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Promoting male participation in maternal healthcare in the Jaman North District in Ghana: Strategies and implementation challenges

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Abstract

Promoting male participation in maternal healthcare is essential for improved maternal health outcomes. This study explored existing strategies to promote male participation in maternal healthcare and assessed their implementation challenges within healthcare facilities in the Jaman North District in Ghana. A qualitative approach was implemented in April 2020. Interviews were administered to a stratified purposive sample of 18 respondents comprising six midwives and 12 male partners of postnatal mothers. All interviews were audio-recorded, transcribed, and manually analysed using thematic analysis. The findings revealed early service, male partner invitation, male partner incentivisation, public sensitization, and male informed education, as strategies to promote male participation in the district. The implementation of these strategies has been constrained by socio-cultural and health system factors, namely, perception of pregnancy as non-illness, perceived experiences gained by women during previous births, cultural stereotypes, unconducive environment of healthcare facilities, inappropriate timing of facility attendance and unexpected costs associated with male participation. Promoting male participation, therefore, requires dedicated policy attention to the existing socio-cultural and health system constraints. The Ghana Health Service and other stakeholders should consider both community-level and targeted sensitization

on the benefits of male participation in maternal healthcare and a general improvement in maternal healthcare infrastructure.

KEYWORDS
Ghana, implementation challenges, male participation, maternal healthcare, strategies

Highlights

- Male participation in maternal healthcare can improve maternal health.
- Early service, incentives and education are strategies for male participation.
- Socio-cultural and health system factors can constrain male participation.
- Sensitisation and improved infrastructure are needed for male participation.

1 | INTRODUCTION

Since the Alma-Ata Declaration of 1978, maternal health has witnessed growing policy attention at both global and national levels.[1] This is evident in the consistent prominence of maternal health in the Millennium and Sustainable Development Goals.[2] Maternal health refers to the state of health of women during pregnancy, childbirth, and after childbirth.[3] Literature suggests that the growing policy attention to maternal health arises from the persistence of adverse maternal health outcomes across the globe.[4,5] Globally, about 295,000 women died in 2017 due to pregnancy-related complications, representing a maternal mortality ratio of 211 deaths per 100,000 live births.[6] In sub-Saharan Africa (SSA), one out of every 13 women dies from pregnancy-related complications as compared to one out of 4085 mothers in industrialised countries.[7] Promoting maternal health, therefore, requires that mothers and prospective mothers in SSA can effectively access antenatal care (ANC), delivery and postnatal care (PNC).[8]

Various countries have put in place policies to promote access to maternal healthcare.[9,10] These include the safe motherhood protocol and the free maternal healthcare policy in Ghana.[10,11] However, for these policies to have positive impacts on maternal health outcomes, all stakeholders, especially (potential) fathers, need to participate in the maternal healthcare process.[12-15] Male participation in maternal healthcare involves the joint visitation of women and their male partners for ANC, delivery and PNC and the offer of emotional, physical and monetary support by men to their female partners during pregnancy and childbirth.[16]

To promote male participation in maternal healthcare, various strategies including community sensitisation, media campaigns and targeted counselling have been recommended[17] and implemented in various SSA settings.[13,18,19] Despite the existence of these policies and strategies, low participation among the large section of the male populace in maternal healthcare have consistently been reported in the empirical literature.[18,20–23] The patriarchy theory provides insights into the complexity of socio-cultural factors that constrain male participation in maternal healthcare especially in a male-dominated societal context like SSA.[24]

Several empirical studies on male participation in maternal healthcare[22,25,28] have largely focussed on assessing the prevalence of and socio-cultural influences over male participation to the neglect of systematically assessing existing strategies towards promoting male participation in maternal healthcare at different levels of the healthcare system, especially within the Ghanaian context.[7,29] Our study explored the strategies for promoting male participation

in maternal healthcare at various levels of the healthcare system and assessed the socio-cultural and health system challenges of implementing such strategies in the Jaman North District of the Bono Region in Ghana.

2 | METHODS

2.1 | Study setting

The study was conducted in the Jaman North District in the Bono Region of Ghana. The Jaman North District was purposely chosen because it experienced the highest male participation in ANC, delivery and PNC between 2015 and 2018 in the region.[30,31] Additionally, the district provides maternal healthcare services for people from diverse socio-cultural backgrounds due to its location as a border district to some neighbouring towns in La cote-d'Ivoire.[32] At the time of this study, there were 21 public (government) healthcare facilities in the district, including a district hospital, 12 health centres, two clinics and six Community-Based Health Planning and Services (CHPS) compounds. The remaining healthcare facilities, including one hospital, one clinic, two laboratories and over 33 chemical shops, were owned and managed by private sector providers.

2.2 | Study design, population and sampling

The study adopted an exploratory qualitative cross-sectional design and followed the Standards for Reporting Qualitative Research.[33] At the initial stage, the existing healthcare facilities in the district were stratified by hospitals, health centres and CHPS compounds. Following the stratification, purposive sampling was used to select two facilities from each stratum, one being public and the other representing private providers. In line with our sampling strategy, two hospitals, one public and the other being private, were purposely selected since they were the only hospitals found in that stratum. Also, a Christian Health Association of Ghana facility and a public health centre were purposively selected to represent the health centre stratum. Again, two CHPS compounds were purposely selected since these were the only two healthcare facilities at that level with evidence of the presence of midwives. Using purposive sampling, we selected one midwife from each of the six sampled healthcare facilities. The heads of reproductive health in the sampled facilities helped us in identifying the most experienced midwives for inclusion in the study. Midwives were selected as frontline implementers of strategies on male participation as well as respondents with first-hand knowledge of implementation challenges of the strategies. All sampled midwives had obtained a tertiary education in midwifery, had between one to seven years of experience in maternal healthcare and aged from 25 to 34 years. In addition, males whose female partners were enroled for PNC were also purposively selected for inclusion in the study. Contact details of males were collected from their female partners and traced. Out of the contacts located, 12 respondents were chosen based on their knowledge, experiences, readiness, and availability to participate in the study. The 12 male partners comprised, nine Christians and three Muslims. Five had no formal education and seven had basic level education. The final sample size was guided by the point of saturation where no new findings would have been obtained with an increase in the sample size.

2.3 | Data collection and analysis

Interview guides containing open-ended questions were used to collect data in two phases. In the first phase, we conducted key informant interviews with midwives, focussing on their perspectives on the existing strategies for promoting male participation in maternal healthcare and implementation challenges of the strategies. In the second phase of the study, in-depth interviews were conducted at each catchment area of the chosen health facilities for

men who had their female partners enroled for PNC to assess their awareness of existing strategies to promote male participation in maternal healthcare and the socio-cultural and health system factors challenging implementation of the strategies. All interviews were conducted face-to-face with respondents and each interview session lasted between 30-45 min. All interviews with the men were conducted in Twi, the local language of participants, but those with the midwives were either in Twi or English depending on the preference of the midwife. All interviews were conducted at enclosed places within the healthcare facilities or at the participants' homes free from external distractions, by the first author, and audio-recorded. To enhance the credibility of the responses, member checking was done in which the recorded interviews were played back for respondents to confirm their responses. All interviews were conducted in April 2020 with strict adherence to COVID-19 protocols. The study complied with the principles of the Declaration of Helsinki.

The recorded interviews were transcribed by the first author and manually analysed by the three authors based on a thematic analytical approach. The transcribed data was reviewed, salient issues reflecting strategies to promote male participation in maternal healthcare and factors challenging implementation of the strategies were inductively coded to identify themes. To ensure consistency, the first author coded all the transcripts. The two other authors later reviewed the initial coding of the first author and agreed on emerging themes from the transcripts. Later, the codes were organised under recurring themes. Quotations from the qualitative transcripts were included in the results under various themes to demonstrate key findings and give the study participants a voice.

3 | RESULTS

3.1 | Strategies to promote male participation in maternal healthcare

3.1.1 | Early service

The most talked-about strategy by respondents was early service, a preferential treatment of couples who visited the facility together. By this strategy, expectant mothers who come with their male partners for ANC or PNC are allowed to see the midwife without joining a queue. Respondents indicated that the early service strategy was instituted by the Ghana Health Service for only ANC and PNC and is observed across all levels of the healthcare system where maternal healthcare is delivered. The early service strategy sought to encourage women to come with their husbands as well as avoid delays that could potentially discourage visiting male partners from continuing to participate in facility visitation.

> "When you come with your partner, we treat you early to go home. It is a practice we always observe when the man and the woman come to the facility. It is not only practised in this facility because when I was working with the government hospital, we equally observed it." **(Midwife, Private Hospital)**

> "We do not want the men to complain that when you go there, you keep long or waste time and so they won't come with their partners again. Hence when you come with your husband, you will be called to see the midwives as soon as the client in the consulting room leaves. We want the men to come with their wives through that process so that they can learn from our education." **(Midwife, Public Health Centre)**

> "As for us, when you come with your male partner, we attend to you first before others. Because we cannot allow a man to come and queue with the women like that, so it is even one benefit that the woman gets when she comes with the male partner." **(Midwife, CHPS)**

"The first time I visited the facility with her during PNC, immediately the nurses saw me, one came to ask whether I was there with my wife. When I said yes, she informed the other women that, my wife was at the facility with the husband, so the nurses will attend to us first before they come to them, hence if they want to also leave the facility early, they should come with their male partners during their next visit." **(Male partner)**

3.1.2 | Male partner invitation

The second emergent strategy was the direct invitation of male partners by midwives. The findings revealed that midwives in some healthcare facilities, through phone calls, invite male partners to come with their female partners in subsequent visits to the health facility for ANC or PNC. In some cases, midwives gave their mobile contacts to clients and requested male partners of the latter to call the former. In other instances, women seeking maternal care could request the midwife to call their male partners and talk to them directly about the need for male support with birth preparedness and other pregnancy-related issues.

"We usually call their male partners using their wives or female partners' phones and tell them we want to see them […], If the woman cannot get the husband's number, we instead give our numbers to the woman to give to the husband to call us." **(Midwife, Public Hospital)**

"Sometimes, we ask them to call their husbands in our presence, and then we ask them to join their wives in their next maternal healthcare session. You will need to try and convince them on the phone, but the thing is, you cannot force them." **(Midwife, Private Health centre)**

"Some mothers, during their first visit for ANC, want us to talk to their male partners on their behalf on birth preparedness. Usually, if the couple do not stay in this community and it is possible to reach the man on the phone, we contact him and invite him to the facility." **(Midwife, CHPS)**

"Also, when she came home yesterday, she told me the doctor (midwife) requested I call her, so she gave me her number. I have not called the doctor yet, but I will." **(Male partner)**

From the quotes, this strategy gives healthcare providers the chance to interact with male partners on various issues about their female partners' health and encourage them to come along during subsequent visits. The respondents also indicated that the male partner invitation strategy was mostly used when providers detected health complications during ANC or PNC, which required further medical attention.

3.1.3 | Male partner incentivisation

A third strategy involved the offer of various forms of incentives to visiting male partners as a means of promoting continuous participation. Most common in CHPS compounds, midwives publicly praised or acknowledged men who accompanied their wives for ANC or PNC sessions. In some instances, the facilities presented gifts to the couple if the male partner continuously accompanied the wife to the facility for maternal healthcare. Participants justified that the male partner incentive strategy aimed to motivate and show appreciation to males for their constant involvement in their wives' healthcare. However, in hospitals and health centres, participants did not mention incentive as a strategy to encourage male participation.

"…Oh for us, if the man is seen at the facility for ANC with the wife at least three times and even just ones for PNC, especially during the first visit after delivery, we appreciate his effort, and my staff and I clap for him, and we tell the other women to learn from what their colleague has done by equally coming with their husbands." **(Midwife, CHPS)**

"Sometimes what we do is that when the man can accompany the wife to complete her PNC visits; we give them a bar of key soap." **(Midwife, CHPS)**

"I have heard of that from my wife but I have not seen anyone who has received anything from accompanying their female partners for maternal healthcare, maybe because I have not yet accompanied her to the facility." **(Male partner)**

3.1.4 | Public sensitisation

Another strategy was public sensitisation through mass media. The study also revealed that some healthcare facilities, mostly CHPS compounds used mass media such as radio and community durbars to educate male partners on their responsibilities during pregnancy and childbirth. Midwives indicated that this was to help keep men who were usually busy with farm activities well informed about the need for their participation in pregnancy and childbirth issues.

"We use the community radio here to educate the men so that they can join their wives for ANC and PNC because, for the delivery, they will come unless the man is not here. So we always go to community radio in the evenings when we think everyone is back from the farm and are in their houses to sensitise them." **(Midwife, CHPS)**

"Yes, this is true, usually in the evenings or at dawn, they come to the information centre to remind the women that, the following day or that very day is for either ANC or PNC hence they should try and come early. They always advise the men to try and accompany their wives. The first time I went with my wife was after I listened to one of their dawn teachings on what women go through during pregnancy and the need for husbands to support their wives during pregancy." **(Male partner)**

3.1.5 | Male partner informed maternal health education

The study revealed that, across all levels of care (hospitals, health centres and CHPS compounds), facilities were also educating visiting male partners on reproductive health, birth preparedness, and obstetric danger signs. Midwives believed that male partners would only actively participate in pregnancy and childbirth care if they were psychologically and adequately oriented on the need for their involvement:

"We teach the men the need to continuously visit with their wives; what they must do to help their wives at any given stage of the pregnancy and the dangers involved if they do not continuously join to monitor the health status of the woman and the unborn child." **(Midwife, Private Hospital)**

"Very often in the consulting room, I talk to the man and discuss issues of the pregnancy and the unborn baby with him so that he can always join the wife at the facility to find out more about the woman's situation." **(Midwife, CHPS)**

"The nurses also teach you and your wife a lot of things when you accompany her to the facility, which will excite you to constantly accompany her to know more […]. The midwife advised that I should constantly join her in the facility so that I can report any changes that I see with her during the pregnancy." **(Male partner)**

4 | FACTORS CHALLENGING THE PROMOTION OF MALE PARTICIPATION IN MATERNAL HEALTHCARE

4.1 | Socio-cultural factors

4.1.1 | Perception of pregnancy as not being illness

Respondents indicated that since being pregnant does not necessarily mean the woman is sick, mostly men do not see the need for accompanying their female partners to the health facility for maternal healthcare. Accordingly, it was only when women fell sick that they needed their male partners to take them to the facility.

"Some men think that the woman should not allow the pregnancy to control her. They expect the woman to only eat well and do everything as it used to be because the woman is not sick but just pregnant hence no need following her to the facility even for a day." **(Midwife, Private Health Centre)**

"Sorry to say that when a woman gets pregnant, that does not mean she is sick, or she has lost all her strength to go to see the doctor all by herself. So why will I waste time to go with her to the facility when I can use that time to do other things in the house to support the family?" **(Male partner)**

4.1.2 | Experiences gained by women from previous pregnancies and childbirth

Respondents revealed that men are often more involved in their wives' first pregnancy than in subsequent ones. Respondents argued that men considered women to have gained experiences from previous pregnancies and childbirth, which could enable them to go through subsequent maternal healthcare sessions without the support of men.

"Sometimes men know it is important to accompany their female partners for maternal healthcare, however, they feel the woman has enough knowledge about pregnancies and its related issues probably because of her previous experience especially if she is not a first-time mother. But every pregnancy comes with its symptoms and complications and so the advice and precautions we give out also differ." **(Midwife, Public Hospital)**.

"For my side, when my wife is pregnant, I don't think there is much expected of me to do because my wife and I have three children now. Aside from our first child when I accompanied her once, I have not gone with her again since that time. She always goes for her ANC without me and delivers safely. So, I do not think it is necessary to be following her every day." **(Male partners)**

4.1.3 | Cultural stereotypes against male participation in maternal healthcare

Respondents indicated that male partners were usually discouraged from actively participating in maternal healthcare because social/cultural stereotypes in their communities suppressed men from accompanying their female partners to healthcare facilities. Some respondents revealed that, in growing up, maternal healthcare issues at the facility had been viewed as the woman's domain, such that it is considered awkward for men to observe the delivery process.

> "Most men in this community believe that it's a woman thing so they are of no use over here but when a woman gives birth and the child starts growing, they will claim the child is for them." **(Midwife, CHPS)**

> "You see, we did not learn this kind of behaviour from our parents when we were growing up and most people do not talk about it. As a result, it becomes difficult to practice even when you want to do it. You are always worried about what people will say." **(Male partner)**

5 | HEALTH SYSTEM FACTORS

5.1 | Unconducive environments of maternal healthcare facilities

The study also revealed that facilities did not provide friendly environments and privacy for visiting male partners. Some respondents indicated that spaces at healthcare facilities were designed to accommodate only women but not men. Others thought that they could not be with their wives during delivery as that would infringe on the privacy of other women in the delivery room.

> "With regards to the nature of the facility, I don't have much to say because I am a worker here but is very terrible. It's in this container called structure, that's where we do especially ANC. A small room and we put two beds there for service delivery, but when this coronavirus came, they said social distancing so one bed to the room instead of two, but you are here, just observe, what proper social distancing protocols are we adhering to? The spaces are small, even when you (man) come, finding a place to sit is a problem and you can witness it yourself." **(Midwife, Public Hospital)**

> "Normally, I don't go with her to the facility because I can't get inside the maternity unit when other women are in labour; I can't get inside because some might be naked." **(Male partner)**

> "It is not as if you do not want to go with her to the facility, but you don't feel comfortable with the place since there are not enough spaces for all of us, especially the men. Usually, the women sit under the tree in front of the facility and wait until they are called, and I can't join the women under that tree." **(Male partner)**

5.2 | Inappropriate timing of facility attendance for men

In many of the facilities, ANC and PNC services were conducted in the mornings on particular dates, by which time men were either on the farm or attending to other family and social commitments. Male partners revealed that the period within the day assigned to maternal healthcare at the facilities was not convenient to promote their active participation.

> "I don't think I can be going with her to the facility because of the time they always have ANC or PNC. I am a farmer, and if you can work well on the farm, it should be in the morning. So, if I must go with her to the facility, then that means I will go to the farm late, and I cannot work because the sun will be too high by then." **(Male partner)**

Although the midwives were aware of the concerns of men concerning the timing for maternal care, they argued that the timing was appropriate because some medications and vaccines could only be administered in the morning.

> "With regards to the time we render the service, I think it shouldn't be a problem because that's the right time. It will help us to use the vaccine we have diluted for the day because after diluting the vaccines it takes 6 hours to expire hence we can't render the service in the afternoon. We know it's a farming community and they would like to go to the farm in the morning but aside from that time and days if you come and we are around we will take care of you however, not all the treatments for ANC or PNC that one can go through." **(Midwife, Public Hospital)**

5.3 | Higher cost of care associated with male participation

Despite the existence of the free maternal healthcare policy in Ghana, some men reported being charged some unexpected fees for medications and other services received by their female partners whenever they visit healthcare facilities with them for maternal healthcare. According to the male partners, midwives asked them to pay for drugs, bed spread and other items because the national health insurance scheme did not cover those items. In contrast, male partners believed mothers usually receive all those services at no cost when men do not accompany them to the health facility. As a result, some men would avoid going to the facility with their female partners.

> "Sometimes the women ask us to increase the cost of the service for the men so that they can get some of the money to buy either pampers or dress for the newly born baby. So, any amount she says we add to the cost of service for the man, but we finally give such added amount back to the woman." **(Midwife, Private Health Centre)**

> "The first time I went with my wife for ANC, I was made to pay for drugs which they said health insurance does not cover. However, all the time she had gone for ANC alone, she comes with her drugs, and when you ask her, she will say the doctor gave them to her." **(Male partner)**

> "I don't think I will go to that facility because when the nurses see that you have come with your wife, they will give you a long list of things for you to go and buy. When you ask the nurses, they will say oh, they will need them when the woman is coming to deliver while after delivery too; you are asked to pay some money. I have a debt to settle at the facility here, and I don't have money to pay." **(Male partner)**

6 | DISCUSSIONS

From the narrative accounts of midwives and male partners, we have for the first time, examined the strategies and challenges of male participation in maternal healthcare in the Jaman North District in Ghana. In doing so, we have sought to situate the context of the study district in growing policy and intellectual discourses on the promotion of

male participation in maternal healthcare. Generally, the paper provides useful findings that could guide stakeholders to design and implement strategies in ways that reflect the peculiar health system and socio-cultural contexts of local communities where care is delivered. First, we discuss the emergent strategies for promoting male participation. Second, we discuss identified challenges of male participation arising from socio-cultural and health system-induced factors. Then, we provide some policy recommendations and directions for future research.

Our finding on early service as a strategy for promoting male participation in maternal healthcare in the district is similar to results found in Malawi, where couples attending maternal healthcare were given preferential treatment compared to women who came alone.[13] This practice reflects the traditional gender role norm that men are the breadwinners and that they should not spend a lot of time at the facility. As the findings indicated, the widespread application of this strategy in the district was attributable to its emergence from the national policy level. This suggests that strategies initiated and supported by policy and regulatory authorities may influence greater uptake than those initiated by individual facilities. However, the strategy raises questions about fairness to single mothers and women who cannot influence their male partners to come along to the facilities. We argue that such women would have to suffer undue delays in seeking ANC and PNC. Others may eventually avoid facility-based maternal healthcare due to the delays and potential stigma associated with their inability to come along with their male partners. We also consider that this strategy may not be sustainable when more men accompany their wives and queuing becomes unavoidable.

Educating men about their involvement in maternal health care is crucial for their participation in maternal healthcare. When men accompany their wives to hospitals, they have more access to reproductive health information which could result in greater communication between men and women on subjects related to reproductive health and childcare.[34] This improved interspousal communication could enhance pregnancy planning and birth preparedness.[34] The use of male informed education as a strategy in the district aligns with calls from the World Health Organisation[8] for male partner education as an approach for allowing professionals to discuss birth preparedness and appropriate maternal healthcare practices with male partners before and after birth.

Similar to other studies,[35,36] the study identified male partner invitations as a strategy for promoting male participation in maternal healthcare in all healthcare facilities in the district. The findings revealed that the implementation of this strategy was the responsibility of both the midwife and the mother. Sometimes, mothers seeking maternal healthcare request this strategy to be implemented. Similar observations elsewhere confirmed that mothers seeking maternal healthcare suggested that healthcare professionals could place a call extending an invitation to their male partners whiles still in the facility.[37] The implementation of this strategy was quite different from what was reported by Kululanga et al,[13] where male partner invitation was solely initiated by the mother.

The media provides information for a large group of people outside the facility.[13] It is reported that partners who watch this information on televisions and listen on radios are more likely to participate in maternal healthcare compared to those who do not watch televisions or listen to radios.[38] Studies in India, Nepal and Kenya revealed that media use as a strategy was associated with higher male participation in maternal healthcare.[38,39] These align with our finding on some healthcare facilities adopting public sensitisations through the media (community radios) as a strategy to promote male participation in maternal healthcare. However, contrary to existing literature where this strategy was practised across various levels of healthcare facilities,[38,39] in the study area, the strategy was practised only at the CHIPS compound level. This was probably because hospitals are referral facilities and therefore could not engage in active male participation campaigns. As a result, community-based strategies like the use of mass media were most likely to be prominent at facilities with a community-based approach to care delivery, a specific feature of the CHPS concept in Ghana.

Also, the findings revealed that CHPS particularly adopted a male incentive strategy as another way of encouraging male partners to participate in maternal health care. While this did not necessarily originate from national policy, nurses and midwives in CHPS compounds occasionally applauded visiting male partners or presented gifts to couples as ways of motivating them to regularly visit the facility together. This is possible because CHPS are community-driven, given the significant role of community health committees and community health volunteers in healthcare

management at that level.[40] Again, the dependency on providers to promote male involvement through incentives indicates the readiness by the healthcare sector in the district to invest in community-based approaches that have proved successful elsewhere.[41] This finding is in tandem with earlier findings that spouses who jointly attended maternal healthcare were given free shawls and rewarded financially in some healthcare facilities.[42] An important reflection here is the potential for such bottom-up innovations to become more widespread if taken up in national policy.

Beyond the strategies identified, as stated previously, the study found socio-cultural and health system constraints to the implementation of the strategies. At the socio-cultural level, male partners stressed on the fact that pregnancy and childbirth are not illness and hence, there was no need to accompany their female partners to healthcare facilities to seek maternal healthcare. A similar pattern was noted among respondents in Uganda.[23] It can, therefore, be suggested that irrespective of the existence of policies or strategies to encourage male participation in maternal healthcare, societal factors like beliefs and understanding of childbirth by male partners can hinder their implementation.

The study also revealed that women's experiences from previous pregnancies and childbirth were considered enough lessons learnt by women to successfully go through maternal healthcare for subsequent pregnancies without the support of men. This finding is in agreement with those obtained by others.[43-45] This finding points to the possibility that men have still not understood the need for their participation in maternal healthcare, which eventually challenges the implementation of strategies to promote male participation in maternal healthcare.

Men revealed that cultural stereotypes such as the view of pregnancy and childbirth care as reserved for women negatively affected their participation in maternal healthcare. This finding resonates well with the patriarchy theory that social structures and practices have created systems of inequality among men and women where men dominate women through the social division of labour.[24] In the patriarchal system, men's role is predominantly in the public sphere of production and politics, while women's is in the domestic, household and child-rearing. The belief that that maternal healthcare activities are culturally described as women affairs was also observed in other studies.[22,46,49] Consistent with empirical literature, the study found that a male partner's presence at delivery rooms was not encouraged by society since the delivery process was considered uncomfortable for men to witness.[23] This implies that the social norm that a woman in labour should be cared for by women is entirely entrenched in the study area.[46,50,51] The implication, therefore, is that strategies to promote male participation are likely not to achieve the intended outcomes if they are not carefully integrated with the cultural values of communities.

Our finding that poor infrastructure and inadequate seating space for clients together discouraged male participation in maternal healthcare is similar to other studies conducted in Ghana, South Africa, Uganda, Zimbabwe and Kenya on barriers to male participation.[48,52,54] Additionally, it was not surprising that men indicated the days and times for maternal healthcare service as bottlenecks to their participation. A study in Tanzania established similar findings.[55] In most African cultures, men are the primary breadwinners in their families and would therefore choose to spend their day time at work fending for their families rather than accompanying their wives to the facility. This implies that, if healthcare facilities have the capacity to allow for customised appointments and visits, more men may be able to accompany their wives at the times most appropriate to them.

Finally, our finding that unexpected cost of service discourages men from accompanying their female partners to healthcare facilities is consistent with the study of Ongolly and Bukachi,[48] who reported that in Kenya, more than half of respondents did not accompany their wives for maternal healthcare due to the cost associated with their participation. To avoid meeting such costs which would compete with their financial obligations at home, men tend to avoid visiting maternal healthcare facilities. The resultant outcome here is that male partners will only accompany their female partners if they have the financial strength to pay for unintended costs of service that may arise.[56,57]

7 | CONCLUSIONS

This study revealed evidence of strategies to promote male participation in maternal healthcare in the study area. The various strategies adopted by healthcare facilities in the study area were early service delivery, male partner invitation, public sensitization, male incentivisation and male informed maternal health education. These strategies represent conscious efforts by healthcare facilities to make male partners an integral part of the maternal healthcare process. However, the implementation of these strategies is challenged by certain socio-cultural factors such as social perception of pregnancy as not illness, experiences gained by women from previous pregnancies and childbirths, cultural stereotypes against male participation, and health system factors such as unconducive environments of maternal healthcare facilities, inapprporiateness of the timing for maternal healthcare and unexpected costs associated with male participation. The study recommends that the Ghana Health Service and its partners should undertake both broader stakeholder and targeted sensitization campaigns at the community level on the consequences of non-participation of men in maternal healthcare. Future research in the study area and within other districts in Ghana should also help to understand the specific challenges to implementing each of the strategies but not just general implementation challenges as covered in this study.

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CONFLICT OF INTEREST

The authors have no conflict of interest to declare.

ETHICS STATEMENT

Ethical approval for the study was obtained from the Kintampo Health Research Centre Institutional Ethics Committee (Ethics Approval ID: KHRCIEC/2021-10). Before data collection commenced, permission was obtained from the Bono Regional and the District Health Directorates, and the in-charges of all the chosen healthcare facilities in the district and local authorities. Written informed consent was obtained from all respondents before the interviews.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

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