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Maternal Health: a Qualitative Study of Male Partners' Participation in Lagos, Nigeria

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Abstract
Purpose Male involvement in maternal healthcare has been described as a key factor to reducing maternal mortality globally. Hence, this study investigated the choice of facility to be used during pregnancy and examined factors that influence male participation in maternal healthcare issues of their spouses as these factors may sometimes influence the choice of health care services for pregnant women.
Method The study was cross-sectional in design; the setting was at Badagry, Lagos, Nigeria. Thirty married men with at least the experience of birth of baby, who consented to participate, were purposively recruited for the study. Data were transcribed and content analysed using free narrative.
Result The results show that orthodox health care, traditional birth attendance (TBA), and faith healing were utilised by the respondents. The majority of the participants identified cost of health care services, economic recession, and their job demand as the reasons for their non-active participation in accompanying their spouses for antenatal clinic visit.
Conclusion However, to increase the level of men's participation in maternal healthcare, especially visiting antenatal clinic with spouses, antenatal services should be free of any monetary charges so as to encourage men to be involved and not look for excuses of financial needs. Utilisation of skilled birth attendance should be reinvigorated.

Keywords Maternal health · Healthcare services · Traditional birth attendance · Economic recession · Cost

Introduction

Maternal health is a key health challenge globally [1]. Each day, 800 women and 7700 new-borns die from complications during pregnancy, childbirth and other neonatal causes [2]. In addition, 7300 women experience stillbirth [3]. With maternal mortality ratio of 1000 per 100,000 birth and an estimated 58,000 deaths annually, Nigeria accounts for one of the highest estimates of maternal mortality globally [4].

Although there has been remarkable progress in reducing the number of child deaths worldwide, too many babies continue to die each year despite the availability of feasible, evidence-based solutions [5]. Study affirmed that antenatal care service is an important service goal concerning the health status of pregnant women during their reproductive period and its health beneficial accounting for nearly one quarter of all pregnancy worldwide [6]. However, Nigeria is poor in the utilisation of antenatal care [7, 8]. The 1994 call at addressing this kind of situation was made under the umbrella of the International Conference on Population and Development (ICPD) that advocated that special efforts should be made to emphasise men's shared responsibility and promote their active involvement in maternal care [9].

In many African countries, pregnancy and childbirth are regarded as exclusive women's affairs, where men are not generally expected to accompany their wives for antenatal care and not expected in the labour room during delivery [10]. In Nigeria, men play a very dominant role, especially on issues concerning women generally and on issues bordering on conceptions and reproductive health in particular. If there must be improvement in maternal health and reduction or elimination of maternal mortality, then it becomes

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imperative to understand the role or involvement of men in maternal care of their wives. This will help in times of decision making, where the man is expected to take such decision.

A study found low participation of men in maternal care, and this was attributable to ignorance, poverty, cultural and religious factors. Other factors for their non-active participation include perception by men that they are not welcome in the maternity unit of the hospitals or clinics, pregnancy and delivery as strictly for women, lack of interest and lack of knowledge [11]. This would have implications for the kind of care the man may render to the wife and subsequent pregnancy outcome.

Previous study shows social, cultural, economic and political factors that affect maternal health outcomes and also indicates that asymmetrical relations of power place women at a disadvantage within the household, the community and health care facilities are barriers to good maternal health care [12]. Other causes of barriers to husband involvement are gender role norms and health system issues [13].

The benefits of positive husband's involvement in maternal health care have been well articulated [14, 15]. USAID defined positive male (husband) in maternal and prenatal and family planning in such a way as to increase maternal and infant survival rates and improve family planning outcomes [16]. The benefits of male involvement in maternal health in any society have been identified, and these include increased maternal access to antenatal and postnatal services, discouragement of unhealthy maternal practices such as smoking [17, 18] and increased likelihood of contraception usage [19]. Equally, studies have also documented the negative side of men's involvement in maternal health to include male dominance in decision making [19]. However, studies indicate that male involvement in maternal health care is low in developing countries [11, 20–22]. Literature on participation of male in maternal health care in Africa identified factors at individual, family, community and health facility levels [23–26].

Studies also found husbands to be influential actors in pregnancy care across a range of social contexts [27, 28]. Husbands were also found to be primary source of pregnancy social support [29]. Hurtado found that some husbands play positive roles, while others seem uninterested, and concluded that husbands may be the most influential among family members regarding women's prenatal health care practices [30]. Carter found that majority of husbands seem to provide pregnancy advice (including issues of which providers to see and at what time), discuss prenatal care with their wives and accompany them on prenatal care visits, and provide money for these visits [24].

Akinpelu and Oluwaseyi noted that educationally informed husband improves antenatal care outcomes, and this can mean the differences between life and death especially in cases of complications, when women need immediate medical care [31]. However, Ezeama and Ezeamah affirmed that the problems of increase maternal morbidity and mortality in the developing countries like Nigeria have been associated with attitudes and socio-cultural practices of women during pregnancy and childbirth outcomes [32]. Umar and Bawa also identified that women who have high family wealth, religious affiliation, higher levels of education and access to skilled health workers and who are within short distance from a health facility are more likely to use institutional delivery services [33]. Researchers found out that spouse financial status influences health-seeking behaviour of pregnant women [34, 35].

Addai documented the coexistence of orthodox and indigenous maternal healthcare services in most African communities, with opportunity for women to choose between two options [36]. More specifically, among pathways utilised for antenatal healthcare include primary health care centres, hospitals, traditional birth attendants and herbalist [35, 37].

A large body of literature on men's involvement in maternal care is largely focused on men's knowledge of danger signs during pregnancy and on critical decisions around seeking care during obstetric emergencies [27, 38–42]. Against this background, this study examined the factors that affect men's preferences for the place of health facility to be used by their pregnant wives for delivery and also investigated the factors that influence men involvement in attending antenatal clinic visits of their pregnant wives. This study will help to identify factors that either facilitate or impede men's participation in maternal healthcare and provide information that can be used to encourage participation as well as generate ideas for further researches that would provide more empirical evidence for policy direction in the formulation, design and implementation of workable programmes that would promote married men's participation in maternal healthcare.

Methods

This study used a non-experimental research design involving a cross-sectional survey carried out among married men with spouses, whose wives have ever had experience of pregnancy. Qualitative method of data collection was used because it enables us to achieve a deep understanding of how and why people view issues in particular ways and the factors that impact upon their experiences. Also, a qualitative research method facilitates respondents to speak, thus enabling the disclosure of insights and resulting in original, deep and rich information. A major strength of qualitative research is its utility in analysing events or phenomenon as they occur in their natural environment or settings and also gain a deep understanding of the phenomenon.

The researchers went from one location to another to identify the respondents, and they were all interviewed individually since the study used in-depth interview (IDI). The respondents were all purposively selected based on the criteria that they are married and whose wives have had the experience of pregnancy at least once, and must be resident of Badagry

town. The criterion of having experienced pregnancy was based on the capacity of the male to have supported one pregnancy previously and also probably supporting another one for more experience. Respondents were expected to have spent some considerable time (not less than 7 months living together, where the pregnancy will be in the last trimester) with their spouses during the time of their pregnancies. This will enable us to draw or reflect on their personal experiences during pregnancy. It was assumed that first-time father may not have enough experience on the objective of the study; thus, they were excluded from the study.

Respondents were selected from both the formal and informal sectors of the community. Different locations accommodating the different sectors were identified from where respondents were identified and approached for interviews after gaining their informed consent. Places in the informal sector include markets, taxi parks, automobile workshops and even farms. While the formal sector include schools and banks. Respondents who met the set criteria were interviewed irrespective of whether their wives were pregnant at the time of the interview or not but most importantly have supported a wife with pregnancy. Verbal informed consent was obtained from respondents after the objective of the study was explained to them.

Questions such as who decides on which health facility to use for antenatal and reasons for the choice of such facility were asked: does job demand allows you to attend to maternal health care issues? Based on your present income, can you access or afford medical health services? How does your present employment status affect you whenever your wife is pregnant? We did not limit ourselves to the interview guide alone; questions were allowed to flow from the nature of information or responses received from the respondents.

The interviews were audio-taped and the information was transcribed verbatim and in some cases translated from local language into English. Words or statements with similar interpretation were grouped into categories. Similar categories were grouped into themes and sub-themes. The results were presented using direct quotes from the data.

The study was carried out in Badagry area of Lagos state; Badagry is a coastal area, noted for the popular slave trade market of the precolonial era. The area is a border area to Benin Republic. The study population was made up of thirty (30) married men mostly engaged in different kinds of economic activities in Badagry (see Table 1). The in-depth interview guide was used to gather information from the selected respondents.

Table 1 Socio-demographic characteristics of the respondents

Variables	Frequency
Gender	
Male	30
Marital status	
Married	30
Occupation	
Driver	5
Trader	3
Teacher	6
Farmer	4
Banker	5
Motor mechanic	4
Border business	3
Total	30
Ethnicity	
Egun	6
Hausa	2
Igbo	8
Ijaw	5
Yoruba	9
Total	30
Religion	
Islam	10
Christianity	16
Traditional religion	4
Total	30
Type of Marriage	
Monogamy	26
Polygyny	4
Total	30

Wives currently using antenatal, 17

Wives used in the past, 13

Data Analysis

Questions were asked both in English and the Yoruba language. We tape recorded and transcribed from the Yoruba language back to the English language before analysis. Data were content analysed. Prior to coding, transcription was read and re-read. The next step was coding the data using 'sensitizing concepts' [42]. A sensitising concept was basically a working tool for this analysis. It was not set in cast and stone, so it was revised and elaborated to conform to the topic being studied. The researcher then proceeded to the two types of phases of coding: 'initial' and 'selective or focused coding' [43]. These approaches allowed for free association of thematic issues and adoption of frequently reappearing initial codes in sorting and synthesising a large amount of data. Narrative inquiries helped us to systematically gather, analyse and represent people's stories as told by them. Narrative inquiry according to Connelly and Clandinin is an umbrella term that captures personal and human dimensions of experience over time and takes account of the relationship between individuals and cultural context [44]. Research assistants were used to

record; experts were consulted in transcription to check for the reliability of data using the necessary method of 'inter-coder reliability'.

Results

All the respondents were married and were also all engaged in one economic activity or another means of livelihood. The composition of the respondents shows some level of heterogeneity as reflected in their religion, economic activities and marriage. At the time of the interview, the wives of 17 of the respondents were utilising one form of antenatal care services or the other, while 13 of the respondents had their wives utilised one or more of these antenatal care services in the past.

Father's Preferences for Antenatal Care

The choice of health care utilisation seems rested primarily on men's decision. While some men advocated for orthodox healthcare, few other opposed the same. Some totally disagreed with the use of traditional medication. Some confused traditional birth attendance (TBA) with fetish practises and at the same time, agreed with the use of herbs if locally made without incantation. Divergent views exist on either to combine the use of certain health care or stick entirely to one. Some purely advocated for faith healing and disagreed with any other means.

Respondent reported three health care choices. They are orthodox maternal health care, traditional health care and faith healing. Although some claimed their spouses patronised more than one health facility at a time, others have restricted the choice of their spouse to a single option. In the words of a respondent, 'I prefer using hospitals' (livestock farmer[1], father of three). Conversely, another participant retorted 'Once one has the belief that whichever method of healing one chooses will work, then, it will work' (cab driver[1], father of six).

Patronage of traditional birth attendant (TBA) and the use of traditional medication were based on their financial concern, perceived effectiveness and conceived source of orthodox medication as an offshoot of traditional medication. One respondent gave reason for the use of traditional medication, especially the use of herbs as his preference:

> I prefer the use of herbs because, despite the fact that its effectiveness may not come quickly as expected or be late to function, it is still very effective in treating ailments but, the orthodox drugs are just extracts from natural leaves and would have lost most of their valuable contents during processing. (automobile mechanic[1], father of three)

However, another respondent prefers orthodox healthcare services but stated that because of financial implication they do utilise both the orthodox and traditional healthcare services. This is because the traditional medication is inexpensive and can be locally prepared by the user. He did synthesise both as demonstrated below:

> The orthodox is far better. It works faster. The traditional one is just preventive most times but for the orthodox you are sure, and it is faster. For example, in the traditional medication, you do not know the dosage for the herbs but, the orthodox has dosage and prescription so it is better, but, because of the money involved, we combine the two. (trader[1], father of five)

Some respondents opted for orthodox service delivery, for the obvious fact that it safeguards the life of the babies and the mothers. Orthodox health care was viewed as cost-effective, with qualified medical personnel, and worked faster. For example, a respondent who utilises orthodox service delivery retorted thus:

> I do not engage Traditional Birth Attendants and I instructed my church members not to. The reason is that there are times when things will get out of hand and the traditional birth attendants won't be able to handle it but, if it were to happen in a hospital, the doctors will know how to go about it. The knowledge of the Traditional Birth Attendants is limited, so, I prefer using qualified medical staff. (clergy[1], father of four)

Some respondents used faith healing alone, while for others, it is sometimes combined with other service delivery. Users of faith healing alone for baby delivery and antenatal care do this because of their religious beliefs. Their argument is for the safety of both the baby's physical and spiritual health among others.

Another respondent supported and advocated for faith healing and the utilisation of prayer houses instead of registered hospitals, his view was based on fear, and according to him:

> To the best of my knowledge, at least with my own personal experiences, I have never heard of any birth complications in churches. Prayer is a very strong weapon, my brother. You see, my fear about all these hospitals is that you cannot be so sure of the kind of spirit that is working with some of these nurses. Some of them are witches. The hands that carry out a new-born baby are crucial. They can tamper with the destiny of the child. But it is a very good thing to welcome a baby into the world with prayers. Divine healing works, my brother it works. (trader[2], father of five)

Mother and child health are at risk if sources of health delivery are perceived as inadequate. Although some individual had not experienced any complications in their choice of health care, this does not mean that they do not exist as assumed by them. Moreover, in some cases, it may not be reported at all. While in places where such is reported, it may be explained away or sometimes people shift the blame to others or resign to fate. Some respondents affirmed that complication does happen, irrespective of choice of the health care.

Religious Beliefs About Orthodox Medicine

Three men out of the thirty men interviewed were of the opinion that the use of drugs or any other form of medication is a deviation from God's will. It is their belief that taking drugs desecrates the human body which is God's temple but none of them could give a biblical backing to their belief other than that was what they were taught in church. The act of ingesting drugs or receiving treatments in the hospital is seen as an act of doubt in the healing powers of God. One of them explained thus:

> When God created man, he created him perfectly without any blemish. It is sin that makes people sick. When anybody falls sick, he or she should seek forgiveness from God and pray for healing and he or she will be healed.

When probed further on how he takes care of his wife during and after pregnancy, he replied:

> Like I said earlier, prayer and a holy life is the key to good health. If you sin, you will fall sick and if you beg for forgiveness and healing, you will be healed. My wife doesn't go to the hospital for any treatments, we just pray and I make sure she eats well. Even her delivery is done in our church. We have prayer warriors who attend to pregnant women in our church and there has never been a time when a child or mother was lost. (trader[3], father of three)

Cases whereby people depend solely on religious birth attendants for child delivery can be very risky in the sense that it is not in all cases that the so-called prayer warriors are knowledgeable enough about pregnancy-related complications and child delivery. There could be cases where complications could arise and they would not know how to handle them other than praying.

The belief among some Christians is that the labour pain during childbirth can be viewed as part of God's plan for mankind having disobeyed God's instructions after creation; hence, they refuse any form of treatment other than prayers during pregnancy. Even when lives are lost in the process of giving birth in religious homes, they see it as 'the will of God'. Furthermore, the submission of a respondent, who does not patronise orthodox medicine nor use herbs, stated that there has been a case where woman died in the course of giving birth in the church. He explained further:

> I do not make use of drugs nor do I go to the hospital as my faith doesn't permit it. I believe that prayer is the key to everything. I have three children and all of them were born in a church. All through the time my wife was pregnant, she has never had any cause to visit the hospital because she has always been in perfect health through prayers. There was a time when a woman passed on during delivery but we all believe that God giveth and God taketh away. Everything that happens to man is God's will. (cab driver[2], father of three)

However, some of the respondents were of the opinion that prayer works but being prayerful does not stop them from patronising orthodox medicine. It is their belief that both work hand in hand as stated by one of the respondents who pastors a church:

> You pray but when sickness comes, you consult a doctor and I believe in English medicine. In Christian faith, God doesn't condemn medicine. It is not against my faith to take medicine. (clergy[2], father of three)

Another respondent explained further:

> My belief is that prayers and medicine work. Once one has the belief that whichever method of healing one chooses will work then it will work. One of Jesus' disciples, Luke, was a doctor. It's just that some people are zealots. They hold firmly to the belief that everything is all about prayers and their faith. But what they need to know is that there are cases that require that one attacks them immediately with drugs and not prayer while there are some that requires prayers immediately (spiritual attacks). It's just a matter of simple logic. (cab driver[1], father of six)

The above statements clearly illustrate the place of faith healing but at the same time, it is not the only means for accessing healthcare. This is because there is a clear distinction between *spiritual attack* (that requires spiritual healing) and physical healthcare issues that require medications or orthodox procedure.

Belief in African Traditional Means of Healing

On the use of herbs for maternal health purposes, the respondents' opinions varied. The respondents who combined herbs

with drugs were of the opinion that God created the leaves and trees for the nutritional and health benefits of mankind, and it is from these plants that some drugs are manufactured. Some of them were also of the opinion that the use of herbs does not imply that one has violated any religious tenet insofar as it does not involve diabolic activities. One of the respondents simply said:

> Personally, so long as it doesn't involve divinations and incantations, I use it. (cab driver[3], father of four)

Interestingly, however, not all the respondents who said they combine the use of drugs with herbs actually prefer it to drugs. The data show that 11 of the respondents prefer herbs to drugs, 16 prefer drugs to herbs and 3 use none of both. The respondents who said they prefer herbs stated that they sometimes make use of herbs because they are cheaper and are more natural and effective than orthodox drugs. A greater number of the respondents who prefer drugs to herbs cited some of the reasons ranging from reservations about the dosage of the herbs to the fact that not all the contents and components of the herbs are subjected to clinical or laboratory tests.

A respondent condemned herbal products:

> Anybody can prepare local medicine and even some of them are harmful but they will not know. I do not encourage local medicine at all except the one that is specific because most of the local medicines are not specific. You can take medicine, they will tell you it will heal headache, malaria, pile; one medicine! I'm afraid of local medicine unless the ones that pass through NAFDAC. (livestock farmer[4], father of three)

Finally, on the patronage of traditional birth attendant, only one respondent had ever patronised them. The remaining 29 have never consulted traditional birth attendants for various reasons despite the fact that some of them believe in the use of herbs. Religion played a role in their aversion to TBAs. Both Christians and Muslims stated that their faiths forbid them to associate with things and practices that are fetish. They believe that TBAs engage in exorcisms and ritual sacrifices. As one of the respondents noted:

> I never even imagine that somebody will go to such a place because if you are expecting a new born baby into the world, it is a precious gift and God gives us nine months to prepare, so if under emergency somebody should go to that kind of place, it is not advisable. I never imagine myself going to such place because some of them are so diabolic, they do consult oracles, they are fetish so you cannot entrust a new born precious baby in their hands. There are personnel that God has given wisdom and prepared them many years in school for them to take care of new born baby. To welcome the baby in the hands of the local people is dangerous because some of their environments are contaminated, immediately the baby is born, he starts suffering from infections. (teacher[3], father of three)

Other than issues of professionalism and contaminated environments, there were respondents who believed that the TBAs have a way of 'tying their customers down' with *juju*. A respondent explained:

> People in this area used to patronise Traditional Birth Attendants until they began to experience certain trends. Forget whatever some people say, whether Christian or Muslim, most of them visit these attendants. But what people found out was that the traditional birth attendants make sure that other than them, no other person will be able to deliver their female customers of the pregnancies. This was done to protect their business. For example, a woman died during childbirth just because she had relocated from the area where the TBA who delivered her of her previous pregnancies. We heard that she had gone to a hospital but things weren't just working out. It was one of the nurses who probably knows something about "Traditional African medicine" that asked the husband how they'd had their babies in the past. It was the nurse who told him that they have to go back to the woman who handled his wife's case in the past. Unfortunately, the woman died before they made it back to Badagry. (teacher[1], father of two)

Findings from the study revealed that religious beliefs did play a role in the involvement of men in maternal health care as only a small number of the respondents gave responses that indicated that they had religious beliefs which could be anti-maternal healthcare. Three respondents stated that their religious doctrine forbade them from receiving orthodox medical care as they explained that their faith is based on the teachings that God is able to heal them and keep them in perfect health; thus, they need not desecrate their body with man-made substances. In this scenario, however insignificant, the number of those affected is a cause for concern because they may contribute to the number of maternal mortality in the state due to their refusal to patronise skilled health professionals. A situation whereby people are entirely dependent on religious birth attendants for delivery, and care is very risky because the 'men and women of God' whom they depend on may not be knowledgeable and adequately qualified to

handle their cases especially if there are complications. Although not all religious doctrines preach abstinence from orthodox medicine, the few that do would have implication for maternal mortality.

Barriers to Men's Participation in Antenatal Care Visit

Respondents itemised various barriers to participation in their wives antenatal care visit to include the cost of health care services, economic recession in the country and their job demands. Some considered some responsibility more important to their participation in antenatal care visit, while some considered it important to support their wives despite their responsibilities. Some even argued that their non-participation is a form of participation because their obvious absence in the antenatal care clinic was to make financial provision to pay the bills.

Time and Job Demand

Fathers working with corporate organisations and even in the informal but competitive business find it extremely difficult to find time attending antenatal care service with their spouse. Although these fathers may find it hard to spare time for the antenatal visit, they argued that their absent was to make enough money for their wives antenatal care. A respondent was so emphatic in his statement, and according to him:

> I cannot be attending such meetings with her. If I do that, where will we be getting the money for treatments when the need arises? I do not make much from my trade and as you can see, we are many here (he pointed to other competitors in the market and continued) so, I cannot afford to close my shop to accompany her for antenatal. (automobile dealer[3], father of two)

However, two major categories of respondents namely those that work in the banking sector and those that conduct businesses around the border have little or no financial challenges when it comes to the issues around maternal care as demonstrated in some of their statements:

> I make enough money in this business to pay my children's school fees and medical bills but I cannot leave the border to follow my wife to the hospital because I will lose a lot of money if I leave. The only time I go to the hospital with my wife is when she wants to give birth. (border merchant[2], father of four)

Coping with the cost of maternal health care is of great concern to some of the respondents, especially when other family demands are put into perspective. The cost identified is mainly monetary. Male non-participation in antenatal care sometimes does not mean un-wiliness to do so. It could even be argued to be another means of participation. The respondents, who affirmed that they were not able to attend antenatal care visit, said they were involved in financing their wives antenatal care service bills. One respondent explained that the nature of his job would not permit him to visit the clinic with his wife:

> In as much as I do love to engage in such, the nature of my job doesn't give me the luxury of time to do so. I leave home as early as 5 am in order to beat the traffic to my place of work at Ikeja and I do not return until about 9 pm on weekdays. There are times when I do not even come home until weekend. It's not possible for me to take a day off just for antenatal programmes (participant laughs out loud). I'd probably get sacked if I do. (banker[1], father of two)

However, the length of time spent at the antenatal clinic visit was identified as a possible barrier to full participation in the visit as noted by a respondent who stated thus:

> Yes. Most of the time I go with her (my wife) but when their teaching is delaying me I have to leave there and go back to work because I'm always very busy as you can see. I attend to church programmes and also I do this small work to assist myself. (clergy[3], father of five)

Financial Constraints

The data show that the financial status or condition of the respondents plays a decisive role in men's participating in maternal health and the general health of their families. Financial barriers do prevent or reduce access to and use of maternal health services and hence become detrimental to household welfare in general.

Respondents reported that financial barrier plays major role in their participation in maternal health care. This may also be because the African family composition goes beyond the nuclear family, so the responsibility of father also extended to his extended family and the in-laws. Cultural practices in the African setting place emphases on the importance of these other relationships, compared to individual spouse needs. Hence, one respondent explained thus:

> There are a lot of financial responsibilities on my head. I have siblings in school who are under my care. Coping with hospital bills, for me, depends on my cash flow at the time. If it happens that I'm broke during my wife's pregnancy, we try to do things according to our pocket… sometimes you cannot just afford the costs. In such cases, my wife consults with one nurse in our neighbourhood for treatment. (livestock farmer[1], father of three)

Some of the respondents depend on family and friends for financial assistance during health crisis or emergency, while others make use of locally prepared herbs. Most of the respondents attributed their financial condition to the state of the economy of the country as illustrated in some of their statements: one of the respondents who deals in auto spare parts said:

> If you put into consideration the recent socio-economic developments in this country, you will see that my occupation doesn't pay much and it's not sufficient to cater for health services but we are managing. (auto spare parts dealer[1], father of four)

When asked further on how he manages to cater for his family health needs, he has this to say:

> Sometimes I plead with the hospital staff to take me as I am and in some cases, I seek financial assistance from my relations or even friends. But in a situation whereby I cannot meet the hospital demands, I make use of herbs and hope that God takes control of the situation. (auto spare parts dealers[1], father of four)

Similarly, another respondent stated that:

> My income is not enough to meet the needs of my family. The situation we are faced with in the country is such that when prices go up, they never come down yet salaries are not increased. Having to deal with health issues is something I don't pray for at all except for maybe the occasional malaria treatment which doesn't cost much. (teacher[1], father of two children)

Some of the respondents are of the view that the financial burden of taking care of a pregnant woman is too heavy due to the delicate nature of pregnancy. According to one of the respondents:

> When it comes to the area of taking care of my wife during pregnancy, I am always under pressure to make ends meet because at that stage if anything happens to her I will be answerable to the whole of her family. If she falls sick when she is not pregnant, we can just get drugs from chemist or take herbs but when she is pregnant I have to look for every means to raise money to make sure every medical attention she needs is gotten from the hospital. God forbids that any harm comes to her, I will be in trouble. (automobile mechanic[2], father of five children)

Despite the financial barriers and economy crunch in the country, some fathers go against all odds to participate in their wives maternal health. The participants in our study itemised their various involvement to include attending antenatal care and the teaching sessions, consulting with medical staff, preparing local herbs for their pregnant wives, praying for safe delivery, paying medical bills and being present at the clinic during their spouse baby delivery.

Discussion

This study explored some of the determinants of male participation in maternal health as it relates to the choice of health care and factors that inhibit spouse involvement in antenatal care visits. The data show that maternal health care choices were mostly made by the male spouses. This is supported by a study by Salami et al. that the choice of antenatal care to use rest primarily with the husbands [45]. Some of the respondents sometimes combined the use of traditional health care system with modern health care; others sometimes combined the use of orthodox healthcare with faith healing. While a few of them advocated for faith healing alone. However, some respondents totally rejected the use of TBA because of their sad experiences. This study identified two major underlying factors that determine which facility or services to use for antenatal care by men whenever their wives were pregnant. This includes beliefs held by the individual involved either to utilise orthodox, TBA or faith healing and mostly transmitted through socialisation either within the family of orientation or through the religious institutions to which the individual identifies with or worship. Secondly, financial constraints manifested through income earned and the type of job currently in place. This was demonstrated by some men, who when in dire financial stress either make financial request for help from relatives or ask for informal help from the healthcare professionals to defy payment for whatever services rendered till a later date. The present findings are unlike what previous studies found that women utilisation of TBAs was based on perceived factors such as skilfulness of the TBAs respect for clients, friendliness, trustworthiness and the availability of the TBA when they are needed [46–48]. The implication is that there are likely to be different factors determining the choice of health facility to use during pregnancy for women,

if women are given the opportunity to choose the healthcare facility to use during pregnancy.

The identification of these two factors has implication for the reduction in maternal mortality. The appropriate agency of the government must continue to educate the public on the need to utilise antenatal healthcare services with those licences to do so. The TBAs are recognised within the communities and even by the government, and so there is need to continue to monitor the activities of the TBAs through umbrella-registered body and ensure full compliance with codes of operation. The religious institutions should be educated on the need to let members, who need antenatal healthcare services, utilise such services, whenever the need arises.

On financial constraints, the urgent need for the government to pursue its policy of incorporating the informal sector into the National Health Insurance Scheme should quickly be completed so as to be able to accept the contributions of those in the informal sector and reduce or eliminate out-of-pocket payments at health facilities. This will reduce anxiety and fear of making payment at health facilities and probably increase utilisation of orthodox maternal health care services.

A related study done on male involvement in choice of family planning methods in Cameroon suggested that men were highly involved [49]. Although their study did not examine maternal health or choice of health care utilisation, its finding could be relevant to our study to confirm male involvement in decision making on health-related matters. According to Awungafac et al., male participation was high in the utilisation of maternal and child health services in Cameroon in the prevention of mother to child transmission of HIV [50]. Although this current study differs in that, participants' spouses were not HIV-infected, but it shows some similarity in the wiliness of men to be actively being involved in maternal healthcare.

However, certain occupations pose serious barriers to male participation in maternal healthcare. A man with paid employment argued that taking a day off work to attend to antenatal care clinic may not be permitted by most managers. Kabagenyi et al. noted that male involvement is limited to financial contribution toward reproductive health [51]. Our study affirmed the same on maternal health where respondents' active involvement is in the area of providing the money needed to pay for services rendered and other medical bills they may be incurred. As such, majority of men who make enough money play the role of financier to maternal health as their level of involvement but attending antenatal care visit with their wives may jeopardise their sources of finances.

Conclusion

The nexus between financial constraints, job demands and time factor plays a vital role in men's participation or involvement in maternal health. Given the present economic situation of the country, most of the respondents were found to be under financial pressure in coping with the cost associated with pregnancy and other family-related issues, especially among the traders and artisans, but often resort to relatives and friends for help when the need arises. Other coping mechanism is to complement whatever care they received with traditional medicines and at times with the hospital staff for assistance.

Current study is limited to male participation. Nevertheless, the study identified modern health care, TBA and faith healing as destination choices for pregnant women in the study area as determined by their husbands. Conversely, male non-active participation in certain health care utilisation was based on cost of health care, economic recession, occupational type and religious affiliation. It is, however, recommended that, to reduce maternal mortality and new-born death, more male should be encouraged to be involved in spouse antenatal care service or clinic visits. Also, the government should as matter of urgency pursue its policy of incorporating those who work in the informal sector into the National Health Insurance Scheme so as to give access to all those who may need to use the orthodox health services the opportunity to do so. This will reduce out-of-pocket payment and encourage usage.

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