

Predictors of Male Involvement in Post-Natal Care Services of their Partners in a Metropolitan City in North-Central Nigeria

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Abstract

Background: Men's behaviour influences the reproductive health of both men and women as well as the health of their children. Yet, men are often unable to make informed decision because they have not been involved in Maternal health services and education.

Objective: This study assessed male involvement in Post-Natal healthcare services of their partners and its predictors in Ilorin metropolis, Nigeria.

Methods: Multistage sampling technique was used to recruit 350 married adult males whose wives had given birth at least once in the last three years. Descriptive cross-sectional study design was employed. Pretested interview administered semi-structured questionnaires were used for the study. Data was analyzed using SPSS version 21.0 software. A *p*-value of less than 0.05 was considered as statistically significant.

Results: Two-thirds of the respondents (66.6%) had good knowledge of Post-Natal healthcare while a little more than half of the respondents (56.3%) were graded as having high overall involvement in the Post-Natal healthcare of their wives. The predictors of male involvement in postnatal care include the employment status (*p*=0.01) and educational status (*p*=0.028) of respondents.

Conclusion: Male involvement in postnatal care in Ilorin is fair though it could be better. Being unemployed and not being educated are predictors of male involvement in post-natal care services in Ilorin. There should be increased public enlightenment on the vital roles of men in Post-Natal healthcare services to encourage male involvement, effective service utilization and continuation.

Keywords: Male Involvement, Postnatal Care Services, Ilorin.

Introduction

Despite the benefits derived from utilization of focused antenatal care, institutional delivery and postnatal care in terms of reducing maternal and neonatal mortality, Nigeria does not seem to be making progress in terms of these services. While there are several studies documenting factors related to utilization of antenatal care and institutional delivery/skilled attendance at delivery in Nigeria, studies exploring utilization of postnatal care are scarce and fragmentary despite its role promoting maternal and neonatal health.

This paucity of data on utilization of postnatal care has also been demonstrated in India where only few studies have been identified (Dahiru and Oche, 2015).

Physical and emotional problems are common after birth and they tend to increase over time. Backache, headache and piles can seriously interfere with day-to-day life. Sexual problems also may be a source of unhappiness for the woman and her partner. Extreme tiredness, anxiety and depression may make a woman feel guilty for not corresponding to the image of a healthy, happy and well-coping mother. In industrialised

countries medical attention is usually high during pregnancy but drops quickly after childbirth. It has recently been emphasised that 'maternal morbidity is an under-researched and neglected field'. Studies on mothers' health after birth have found consistent and worrying results: the incidence of various health problems is high; many of these problems persist well beyond what is usually considered as the postpartum period; and only a small proportion of affected women ask for professional help (Saurel-Cubizolles et al., 2000).

Traditionally, the medical perspective of the postpartum period refers to the time after childbirth that is required for the reproductive organs to return to their non-pregnant state, a process of about 6 weeks. For physicians, this time is often perceived as one that requires little assistance other than the single postpartum visit recommended at 4 to 6 weeks after delivery. Yet findings from longitudinal studies suggest that recovery from childbirth involves more than the healing of reproductive organs. Most women contend with several minor to moderate discomforts for weeks (eg, fatigue, breast soreness, caesarean section or episiotomy discomfort, constipation, hemorrhoids and sexual concerns) and some face serious problems, such as depression that may limit daily activities for months (McGovern et al., 2006).

Post-partum period presents an opportune moment when women should be counselled on birth spacing and family planning. Contraceptive options should be discussed and contraceptive methods should be provided if requested. WHO recommends that women who have delivered in a health facility should receive PNC for at least 24 hours after birth. If a birth is at home, the first postnatal contact should be as early as possible within 24 hours of birth. Three additional PNC contacts are recommended on day 3, between days 7–14 after birth and 6 weeks after birth. It is important to reach women before they are at risk for an unintended pregnancy with information about return of fertility, their options to space or limit future pregnancies and the benefits to their own and their newborn's health of doing so (World Health Organisation, 2013).

Men's behaviour influences the reproductive health of both men and women and the health of

their children as well. Yet, men are often unable to make informed decision because they have not been involved in maternal health services and education. Inadequate knowledge, cultural factors and lack of appropriate services were found to have negatively influenced male participation and involvement in maternal healthcare services. Findings show that men still view maternal health as women's issues. A study conducted on father's participation in maternity care in Northern Nigeria revealed that even though 80.4% gave money to their wives for transport and drugs, only 12.0% accompanied their spouses for post-natal care services (Nawaz et al., 2013). Although men are not direct beneficiaries safe motherhood services, their understanding, participation, involvement and support is crucial in order for women to access basic reproductive health services (Nesane et al., 2016).

It is important to examine the relationship that male partners have to women's health and health seeking behaviour, both for the way that it reflects the practices of gender inequalities within the family and the community and for the way that it affects women's health. Various policies and programmatic interventions aimed at creating a space and engaging men in maternal health have been adopted in various countries. For instance, the International Conference on Population and Development (ICPD), held in Cairo in 1994 recognizes the importance of men to women's reproductive health and draws attention to the unfairness inherent in many men and women's gender roles.

The predominant patriarchal nature of the Nigerian society, the decision to access maternal care services many times depends on the husband or a male figure in the household, the implication of male supremacy here could be extreme and affect a pregnant woman when and where is allowed to seek care. It is therefore important to involve the fathers because this could mean a difference between a healthy birth and maternal death. Men need to be informed about the danger signs in pregnancy during and after delivery and be rightly counselled to seek assistance without delay (Kinanee and Ezekiel-Hart, 2009; Sekoni and Owoaje, 2014). This study therefore assessed male involvement in Post-Natal healthcare

services of their partners in Ilorin metropolis, Nigeria.

Materials and Methods

There are 35 wards in the three local governments in Ilorin according to the 2006 population census. However, 26 political wards are represented in Ilorin metropolis. Nine (9) wards have been excluded to make up the metropolis, this include; Akanbi I, Akanbi II, Wara/Osin/Egbejila, Iponrin, Agbeyangi. Apado, Oke Oyi/ Oke Ose/ Alalubosa, Marafa/Pepele and Maya Ile apa. The religions of the inhabitants of Ilorin area are Islam and Christianity. The occupation of the inhabitants of Ilorin includes civil service, trading, weaving of Asooke and farming. The culture in Ilorin is a mixture of Yoruba, Fulani and Hausa, which has been greatly influenced by Islamic culture. Ilorin city is the gate way between Northern and Southern Nigeria. It is an important cultural and industrial centre in the middle belt zone of Nigeria.

The study population was made up of 350 married adult male residents whose partners have been pregnant in the last three years or who have fathered a child in the last three years. The respondents all consented to participating in the study. Multistage sampling technique was employed in the selection of the study population.

Simple random sampling by balloting was used to select 3 wards from each of the 3 LGAs then 3 communities respectively from each selected ward after which proportional allocation was used to determine the total number of respondents required from each community. Systematic random sampling by balloting was used in selection of respondents to ensure equal representation and avoid errors due to bias. The first house in each community was selected by adopting the grid method. Simple random sampling was used to select the first respondents (where there was more than one eligible respondent in a household) after which sampling interval was added till the required sample size was obtained.

Collection of data took place with the aid of interviewer-administered semi-structured and pretested questionnaires which are divided into 3 sections; Sociodemographic Data, Knowledge and

Involvement in Post Natal care and their Determinants.

There was scoring of outcome variables for the knowledge and involvement of respondents in Post Natal care of their partners. A respondent was scored **1** if he has good knowledge or is involved in Post Natal care variable and **0** if otherwise. Respondents who scored below the mean were regarded as having poor knowledge or low involvement in Post Natal care services while those who scored up to or above the mean were regarded as having good knowledge or high involvement in Post Natal care.

Results

A little more than half of the respondents (56.2%) were less than 40 years of age. About two-thirds (65.7%) were in polygamous relationships with almost three-quarters (74.3%) been educated to the tertiary level. Respondents from the Islamic faith constituted 62.3% of all the respondents with almost all the respondents (91.4%) being employed. A majority (81.1%) of the respondents earn more than NGN18,000 monthly. Mean number of children is 3.2 ± 1.6 . (Table 1).

About a third of the respondents reported not knowing what post-natal care is and of the proportion that knew, less than half of them 48.1% heard from a health facility/healthcare provider (Table 2). With regards to overall level of involvement in postnatal care, 43.7% of the respondents were graded as having low involvement in their wives PNC services. For those who were graded as being involved, their involvements were in the following forms; supported the wives with transport money to go to the health facility (93.3%), reminded the wives about PNC appointment (71.6%), accompanied the wife to the health facility (47%) and helping out with household chores during the weeks following delivery (52%) (Table 3).

Male involvement in wife's PNC was highest (61.0%) among respondents within the age of 40-49 years. Involvement in PNC was lowest at the extreme of ages. Respondents in monogamous marriages had higher involvement (59.1%) in their partner's PNC. Respondents who were educated also had higher involvement in PNC (57.5%).

However, there was no statistically significant relationship between level of male involvement in partner's use of PNC services and the respondent's Age, type of marriage, religion, household income or number of children. There was a statistically significant relationship between male involvement in PNC and the respondents' educational status ($p=0.039$) and employment status ($p=0.049$). Majority of the respondents who were unemployed (73.3%) had a higher level of involvement in their partner's PNC than those who were employed. (Table 4).

The predictors of male involvement in PNC from the study included employment status and educational status of the respondents. Respondents who were unemployed had about 3 times likelihood of participating in their partners PNC compared to employed respondents ($p=0.02$). Also, respondents who had formal education were 0.3 times less likely to participate in their partners PNC compared to respondents with no formal education. (Table 5)

Discussion

In many low and middle income countries where men hold the economic and decision making power as regards their partners seeking for healthcare services, male involvement is a crucial factor influencing the acceptance, effective and continuous use of maternal health programmes including family planning, antenatal care, delivery services and post-natal care (Kinanee and Ezekiel-Hart, 2009). A positive change in the attitude of men towards maternal healthcare would improve the overall maternal health of the country.

Majority of the respondents in this study were below the age of 40 years. This is similar to the age distribution of respondents in a study carried out in Ghana to assess male involvement in maternal health services including PNC (Craymah et al., 2017). About two thirds of the respondents were aware of PNC, this is at par with findings from India in which about two thirds of the respondents were aware of PNC (Barua et al., 2004). Majority of those who were aware of PNC heard from a healthcare provider/facility (48%) while a lesser proportion of them heard from their partners. This may insinuate poor communication among couples. The ICPD has identified the need

to improve communication between couples as good communication among couples has the potential to lead to more support from male partners who play a crucial role in decision making in relation to their partner's maternal health (Gibore et al., 2019; United Nations, 1994). Studies have shown that partners who are aware of the importance of routine care are more likely to be involved in maternal care services (Barua et al., 2004). PNC is an important period in which the mother is educated on her needs and the needs of the child in the post-partum period. Also, it offers an opportunity for early detection of illness in the child. This can therefore help to reduce maternal and child mortality. When men are made aware of the importance of PNC, it may increase the chances of the woman utilising this service, thus improving her health and that of her child.

Slightly over half of the respondents had a high level of involvement in their partner's PNC, as defined by providing transportation fare to the health facility, reminding their partners about their appointments, accompanying their partners to the health facility and helping out with household chores. While this study found that almost half of the respondents accompanied their partners to the health facility, a similar study done in Northern Nigeria found that only about a tenth (12%) found accompanied their partners (Iliyasu et al., 2010). The differences in results could be due to the disparities in study settings and geographical location. Albeit, these studies both indicate a gap in male involvement in PNC.

There is paucity of data as regards the effect of including men in post-natal health education services in Nigeria but a study done in Nepal has shown that there is a better outcome in maternal health when pregnant women and their partners are educated together during antenatal clinics (Mullany et al., 2007). This may also be inferred towards PNC services.

This study found a significant relationship between educational and employment status of men and their involvement in PNC. Those who were unemployed were 3 times more likely to be involved in their partner's PNC compared to those who were employed. This may be linked to the fact that those who were employed had work obligations which were impeding their

involvement such as accompanying their partners to the health facility. This is similar to findings from Gambia, in which work obligations were found to be hindering factors to the men's participation in the maternal health of their partners (Lowe, 2017).

However, those with formal education were found to be 0.3 times less likely to be involved in their partner's PNC. This may be explained by the fact that those who had formal education were more likely to be formally employed and thus not readily available to be involved due to work obligations. However, this is in contrast to the study in India which found that increased educational levels have been found to be associated with increased utilization of maternal health services by their partners (Jungari and Paswan, 2019). A further qualitative study in the subject area could further help understand the perspective of men in their involvement in PNC and also the perspective of women in relation to

the importance of their partners being more involved in their maternal health. A qualitative study could also explore suggested solutions from men which could help direct policies in the subject area.

Conclusion

It is concluded based on the findings of the study that male involvement in postnatal care in Ilorin is fair though it could be better. Unemployment and lack of formal education are predictors of male involvement in post-natal care services in Ilorin. It is therefore recommended that there should be increased public enlightenment on the vital roles of men in Post-Natal healthcare services to encourage male involvement, effective service utilization and continuation. Furthermore, it is recommended that employers officially excuse men from work to allow them attend maternal health appointments with their spouses in the health facility.

Table 1. Distribution of Respondents by Sociodemographic Characteristics

Variables	Freq	(%)
Age (in years) (n= 350)		
20-29	46	13.1
30-39	151	43.1
40-49	118	33.7
≥ 50	35	10.0
Type of Marriage (n=350)		
Monogamy	120	34.3
Polygamy	230	65.7
Educational Status (n=350)		
No formal education	16	4.6
Primary	25	7.1
Secondary	49	14.0
Tertiary	260	74.3
Religion (n=350)		
Christian	132	37.7
Muslim	218	62.3
Employment Status (n=350)		
Employed	320	91.4
Unemployed	30	8.6
Monthly Income (n=350)		
≤ 18,000	66	18.9
> 18,000	284	81.1
Number of Children (n=350)		
1-4	296	84.6

≥ 5 Mean: 3.16 \pm 1.63	54	15.4
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Table 2. Distribution of Respondents by Knowledge of Post-Natal Care

VARIABLE	Freq	(%)
Level of Knowledge of PNC (n=350)		
Good	233	66.6
Poor	117	33.4
Source of information on PNC. (n= 233)		
Partner (Wife)	46	19.7
Health facility/ Healthcare provider	112	48.1
Billboards/ Radio or TV advert	35	15.0
Family/ Friends	37	15.9
Others	3	1.3

Table 3. Male Involvement in Post-Natal Care

Variable	Freq	(%)
Partner (wife) visited health facility after delivery. (n=350)		
Yes	202	57.7
No	148	42.3
Supported partner going to the health facility. (n= 202)		
Yes	194	96.0
No	8	4.0
Method of support. *(n= 194)		
Money for transport/services	181	93.3
Remind her of appointments	139	71.6
Accompanied partner to the health facility	95	47.0
Helped out with household chores during weeks that followed delivery. (n=350)		
Yes	182	52.0
No	168	48.0
Overall Level of Involvement in PNC (n= 350)		
High	197	56.3
Low	153	43.7

*multiple response

Table 4. Association Between Socio-demographic Characteristics and Level of Male Involvement in Post-Natal Care

Variable	Male Involvement In PNC		χ^2	<i>p</i> Value
	High (%)	Low (%)		
Age group				
20 – 29	21 (45.7)	25 (54.3)	5.021	0.170
30 – 39	88 (58.3)	63 (41.7)		
40 – 49	72 (61.0)	46 (39.0)		
≥50	16 (45.7)	19 (54.3)		
Type of Marriage				
Polygamy	61 (50.8)	59 (49.2)	2.206	0.137
Monogamy	136 (59.1)	94 (40.9)		
Educational Status				
Educated	192 (57.5)	142 (42.5)	4.271	0.039
No Formal Education	5 (31.3)	11 (68.7)		
Religion				
Christianity	74 (56.1)	58 (43.9)	0.004	0.947
Islam	123 (56.4)	95 (43.6)		
Employment Status	175 (54.7)	145 (45.3)	3.876	0.049
Employed	22 (73.3)	8 (26.7)	2.012	0.156
Unemployed	32 (48.5)	34 (51.5)	0.033	0.857
Household Income	165 (58.1)	119 (41.9)		
≤ 18,000	166 (56.1)	130 (43.9)		
> 18,000	31 (57.4)	23 (42.6)		
Nos. of Children				
1 – 4				
> 4				

Table 5. Predictors of Male Involvement in PNC

	Exp(B)	Sig.	95% C.I. for EXP(B)	
			Lower	Upper
First Step				
Employment Status (Unemployed)	2.893	0.020*	1.179	7.099
Educational Status (Had Formal Education)	0.248	0.017*	0.079	0.783
Constant	0.274	0.004	0.967	1.025
Second Step	0.996	0.780	0.864	2.256
Age	1.396	0.173	0.743	1.909
Marriage Type (Polygamy)	1.191	0.469	1.337	8.553
Religion (Christianity)	3.382	0.010*	0.579	2.151
Employment Status (Unemployed)	1.116	0.742	0.084	0.868
Number of Children (1-4)	0.270	0.028*	0.335	1.083
Educ. Status (Had Formal Education)	0.602	0.090		
Income (> 18,000)	1.187	0.853		
Constant				

* p-value < 0.05

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