women and infants before and during pregnancy through a variety of evidence-based interventions and attention to emerging public health concerns (Kaye et al. 2014), maternal and child health outcome is improved. Men have social and tremendous control over their partners... decide the timing and conditions of sexual relations, family size and whether their spouse will utilize available health care services… this makes male involvement critical in improving maternal health and reducing maternal mortality and morbidity (Onchong'a et al. 2016).

Male involvement in pregnancy and childbirth influence pregnancy outcomes (Kaye et al. 2014). So therefore, as men get fully involved and are able to adequately perform their roles throughout the perinatal period, the maternal and child health outcomes will be promoted. The role of males in care is not restricted to either pregnancy, childbirth or postpartum care, but "the father's role [is] throughout the transition to parenthood" (WHO, 2002).

2.6 POSSIBLE SUGGESTIONS FOR IMPROVING MALE INVOLVEMENT IN PERINATAL CARE SERVICES

In a meeting, PROGRAMMING FOR MALE INVOLVEMENT IN REPRODUCTIVE HEALTH, held by WHO, in Geneva (2002); they listed out some basic strategies to employ to achieving the aims of the meeting (male involvement). They:

- Called for the collection and dissemination of the best practices for increasing male involvement.
- Recognized the need for measures to increase male involvement that are adaptable to diverse local and cultural settings.
- Identified the need for global information-sharing and capacity-building networks in order to achieve optimum male-involvement programmes.
- Called for the development of national policy frameworks on male involvement in countries where such frameworks are lacking.
- Recognized the need to enlist the support of programmes outside the health sector as sources of information and education on men's and women's health issues: communities, media, policymakers, and providers must all take part in promoting male involvement.
- Recognized that male programming cannot be accomplished at the expense of existing women's health services, and that the development of cost-effective programmes is possible.
- Identified the need for a spectrum of male involvement programmes that address men's needs throughout their sexual and reproductive health life cycles, from youth to old age.
- Called for the development of information guidelines and tools addressing male involvement.
- Recommended that a greater degree of monitoring and more rigorous evaluation of programmes targeting men be carried out and that they include process as well as outcome indicators.
- Urged that more advocacy programmes for involving men in reproductive health at the local, national, and international levels be launched.
- Identified the need to promote the concept of dual protection among men.
- Recommended specific targeting of adolescent males.
- Identified the need for research focusing not only on behavioural outcomes but also on epidemiological and health outcomes.

- Recognized that male involvement means providing reproductive health services for men and women, as individuals as well as partners, in a way that best serves their needs as men, women, and couples.
- Recommended that regional programmes of action be developed for involving men in reproductive health that include local organizations,

communities, the private sector, traditional healers, and nongovernmental organizations (NGOs).

Providing motivational information, ensuring positive healthcare provider attitudes, and providing educational support and a conducive environment to men are potential interventions to increase male involvement in pregnancy and childbirth. Programs which provide information about this perinatal period to men, or which provide counseling and support should also be established. (Kaye et al. 2014). Onchong's et al. (2016) also added that, there is need to empower women with adequate and accurate knowledge on male partner involvement and its benefits to improve male partner involvement. The information should be given to both males and females to ensure the effective implementation of male involvement.

Health care providers should ensure they provide male partners with the necessary information. Kaye et al. (2014) added that, while 'doctors' knew what they were doing (had the expertise), they should not make men passive recipients of care. The doctors should at least inform the men about major decisions taken regarding their partners' healthcare.

Advocacy from NGOs, media, male champions as well as traditional leaders plays a critical role; not only facilitating men's involvement but also in overcoming gender stereotypes and reinforcing gender equality (Mkandawire et al. 2018). Besada et al. (2016) also added that increased male participation has been facilitated through the use of male champions, to deliver messages around benefits of male involvement, dispel myths and reconstruct cultural notions around the strength of men who participate in their partners' health and lead by example.

According to a study by Kaye et al. (2014), health care providers are expected to appreciate and support the involvement of men in maternal health issues during antenatal care and childbirth. They should also provide support and undergo training in customer care and communication so as to improve their relationship with secondary clients, who are partners of women during pregnancy and childbirth.The process of involving males within the context of reproductive health is possible only in an environment in which a platform has been created which encourages both partners to participate in reproductive health and, also, an environment in

which this process has the support and guidance of the health workers who are, indeed, the custodians and advocates within the reproductive health context…(Amukugo et al. 2016).

August et al. (2016) also added that training of health workers on how to counsel couples in terms of understanding that health behaviours and outcomes are a result of social norms and socio-economic relationships could be beneficial.

National policies around male partner involvement would be beneficial to streamline approaches across implementing partners and ensure wide-scale implementation, to achieve significant improvements in family health outcomes (Besada et al. 2016). Full explanation should be provided on the policy which encourages male involvement and what it expects of men once they escort their spouses to the hospitals during childbirth and innovative ways of operationalizing the policy of male involvement in pregnancy and childbirth should be identified (Kaye et al. 2014).WHO (1999) also suggested that governments and institutions come up with models of reproductive health that could serve as platforms in terms of which male partners could be involved (Amukugo et al. 2016).

As a strategy to promote male involvement, health education of men who escort their partners to antenatal clinics, on their expected roles during pregnancy and childbirth should be ensured and the … Ministry of health needs to offer health education to all men on specific roles in pregnancy and childbirth, and the importance of this role to positive pregnancy outcomes Kaye et al. (2014).

According to Besada et al. (2016), sensitizing men to the importance of participating as a unit in the health of their partners and children is equally vital;formal adoption of a male involvement policy lends credibility to the importance of the approach in improving patient health outcomes and ensuring systematic implementation of strategies. August et al. (2016), a way to involve men in sexual and reproductive health is to increase the knowledge of both men and women in the community.

A study by Okeke et al. (2016) on women's perception of males' involvement in maternal health care in Rivers state, Nigeria, opined that male's involvement in maternal health care should include economically empowering them and granting them autonomy to be able to determine and contribute to the quality of care the woman desires. Programs to engage men in MCH clinical services must also allow women to choose how and when male partners are present and involved in maternal health clinical services (Davis et al. 2016). In empowering women, it is also important to stress the need for adequate communication between the couples

as stated by Mutombo, Bakibinga, Mukiira, Kamande, that increased couple communication is associated with increased knowledge of maternal and reproductive health services (August et al. 2016)

The Ministry of Health and Social Services (2001) has identified two important male partner roles in assisting female partners … These roles include an advisory role in which men take the lead in providing information related to reproductive health, and a supportive role in respect of family planning in which male partners support their female counterparts in terms of suitable methods of contraception (Amukugo et al. 2016).

Kaye et al. (2014) also added that the hospital should also train health care providers in customer care, and needs to identify waiting rooms in which male are welcomed, provided with information on their spouses and given health education on expected roles. Health workers need to improve on customer care, particularly regarding communication of the patients' condition or health care to patient attendants.

Community participation at every stage of the implementation of male participation programmes is paramount in ensuring its effectiveness as "lack of consultation withthe community has a bearing on the sustainability of the programme" Kululanga et al. (2012).

Besada et al. (2016) recognized two strategic levels for promoting the participation of male partners. They are the community level strategy and the facility level strategy. The community level strategy should include: collaboration with community leaders and influential institutions, use of existing community health worker cadres, creation of peer support groups, use of model clients/ couples, radio messages/ theatre groups and male champions/ Motivators.

Facility level strategy should involve integration of male friendly services within reproductive, maternal, newborn, and child health settings. This entails: Incentives/ Disincentives (e.g. free male health check-up, free ANC for women accompanied by partners, certificates for couple testing, prioritization for women accompanied by a male partner, partner invitation letters and fines for partners); and facilitated access (extended ANC clinic hours and services provided on weekends)

According to Okeke et al. (2016), on the notes of UNFPA (1996:117), male involvement can be achieved through:

- The promotion and encouragement, by Governments, of the equal participation of women and men in all areas of family and household responsibilities, including family planning, child-rearing and housework;
- The emphasis of men's shared responsibility and the promotion of their active involvement in responsible parenthood, sexual and reproductive behaviour, including family planning; prenatal, maternal and child health; prevention of sexually transmitted diseases, including HIV; prevention of unwanted and high-risk pregnancies; shared control and contribution to family income, children's education, health and nutrition; and recognition and promotion of the equal value of children of both sexes;
- Ensuring that children receive appropriate financial support from their parents by, among other measures, enforcing child- support laws.

2.7 THEORETICAL FRAMEWORK

THEORY OF PLANNED BEHAVIOUR

The Theory of Planned Behavior (TPB) started as the Theory of Reasoned Action in 1980 to predict an individual's intention to engage in a behavior at a specific time and place. The theory was intended to explain all behaviors over which people have the ability to exert self-control (LaMorte, 2016). This theory is postulated by Icek Azjen in 1991.

Icek Ajzen is a social psychologist and professor emeritus at the University of Massachusetts Amherst. He received his doctorate from the University of Illinois at Urbana–Champaign, and is best known for his work, with Martin Fishbein, on the theory of planned behavior. Ajzen has been ranked the most influential individual scientist within social psychology in terms of cumulative research impact and, in 2013, received the Distinguished Scientist Award from the Society of Experimental Social Psychology. His research has been influential across diverse fields such as advertising, health psychology, and environmental psychology, and has been cited over 200,000 times (Wikipedia, 2018).

The TPB is concerned with the prediction of intentions. Behavioural, normative and control beliefs as well as attitudes, subjective norms and perceptions of behavioural control are assumed to feed into and explain behavioural intentions. (Ajzen, 2011)

The Theory of Planned Behavior (TPB) is comprised of six constructs that collectively represent a person's actual control over the behavior.

1. **Attitudes** - This refers to the degree to which a person has a favorable or unfavorable evaluation of the behavior of interest. It entails a consideration of the outcomes of performing the behavior.

2. **Behavioral intention** - This refers to the motivational factors that influence a given behavior where the stronger the intention to perform the behavior, the more likely the behavior will be performed.

3. **Subjective norms** - This refers to the belief about whether most people approve or disapprove of the behavior. It relates to a person's beliefs about whether peers and people of importance to the person think he or she should engage in the behavior.

4. **Social norms** - This refers to the customary codes of behavior in a group or people or larger cultural context. Social norms are considered normative, or standard, in a group of people.

5. **Perceived power** - This refers to the perceived presence of factors that may facilitate or impede performance of a behavior. Perceived power contributes to a person's perceived behavioral control over each of those factors.

6. **Perceived behavioral control** - This refers to a person's perception of the ease or difficulty of performing the behavior of interest. Perceived behavioral control varies across situations and actions, which results in a person having varying perceptions of behavioral control depending on the situation. This construct of the theory was added later, and created the shift from the Theory of Reasoned Action to the Theory of Planned Behavior.

According to the theory, humans' actions are guided by three considerations:

Behavioural belief: which entails the beliefs about the possible consequences of the behaviour

Normative belief: concerned with the beliefs about the normative expectations of others

Control belief: has to do with the belief about factors that will impede or facilitate a particular behaviour.

THE CONCEPT OF THE KEY VARIABLES IN THE THEORY OF PLANNED BEHAVIOUR (Wikipedia, 2018)

1. Normative beliefs and subjective norms

Normative belief: an individual's perception of social normative pressures, or relevant others' beliefs that he or she should or should not perform such behavior.

Subjective norm: an individual's perception about the particular behavior, which is influenced by the judgment of significant others (e.g., parents, spouse, friends, teachers).

2. **Control beliefs and perceived behavioral control**

Control beliefs: an individual's beliefs about the presence of factors that may facilitate or hinder performance of the behavior.The concept of perceived behavioral control is conceptually related to self-efficacy.

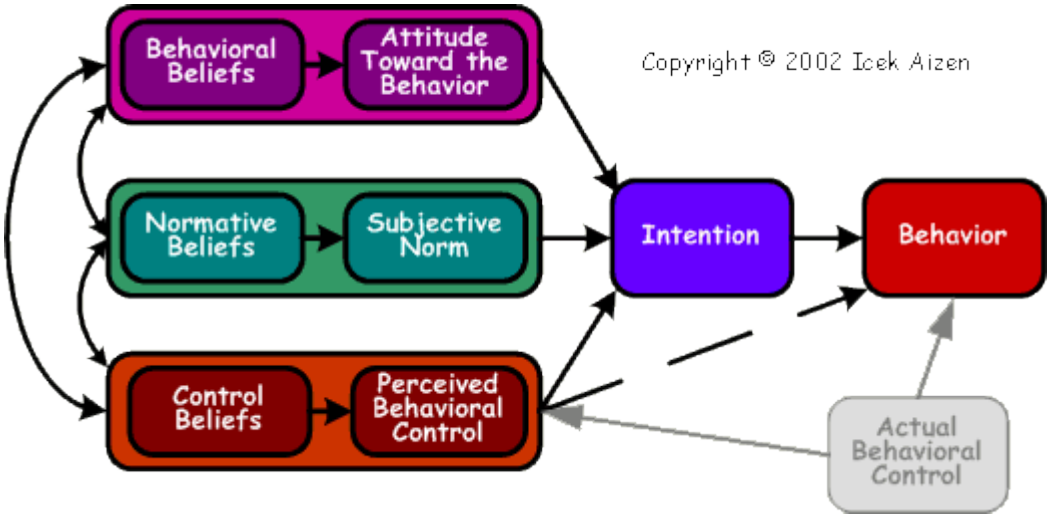
Perceived behavioral control: an individual's perceived ease or difficulty of performing the particular behavior. It is assumed that perceived behavioral control is determined by the total set of accessible control beliefs.

3. **Behavioral intention and behavior**

Behavioral intention: an indication of an individual's readiness to perform a given behavior. It is assumed to be an immediate antecedent of behavior. It is based on attitude toward the behavior, subjective norm, and perceived behavioral control, with each predictor weighted for its importance in relation to the behavior and population of interest.

Behavior: an individual's observable response in a given situation with respect to a given target. Ajzen said a behavior is a function of compatible intentions and perceptions of behavioral control in that perceived behavioral control is expected to moderate the effect of intention on behavior, such that a favorable intention produces the behavior only when perceived behavioral control is strong.

MODEL OF THEORY OF PLANNED BEHAVIOR



Any human behavior is guided by behavioral beliefs, normative beliefs and control beliefs. The behavioral beliefs of the individual will determine the attitude towards such behaviour. Normative beliefs will lead to a behavior controlled by people's judgement about the behavior (Subjective norm). the individual's perception about the factors that can affect such behavior (Control Beliefs) can into result in the beliefs of how easy or difficult it is to perform such behavior (Perceived behavioral control)

According to Ajzen, a combination of, "attitude toward the behavior,""subjective norm," and "perceived behavioral control"will lead to the formation of a "behavioral intention"(Wikipedia, 2018). The perceived behavioral control has a direct effect on "actual behavior". Perceived behavioral control also affects "actual behavior" indirectly through "behavioral intention".

Generally, when the attitude towards behaviour and subjective norms is favorable, and the the individual has a increased perceived behavioral control, the individuals intention to perform the action/behavior will be strong.

APPLICATION OF THE THEORY OF PLANNED BEHAVIOUR

This study is concerned with the perception of students as regards male involvement in perinatal services as well as its influence on maternal and child health. This theory deals with the prediction of behaviour. We want to predict the response of men and woman to the concept of male involvement.

1. **Attitudes** - This refers to the degree to which the males have a favorable or unfavorable evaluation of the concept of male involvement in perinatal care. This is influence by their beliefs about the outcomes of male involvement.

2. **Behavioral intention** - This refers to the motivational factors that could influence men's decision in getting involved in perinatal care. The stronger the motivational factor e.g. Incentive, better health outcomes, etc. the more likely they will get involved.

3. **Subjective norms** - the beliefs of friends and peers of the man as regards male involvement can also affect his perceived believe about the concept.

4. **Social norms** - This refers to males belief as to if this concept of male involvement is generally acceptable by their culture and tradition. A society and culture that foster the involvement of males in perinatal care will influence the belief of men about male involvement, positively and vice versa.

5. **Perceived power** - National and institutional barriers can affect the involvement of males in perinatal care, and the perception of the strength of such barriers can affect the behavior of men towards male involvement.

6. **Perceived behavioral control** - When the implementation of male involvement is done with ease and effectiveness, male partners will get more involved in perinatal care. The perceived level of ease and control the man has as regards male involvement will affect his relative participation.

Based on this theory of planned behaviour, it is shows that the attitude of individuals towards a phenomenon is linked to the three basic beliefs (behavioral, normative and controlled). This further expresses that the involvement of males in perinatal care can be affected by their beliefs about - how their involvement or neglect (behaviour) can affect maternal and child health; the expectation of the society and relevant bodies as regards their participation; the various factors that can facilitate or impede their participation in perinatal care.

The perceived belief of males about the outcomes of their involvement in perinatal care services on the maternal and child health (behavioral belief), will affect their attitude and also determine the type of motivation they will end up developing. Societal and cultural norms and beliefs concerning male involvement in perinatal care and how it influence maternal and child health care (normative beliefs) can also affect the perception of males as regards their involvement in perinatal care. The perception of males about external factors (e.g. national and

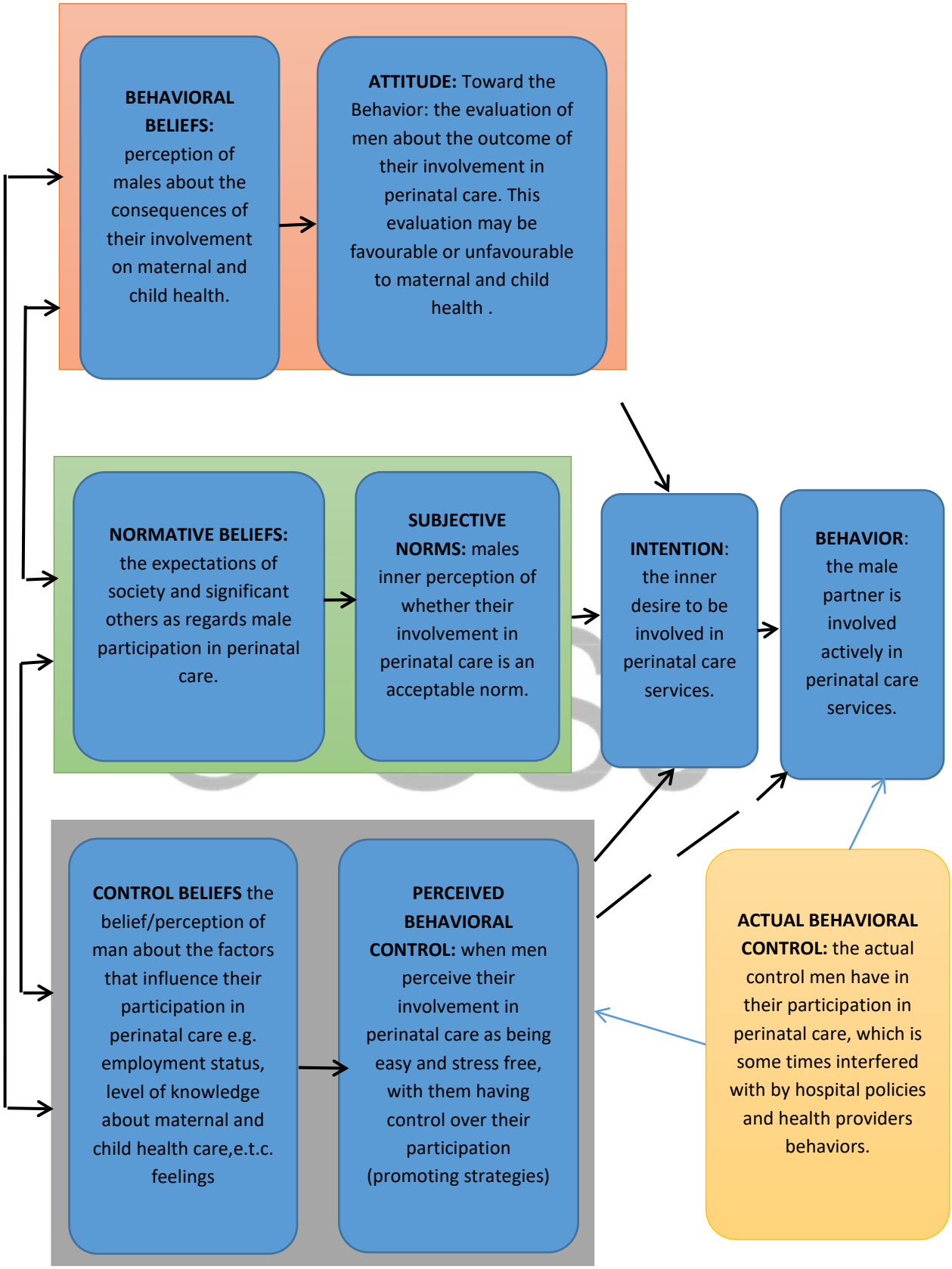
institutional policies) and internal factors (e.g. socioeconomic status, age, e.t.c.) that could either make his participation in maternal and child health care easy and effective (control beliefs), can influence his level of involvement.

All the above beliefs and perception can move the male partner to developing an intention to be involved in perinatal care, which will further develop to the actual behavior of their involvement in perinatal services.

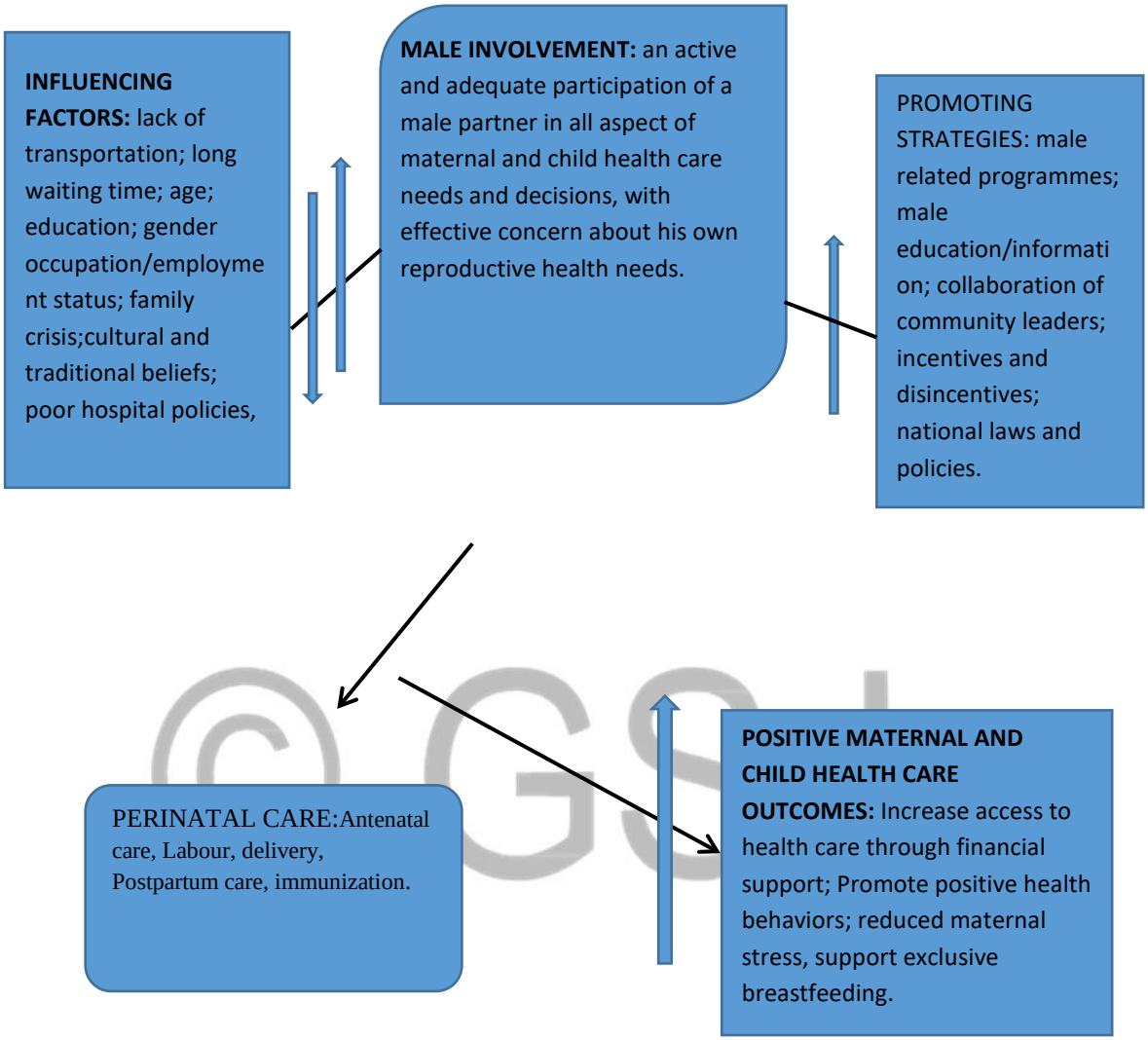
When men who have decided to be involved in perinatal care begin to be sidelined by the health care provider rendering care to their wife (actual behavior control) that could affect the perceive control and ease the male partner beliefs he will experience when he is involved in perinatal care. This will also affect their involvement in perinatal care (behavior of interest).

With this theory, assessing the perception about male involvement will have to consider the belief system of the participants about the various concepts in the study, so as to provide sufficient data and information as to why people behave the way they do, as regards male involvement in perinatal care.

2.8 CONCEPTUAL FRAMEWORK



2.9 LOGICAL FRAMEWORK



From the above logical framework, their is a relationship between male involvement and the factors influencing male involvement. These factors can either increase or decrease male involvement in perinatal care. Promoting strategies on the other hand increase the level of male involvement in perinatal care.

Positive maternal and child health care outcomes is influenced by male involvement in perinatal care. When men get involved in perinatal care, there is an increase in positive maternal and child health care outcomes.

CHAPTER THREE: METHODS

This chapter discusses the methods to be adopted in carrying out this study, obtaining and analysing data. Details about the study design, study setting, target population, sample size, sampling technique, instrument for data collection, reliability and validity of instrument, and method of data analysis is stated.

3.1 Research Design

This study made use of descriptive survey research as it is concerned with describing the perception of University of Ibadan postgraduate students about the influence of male involvement in perinatal care on the promotion of maternal and child health.

3.2 Study Setting

This study was carried out in Tafawa Balewa Hall of Residence and in Abdusalam Abubakar Hall of Residence. Both halls are postgraduate halls of residence in University of Ibadan.

Tafawa Balewa Hall is a mixed (males and females), postgraduate hall of residence. This hall is located along EI-Kanemi Road and directly behind Sultan Bellow Hall. It is mainly occupied by Ph.D. students. Tafawa Balewa Hall is the first post-graduate hall of residence in the university. Named after Sir Alhaji Tafawa Balewa, it was opened in 1968 (Wikipedia, 2018). it has five blocks, 186 rooms and an average number of 207 students (University of Ibadan, 2018)

Abdulsalam Abubakar Hall is a mixed postgraduate hall of residence, constructed in the year 2000; it is made up of 4 blocks, 280 rooms and an average numbe of 700 students (University of Ibadan, 2018). This hall is located along Barth Road, opposite Queen Idia Hall. It is easy to recall that this magnificent edifice was kindly donated to the University during her 50th Anniversary celebrations in 1998 while Gen. (Dr) Abdulsalami Abubakar was the visitor to the University. The donation was made by a pronouncement during the Foundation Day Ceremony. The first set of postgraduate students moved into the hall on March 1st, 2002. This hall is the pride of the University (Wikipedia, 2018).

3.3 Target Population

The target population is this study were the postgraduate students (both MSc and PhD) of University of Ibadan resident within the university campus. This group of students provided a population of academicians who are mostly at marriageable age; although there are both singles and married among them, their diversity in marital status provided data that covered the perception of both married and single adults.

3.4 Study Population: University of Ibadan postgraduate students were used in this study.

Inclusion criteria:

MSc and PhD students resident in Abdusalam Abubakar and Tafawa Balewa Hall of University of Ibadan.

Exclusion criteria:

-MSc and PhD students in Obafemi Awolowo Hall of University of Ibadan

-MSc and PhD students of University of Ibadan living outside the campus

-MSc and PhD students who are unwilling to participate in the study

-MSc and PhD students with any medical/health challenge that can hinder their participation e.g. students that are sick or visually challenged.

3.5 Sample Size

Using the Cochran's formula for calculating sample size, a sample size of **308** was used in this study; with a confidence level of 95%, margin error of 5%, attrition of 10%, and estimated population size of 1000 students -

Tafawa Balewa Hall = 207 students; Abdusalam Abubakar Hall = 700 students (University of Ibadan, 2018)

$$nf = \frac{n}{1+n/N}$$

Where nf= the sample size when population is less than 10,000

To get n,

$n = z^2pq/d^2$

z = 1.96 (for 95% confidence level)

p = the estimated proportion of the target population - 50% (0.5)

q = 1 - p; 1 - 0.5; = 0.5

d = desired degree of accuracy; 95% (0.05)

Therefore,

$$n = \frac{1.96^2 \times 0.5 \times 0.5}{0.05^2}$$

$$= \frac{3.88416 \times 0.25}{0.0025} = \frac{0.97104}{0.0025}$$

n = 388.416

n = 388

Then;

$$nf = \frac{n}{1+n/N}$$

N = average total population (1000)

$$nf = \frac{388}{1 + 388/1000}$$

= 388/1.388

= 279.539

nf = 280

Attrition, = 10% of 280

= (10/100) x 280

= 28

Attrition = 28

Sample size: nf + attrition; 280 + 28

Sample size = **308 postgraduate students of University of Ibadan.**

3.6 Sampling Technique

Cluster sampling technique was used in drawing the sample for the study. The halls of residence for postgraduate students within the university used for this study were Tafawa Balewa hall, and Abdusalam Abubakar hall.

For each of the halls of residence, the blocks within the hall were grouped into male and female blocks.

For Abdusalam Abubakar hall, there were four blocks (Block A, B, C, D). Block D and A, were male blocks. Students living in block A were selected to represent the male populace in Abdusalam hall. Block C students were used to represent the female populace in Abdusalam hall for this study.

Based on the percentage (about 70%) of students in Abdusalam Abubakar hall in the total study population (1000), about 215 students were needed to represent Abdusalam Abubakar hall in the total sample size. Each block in Abdusalam Abubakar hall has an average number of 70 rooms, with an average number of 2 occupants, thus, two blocks were used from Abdusalam Abubakar hall in this study (Block A and C)

In Tafawa Balewa hall,there are five blocks (A, B, C, D, E). Block A and E were female blocks, and both blocks were used in the study. From the male blocks, only block B and D was used in this study.

An average number of 98 respondents (about 30% of sample size) was needed from Tafawa Balewa hall for this study. With an average number of 36 rooms per block, 4 blocks were selected from this hall (block A, B, D, E) for this study to suffice for the number of students needed, in case of unavailability of the students at the point of data collection, due to any

personal reason that can be associated to the nature of their course (e.g. working-schooling, using of the hall as temporal residence, travelling out for project work, e.t.c.)

Selection of each blocks within the halls were done by simple random selection process.

3.7 Instrument for Data Collection

Self-administered questionnaires were used in collecting data from the study participants, to assess their perception about the influence of male involvement in perinatal care on the promotion of maternal and child health.

The first section of the questionnaire contained questions to elicitrelevant data on participants socio-demographic characteristics.

The second section, was divided into sub-sections, and contained questions about the basic variables in the study. The questions in this section were derived from the body of the literature review.

In sub-section A (Perception about male involvement), the Likert rating scale was used to grade the participants' perception about male involvement. Nine questions were asked under this section.

Under sub-section B (Knowledge about perinatal care), dichotomous questions were elicited, to determine the knowledge of participants about perinatal care.

Sub-section C (Factors that influence effective implementation of male involvement in perinatal care) contains thirteen questions graded using the Likert scale.

The concept of positive maternal and child health was assessed in sub-section D, with the use of dichotomous questions. Five question were elicited in this section.

Sub-section E (Influence of male involvement in perinatal care on the promotion of maternal and child health) and Sub-section F (Possible suggestions for improving male involvement in perinatal care services) both contains questions using the Likert scale format. There were fourteen questions under sub-section E and nine questions in sub-section F.

3.8 Reliability of the Instrument

A pilot study was carried out determine the reliability of the instrument. The pretesting of the questionnaire was done among post graduate student living off-campus and in Obafemi Awolowo Hall, University of Ibadan. Thirty (30) postgraduate students were used.

The result from the pilot study was used to revise the instrument for clarity of questions, sequence and order of question; before final administration.

The stability of the instrument was measured using Cronbach's alpha (0.648).

3.9 Validity of the Instrument

The instrument wastested for face and content validity. The questionnaire was submitted to the research supervisor for thorough assessment for content and face validity.

The contents of the instrument were derived from reviewed literature to ensure that the concepts/variables in the study are covered. This was also done in line with the aims and objectives of the study.

All necessary corrections after the review by the supervisor were put into consideration before the administration of the questionnaire.

3.10 Method of Data Collection

Self-administered questionnaires was used in collecting data. Research assistants were employed to aid in the collection of data, after proper training to ensure their efficiency and maintenance of ethical principle throughout the study.

3.11 Data Analysis

The questionnaires were sorted out for complete filling and then coded, before they are imputed for statistical analysis. Responses from the participants were coded to ensure easy analysis of the data.

Quantitative data analysis was used in analysing the data collected. Statistical Package for Social Sciences (SPSS) Version 20 was used to compute and analyse the data. The statistical tools used were: frequency tables andmeasures of central tendency (mean and mode).

Inferential analysis was also used to determine the relationship between some of the variables in the study. They were represented using contingency tables. Chi-square test, independent t-test and analysis of variance (ANOVA)were used to test the hypothesis.

The first section in the instrument, which contains the socio-demographic data, was analysed with Statistical Package for Social Sciences (SPSS) using frequency distribution table.

Objective 1: To identify perceptions about the concept of male involvement. The data gotten from the participants was coded based on their choice in the likert grading system and it was then analysed with univariate analytical technique using frequency distribution tables and percentages.

Objective 2: To assess the knowledge of the respondents about perinatal care services. The responses were analysed with univariate analytical method after the data gotten from the participants were coded based on their choice in the 5 point- likert scale grading system.

Objective 3: To determine the factors influencing effective implementation of male involvement in perinatal care. Univariate analysis of the responses was employed and frequency distribution tables and percentages were used to present the data.

Objective 4: To explore the concept of positive maternal and child health and determine the influence of male involvement in perinatal on the promotion of maternal and child health. Univariate descriptive statistics of the participants' perception was used for the analysis. Frequency distribution tables and percentages were used for representation of the data.

Objective 5: To obtain possible suggestions for improving male involvement in perinatal care services. The suggestions of the respondents was graded from 1 - 5, using the likert scale. Frequency distribution table with percentage was used in presentation after analysis with univariate technique.

3.12 Ethical Consideration

The proposal for this study was sent to the Ethical Review Board of University of Ibadan and, University College Hospital for proper review. Confidentiality of participants was ensured throughout the study, and the process of data collection was not of harm to the participants.

Proper informed individual consent was sought for their participation in the study, and no one was involved against his/her will. Anonymity was ensured during data collection, analysis and presentation.

CHAPTER FOUR: RESULTS

4.0 Introduction

This chapter presents the result of the research carried out on the **Perception of Postgraduate Students about the Influence of Male Involvement in Perinatal Care on Maternal and Child Health.**It basically involves the presentation and analysis of data gathered through the use of questionnaire distributed to the respondents. Three hundred and ten (310) questionnaires were distributed and two hundred and forty (240) copies were retrieved. This gave a response rate of return of 77%.

Six research questions and four hypotheses were formulated and tested. The data was analyzed using frequency count, percentage, analysis of variance (ANOVA), independent T-test and Chi-square test. The presentation of the results of data analysis shall be discussed under the three subheadings:

- Presentation of the analysis of the socio-economic data
- Presentation of the analysis of the research questions
- Presentation of the analysis of the hypothesis

4.1. PRESENTATION OF THE ANALYSIS OF THE SOCIO-ECONOMIC DATA

The socio-economic characteristics of the respondents included their age, gender, tribe, religion, academic level, marital status, employment status. The frequency and percentage distributions are presented as follows:

Table 4.1: Distribution of Socio-demographic Characteristics of the Respondents

VARIABLE	GROUP	FREQUENCY	PERCENTAGE%
GENDER	Female	90	37.5
	Male	150	62.5
	Total	**240**	**100.0**
TRIBE	Igbo	17	7.1
	Hausa	6	2.5
	Yoruba	176	73.3
	Others	41	17.1
	Total	**240**	**100.0**
RELIGION	Christianity	208	86.7
	Islam	31	12.9
	Others	1	0.4
	Total	**240**	**100.0**
ACADEMIC LEVEL	M.Sc	215	89.6
	PhD	25	10.4
	Total	**240**	**100.0**
MARITAL STATUS	Married	28	11.7
	Single	212	88.3
	Total	**240**	**100.0**
EMPLOYMENT STATUS	Employed	56	23.3
	Unemployed	109	45.4
	Self employed	75	31.3
	Total	**240**	**100.0**
AGE	20-25 yrs	89	37.1
	26-31yrs	125	52.1
	32-37yrs	23	9.6
	38-43yrs	2	.8

44-49yrs	1	0.4
Total	**240**	**100.0**

Age(Mean± Standard deviation) 27.16±3.48

Table 4.1. above shows the socio-demographic characteristics of 240 sampled respondents. The mean age in the study was 27.16 ±3.48 with an age range of 22 - 45 years. The distribution of the gender showed that 150 (62.5%) of the respondents are males. The tribal distribution of the respondents indicated that 176 (73.3%) of the respondents were of the Yoruba tribe and those belonging to the Igbo and Hausa tribe were 17 (7.1%) and 6 (2.5%) respectively. The distribution of religion showed that 208 (86.7%) of the respondents were Christians and 31 (12.9%) were Muslims. The academic level of the respondents were either MSc or PhD, of which 215 (89.6%) were MSc. The marital status distribution showed that 212 (88.3%) of the respondents were single and 28 (11.7%) were married and the employment status of the respondents showed that 109 (45.4%) are unemployed and 56 (23.3%) are employed.

4.2 PRESENTATION OF THE ANALYSIS OF THE RESEARCH QUESTIONS

Research Question One: What is male involvement?

Table 4.2.1: Showing the Perception of the Respondents About the Concept ofMale Involvement

KEY: **SA**=Strongly Agree; **A**=Agree; **UD**=Undecided; **D**=Disagree; **SD**=Strongly Disagree

S/N	CONTENT	SA	A	UD	D	SD	MODAL RESPONSE
1.	Effective male involvement is **not** just the presence of a male figure in maternal (mother) and child health care activities, but also his total involvement in the care.	167 (69.6%)	68 (28.3%)	4 (1.7%)	1 (0.4%)	0 (0%)	Strongly agree
2.	In male involvement the man does **not** need to provide financial support for pregnancy-related and childbirth-related expenses. His presence **alone** covers it all.	8 (3.3.%)	9 (3.8%)	7 (2.9%)	64 (26.7%)	152 (63.3%)	Strongly disagree
3.	Decisions about pregnancy and child birth related issues is **solely** the the responsibility of the woman.	6 (2.5%)	6 (2.5%)	10 (4.2%)	71 (29.6%)	147 (61.2%)	Strongly disagree
4.	Male involvement in maternal and child care should be restricted to **Antenatal care only**.	3 (1.3%)	7 (2.9%)	19 (7.9%)	96 (40%)	115 (47.9%)	Strongly disagree
5.	When the man is been represented by **his mother** during his wife's visits to the clinic for perinatal care, that can still be termed as male involvement.	10 (4.2%)	48 (20%)	41 (17%)	88 (36.7%)	53 (22.1%)	Disagree
6. *	Men should **always** go with their wife when ever she goes for antenatal care or she is in labour.	41 (17.1%)	88 (36.7%)	65 (27.1%)	39 (16.3%)	7 (2.9%)	Agree
7.	Male involvement is **not** limited to men being involved in their wife and children care, but also in their **own** reproductive health needs.	105 (43.8%)	113 (47.1%)	16 (6.7%)	4 (1.7%)	2 (0.8%)	Agree
8.	Concern for the well-being of the mother and child, by the man, is **not** an attribute of effective male involvement.	10 (4.2%)	28 (11.7%)	19 (7.9%)	92 (38.3%)	91 (37.9%)	Disagree
9.	Male involvement does **not** improve the maternal (mother) and fetal (unborn child) health status.	8 (3.3%)	24 (10.0%)	34 (14.2%)	80 (33.5%)	93 (38.9%)	Strongly disagree

Table 4.2.1 above shows the perception of the respondents about the concept of male involvement. 167 (69.6%) respondents strongly agreed that effective male involvement is not only the presence of a male figure in maternal (mother) and child health care activities, but also his total involvement in the care; whereas 0.4% of the respondents disagreed to this statement. Also, 113 (47.1%) of the respondents agreed that male involvement is not limited to men being involved in their wife and children care, but also in their own reproductive health needs. The respondents, 152 (63.3%) strongly disagreed that in male involvement the man does not need to provide financial support for pregnancy-related and childbirth-related expenses. His presence alone covers it all. 3 (1.3%) respondents strongly agreed that male involvement in maternal and child care should be restricted to Antenatal care only, but 115 (47.9%) respondents strongly disagreed to this, whereas 19 (7.9%) respondents were undecided about it. Consequently, 88 (36.7%) of the respondents agreed that men should always go with their wife when ever she goes for antenatal care or she is in labour, but 65 (27.1%) respondents were undecided about this.

Table 4.2.2 below shows the knowledge of the respondents about the concept of perinatal care. It showed that 134 (44.2%) of the respondents had the knowledge that perinatal care is not restricted to care during pregnancy alone. Some respondents also stated that the management of labour and delivery is an aspect of perinatal care (88.3%) and not anybody can provide perinatal services (71.7%) as it involves a multidisciplinary approach (88.8%). Tests like, blood pressure, urinalysis, weight, fundal height, abdominal palpation, pelvimetry, fetal heart/fetal movements, blood tests, rhesus, and ultrasound scans, e.t.c were also stated by the respondents (92.1%) to be important in caring for a pregnant woman. 87.5% were knowledgeable about the need for ensuring the comfort of the woman during delivery, assessing for the fetal heartbeat and heart rate (90.4%) and education of pregnant woman about birth preparedness and readiness for complication (90.0%) as care provided by midwives during labour, antenatal and postnatal care. 17.5% of the respondents were not knowledgeable about the aspect of perinatal care that involves: care of the baby, coping with crying babies, stimulating the baby, monitoring the baby's developmental milestones, and immunization for babies.

Research Question Two: What is the concept of perinatal care?

Table 4.2.2: Showing The Knowledge of the Respondents About Perinatal Care

S/N	Statement	Group	Frequency	Percentage (%)
1.	Perinatal care is the care given to a woman **only** during pregnancy.	True:	106	55.8
		False:	134	44.2
		Total:	**240**	**100**
2.	Management of labour and delivery is not an aspect of perinatal care.	True:	40	16.7
		False:	200	88.3
		Total:	**240**	**100**
3.	**Any body** can provide provide perinatal services.	True:	68	28.3
		False:	174	71.7
		Total:	**240**	**100**
4.	Tests like, blood pressure, urinalysis, weight, fundal height, abdominal palpation, pelvimetry, fetal heart/fetal movements, blood tests, rhesus, and ultrasound scans, e.t.c are **NOT** important in caring for a pregnant woman.	True:	19	7.9
		False:	221	92.1
		Total:	**240**	**100**
5.	Ensuring the comfort of the woman during delivery is **not** a major care to provided by the midwife.	True:	30	12.5
		False:	110	87.5
		Total:	**240**	**100**
6.	Assessing for the fetal heartbeat and heart rate is **essentia**l during the period of labour.	True:	217	90.4
		False:	23	9.6
		Total:	**240**	**100**
7.	Education of pregnant woman about birth preparedness and readiness for complication is **needed** during the antenatal period.	True:	216	90.0
		False:	24	10.0
		Total:	**240**	**100**
8.	Although the woman has been cared for during pregnancy and delivery, it is still **vital** to give her adequate postnatal care.	True:	230	95.8
		False:	10	4.2
		Total:	**240**	**100**
9.	There is an aspect of perinatal care that involves: care of the baby, coping with crying babies, stimulating the baby, monitoring the baby's developmental milestones, and immunization for babies.	True:	198	82.5
		False:	42	17.5
		Total:	**240**	**100**
10.	Perinatal care should involve a multidisciplinary approach.	True:	213	88.8
		False:	27	11.3
		Total:	**240**	**100**
11.	The culture of the woman should **not** be put into consideration in providing perinatal care.	True:	132	55.0
		False:	108	45.0
		Total:	**240**	**100**

Research Question Three: What are the factors influencing effective implementation of male involvement in perinatal care?

Table 4.2.3: Showing the Factors Influencing Effective Implementation of Male Involvement in Perinatal Care
KEY: **SA**=Strongly Agree; **A**=Agree; **UD**=Undecided; **D**=Disagree; **SD**=Strongly Disagree

S/N	FACTORS	SA	A	UD	D	SD	MODAL RESPONSE
1.	Lack of transportation to the hospital facility **can** hinder men from getting involved in the perinatal care.	19 (7.9%)	59 (24.6%)	35 (14.6%)	79 (32.9%)	48 (20.0%)	Disagree
2.	Long waiting time before being attended to by the health practitioner **can not** influence the rate at which males get involved in their pregnant wife' care.	22 (9.2%)	74 (30.8%)	35 (14.6%)	77 (32.1%)	32 (13.3%)	Disagree
3.	The cultural beliefs of the the male **should** hinder him from being with his wife during labour.	14 (5.8%)	38 (15.8%)	27 (11.3%)	86 (35.8%)	75 (31.3%)	Disagree
4.	Lack of adequate finance **should** influence the way men participate in the care of their wife before, during and after pregnancy.	18 (7.5%)	59 (24.6%)	23 (9.6%)	84 (35.0%)	56 (23.3%)	Disagree
5.	Working class/Employed husbands provide **better support** to their wife during, before and after pregnancy.	33 (13.8%)	77 (32.1%)	60 (25.0%)	59 (24.6%)	11 (4.6%)	Agree
6.	When a man sees his presence during the care of his wife as beneficial to the health of his wife and unborn child, he will get more involved in their care.	120 (50.0%)	94 (39.2%)	18 (7.5%)	3 (1.3%)	5 (2.1%)	Strongly agree
7.	The nature, quality and importance of the information provided to the man as regards the health of his wife and unborn child can influence his level of participation in their care.	121 (50.4%)	105 (43.8%)	10 (4.2%)	4 (1.7%)	0 (0.0%)	Strongly agree
8.	The nature of the relationship between the man and the wife can influence the extent of male involvement.	126 (52.5%)	100 (41.7%)	12 (5.0%)	0 (0.0%)	2 (0.8%)	Strongly agree
9.	Family separation and possible crises could pose a significant barrier to effective participation of males in perinatal care	112 (46.7%)	97 (40.4%)	18 (7.5%)	10 (4.2%)	3 (1.3%)	Strongly agree
10.	Unclear roles, **not knowing** what the health care system expected of them (the males), and lack of information on what to the men should expect through the perinatal period **cannot** influence the their participation.	32 (13.3%)	47 (19.6%)	42 (17.5%)	78 (32.5%)	41 (17.1%)	Disagree
11.	The behaviour and approach of the health workers **can** influence the man's decision to fully participate in every aspect of the wives care.	54 (22.5%)	131 (54.6%)	28 (11.7%)	17 (7.1%)	10 (4.2%)	Agree
12.	Restricted access offered to men who want to provide support to their wives during labour and delivery by health care providers**can** pose as a barriers to effective male involvement.	51 (21.3%)	118 (49.2%)	33 (13.8%)	28 (11.7%)	10 (4.2%)	Agree
13.	The place where the woman had her previous delivery (hospital/home) can influence the way the man will participate in her current perinatal care.	44 (18.3%)	86 (35.8%)	56 (23.3%)	37 (15.4%)	17 (7.1%)	Agree

Table 4.2.3 above shows the factors influencing effective implementation of male involvement in perinatal care. Factors such as lack of transportation to hospital facility (32.9%), the cultural beliefs of the man (35.8%) and lack of adequate finance were disagreed upon as factors that could influence effective implementation of male involvement. Majority of the respondents agreed that long waiting time before being attended to by the health practitioner (32.1%) can influence the rate at which males get involved in their pregnant wife' care. Also, working class/Employed husbands were believed to provide better support to their wife during, before and after pregnancy (32.1%). Factors such as the nature, quality and importance of the information provided to the man as regards the health of his wife and unborn (50.4%), the nature of the relationship between the man and the wife (52.5%), family separation and possible crises (46.7%), the behaviour and approach of the health workers (54.6%), and unclear roles and lack of information on what to the men should expect through the perinatal period (32.5%), can influence the effective implementation of male involvement in perinatal care.

Table 4.2.4 below shows the perception of the respondents about the concept of maternal and child health. Maternal and child health was seen as not to be concerned with **only** the prevention of disease (85.0%), but should involve: care during pregnancy, childbirth and post-partum period (90.8%), focusing on the reduction of maternal, perinatal, infant and childhood mortality and morbidity(88.3%), Provision of commodities and supplies needed in the care of mother and child (85.4%), and also family planning (78.3%).

Research Question Four: What is positive maternal and child health?

Table 4.2.4: Showing the Concept of Positive Maternal and Child Health

S/N	Statement	Group	Frequency	Percentage (%)
1.	Maternal and child health is only concerned with the prevention of disease.	True:	36	15.0
		False:	204	85.0
		Total:	**240**	**100**
2.	Positive maternal health should involve care during pregnancy, childbirth and postpartum period.	True:	218	90.8
		False:	22	9.2
		Total:	**240**	**100**
3.	Maternal and child health should focus also on the reduction of maternal, perinatal, infant and childhood mortality and morbidity.	True:	212	88.3
		False:	28	11.7
		Total:	**240**	**100**
4.	Family planning is **not** a component of positive maternal care services.	True:	52	21.7
		False:	188	78.3
		Total:	**240**	**100**
5.	Providing commodities and supplies needed in the care of mother and child is **not** an integral component of positive maternal and child health.	True:	35	14.6
		False:	205	85.4
		Total:	**240**	**100**

Table 4.2.5 below shows the Influence of male involvement in perinatal care on the promotion of maternal and child health. When men get involved in perinatal care it influences the maternal and child health as it ensures: the safety of the wife's pregnancy and childbirth (49.2%), reduction in maternal and newborn death (38.3%), reduction of any unhealthy behaviour in the wife with promotion positive behaviour (45.5%), reduction in maternal stress (44.2%), better health outcomes for the wives and children (35.8%) and reduction of low birth weight, risk of preterm birth, fetal growth restriction and infant mortality (27.1%) - although 26.3% of the respondents disagreed about the influence of male involvement on the reduction of low birth weight, risk of preterm birth, fetal growth restriction and infant mortality. 44.2% of the respondents also agreed that maternal access to care and provision of emotional and financial support is a function of effective male involvement, as women have easier and quicker access to health care when their husband is fully involved in their health needs (39.2%). Consequently, when males get involved in perinatal care, it spells out their sense of commitment to having healthy a mother and baby (44.8%), influences the wife's experience and meaning of the labour/delivery process (50.0%), and strengthens their relationship with their wife (62.5%).

Research Question Five: What influence does male involvement in perinatal care have on the promotion of maternal and child health?

Table 4.2.5: Showing the Influence of Male Involvement in Perinatal Care on the Promotion of Maternal and Child Health

KEY: **SA**=Strongly Agree; **A**=Agree; **UD**=Undecided; **D**=Disagree; **SD**=Strongly Disagree

S/N	CONTENT	SA	A	UD	D	SD	MODAL RESPONSE
1.	The safety of their wife's pregnancy and childbirth**can** be influenced by the role the man plays in their care.	100 (41.4%)	118 (49.2%)	13 (5.4%)	8 (3.3%)	1 (0.4%)	Agree
2.	Maternal and newborn death **cannot** be reduced by getting males to be more involved in their care.	24 (10.0%)	43 (17.9%)	52 (21.7%)	92 (38.3%)	29 (12.1%)	Disagree
3.	When men are involved in perinatal care, they will **aid** in the reduction of any unhealthy behaviour in the wife and promote positive behaviour.	93 (38.8%)	109 (45.5%)	26 (10.8%)	9 (3.8%)	3 (1.3%)	Agree
4.	Male involvement has **nothing** to do with the reduction of low birth weight, risk of preterm birth, fetal growth restriction and infant mortality.	26 (10.8%)	63 (26.3%)	55 (22.9%)	65 (27.1%)	31 (12.9%)	Disagree
5.	The presence of the man during delivery will **reduce** maternal stress and also boast her morale.	95 (39.6%)	106 (44.2%)	29 (12.1%)	6 (2.5%)	4 (1.7%)	Agree
6.	The way at which the man gets involved in perinatal care spells out his sense of commitment to having a healthy mother and baby.	98 (40.8%)	117 (48.8%)	18 (7.5%)	5 (2.1%)	2 (0.8%)	Agree
7.	Maternal access to care and provision of emotional and financial support is a function of effective male involvement.	96 (40.0%)	106 (44.2%)	23 (9.6%)	11 (4.6%)	4 (1.7%)	Agree
8.	The involvement of the man in antenatal care does **not** really make the wife to visit the antenatal clinic as expected.	13 (5.4%)	32 (13.3%)	43 (17.9%)	111 (46.3%)	41 (17.1%)	Disagree
9.	The presence and companionship of the man during labour/delivery **can** influence the wife's experience and meaning of the process.	88 (36.7%)	120 (50.0%)	27 (11.3%)	5 (2.1%)	0 (0.0%)	Agree
10.	When men get involved in their wife's care, their relationship is strengthen.	150 (62.5%)	73 (30.4%)	15 (6.3%)	1 (0.4%)	1 (0.4%)	Strongly agree
11.	Men have social and tremendous control over their partners and make vital decisions as regards their wife's health, as such, their involvement is critical in improving maternal health and reducing maternal mortality and morbidity	90 (37.5%)	114 (47.5%)	27 (11.3%)	9 (3.8%)	0 (0.0%)	Agree
12.	Women have easier and quicker access to health care when their husband is fully involved in their health needs.	79 (32.9%)	94 (39.2%)	50 (20.8%)	12 (5.0%)	5 (2.1%)	Agree
13.	Male involvement is an important avenue for giving men information so they can support healthy behaviors and health care seeking for children, such as exclusive breastfeeding and childhood immunization	115 (47.9%)	96 (40.0%)	24 (10.0%)	5 (2.1%)	0 (0.0%)	Strongly agree

14.	Wives and children of actively involved males have better health outcomes than those whose husbands don't get involved in their care.	81 (33.8%)	86 (35.8%)	52 (21.7%)	16 (6.7%)	5 (2.1%)	Agree

Research Question Six: What are the possible suggestions for improving male involvement in perinatal care services?

Table 4.2.6: Showing the Possible Suggestions for Improving Male Involvement in Perinatal Care Services

S/N	SUGGESTIONS	SA	A	UD	D	SD	MODAL RESPONSE
1.	Increase **level of awareness and education** of what male involvement entails, with its attributed benefit.	152 (63.3%)	82 (34.2%)	6 (2.5%)	0 (0.0%)	0 (0.0%)	Strongly agree
2.	Development of **national policies** to ensure the participation of males in every aspect of maternal and child health care.	92 (38.3%)	106 (44.2%)	35 (14.6%)	7 (2.9%)	0 (0.0%)	Agree
3.	**Only** programmes within the health sector should be involved; programmes such as social media should **not** be employed.	15 (6.3%)	30 (12.5%)	37 (15.4%)	110 (45.8%)	48 (20.0%)	Disagree
4.	**Women also** should have adequate and accurate knowledge on male partner involvement and its benefits; not just the males.	116 (48.3%)	110 (45.8%)	12 (5.0%)	2 (0.8%)	0 (0.0%)	Strongly agree
5.	Health practitioners **should always** provide the man with all relevant information about their wife's care and **not** make them feel alienated.	132 (55.0%)	88 (36.7%)	17 (7.1%)	2 (0.8%)	1 (0.4%)	Strongly agree
6.	Men should be told the exact roles they are to perform when they accompany their wife to the clinic/hospital.	108 (45.0%)	104 (43.3%)	22 (9.2%)	6 (2.5%)	0 (0.0%)	Strongly agree
7.	Health care providers do **not** need training on customer care, communication skills and relations.	14 (5.8%)	21 (8.8%)	22 (9.2%)	67 (27.9%)	116 (48.3%)	Strongly disagree
8.	Male involvement can be actualized **without** active involvement of the community members and stakeholders.	17 (7.1%)	53 (22.1%)	41 (17.1%)	84 (35.0%)	45 (18.0%)	Disagree
9.	**Incentives/ Disincentives** (e.g. free male health check-up, free ANC for women accompanied by partners, certificates for couple testing, prioritization for women accompanied by a male partner, partner invitation letters and fines for partners) should be employed by hospital facilities.	95 (39.6%)	99 (41.3%)	31 (12.9%)	10 (4.2%)	5 (2.1%)	Agree

KEY: **SA**=Strongly Agree; **A**=Agree; **UD**=Undecided; **D**=Disagree; **SD**=Strongly Disagree

Table 2.2.6 above shows the possible suggestions for improving male involvement in perinatal care services. Most of the respondents suggested: an increase level of awareness and education of what male involvement entails (63.3%), development of national policies to ensure the participation of males in every aspect of maternal and child health care (44.2%), integration of other programmes outside the health sector like social media (45.8%), providing the man with all relevant information about their wife's care and not make them feel alienated (55.0%), telling men the exact roles they are to perform when they accompany their wife to the clinic/hospital (45.0%), active involvement of the community members and stakeholders (48.3%), training of health care providers on customer care, communication skills and relations (35.0%), and the active use of Incentives/ Disincentives (e.g. free male health check-up, free ANC for women accompanied by partners, certificates for couple testing, prioritization for women accompanied by a male partner, partner invitation letters and fines for partners) by hospital facilities (41.3%). Also, majority of the respondents agreed that to promote male involvement in perinatal care, women also should have adequate and accurate knowledge on male partner involvement and its benefits; not just the males (48.3%).

4.3. PRESENTATION OF THE ANALYSIS OF THE HYPOTHESIS

Hypothesis 1

H_0: There is no relationship between gender and the level ofknowledge about perinatal and maternal care services.

Table 4.3.2 showing a cross-tabulation between gender and the level of knowledge about perinatal care

gender and level of knowledge about perinatal care Cross-tabulation

			level of knowledge about perinatalcare		Total
			low	high	
gender	female	Count	23	34	57
		% within gender	40.4%	59.6%	100.0%
	male	Count	39	55	94
		% within gender	41.5%	58.5%	100.0%
Total		Count	62	89	151
		% within gender	41.1%	58.9%	100.0%

Table 4.3.3 showing the relationship between gender and the level of knowledge about perinatal care

Chi-Square Tests

	Value	df	P-value
Pearson Chi-Square	0.019[a]	1	0.890

In table 4.3.2 above, it shows that majority of the respondents (58.9%) have high level of knowledge above perinatal care and Table 4.3.3 shows the relationship between gender and the level of knowledge about perinatal care using Pearson Chi-square test, which indicates that there is no significant relationship between gender and the level of knowledge about perinatal care as the resultant P-value (0.890) is greater than 0.005; therefore we fail to reject the null hypothesis.

Hypothesis 2

H_0: There is no relationship between marital status and the perceived concept of male involvement

Table 4.3.4 showing the relationship between marital status and the perceived concept of male involvement

Independent Samples Test			
		t-test for Equality of Means	
		df	P-value
perception of the concept of male involvement	Equal variances assumed	237	0.272

The table 4.3.4. above shows that there is no significant relationship between marital status and the perceived concept of male involvement as the result of the independent t-test indicates a P-value greater than 0.005 (P-value = 0.272). So therefore. we fail to reject the null hypothesis.

Hypothesis 3

H_0: There is no relationship between socio-economic status (employed, unemployed, self employed) and the perceived factors that influence effective implementation of male involvement in perinatal care.

Table 4.3.5 showing the relationship between socio-economic status (employed, unemployed, self employed) and the perceived factors that influence effective implementation of male involvement in perinatal care

ANOVA			
Factors that influence effective implementation of male involvement in perinatal care			
	df	F	P-value.
Between Groups	2	2.138	0.120
Within Groups	237		
Total	239		

Table 4.3.5 above uses analysis of variance (ANOVA) to demonstrate that the relationship between socio-economic status (employed, unemployed, self employed) and the perceived factors that influence effective implementation of male involvement in perinatal care is not statistically relevant as the P-value (0.120) is greater than 0.005. Therefore, we fail to reject the null hypothesis.

CHAPTER FIVE: DISCUSSION OF FINDINGS, RECOMMENDATION AND CONCLUSION

5.0 INTRODUCTION

This chapter deals with the discussion of necessary findings in the study, its implication to nursing, summary, conclusion, recommendation and suggestions for further studies.

5.1 DISCUSSION OF FINDINGS

A total of 240 respondents were used in this study with a mean age and age range of 27.16 ±3.48 and 22 - 45 years respectively. Most of the respondents were males (62.5%) with 37.5% being females.The tribal distribution showed that 73.3% of the respondents were Yoruba. 7.1% were Igbo, 2.5% were Hausa and 17.1% belonged to other tribes outside the mentioned three. The major religion of the respondents was Christianity (86.7%) followed by the Islamic religions (12.9%), and other religion (0.4%). As the respondents were basically postgraduate students, their academical level was grouped into MSc and PhD, with the distribution being 89.6% and 10.4% respectively. Most of the respondents were single (88.3%) and others were married (11.7%), and the employment status of the respondents varied from unemployed (45.4%), self employed (31.3%) and employed (23.3%).

5.1.1 Perception of Male Involvement in Perinatal Care

In exploring the perception of the respondents about the concept of male involvement, most of the respondents were of the view that male involvement is the presence of the man in maternal and child health care activities, but also his active and total involvement in the care (97.9%). Majority (97.6%) of the respondents also believed that there is a need for the man to provide financial support for both pregnancy and child birth related issues, this is in consensus with the categorisation of male involvement stated in a study by Yargawa and Leonardi-Bee (2015).

From the findings of this study, it was discovered that in effective male involvement, decisions about pregnancy-related and childbirth-related issues should be carried out jointly by the man and woman (90.8%); the man's involvement in maternal and child care should not be restricted to only the antenatal care (87.9%); and the representation of the man by his mother during perinatal care activities, does not suffice for effective male involvement (58.8%) as more than half of the respondents agreed that the man should always go with wife when ever she goes for antenatal or is in labour (53.8%). These findings in this study are similar to the findings in the study conducted by Yargawa et al. (2015), where three broad categories were considered as

indicating male involvement ranging from, active participation in all aspects of perinatal care, financial support, and shared decision making powers on maternal health issues.

Furthermore, male involvement was also perceived by the respondents (90.9%) as not being limited to the man being involved in the care of the wife and the child but also being involved in issues concerning his own reproductive health, this finding is in line with the description of male involvement in the study by Yargawa et al (2015). Also, it was discovered in this study that in effective male involvement, the man should show concern for the wellbeing of both the mother and the child (76.2%); and this is in consensus with the description of male involvement at the International Conference on Population and Development as stated in a study carried out by (Mfuh, Lukong, Olokoba, and Zubema (2016).

5.1.2 Perinatal Care

As regards the perception of the respondents about perinatal care, which in the long run displayed their level of knowledge about the concept. Most of the respondents (55.8%) did not know explicitly the coverage of perinatal care, as they responded that perinatal care was the care given to the woman **only** during pregnancy. This response is not in accordance with the Guidelines for Perinatal Care (7th edition), by the American Academy of Pediatrics (AAP) and the American College of Obstetricians and Gynecologists (ACOG) which states that perinatal care "should address the care received by the mother before pregnancy and during pregnancy, the management of labor and delivery, postpartum care, and neonatal care".

Also, most of the respondents (92.1%) perceived that test like blood pressure, urinalysis, weight, fundal height, abdominal palpation, pelvimetry, fetal heart/fetal movements, blood tests, rhesus, and ultrasound scans, e.t.c were important in caring for a pregnant woman. This finding is similar to the findings in a study by Worku, Yalew and Afework (2013), where participants stated the important services the pregnant woman received during antenatal care to be blood pressure check-up, urine testing, weight monitoring and diagnostics investigations like ultrasound scan.

Furthermore, the respondents perceived perinatal care as care involving the provision of comfort to the woman during labour (87.5%), assessing of fetal heart beat and rate (90.4%) and antenatal education on birth preparedness and readiness for complication (90%). These findings are in line with that of Worku, et al. (2013) and the Ministry of Health and Social Welfare, Tanzania, cited in August, et al. (2016), where auscultation of fetal heartbeat, control bleeding by drugs, information on progress of labor, ensuring comfort of mother, providing care for the baby,

discussion of birth preparedness and complication readiness (BP/CR) with the couple, were stated as relevant services to render to the woman during pregnancy and delivery.

Most of the respondents agreed to perinatal care being multidisciplinary (88.8%), which is in line with Values and Principles of Perinatal Care by the Perinatal Care Task Force, Venice, 1998, which states that perinatal care should be multidisciplinary and culturally appropriate, but 55.0% of the respondents in this study disagreed with the consideration of culture in the provision of perinatal care. The respondents were also agreed that the care/services given during the postpartum period is a part of the perinatal care services (82.5%), this in agreement with the postpartum services mentioned by WHO (2002), and component of perinatal care stated by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists (2012).

5.1.3 Factors that Influence Effective Implementation of Male Involvement in Perinatal Care

Several factors could influence the effective implementation of male involvement in perinatal care. From the findings of the study, lack of transportation to the hospital facility was not perceived by most the respondents (52.9%) as a factor that could influence the implementation of male involvement. This is different from the findings of Tweheyo et al. (2010) where one of the main factors identified by the respondents in the survey was lack of transportation,. This difference in findings may be as a result of the different setting used in the study. Tweheyo et al. (2010) made used of a peri-urban setting where the the walking distance to the health facility was considered by the respondents as long (one-hour walk), as compared to distance between the setting used in this study to the nearest health facility (twenty minute walk); so therefore, lack of transportation could have been a major factor in the study by Tweheyo et al. (2010), but not a major factor in this study .

Also, 45.4% of the respondents in this study agreed that long waiting time before the clients are being attended to by the health practitioners could influence male involvement in perinatal care, and this is similar to the study of Mfuh et al. (2016), and Tweheyo et al. (2010) where one of the major barriers identified by their respondents to male involvement was long waiting time. Adenike, et al. (2013), Lowe et al. (2017),Kiptoo et al. (2016) and Mfuh et al. (2016) all discovered that culture is a major factor that could influence effective male involvement, but this is different from the findings in this study as 67.1% of the respondents were of the view that the cultural beliefs should not influence male involvement.

Most of the respondents (58.3%) were of the opinion that finance should not influence how the male get involved in perinatal care of their wife. This is in contrast with the findings byAdenike, et al. (2013); Kiptoo, Mutai and Kipmerewo (2016); and Mfuh et al. (2016) where socio-economic factors, occupation, employment status and financial constraints, were stated as factors that could influence the man's decision about male involvement; although 45.9% of the respondents in this study, on the other hand, were of the opinion that the working class/employed husband will provide better perinatal support to their wife.

Also, the respondents in this study agreed that the nature, quality and importance of the information provided to the man as regards - the health of his wife and unborn child (94.2%), and the benefit of his involvement (89.2%), can influence his level of participation in their care. This is in line with findings of Tweheyo et al. (2010); Onchong'a, et al. (2016); August, et al. (2016); and Okeke, et al. (2016), where they were of the opinion that the nature and quality of knowledge and information that the man possesses about perinatal care, its complications and benefits, will influence his effective involvement in perinatal care.

Other factors like the nature of the relationship between the man and his wife (84.2%) family separation and possible family crisis (87.1%) were also perceived by the respondents as influential factors to effective male involvement. This is supported by the findings of Kaye et al. (2014) and Kiptoo et al. (2016). In the study of Kaye et al. (2014) it was stated that the perceived major deterrents to men's involvement during childbirth were personal factors (such as unhealthy couple relationship). Additionally, Kiptoo et al. (2016) focused on how close intimacy between the couple can promote the man's involvement in ANC.

The respondents in this study also gave their view about some hospital/health practitioner based factors that could influence effective male involvement. They agreed that the following factors could influence effective male involvement: unclear roles, not knowing what the health care system expected of them (the males), and lack of information on what to the men should expect through the perinatal period (49.6%); the behaviour and approach of the health workers (77.1%); and the place where the woman had her previous delivery either the hospital/home (54.1%). These factors were similarly seen in the study by Kaye et al. (2014); Kululanga et al. (2012); Amukugo, Neshuku and Julia, (2016) and Tweheyo et al. (2010), where unclear roles by the health care system, feeling of being ignored and underestimated by the health care providers, and previous birth/delivery place, were stated by their respondents as influential factors to male involvement;

Also, the respondents also agreed that restricted access offered to men who want to provide support to their wives during labour and delivery by health care providers could influence their involvement in perinatal care (70.5%), this is in line with the findings in the study by Kiptoo et al. (2016) where they stated that restricted access offered to men who want to provide support to their wives during labour and delivery by health care providers, can influence the rate at which males get involved in the care of their wives.

From the findings in this study, the factors that can influence effective male involvement in perinatal care, as stated by the respondents are: long waiting time before being attended to in the hospital (45.4%), the nature, quality and importance of information available to the males about perinatal care (94.2%), the nature of the relationship between the spouses (94.2%), health practitioners behaviours (77.1%), lack of clearly spelt out roles for males during their involvement in perinatal clear (49.6%), and the restrictive access offered to male who are willing to participate in perinatal care (70.5%).

5.1.4 Concept of Positive Maternal and Child Health

Positive maternal and child health was perceived by majority of the respondents as, a concept that is not restricted to the prevention of disease only (85.0%); but it encompasses the care during pregnancy, childbirth and postpartum period (90.8%), This is in line with the study by Lucas et al. (2003), cited in Mfuh et al. (2016); Adenike et al. (2016); and Okeke et al. (2016) where they stated that maternal and child health involves provision of promotive, preventing, curative and rehabilitative care; and health care services given to the mother before pregnancy, during pregnancy, labour and after delivery.

Maternal and child health was also perceived by the respondents to focus on the reduction of maternal, perinatal, infant and childhood mortality and morbidity (88.3%), including the provision of family planning services (78.3%). This is in line with the specific objectives of Maternal and Child Health (MCH) stated byUSAID (2013), where the reduction of maternal, perinatal, infant and childhood mortality and morbidity, and family planning were the central focus.

Also, 85.4% of the respondents in this study were of the view that providing commodities and supplies needed in the care of mother and child is also an integral part of maternal and child health. This is in line with the components of Maternal and Child Health (MCH) Program stated by USAID (2013),

So therefore, the findings in this study has shown that positive maternal and child health involves: the preventing, promotive and curative care, given to the mother and the child before pregnancy, during pregnancy, during delivery and after delivery, with a focus on the reduction of maternal, perinatal, infant and childhood mortality and morbidity, including the provision of family planning services and the commodities/supplies needed in the care of both the mother and the child.

5.1.5 Influence of Male Involvement in Perinatal Care on the Promotion of Maternal and Child Health

Male involvement in perinatal care is perceived by the respondents (90.6%) to have influence on the safety of the mother and child during pregnancy and childbirth as agreed by Kaye et al. (2014) and Onchong'a et al. (2016)in their study where they stated that men's involvement during pregnancy and childbirth plays a vital role in the safety of their female partners' pregnancy and childbirth. The respondents in this study also agreed that maternal and newborn death is reduced by male involvement (50.4%). This is in line with the study by Adenike et al. (2016), and Onchong'a et al. (2016) where it was reported that males are critical partners in the reduction of maternal and child mortality and their involvement in reproductive health is vital to ensuring the reduction of maternal and newborn death.

Also, 84.3% of the respondents in this study also agreed that when males get involved in perinatal care it can aid in the reduction of any unhealthy behaviour in the wife and promote positive behaviour. This is similar to the findings in the study by Alio et al. (2013) and Kaye et al. (2014) where they were of the opinion that male involvement reduces negative maternal health behaviours.

A higher percentage of the respondents in this study agreed that male involvement could reduce the risk of preterm birth, low birth weight, fetal growth restriction and infant mortality (40%), although 37.1% of the respondents had a contradicting opinion. This is supported by the findings in the study of Kaye et al. (2014) where he stated that male involvement could reduce the risk of preterm birth, low birth weight, fetal growth restriction and infant mortality.

According to the respondents in this study, when males get involved in perinatal care, their presence during delivery will reduce maternal stress and also boast her morale (83.8%); as well as spell out the man's sense of commitment to having healthy a mother and baby (89.6%). This is in line with the findings of Alio et al. (2013) and Adenike et al. (2016) in which they agreed that male involvement during pregnancy and their presence in the health facility during ANC, will

reduce the maternal stress levels, boost their morale and also bring about a greater sense of commitment of both parents to having healthy mothers and babies.

Most of the respondents (84.2%) were also of the of the view that maternal access to care and provision of emotional and financial support is a function of effective male involvement; which is supported by the study of Kaye et al. (2014), Onchong'a et al. (2016) and Adenike et al. (2016) where they stated that ensuring access of the woman to care and provision of emotional and financial support, are vital roles of male involvement. Additionally, 63.4% respondents agreed that male involvement could influence how the wife attends antenatal clinic, as it will make them attend as expected, which is in line with the findings in the study by Mkandawire et al.(2018) and August et al. (2016) where that viewed male involvement to have a positive influence on the attendance of women to ANC and even their compliance with breast feeding and family planning.

The respondents in this study agreed that the presence and companionship of the man during labour/delivery can influence the wife's experience and meaning of the process (86.7%). Strengthening of relationship between the man and the woman was also accepted by the respondents (92.9%) as an influence of male involvement. These findings are similar to the study by Hofmeyr et al. (1991) cited in WHO (2002) where it was stated that the companionship of the males had a striking, effect on the way that the participants reported experiencing labour; and also similar to the study conducted by Chalmers and Wolman on Social support in labour, where 90% of mothers concluded that the father's presence increased the meaning of the labour and delivery experience, and all mothers and fathers felt that the shared experience had strengthened their relationship.

Male involvement was also perceived by the respondents as an avenue for giving men information so they can support healthy behaviours and health care seeking for children (87.9%), which is also similar the study by Davis et al. (2016) and August et al. (2016) where Male involvement was stated to be an important avenue for giving men information so they can support healthy behaviours and obtain information regarding the pregnancy.

Although it is disputable, but 69.9% of the respondents agreed that wives and children of actively involved males have better health outcomes than those whose husbands don't get involved in their care, and this is supported by the findings of Alio et al. (2013), Kaye et al. (2014) where positive male involvement is said to improve the health outcome of both the mother and the child and even influence pregnancy outcomes.

Consequently, male involvement in perinatal care can influence every aspect of maternal and child health from pregnancy care or outcome to delivery and infant care. Effective male involvement in every aspect of maternal and child health care is seen as strong measure to ensure positive maternal and child health outcomes.

5.1.6 Possible Suggestions for Improving Male Involvement in Perinatal Care Services

Several suggestions were put forward to the respondents on how to improve male involvement in perinatal care. Most of the respondents agreed that their should be an increase in the level of awareness and education on what male involvement entails, with its attributed benefit (97.5%), which is in line with the study of Kaye et al. (2014) and the WHO, Geneva meeting in 2002, where they emphasised the need of creating awareness and ensuring adequate dissemination of information of what male involvement is.

Also, 82.5% of the respondents agreed that national policies should be developed to ensure the participation of males in every aspect of maternal and child health care which is also in line with the basic strategies to put forward by WHO, Geneva meeting in 2002, in achieving effective male involvement; and also in line with the findings of Kaye et al. (2014); Amukugo et al. (2016); and Besada et al. (2016) which stated that national policy which encourages male involvement should be set up by government official as it would be beneficial to streamline approaches across implementing partners and ensure wide-scale implementation to promote male involvement.

Furthermore, the respondents agreed that the programs used in the promotion of male involvements should not be restricted to health sector based programmes only, but programmes like the social media should be employed (65.8%). This is similar to the findings by Kaye et al. (2014) and in line with the WHO, Geneva meeting in 2002, when the need to enlist the support of programmes outside the health sector was recognized.

To improve male involvement, 94.1% of the respondents were of the opinion that women also should have adequate and accurate knowledge on male partner involvement and its benefits; not just the males. This is supported by the findings of Onchong's et al. (2016), Davis et al. (2016); Okeke et al. (2016); and August et al, (2016), where their respondents saw the need to empower the women with adequate and accurate knowledge as increasing the knowledge of both men and women in the community is a way to involve men in sexual and reproductive health matters.

Those providing health care services also have a role to play in improving male involvement in perinatal care, as the respondents were of the view that the health practitioners should always provide the man with all relevant information about their wife's care and not make them feel

alienated (91.7%), while telling them the exact roles they are to perform as they accompany their wife to the clinic/hospital (88.3%). Also, the respondents agreed to the need to train health care providers on customer care, communication skills and relations (76.2%). These findings are in line with that of Kaye et al. (2014); Okeke et al. (2016); and August et al. (2016 which states that health care providers are expected to appreciate and support the involvement of men in maternal health issues, support and undergo training in customer care, communication, and how to counsel couples in terms of understanding their health behaviours and outcomes.

As agreed by 53% of the respondents, the actualization of effective male involvement will not be possible without the active involvement of the community members and stakeholders, although, 29.2% of the respondents thought contrary. This is supported by the findings of -Mkandawire et al. (2018), Kululanga et al. (2012) and Besada et al. (2016) that community participation at every stage of the implementation of male participation programmes is paramount in ensuring its effectiveness, as community leaders and stakeholders can dispel myths and reconstruct cultural notions around the strength of men who participate in their partners' health and lead by example.

The use of incentives and disincentives by hospital facilities was also supported by 80.9% of the respondents as a means of promoting effective male involvement in perinatal care, which is also supported by the findings of Besada et al. (2016) where the use of incentives and disincentives were categorised under the facility level of the two strategic levels for promoting the participation of male partners in maternal and child health care.

So therefore, effective male involvement in perinatal care can be implemented when necessary changes and collaborations are made by the individuals, family, health workers, health facilities, community members and stakeholders, policy makers and the government.

5.1.7 Hypothesis

Hypothesis 1: There is no relationship between gender and the level ofknowledge about perinatal and maternal care services. According to the findings of this study there is no relationship between gender and the level of knowledge about perinatal care gender and level of knowledge about perinatal care (0.890). This is in contrast to the findings of Onchong'a et al (2016) where there are variations between the women and male partners on their understanding of what male partner involvement entails and the importance of male partner involvement in choice of delivery site.

Hypothesis 2: There is no relationship between marital status and the perceived concept of male involvement. The relationship between marital status and the perceived concept of

male involvement is also not statistically significant (P-value = 0.272). This is contrast to the findings of Adenike et al. (2016) where the categorized knowledge about maternal health care was found to be significantly associated with the respondents' marital status (p = 0.039), with the married having a better knowledge than the single; and the involvement of men in maternal health care was found to be significantly associated with the respondents' marital status (p = 0.0001.)

Hypothesis 3: There is no relationship between socio-economic status (employed, unemployed, self employed) and the perceived factors that influence effective implementation of male involvement in perinatal care. The relationship between socio-economic status (employed, unemployed, self employed) and the perceived factors that influence effective implementation of male involvement in perinatal care, is statistically not significant at p-value of 0.120. This is similar to that of Okeke et al. (2016), where there is no significant difference (p-value 0.200) in the perception of employed and unemployed women in his study, with regards to men's determination of economic accessibility to maternal healthcare; but different from the findings of Adenike et al. (2016), where the involvement of men in maternal health care was found to be significantly associated with the occupation (p = 0.009) and the categorized attitude was found to be significantly associated with the occupation (p = 0.015) and educational status (0.001) of the respondents.

5.2 IMPLICATION OF STUDY TO NURSING

This study have provided a perceptive view of a sampled population, that represents the young adults population, about male involvement in perinatal care and its influence on maternal and child health.

Implication to Nursing Practice: This study will help individual nurses to know the areas of concern of the society about male involvement, such that they can make use of this knowledge to effect changes in their approach to male partner especially in the rendering of reproductive and maternal/child health care services; as a positive approach to male partners can foster their involvement and thus improve maternal and child health.

Implication to Nursing Profession: Furthermore, this study is of importance to the nursing profession as a whole, as it provides basic information on certain factors that could be put in place to ensure effective implementation of male involvement which will in the long run promote the health of not just the mother and the child, but also the males.

Implication to Nursing Research: To nurse researchers, this study will provide enough baseline data that can be used to determine areas that needs improvement, changes or reinforcement, in ensuring effective male involvement and a positive maternal and child health in the long run.

5.3 SUMMARY

This study was carried out to obtain the perception of University of Ibadan postgraduate students about the influence of male involvement in perinatal care on the promotion of positive maternal and child health. Two hundred and forty (240) questionnaires were retrieved out of the three hundred and ten (310) administered to the respondents. Statistical Package for Social Sciences (SPSS) Version 20 was used to compute and analyse the data.. Data obtained were presented in frequency tables and percentages. Hypotheses were tested using Chi-square test, independent t-test and analysis of variance (ANOVA).The findings of this study showed that, there is no statistical relationship between: gender and the level ofknowledge about perinatal and maternal care services (0.890); marital status and the perceived concept of male involvement (0.272); and socio-economic status (employed, unemployed, self employed) and the perceived factors that influence effective implementation of male involvement in perinatal care (0.120). Factors influencing effective male involvement as revealed from this study include: long waiting time, the nature of the relationship between the man and the woman, unclear roles of men and restricted access to involve in care, inadequate information and poor behaviour of health workers towards the males. According to the findings in this study, male involvement in perinatal care was discovered to result in: safety during pregnancy and child birth, reduction in maternal and fetal mortality, strengthening relationship between the man and the woman, easier access to health care, and general improvement of maternal and child health outcomes.

5.4 CONCLUSION

Male involvement, as shown in this study is an important aspect of reproductive health that is beneficial to the mother, the child and the man. There is a need to involve males in every aspect of perinatal care as their involvement have great benefits to both maternal and child health, as shown in this study. With the collaborative effort of all health care professionals and decision making bodies, the barriers to effective implementation of male involvement can be tackled. Also, with proper implementation of the possible suggestions for improving male involvement in perinatal care, given by the respondents of this study, effective male involvement can be fully actualized in this nation.

The perceived concept of male involvement was gotten by the respondents, and further data as regards what perinatal care and positive maternal and child health entails, were also collected. This study has provided necessary data that indicates the view of the respondents as regards to male involvement in perinatal care, factors that could influence male involvement in perinatal care, and how male involvement in perinatal care can influence the promotion of positive maternal and child health. Possible suggestions were also raised in this study on how effective male involvement in perinatal care can be improved. The perception of the respondents about the concept of the study indicated that most of the respondents agreed that male involvement in perinatal care is of importance to the promotion of positive maternal and child health, and men who want a better health outcomes for their wives and children will get more involved in their care.

5.5 RECOMMENDATIONS

Despite the visible importance of male involvement in perinatal care on maternal and child health, its implementation in Nigeria currently has a low feasibility level. The most common factor as seen in the study and others is linked to the hospital and national policies, aggravated by the lack of clear roles of males in perinatal care. Therefore, there is a need for the Ministry of health and other policy making bodies to revisits health policies as regards male involvement; and hospitals should ensure prompt implementations of newly restructured policies and allow room for men to be carried along in maternal and child health care. Structural factors that impedes effective implementation of male involvement, such as open delivery wards, should be revisited and reconstructed to imbibe privacy which will allow for effective male involvement. Health practitioners should also be trained and given due orientation on how to accommodate the male partners in their provision of care. National policies should also be made to ensure effective implementation of male involvement in every part of the country. Additionally, policy

makers should work hand-in-hand with health care professionals to clearly spell out the responsibilities of the male partners in every aspect of perinatal care.

5.6 SUGGESTIONS FOR FURTHER STUDY

1. Male involvement in intrapartum care (delivery): experiential perspective of married women and men.

2. The influence of male involvement in antenatal care on spousal relationship: a retrospective or prospective study on maternal health outcome.

REFERENCES

Adenike I. O., Asekun-Olarinmoye E. O., Adewole A. O., Adeomi A. A. and Olarewaju S. O. (2013). Perception, attitude and involvement of men in maternal health care in a Nigerian community. *Journal of Public Health and Epidemiology, Vol. 5(6), pp. 262-270, June 2013* DOI: 10.5897/JPHE2013.0505

Alio A. P., Lewis C. A., Scarborough K., Harris K. and Fiscella K. (2013). A community perspective on the role of fathers during pregnancy: a qualitative study. *BMC Pregnancy Childbirth. 2013; 13: 60.* Published online 2013 Mar 7. doi: 10.1186/1471-2393-13-60 PMCID: PMC3606253 PMID: 23497131; https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3606253/

Amukugo H. J., Neshuku H. and Nangombe J. P. (2016). Guidelines to operationalize a model to facilitate male involvement in the reproductive health context by the registered nurses. *International Journal of Advanced Nursing Studies, 5 (1) (2016) 32-42* doi: 10.14419/ijans.v5i1.5362

August F., Pembe A. B., Mpembeni R., Axemo P. and Darj E. (2016). Community health workers can improve male involvement in maternal health: evidence from rural Tanzania. BMJ Open 2014; 4: e004643. *Global Health Action 2016, 9: 30064* - http://dx.doi.org/10.3402/gha.v9.30064

Besada D., Rohde S., Goga A., Raphaely N., Daviaud E., Ramokolo V., Magasana V., Noveve N. and Doherty T. (2016). Strategies to improve male involvement in PMTCT Option B+ in four African countries: a qualitative rapid appraisal; *Glob Health Action 2016, 9: 33507* - http://dx.doi.org/10.3402/gha.v9.33507

Comrie-Thomson L., Tokhi M., Ampt F., Portela A., Chersich M., Khanna R. and Luchters S. (2015) Challenging gender inequity through male involvement in maternal and newborn health: critical assessment of an emerging evidence base, Culture, Health and Sexuality, 17:sup2, 177-189. doi://www.tandfonline.com/doi/full/10.1080/13691058.2015.1053412

Craymah J. P., Oppong R. K. and Tuoyire D. A. (2017). Male involvement in maternal health care at Anomabo, Central Region of Ghana. *Int J Repro Med* doi: 10.1155/2017/2929013

Davis J., Vyankandondera J., LuchtersS., Simon D. and Holmes W. (2016). Male involvement in reproductive, maternal and child health: a qualitative study of policymaker and practitioner perspectives in the Pacific.*Reproductive Health 13:81* DOI 10.1186/s12978-016-0184--2

Dumbaugh M., Tawiah-Agyemang C., Manu A., Asbroek G. H., Kirkwood B. and Hill Z. (2014). Perceptions of, attitudes towards and barriers to male involvement in newborn care in rural Ghana, West Africa: a qualitative analysis. *BioMed Central pregnancy and childbirth 14 (1), 269, 2014*

EuroPROFEM - The European Men Profeminist Network. Male Involvement in Reproductive Health. Family Care International. doi://www.europrofem.org/contri/2_04_en/en-masc/53en_mas.htm

Guidelines for perinatal care. 7th ed. 2012. American Academy of Pediatrics and the American College of Obstetricians and Gynecologists. ISBN 978-1-58110-734-0 (AAP)—ISBN 978-1-934984-17-8 (ACOG)

howMed (2015). Introduction to Maternal & Child Health –Reproductive Health and Safe Motherhood doi://howmed.net/community-medicine/introduction-to-maternal-child-health-reproductive-health-and-safe-motherhood/

Jennings L., Na M., Cherewick M., Hindin M., Mullany B. and Ahmed S. (2014). Women's em[owerment and male involvement in antenatal care: analyses of Demographic and Health Survey (DHS) in selected African countries. *BioMed Central Ltd. 2014,* Pregnancy and Childbirth 14:297 doi.org/10.1186/1471-2393-14-297

Kaye D. K., Kakaire O., Nakimuli A., Osinde M. O., Mbalinda S. N. and Kakande N. (2014). Male involvement during pregnancy and childbirth: men's perceptions, practices and experiences during the care for women who developed childbirth complications in Mulago Hospital, Uganda. *BMC Pregnancy and Childbirth 14:54* doi://www.biomedcentral.com/1471-2393/14/54

Kiptoo S. J., Mutai C. and Kipmerewo M. (2016). Factors that influence effective implementation of male involvement in perinatal care. *International Journal of Advanced Research.*doi://dx.doi.org/10.21474/IJAR01/2206

Kiwanuka S. (2015). Male involvement in maternal health: Helpful of Harmful? Maternal Health Task Force/January 30, 2015

Kululanga L. I., Sundby J., Malata A. and Chirwa E. (2012). Male Involvement in Maternity Health Care in Malawi. *African Journal of Reproductive Health March 2012; 16(1): 146*

Lowe M and Lowe M.(2017). Social and cultural barriers to husbands' involvement in maternal health in rural, Gambia; 2017 - *The Pan African Medical Journal*. 2017;27:255. doi:10.11604/pamj.2017.27.255.11378 ISSN 1937-8688. Retrieved from: http://www.panafrican-med-journal.com/content/article/27/255/full

Okeke E. C., Oluwuo S. O. and Azil E. I. (2016). Women's perception of males' involvement in maternal healthcare in Rivers state, Nigeria. *International Journal of Health and Psychology Research Vol.4, No.1, pp.9-21*. European Centre for Research Training and Development UK

Onchong'a J. M., Were T. and Osero J. O.S. (2016). Knowledge, Perception and Level of Male Partner Involvement in Choice of Delivery Site among Couples at Coast Level Five Hospital, Mombasa County, Kenya. *African Journal of Reproductive Health, March 2016; 20 (1): 71*

Ornella L, Seipati M, Patricia G, Stephen M; Antenatal Care; Opportunities for Africa's Newborns

LaMorte W. W., 2016; Boston University School of Public Health; http://sphweb.bumc.bu.edu/otlt/MPH-Modules/SB/BehavioralChangeTheories/BehavioralChangeTheories3.html

Maternal health; From Wikipedia, the free encyclopedia (2018), 21:43; doi://en.wikipedia.org/wiki/Maternal_health#Prenatal_health

Mkandawire E.and HendriksS. 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 ChildbirthBMC series 2018, 18:37*https://doi.org/10.1186/s12884-018-1669-5

Mfuh A. Y., Lukong C. S., Olokoba O. E. and Zubema H. J. (2016). Male Involvement in Maternal Health Care in Jimeta Metropolis, Adamawa State, Nigeria. *Greener Journal of*

Epidemiology and Public Health ISSN: 2354-2381 Vol. 4 (2), pp. 027-039, DOI: 10.15580/GJEPH.2016.2.082216132

Nansubuga E., Ayiga N. (2015). Male involvement in utilization of emergency obstetric care and averting of deaths for maternal near misses in Rakai district in Central Uganda. *African Population Studies Vol. 29, No. 2, 2015*

Reference.MD, Perinatal care, doi://www.reference.md/files/D018/mD018743.html

Singh D., Lample M. and 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), 68, 2014*

Stanback J. and Shattuck D. (2015). University Secondary Outcomes of Male Involvement in Family Planning Interventions. *Institute for Reproductive Health,* Georgetown.http://irh.org/blog/outcomes-of-male-involvement-in-family-planning/

Tweheyo R., Konde-Lule J., Tumwesigye M. N. and Sekandi J. N. (2010). Male partner attendance of skilled antenatal care in peri-urban Gulu district, Northern Uganda. *BMC Pregnancy and Childbirth. 10:53*http://www.biomedcentral.com/1471-2393/10/53

University of Ibadan, 2018 PROFILE OF EXISTING HALLS OF RESIDENCE https://www.ui.edu.ng/content/profile-existing-halls-residence

USAID Parkistan; Healthcare worker providing newborn care Maternal and Child Health Program October 17, 2013 http://www.usaid.gov/where-we-work/afghanistan-and-pakistan/pakistan

World Health Organization (2002). Programming for male involvement in reproductive health: Report of the meeting of WHO Regional Advisers in Reproductive Health. Geneva, UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction Department of Reproductive Health and Research Family and Community Health

World Health Organization (2003). Essential Antenatal, Perinatal and Postpartum Care. WHO Regional Office for Europe. Pg -13. EUR/02/5035043 30062 ORIGINAL: ENGLISH UNEDITED E79235

WHO (2018) Maternal, newborn, child and adolescent health http://www.who.int/maternal_child_adolescent/topics/maternal/maternal_perinatal/en/

Worku A. G., Yalew A. W. and Afework M. F. (2013). Availability and components of maternity services according to providers and users perspectives in North Gondar, northwest Ethiopia. *Reproductive Health 2013, 10:43* http://www.reproductive-health-journal.com/content/10/1/43

Yargawa J., Leonardi-Bee J. (2015). Male involvement and maternal health outcomes: systematic review and meta-analysis. *J Epidemiol Community Health 2015, 69:604–612*. doi:10.1136/jech-2014-204784

Yahaya MK (2002). Analysis of women's reproductive health situation in Bida Emirate of Niger State, Nigeria. *African. J. Rep Health 6(1):5064.*

APPENDIX

QUESTIONNAIRE

DEPARTMENT OF NURSING,

COLLEGE OF MEDICINE, UNIVERSITY OF IBADAN

Dear Respondent,

I am a 400l student of the above named department carrying out a study on the **Perception of Postgraduate Students about the Influence of Male Involvement in Perinatal Care on Maternal and Child Health.** I kindly request that you provided all the necessary information needed in the questionnaire. Every information provided will be treated as confidential, and used only for academic and research purposes.

Thank you so much for your participation and time.

SECTION A: Socio-demographic Characteristics:

Please tick (√) as it applies to you.

1. **Age** (in years, as at last birthday): ……
2. **Gender:** Male ( ); Female ( )
3. **Tribe:** Igbo ( ); Hausa ( ); Yoruba ( ); Others, please specify ( )
4. **Religion:** Christianity ( ); Islam ( ); Others, please specify ( )
5. **Academic Level:** MSc ( ); PhD ( )
6. **Marital Status:** Married ( ); Single ( ); Divorced ( ); Widow(er) ( )
7. **Employment Status:** Employed ( ); Unemployed ( ); Self-employed ( )

SECTION B

A. PERCEPTION ABOUT THE CONCEPT OF MALE INVOLVEMENT

Please provide all information as appropriate.

Where, SA=Strongly Agree; A=Agree; UD=Undecided; D=Disagree;
SD=Strongly Disagree: Please tick [√] the option of your choice.

S/N	CONTENT	SA	A	UD	D	SD
1.	Effective male involvement is **not** just the presence of a male figure in maternal (mother) and child health care activities, but also his total involvement in the care.					
2.	In male involvement the man does **not** need to provide financial support for pregnancy-related and childbirth-related expenses. His presence **alone** covers it all.					
3.	Decisions about pregnancy and child birth related issues is **solely** the the responsibility of the woman.					
4.	Male involvement in maternal and child care should be restricted to **Antenatal care only**.					
5.	When the man is been represented by **his mother** during his wife's visits to the clinic for perinatal care, that can still be termed as male involvement.					
6.	Men should **always** go with their wife when ever she goes for antenatal care or she is in labour.					
7.	Male involvement is **not** limited to men being involved in their wife and children care, but also in their **own** reproductive health needs.					
8.	Concern for the well-being of the mother and child, by the man, is **not** an attribute of effective male involvement.					
9.	Male involvement does **not** improve the maternal (mother) and fetal (unborn child) health status.					

B. KNOWLEDGE ABOUT THE CONCEPT OF PERINATAL CARE

Please tick [√]**True of False for the appropriate answer**

1. Perinatal care is the care given to a woman **only** during pregnancy.

True ( ); False ( )

2. Management of labour and delivery is not an aspect of perinatal care.

True ( ); False ( )

3. **Any body** can provide provide perinatal services. True ( ); False ( )

4. Tests like, blood pressure, urinalysis, weight, fundal height, abdominal palpation, pelvimetry, fetal heart/fetal movements, blood tests, rhesus, and ultrasound scans, e.t.c are **NOT** important in caring for a pregnant woman. True ( ); False ( )

5. Ensuring the comfort of the woman during delivery is **not** a major care to provided by the midwife. True ( ); False ( )
6. Assessing for the fetal heartbeat and heart rate is **essentia**l during the period of labour. True ( ); False ( )
7. Education of pregnant woman about birth preparedness and readiness for complication is **needed** during the antenatal period. True ( ); False ( )
8. Although the woman has been cared for during pregnancy and delivery, it is still **vital** to give her adequate postnatal care. True ( ); False ( )
9. There is an aspect of perinatal care that involves: care of the baby, coping with crying babies, stimulating the baby, monitoring the baby's developmental milestones, and immunization for babies. True ( ); False ( )
10. Perinatal care should involve a multidisciplinary approach.
True ( ); False ( )
11. The culture of the woman should **not** be put into consideration in providing perinatal care. True ( ); False ( )

C. FACTORS THAT INFLUENCE EFFECTIVE IMPLEMENTATION OF MALE INVOLVEMENT IN PERINATAL CARE

Please provide all information as appropriate.

Where, SA=Strongly Agree; A=Agree; UD=Undecided; D=Disagree;
SD=Strongly Disagree

Please tick [√] the option of your choice.

S/N	FACTORS	SA	A	UD	D	SD
1.	Lack of transportation to the hospital facility **can** hinder men from getting involved in the perinatal care.					
2.	Long waiting time before being attended to by the health practitioner **can not** influence the rate at which males get involved in their pregnant wife' care.					
3.	The cultural beliefs of the the male **should** hinder him from being with his wife during labour.					
4.	Lack of adequate finance **should** influence the way men participate in the care of their wife before, during and after pregnancy.					
5.	Working class/Employed husbands provide **better support** to their wife during, before and after pregnancy.					
6.	When a man sees his presence during the care of his wife as beneficial to the health of his wife and unborn child, he will get more involved in their care.					
7.	The nature, quality and importance of the information provided to the man as regards the health of his wife and unborn can influence his level of participation in their care.					
8.	The nature of the relationship between the man and the wife can influence the extent of male involvement.					
9.	Family separation and possible crises could pose a significant barrier to effective participation of males in perinatal care					
10.	Unclear roles, **not knowing** what the health care system expected of them (the males), and lack of information on what to the men should expect through the perinatal period **cannot** influence the their participation.					
11.	The behaviour and approach of the health workers **can** influence the man's decision to fully					

	participate in every aspect of the wives care.					
12.	Restricted access offered to men who want to provide support to their wives during labour and delivery by health care providers**can** pose as a barriers to effective male involvement.					
13.	The place where the woman had her previous delivery (hospital/home) can influence the way the man will participate in her current perinatal care.					

D. CONCEPT OF POSITIVE MATERNAL AND CHILD HEALTH

Please tick [√]**True of False for the appropriate answer**

1. Maternal and child health is only concerned with the prevention of disease.
True ( ); False ( )
2. Positive maternal health should involve care during pregnancy, childbirth and postpartum period. True ( ); False ( )
3. Maternal and child health should focus also on the reduction of maternal, perinatal, infant and childhood mortality and morbidity. True ( ); False ( )
4. Family planning is **not** a component of positive maternal care services.
True ( ); False ( )
5. Providing commodities and supplies needed in the care of mother and child is **not** an integral component of positive maternal and child health. True ( ); False ( )

E. INFLUENCE OF MALE INVOLVEMENT IN PERINATAL CARE ON THE PROMOTION OF MATERNAL AND CHILD HEALTH

Please provide all information as appropriate.

Where, SA=Strongly Agree; A=Agree; UD=Undecided; D=Disagree;
SD=Strongly Disagree
Please tick [√] the option of your choice.

S/N	CONTENT	SA	A	UD	D	SD
1.	The safety of their wife's pregnancy and childbirth**can** be influenced by the role the man plays in their care.					
2.	Maternal and newborn death **cannot** be reduced by getting males to be more involved in their care.					
3.	When men are involved in perinatal care, they will **aid** in the reduction of any unhealthy behaviour in the wife and promote positive behaviour.					
4.	Male involvement has **nothing** to do with the reduction of low birth weight, risk of preterm birth, fetal growth restriction and infant mortality.					

5.	The presence of the man during delivery will **reduce** maternal stress and also boast her morale.					
6.	The way at which the man gets involved in perinatal care spells out his sense of commitment to having healthy a mother and baby.					
7.	Maternal access to care and provision of emotional and financial support is a function of effective male involvement.					
8.	The involvement of the man in antenatal care does **not** really make the wife to visit the antenatal clinic as expected.					
9.	The presence and companionship of the man during labour/delivery **can** influence the wife's experience and meaning of the process.					
10.	When men get involved in their wife's care, their relationship is strengthen.					
11.	Men have social and tremendous control over their partners and make vital decisions as regards their wife's health, as such, their involvement is critical in improving maternal health and reducing maternal mortality and morbidity					
12.	Women have easier and quicker access to health care when their husband is fully involved in their health needs.					
13.	Male involvement is an important avenue for giving men information so they can support healthy behaviours and health care seeking for children, such as exclusive breastfeeding and childhood immunization					
14.	Wives and children of actively involved males have better health outcomes than those whose husbands don't get involved in their care.					

F. POSSIBLE SUGGESTIONS FOR IMPROVING MALE INVOLVEMENT IN PERINATAL CARE SERVICES

Please provide all information as appropriate.

Where, SA=Strongly Agree; A=Agree; UD=Undecided; D=Disagree;
SD=Strongly Disagree
Please tick [√] the option of your choice.

S/N	SUGGESTIONS	SA	A	UD	D	SD
1.	Increase **level of awareness and education** of what male involvement entails, with its attributed benefit.					
2.	Development of **national policies** to ensure the participation of males in every aspect of maternal and child health care.					
3.	**Only** programmes within the health sector should be involved; programmes such as social media should **not** be employed.					
4.	**Women also** should have adequate and accurate knowledge on male partner involvement and its benefits; not just the males.					
5.	Health practitioners **should always** provide the man with all relevant information about their wife's care and **not** make them feel alienated.					
6.	Men should be told the exact roles they are to perform when they accompany their wife to the clinic/hospital.					
7.	Health care providers do **not** need training on customer care, communication skills and relations.					
8.	Male involvement can be actualized **without** active involvement of the community members and stakeholders.					
9.	**Incentives/ Disincentives** (e.g. free male health check-up, free ANC for women accompanied by partners, certificates for couple testing, prioritization for women accompanied by a male partner, partner invitation letters and fines for partners) should be employed by hospital facilities.					