

MEN'S INVOLVEMENT IN CARE AND SUPPORT DURING PREGNANCY AND CHILDBIRTH

A QUALITATIVE STUDY CONDUCTED IN THE GAMBIA



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ABSTRACT

AIM AND OBJECTIVES - This study qualitatively explored socio-cultural factors associated with men's involvement in care and support of women during pregnancy and childbirth through in-depth interviews and focus group discussions. It also specifically looked into men's influence of women in taking decision to seek antenatal and delivery care, arrangement of transport and transport fares, escort and company to clinics and perspectives of men's presence during the delivery process.

METHODS – A qualitative research method with purposive sampling was applied. 17 pregnant women, 16 husbands, 10 midwives, 2 traditional birth attendant and 2 village health workers were interviewed. Four focus group discussions were conducted in groups of seven as well; two held in the urban areas and two in the rural. 14 husbands and 14 women participated. All informants were between the ages of 21 and 58 years. Interviews were conducted in the main referral hospital, six health centres and six communities in western health region, one of the six health regions in the Gambia.

RESULTS – This study found that women mostly initiated to seek antenatal care, but men eventually decide. Decision making power of men was grounded in religious obligations, cultural and traditional factors and the conventional view of husbands being providers and custodians of monies. TBAs, mothers, mother's in-laws and elderly female relatives in the communities had substantial influenced on women's decision to seek delivery care. Reproductive communication between couples was restricted by cultural beliefs and individual dispositions. Men's knowledge on danger signs was reported limited in this study, but most male informants expressed interest to learn about danger signs. Transport fares were mostly provided by husbands in the urban areas where means of communication were as well easier. In contrast to the urban areas, husbands were reported to have hardly provided transport fares for women to access antenatal care, but involved in arrangement of transport for women to access delivery care. Men mostly stayed at home when women sought antenatal and delivery care. Reasons of men's non escort were derived from husband's job responsibilities, long waiting time of antenatal and laboratory services, repeated antenatal visits, cultural restrictions and husband-wife large age difference as old men married young girls and felt discomfort to be with them in the clinics. The use of

mobile phones were reported to help in reaching men where their supports were needed by their partners in emergency obstetric situations to either donate blood or run errands. Educated men, men with travelling experience abroad and foreign nationals like Nigerians and Guineans were reported to have escorted their partners and relatives to clinics. Men who escorted their partners to clinics were some times subjected to gossip by their male counterparts and interestingly by women found in the clinics while in the process of seeking pregnancy care. Foreign nationals escorted their wives and relatives to get the opportunity to negotiate for what was regarded as expensive antenatal and delivery fees. They also served as interpreters between service providers and their partners and relatives. Husband's presence during the delivery process was restricted by cultural and religious beliefs, attitude of midwives, limited space in clinics and non cubicle structured labour wards compromising women's privacy. Spouses who got the opportunity to witness their partners' delivery process expressed satisfaction, sense of companionship, love and support and feelings of empathy and sympathy. This study concluded that the involvement of men in pregnancy and child birth in the Gambia was restricted by myriad of socio-economic and cultural factors including men's limited knowledge on danger signs, as well as health service and structural factors and finally advocates for men's education on their reproductive responsibilities.

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DEDICATION

This academic work is dedicated to my grand father (Manjomeh Mbenga) and grand mother (Ya- Awa Nding Ngom). They both nurtured me up and sent me to school but never lived long to benefit from the fruits of my education; (May their souls rest in the highest place in heaven, Amen). Grand Ma and Pa, you will ever be fresh in my memories as I continuously cherished the efforts you accorded me during the challenging times of the tender ages of my life. To my mother, Yamundow Mbenga, your care and love for the family is profoundly acknowledged. My wife Fatou Jeng and children (Ya- Awa Secka, Bukary Secka and Muhammed Secka), It has been a difficult moment to missed my physical absence from home over the period, and thank you for your patience. My Brother Musa Secka and wife Mariam Yasback and of course my name sake Ebba Musa Secka, thank you for the cooperation. Musa, your wonderful stance for the family was actually remarkable and thanks for been a proxy.

ABBREVIATIONS

- ❖ **TBAs:** Traditional Birth Attendants
- ❖ **VHW:** Village Health Worker
- ❖ **OIC'S:** Officer In Charges
- ❖ **FGD'S:** Focus Group Discussions
- ❖ **WHO :**World Health Organisation
- ❖ **ECOSOC :** United Nation Economic and Social Council
- ❖ **RVTH:** Royal Victoria Teaching Hospital
- ❖ **MMR:** Maternal Mortality Ratio
- ❖ **CEDAW:** Convention Against all Forms of Discrimination against Women
- ❖ **MDG'S:** Millennium Development Goals
- ❖ **IMR:** Infant Mortality Rate
- ❖ **RCH:** Reproductive and Child Health
- ❖ **IUCD:** Intra Uterine Contraceptive Device
- ❖ **PHC:** Primary Health Care
- ❖ **CHN:** Community Health Nurse
- ❖ **VHS:** Village Health Services
- ❖ **IPT:** Intermittent Preventive Treatment
- ❖ **CIDA:** Canadian Development Agency
- ❖ **AIDS:** Acquired Immune Deficiency Syndrome
- ❖ **IEC:** Information Education and Communication
- ❖ **NGO'S :** Non Governmental Organisations
- ❖ **IMF:** International Monetary Fund
- ❖ **WB:** World Bank
- ❖ **PROGEBE;** Sustainable Management for Endemic Ruminant Livestock in West Africa Project.

COLLABORATORS

- ❖ The Gambia Ministry of Health and Social Welfare
 - Regional Health Team Western
 - Serekunda Health Centre
 - Bakau Health Centre
 - Sukuta Health Centre
 - Brufut Health Centre
 - Brikama Health Centre
 - Banjuliding Health Centre.
 - Basori Circuit
 - Pirang Circuit
 - Brufut Circuit
- ❖ Royal Victoria Teaching Hospital
- ❖ Giboro private Clinic - (Narang).
- ❖ Riders for Health.

1.0 INTRODUCTION

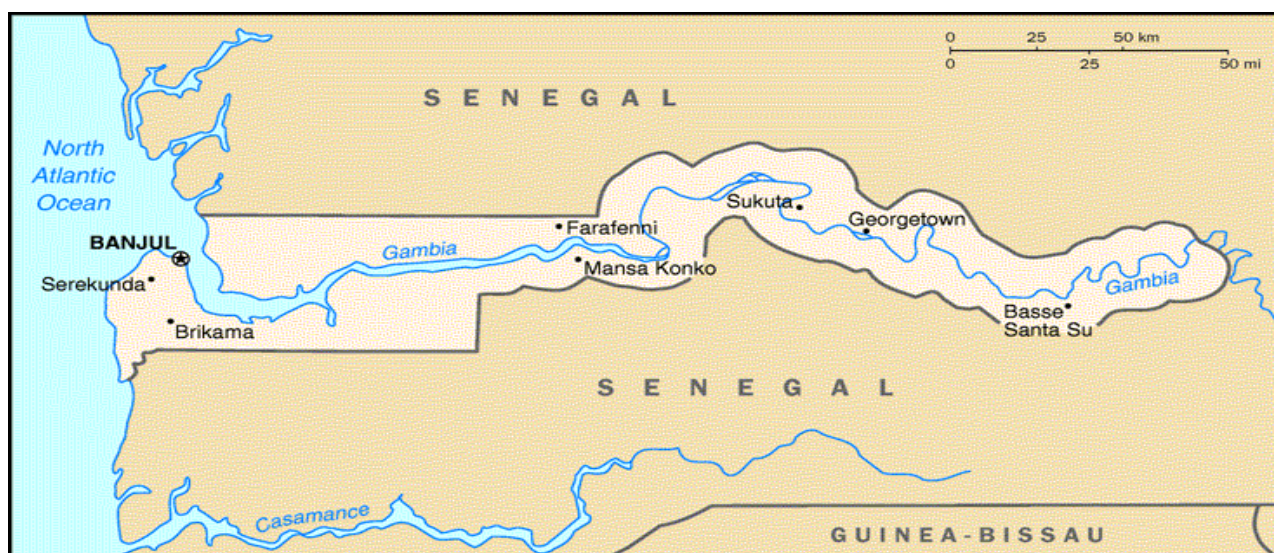
Reproductive health has emerged as an organisational frame work that incorporates men into maternal and child health (MCH) programmes and this has attracted growing research and anthropological interest(1). However, men's reproductive responsibilities have received global attention at the International Conference on Population and Development in Cairo 1994 and at the Fourth Conference of Women in Beijing 1995. Resolutions of both meetings advocated for men's shared responsibility, promotion of their active involvement in responsible parenthood, and reproductive and sexual health behaviour(2). Pregnancy and childbirth are privilege functions of women essential for the survival of our species but often accompanied with potential risk that women deserve to be protected from, and this responsibility summons for collective support of the entire family notably the husband, the community and the state as a whole. Globally, it is estimated that nearly 500,000 women die annually from causes related to pregnancy and child birth and 99% of these deaths occur in developing countries in which the Gambia is not an exception(3). According to professor Mahmoud Fathalla, "women are dying during pregnancy and child birth not only because of conditions that are difficult to manage, but women are dying because the society in which they live did not see it fit to invest what is needed to save their lives" (4). This statement could be underpinned by the statement of the Norwegian Prime Minister Jens Stoltenberg in a keynote address at the opening of the high-level segment of United Nation Economic and Social Council (ECOSOC) in Geneva 2006 "The greatest gains countries can achieve, economically as well as politically comes with empowering women, ensuring equal opportunity and health care, and increasing the ratio of women's participation in working life"(5). Imperatively, Pregnancy and childbirth should be a pleasure of joy for the family and the community, but in most developing countries the reality of motherhood is often accompanied with difficult experiences and women need to be supported by their male counterparts to abate the situation. This study qualitatively explored socio cultural factors associated with men's involvement in care and support of women during pregnancy and childbirth.

2.0 THE PROFILE OF THE GAMBIA

2.1 GEOGRAPHY

The Gambia is a small country located at the West African Atlantic coast. It's bordered by Senegal to the North, East and South. It covers an area of 10,680 square kilometres and stretches on approximately 400 kilometres length on either side of Gambian River, which divides the country into almost two equal halves(6;7). Gambia experiences two climatic seasons, a long dry season which stretches from October to May and a rainy season from June to September.

MAP OF THE GAMBIA



2.2 POPULATION

According to the 2003 census report, the total population of the Gambia stands at nearly 1.4 million people and by the year 2011 is estimated to 1.79 million with annual growth rate of 2.7 %(7). 50.4% of the population live in settlement considered urban and the rest in rural areas. Women constitute 51% of the total population and crude birth rate is 46 per 1000 population ,whilst the fertility rate is 5.4 births per woman, contraceptive prevalence rate is 17.5% and average life expectancy is 64% years overall(7;8). However, despite the drop in the fertility level from 6.04 in 1993, the level is still considered high and attributable to the youthful population structure; nearly 44% of the population are below 15 years and 19% between 19 and 24 years. The population of the Gambia has increased steadily in the last 3 decades from half a million in 1973 and 1.4 million in 2003, but the growth rate between the three inter

censal periods has increased from 3.4% between 1973-1983 to 4.2% between 1983-1993, but declined to 2.7% between 1993 – 2003. This decline in population growth observed in 2003 was largely attributed to decline in fertility and net migration rate(7).

2.3 ECONOMY

According to the 2007 United Nation Human Development Index report, the Gambia ranked 155th out of 177 countries(9). The Gross National Income per capita as at 2006 was US \$ 310 and the GDP registered 6% growth rate since 2004(10). However, a National House Hold Poverty Survey conducted in 1998 showed 61% among the rural population and 48% among the urban population live below the poverty line. The main economic backbone of the Gambia is agriculture, fishing and tourism. Agriculture employs over 75% of the population and groundnut cultivation accounts for 60% of the crop land and further accounts for 9% of the total export(11). Essentially, The Gambia has initiated several economic reforms over the past two decades with the assistance of the World Bank and the International Monetary Funds starting with the Economic Recovery Programmes in 1985, and the Programmes for Sustainable Development in 1989. In the year 2000-2001, The Gambia prepared its Poverty Reduction Strategy Paper (PRSP), based on the strategy for poverty alleviation. Through this work, prioritized public actions were identified resulting in some outlined development objectives, one of which merited improving coverage of the unmet basic needs of the poor which further embraces reduction of maternal and Child mortality rates as well as enhancing educational enrolments especially for the girl child. Health budgetary allocation has been marginally increased to 6.7% and the current infrastructural and economic development has been impressive(12).

2.4 POLITICAL SITUATION

Following two centuries of British colonial rule, The Gambia attained independence in 18th February 1965 and internal self Government in 1970(10). However, it formed a short lived federation with Senegal between 1982- 1989. There was a military take over in July 1994, which followed a returned to democratic ruled in 1996(10). It has five administrative Regions and two municipalities thus, Western Region, North Bank Region, Lower River Region, Central River Region, Upper River Region and Kombo Saint Marry's and Banjul municipality. Each administrative region is headed by a Governor and the municipalities headed by a mayor. The Gambia is in its second republic under the leadership of Dr. Alhagie Yahya A.J.J Jammeh.

2.5 ETHNICITY AND RELIGION

According to the 2003 census report the Mandinkas constitute the largest ethnic group 35.9%, Fullas 21.9, Wollof 14.4%, Jolas 11.3%, Sarahuleh 8%, Serrere 3%, Manjago 1%, Bambara 1% and Aku Marabout 0.5%(7). The Gambia is predominantly a Muslim practice country nearly 90% Muslim and 9% Christian(10). There is cordial co-existence between Muslims and Christians, some families also inter-marry resulting to close family ties(13). Wollof and Mandinka are the most spoken local languages but the official language is English.

3.0 GENDER AND WOMEN'S RIGHT

Goal number three of the MDG'S aims to promote gender equality and empowerment of women. There is also a series of international conventions that endeavours to protect and preserve the right of women including the Convention on Elimination of all forms of Discrimination against Women (CEDAW). CEDAW is an instrument with regard to women's right that establishes free and independent choice of Marriage, Education, Health and political and economic participation. Article 12 of CEDAW requires states to ensure equality of men and women on basis of access to health services including those related to family planning and appropriate services in connection to pregnancy ,confinement and granting free services where necessary (14). However, gender equality implies equal rights and opportunities regardless of gender. It involves changing how men and women relate to each other and bringing about distribution of power and resources and care giver responsibilities(14). It also advocates for mutual respect and freedom from gender base violence and applying the perspective of gender involves taking socially and culturally determined gender roles into account which will help in better understanding of the context of gender (14). In the Gambia, the Women's Council Act was enacted in 1980 to set up a body to advice Government and a women's Bureau was established to implement decision of this council. The CEDAW convention and the Beijing platform of action were ratified and Five year development plan was drawn and this follows pilot of Women in Development Project by the World Bank in 1990 (15). The World Bank Women in Development Project contributed a lot to the elimination of socio-cultural and traditional barriers to women and girls advancement in the Gambia through IEC and advocacy. Information dissemination was facilitated through the establishment of village video halls and community radio stations. Other components of the project included skills improvement, adult literacy and agricultural development. Although the shortcoming of the project was the approach ,which focused on women in development and not gender and development(16). More recently, the 8th African conference for the review of Beijing +15 was held in the Gambia in November 2009. The compendium gave special recognition to the efforts applied by respective governments and institutions to mainstream gender at policy formulation and implementation of various countries(17).

4.0 HEALTH SYSTEM

4.1 HEALTH SYSTEM MANAGEMENT

The Ministry of Health and Social Welfare is responsible for the management of the health sector in the Gambia. Its administration regulates and provides health services to the people of the Gambia and beyond. It mobilise resources for the up-keep of services. This Department is headed by a minister assisted by a Permanent Secretary (chief administrator) and his staff. The rest of the department is organized around three directorates: thus Directorate of Health Services, Directorate of Planning and Information and Directorate of Social Welfare. However, the Directorate of health services covers health program areas, like Disease Control, Reproductive Health, Public Health Inspectorate and Regional health services provision management, and pharmaceutical services. Whereas Planning and Information includes budget, Planning and Policy Analysis; Human Resource Management; Health Planning and Monitoring, Policy Implementation, Health System Research and Health Management Information System. And the Directorate of Social Welfare focuses on the social aspect of health(18).

4.2 HEALTH SERVICE DELIVERY

The public health service delivery system in the Gambia operates round three tiers on the basis of a primary health care strategy. Services are provided by 3 General hospitals and one main referral and specialist Hospital, 41 health facilities at the secondary level, 492 health posts and 38 village clinics at the primary level(19).

4.3 VILLAGE HEALTH SERVICES AND COMMUNITY CLINICS

The village health services and community health post are the lowest level of the health delivery system in the Gambia. At this level basic minimum health services are provided by village health workers and traditional birth attendants supervised by the community health nurse village health services. Some of the services provided include conducting normal deliveries by the traditional birth attendant and referral of cases beyond her control and giving health talks. Village health worker treats minor ailments like malaria, diarrhoea and offer health education talks as well. The village clinics which are commonly referred to as Cuban clinics are mostly run by community health nurses or State Enrolled Nurses (Second Level Nurses). This clinics offer

treatment of minor ailments through out patient consultation and mediate referrals of cases beyond their level to a minor or major health centre. The health services provided at this level are complemented by Reproductive and Child Health (RCH) trekking visits from the health centres. Reproductive and child health care offered on these visits includes antenatal care, child immunisation, weight monitoring and treatment of minor ailments for both pregnant women and children under-five years (18).

4.4 MINOR AND MAJOR HEALTH CENTRES

The minor health centre is the unit for the delivery of basic health services and mediates referral between the village health service and the major health centres. It provides reproductive and delivery services, out patient consultations and treatment, immunisations of children under five years amongst others. The national standard is 15,000 populations for a minor health centre and it is to provide up to 70% of the basic health care needs of this population(18). The minor health centre coverage for the rural community is nearly 65 per cent and for the Greater Banjul Area it is below 15 percent(18). The major health centres serve as the referral point for minor health centres for services like obstetric emergencies, essential surgical services, and further medical care. It has Bed capacity up to 100 and provides blood transfusion services. The national standard is 200,000 populations for a major health centre(18)

4.5 GENERAL HOSPITALS AND TEACHING AND SPECIALIST HOSPITAL

The general hospitals are the regional referral points. They have bigger bed capacities up to 250 beds and are to provide additional services not available at the major and minor health centre levels(18). Royal Victoria Teaching Hospital is the only specialist hospital in the Gambia. It serves as the final referral point and cases beyond the capacity of this facility services would have to seek overseas treatment.

4.6 PRIVATE SECTOR HEALTH SERVICE PROVISION.

The private sector health service in the Gambia includes private for profit and private for non-profit. There are few numbering less than 20. They are small in sizes with bed capacity less than 50 and less than 10 per cent of these are located in the rural community(18). Majority are located in the Greater Banjul Area, making choice in health service delivery point in the rural community limited.

4.7 TRADITIONAL HEALING SYSTEM

It is useful to mention the traditional healing system. This system includes bone setters, herbalists, spiritualists and those who combine the methods. Its attract health seeking attention of many in the Gambia. There is increased need for collaboration between orthodox and traditional medicine and in response to this; the ministry of health and social welfare has established a unit responsible for the coordination of issues related to traditional medicine.

5.0 MATERNAL AND REPRODUCTIVE HEALTH

Maternal and reproductive health services are provided mainly by the public health sector with support from the private sector and few other NGO's and faith based organisations. This has led to a wide coverage of reproductive and child health services in the Gambia, thus services are provided by all the hospitals, major and minor health centres with 212 out reach stations(18). Maternal and reproductive health issues remain a priority in the agenda of health in the Gambia. However, despite efforts by Government of the Gambia and stakeholders maternal and child mortality are still unacceptably high. According to a maternal mortality study conducted in 2001, maternal mortality ratio was estimated to be 730 per 100,000 live births, While infant and under five mortality in 2006 was estimated to be 91 and 131 per 1.000, but antenatal care coverage is very high 96% at one visit(6;20). The maternal mortality ratio in rural Gambia is estimated higher than the urban areas. The most important direct causes of maternal deaths are eclampsia 18%, sepsis 12%, Ante partum haemorrhage 10%, and post partum haemorrhage 10%(21). Most of these causes could be address by improving reproductive access to quality emergency obstetric care for treatment of obstetric complications, as well as providing appropriate and timely obstetric referrals(16). Imperatively, a major political decision

in support of RCH services was taken by government in 2007 to make RCH services free for all Gambian infants and antenatal mothers(22). And according to a tariff document acquired from the drug revolving fund unit of the Gambia Ministry of Health, the charges for non Gambian for antenatal care stood at 225 GMD, which is approximately (US\$ 9) and delivery care charges were 1800 GMD, which is also approximately equivalent to (US\$ 69).

5.1 REPRODUCTIVE HEALTH POLICY

The first National Reproductive Health Policy was approved by cabinet in December 2002. The ultimate goal of this policy was to improve the quality of reproductive life of all people living in the Gambia by providing directions for planning and implementation of accessible quality reproductive health services, which are as well gender sensitive. This will promote reproductive health issues and help in prevention of morbidity and mortality. The policy also provides direction for coordination, monitoring and evaluation of such reproductive programmes(22). In this line, an institutional framework was developed for policy implementation of reproductive health services at all levels in accordance with primary health care approach. This endeavoured to build capacities of reproductive health service providers, provide appropriate resources and increase awareness on sexual and reproductive health through advocacy and use of appropriate IEC strategies.

6.0 RATIONAL FOR THE STUDY

The Gambia is a patriarchal country where pregnancy and child birth are largely seen as a domain of women. In patriarchal societies men are to a large extent leaders and decision-makers at house hold and policy level(2). Additionally, division of responsibilities is drawn on the basis of gender and this favours men, which eventually makes them dominant in decision making process at household level, while leaving women with little or no say in matters that affect their reproductive life (23). My interest in studying men's involvement during pregnancy and child birth departed from my empirical experienced as a practicing Nurse Midwife in the Gambia. Through this experience, I observed that most women referred for obstetric care were escorted by old women as opposed to men especially husbands. This was despite the fact that men may be able offer physical support and being seemingly closer to their spouse to offer psychological support. My assumption as a Nurse Midwife was also men could be resourceful in facilitating solutions needed in emergency obstetric care services, for instance running errands, negotiating payment of care and being a potential blood donor. The trend I observed in my clinical practice is confirmed in the literature. A quantitative study conducted in the Gambia explored the price to pay for maternal health care in rural Gambia, and indicated that only 11% of the women studied were escorted to deliver in clinics by husbands while leaving the rest escorted by in-laws, relatives and friends(24). Another study argues that although men might be uninvolved but they are significant decision makers with regards to pregnancy care and expenditure (25).

Maternal mortality in the Gambia is estimated to 730 per 100,000 live births which is unacceptably high(6). A maternal mortality study conducted in rural Gambia in 2003 has identified socio cultural and health service factors as contributing factors to maternal deaths(26). factors that influenced maternal health transverse the individual level, the family, community and the health system(27;28). At the level of the individual woman several interrelated factors influence maternal health outcomes and this including women's poor nutritional status and diet, the practice of early married and child bearing, women limited awareness of health practices and their limited autonomy within the family(27). At the level of the family key factors also influence women's health directly or indirectly, and this includes awareness of senior family members about pregnancy related care, husband's involvement about pregnancy

related care, and willingness of the family to invest in good health practices and care during pregnancy(28;29). Improving maternal health and reducing maternal and child mortality are targets of the millennium development goals, which summons for ardent efforts of all sectors to reducing child mortality by two-third and maternal mortality by three quarters by 2015. Although men have an important role to play in efforts to improve maternal and child health but reported at times isolated or even presented as obstacles and not seen as part of the problem(2). Besides, the majority of reproductive health services in developing countries that promote sexual and reproductive health including care and support during pregnancy and child birth mostly focussed on women, yet men and women living in the same society are influenced by the same beliefs about roles and responsibilities that are appropriate for both gender(2). Advocating for men's involvement on reproductive health including care and support during pregnancy and child birth should not only be seen rhetoric in health policies but rather implemented, and this includes educating men on their reproductive responsibilities base on evidence(2). However, most studies reviewed and included in the literature review part of this study applied different methodologies ranging from intervention studies, qualitative, and quantitative studies. Most of these studies found looked into impact and reasons of non male involvement in reproductive health in general, but in the Gambia there were no study found that exclusively investigated men's involvement in care and support during pregnancy and child birth and therefore important to explore evidence to dictate practice.

7.0 LITERATURE REVIEW

7.1 EVIDENCE ON MALE INVOLVEMENT IN REPRODUCTIVE HEALTH

A search of literature from Pub-Med, Google scholars and other bibliography have reported studies with interesting findings on men's involvement from different parts of the world using different methodologies including intervention studies.

A longitudinal study conducted in the United States in 2002 with a sample size of 5404 women and their partners explored the effect of father involvement during pregnancy on receipt of prenatal care and maternal smoking. The findings of the study indicated that women whose partners were involved in their pregnancy care were 1.5 times likely to attend prenatal care in the first trimester and smokers reduced smoking by 36% as opposed to those whose partners were not involved in their pregnancy care(30). A similar study conducted in two rural clinics in Tanzania in 2007, aim to describe the prevalence and predictors of male partner participation in HIV voluntary counselling and testing and the effect of partner participation and uptake of HIV prenatal intervention. The findings of this study indicate that sero-positive mothers whose partners attended voluntary counselling and testing after being encouraged to inform and invite their partners were 3 times more likely to use Nivarapine prophylaxis , 4 times more likely to avoid breast feeding and 6 times more likely to adhere to the feeding method selected than those whose partners did not attend(31). Many intervention studies conducted in Pakistan between 1985 and 1993 funded by Canadian Development Agency CIDA and Path Finder International (A United States based organisation) involved men after the request of women in implementation of projects on safe motherhood, as they are regarded as key decision makers in the family. Men were involved by educating them on the dangers signs of the two main causes of maternal deaths (eclampsia and haemorrhage) through seminars and film shows as well as encouraging their partnership care and support. Findings in these studies indicated a positive influence on the two of the three delays of maternal deaths, the delay to make a decision to seek health care and delay in accessing health care, but there were limitations to assess impact on maternal mortality. Additionally, initial findings show an increase in women attending antenatal care and men's interest in learning pregnancy related issues and this was not

expected from Muslim men(32). Another intervention study conducted in Andhra Pradesh in rural India in 2004-2006, aimed at improving maternal health outcomes and pregnancy related care by building support for pregnant women to access health care services through involvement of the family especially the husband, has also indicated an increased use of Government health facilities and increased institutional deliveries. Women also reported being accompanied by husbands and mothers to access antenatal care more, consuming more nutritious diet and reduction in their work load(33).

A study on men's involvement in South African family entitled engendering change in the AIDS Era conducted in 2006, has explored the range of roles played by whole household members including men using participant observation of 20 households caring for at least one adult with disease symptom indicative of tuberculosis or AIDS and data was also examined from a small sample of households affected by HIV and AIDS in rural KwaZulu for two and half years. The findings of this study indicated that men are positively involved with their families and households in a wide range of ways, thus caring for patients and children, giving financial support and their presence and support at home permit the woman to be able to engage on other household work. Conversely, the same study has also demonstrated that such activities are not acknowledged and the dominant perception of both female respondents and research assistants continue to be that men are not caring for their families and are profligate (34). Lessons were also learnt in a qualitative study conducted in Bangladesh in 2006 through focus group discussions to explore why are men not participating in reproductive health services. The findings of which indicated that men are not motivated and traditionally not encouraged to participate in reproductive health services. Other factors like poor husband wife interaction which makes it difficult for men to understand reproductive problems of women, unmet men reproductive health needs, men's discomfort to visit clinics with their wives because of cultural myths and men's discomfort to discuss reproductive health issues with service providers were also identified(35). A study in rural Guatemala in 2002 also exploring Husbands' involvement in maternal health through individual interviews and focus group discussions reported a relatively desirable and unique involvement of husband in maternal health but rather affected by factors like husband love for the wife, work demands, economic concerns and men's level of knowledge on maternal health(36).

A similar study in Kathmandu Nepal conducted in 2006 which explored opinions of couples and health workers on the understanding on the barriers of male involvement in maternal health unfolded that some of the barriers that prevent men from participating in maternal health includes low level of knowledge, social stigma, shyness and embarrassment ,job responsibility, space problem ,non couple friendly maternal health services and hospital policy restrictions(37). Furthermore, hospital policy restrictions are factors that have been known to impede men's participation in labour. A cross-sectional study of Greek father's reaction to their presence and participation of baby and child practices explored 4 to 6 weeks postpartum indicated that only 10% of the 157 fathers studied attended the delivery of their spouse and non attendance was attributed to hospital restrictions. Yet fathers, who were opportune, reported that their attendance resulted to closer emotional bond with their partners and new born(38). The above evidence has highlighted that men could offer good reproductive responsibilities which could contribute to improving the health of both the mother and the child, if informed and involved in reproductive health issues, but also their involvement can be restricted by a series of factors.

7.2 PURPOSE OF THE STUDY

The purpose of this study was to explore socio-cultural factors associated with men's care and support of women during pregnancy and child birth in the Gambia. Specifically, the study explored men's influence on decision-making around women's antenatal and delivery care-seeking, their support to facilitating women's care in taking decision to seek antenatal and delivery care, and their presence and role during delivery.

7.3 RESEARCH QUESTION

How are men involved in care and support of women during pregnancy and childbirth and what make them not involved?

7.4 AIM

To explore socio-cultural factors affecting men's involvement during pregnancy and child birth.

SPECIFIC OBJECTIVES

- To determine men's influence on pregnant women's decisions to seek antenatal and delivery care.
- To investigate men's support in mobilising transport and transport fare for pregnant women to seek antenatal and delivery care.
- To explore men's escort and company of pregnant women to seek antenatal and delivery care.
- To explore men's perspective on their own involvement in the delivery process.

8.0 STUDY AREA

This study was conducted in Western Health Region of the Gambia .Western Health Region is one of the six health regions in the Gambia and comprises of two municipality and one local government area thus, Banjul and Kanifing municipality and Brikama local government area. It covers 17.3% of the geographical area of the country and accommodates 55% of the national population(7). Brikama local Government Area has a population of 389,589, kanifing Municipal area has a population of 322,735, and Banjul Municipality 35,061(7). Banjul, Kanifing Municipality and the western division (Western Health Region) which are focal areas of this study are urban and periurban with a fairly good net-work of public transport system and health facilities.

8.1 REASONS FOR SELECTION OF STUDY AREA

Western Region, comprising Banjul and Kanifing municipality was selected because of its urban and rural characteristics as well as its diverse and more proportionate ethnic distribution. This has provided the opportunity to involved informants from different ethnic groups in the study, which further provided broader epistemological understanding of the subject in terms of individual and cultural variations. Additionally, literacy rate are higher in this region and health services are fairly reachable. Therefore the findings generated could give a feeling of what it would have been obtained in the rural communities where services are less accessible and the literacy rate is lower.

9.0 METHODOLOGY

9.1 STUDY DESIGN

This study employed a qualitative research method. Qualitative research methods are appropriate when the central objective of an enquiry is to explore behaviour rather than to describe it, when the subject matter is unfamiliar and insufficiently researched, or when a suitable vocabulary with which to communicate with respondent is not available(39). In this study extensive search of literatures has not found any study done in the Gambia that investigated men's involvement in care and support of women during pregnancy and child birth. There is therefore insufficient information about the subject in the Gambia. A qualitative approach can help generate broader understanding of the issue. Qualitative methods also allow non-restricted answers in contrast to quantitative methods in which questions are structured and tied and thereby restrict answers. In-depth interviews and focus group discussions were conducted with use of self designed interview guides adapted to each category of informant interviewed.

9.2 STUDY POPULATION

The study population included pregnant women with delivery experience, husbands, male and female midwives, traditional birth attendants and village health workers. Interviews were conducted in the main referral hospital, six minor and major health centres and six communities in western health region. Pregnant women with delivery experience were selected in order to provide the opportunity to share their experiences in their current pregnancy and reflection of previous pregnancies and deliveries. Involvement of husbands Provides men's perspective and inclusion of Midwives, traditional birth attendants and village health workers, who provide reproductive health services in all levels of the health delivery system, further triangulates the data source.

9.3 SAMPLING AND SAMPLE SIZE

A purposive sampling of 17 pregnant women, 16 husbands, 10 midwives, 2 traditional birth attendant and 2 village health workers were interviewed. Informants included Gambians and foreign nationals residing in the Gambia. All respondents were between the ages of 21 and 58 years. Four focus group discussions were conducted in groups of seven; two held in the urban areas and two in the rural. 14 husbands and 14 women participated. Pregnant women were purposively selected in clinics on antenatal clinic days. Each woman offered consent to participate and was privately interviewed in the clinics. Husbands were as well purposively selected in the communities with the help of the community health nurse village health services, and consented before being privately interviewed. FDG participants were purposively selected from various traditional structures and women's groups. Interviews were conducted in the main referral hospital, six minor and major health centres and six communities in western health region. I decided not to interview couples together in order to minimize the risk that husbands would influence or restrict women's ability to answer freely. Furthermore, attempts to interview them together created discomfort for women and appeared to restrict their opinions. Therefore the husbands interviewed in this study were not necessarily the husbands of the women in the sample. Traditionally in the Gambia, women are perceived to be submissive to their husbands(23). Besides if men and women are brought together to discuss issues, more so reproductive issues, opinions of women are mostly presupposed by men and hardly women go against the opinion of men. This is even worse when one talk's to couples separately in the same place, when the woman has already developed pre-conceived mind not to go against the thoughts of her husband, while not knowing what the husband has said at the other end. Additionally, at times husbands emphatically caution wives on what response to give when they are interviewed. This however, bears some ethical issues, because women should be independent and have an independent mind to speak freely.

9.4 ETHICAL CONSIDERATION

This study was approved by the Norwegian ethical committee, and by both the Gambian Government and Medical Research Council Joint Ethical Committee. The objective and purpose of the study were explained to study participants and all participants were given the opportunity to make an independent decision to voluntarily participate in the study without intimidation. Participants either consented verbally or thumb printed or sign a consent form. Some participants were uncomfortable about offering their thumb print because they regarded it as legal commitment. However, those not comfortable were left to offer verbal consent and this is a common ethical phenomena in the Gambia.

9.5 DATA COLLECTION TOOLS AND TECHNIQUE

Interview guides were designed and developed by the researcher, and a tape recorder was also available. In-depth interviews of women and midwives were privately conducted in the main referral hospital and in six minor and major health centres upon consent. While husbands, traditional birth attendants and village health workers were interviewed in the communities. Focus group discussions were as well held in the communities. The interviews were open ended and the guides were not strictly followed because sometimes answers provided by respondents required probing to further explain emerging issues. Interviews were tape recorded with participants' consent.

9.6 PRE- DATA SENSITIZATION

Following a formal request made through the regional Director of Western Health Region, Officer in charges of public and private health facilities, midwives, community health nurse's village health services and public health officers were sensitized about the study in a quarterly in-service meeting held at the regional health team resource centre. These collaborators assisted in further sensitisation of the study to health facility staff and community members, make arrangements in facilitating interviews held in clinics, and participated as scribes in FGD'S.

9.7 DATA COLLECTION PROCEDURE

Participants were consented prior to be interviewed. In-depth interviews of pregnant women with delivery experience were conducted privately in the main referral hospital and in six minor and major health centres. Interviews were conducted mainly by the researcher in two main local languages in the Gambia, thus Wollof and Mandinka, which the researcher speaks fluently. These interactions enabled shared experience of pregnant women during current pregnancy and reflection on past pregnancy and delivery experiences. Midwives were as well interviewed privately in the health facilities. In-depth interviews of husbands, traditional birth attendants (TBAs), village health workers (VHW) and focus group discussions (FGDs) were conducted in six communities in Wollof and Mandinka. The FGD's were mainly coordinated by the researcher supported by a scribe. Interviews were tape recorded with the consent of the study participants and demographic characteristics of study participants were as well collected at the end of the interviews. However, in the communities, courtesy calls were first made to the village heads together with the CHN/VHS to seek permission and clearance to perform a duty in a community, which is both customary and administratively sound of Gambian societies.

9.8 DATA HANDLING

All tape recorded data were uploaded into a computer in sound files and labelled with reference numbers allocated to different interviewees in order to protect their anonymity. The data was password protected and not accessible by any third party. Hand written information was kept confidential in a pocket file locked in cupboard when not in used. Uploaded interview files were carefully listened to, and transcribed verbatim by the researcher.

9.9 RELIABILITY AND VALIDITY

The informants of this study varied in terms of age; ethnicity and occupation, which kind of triangulated the data source. This has provided the opportunity to seek diverse opinions which rendered some form of reliability of the information collected. To further validate the transcribed data, samples of interviews were as well given to a person who can speak and understand English, Mandinka and Wollof to further transcribe. This transcribed interview samples were compared to the ones done by the researcher to ensure consistency.

9.10 REFLEXIVITY

It was a challenge for me as a male researcher, husband and a midwife investigating pregnancy and child birth, but I tried to keep my position as a researcher separated from my other role. Reflexivity involves a process of self-awareness that should clarify how one's beliefs have been socially constructed and how these values are impacting on interaction in research setting(40). However, most women interviewed were open to talk to me as a male midwife because in the Gambia there are many practicing male midwives and women talk to male midwives about their reproductive problems. This was a plus for the researcher. Some of the more religious respondents were not very open. This suggests that, it would be ideal to have both male and female interviewers in such studies. It was also expected that it may be difficult to talk to men about pregnancy and childbirth because of presumed perceived cultural beliefs that could have been barriers. This comes to be in the reserves as men were receptive to talk about pregnancy and child birth and even express feelings of interest to learn about danger signs.

9.11 DATA ANALYSIS

A qualitative software **opencode-3.4** (Umeå University, Epidemiology and Global health Research Opencode) was permitted to be downloaded and installed. Transcribed data was read several times before being uploaded into the software. All files were labelled with reference numbers to protect informants' anonymity. After uploading files, interviews were carefully read in statements, comprehended and assigned codes. Categories were further derived from codes. This followed further progressive thematic content analysis to generate themes and sub-themes for presentation of findings. Thematic content analysis aims to report the key elements of respondents' accounts. It is also a useful approach for answering questions about the salient issues for particular group(s) of respondents or identifying typical responses(41).

10.0 FINDINGS

10.1 DECISION MAKING AND HEALTH SEEKING BEHAVIOUR

10.1.1 APPROVAL OF VISITS

Most informants reported that it is mostly women who initiated to seek antenatal care but men made approval of proposed visits and eventually take decisions. Decision making powers of men (husbands) were said to be derive from religious obligations, cultural and traditional factors and the conventional view of husbands being providers. The Gambia is predominantly a Muslim country and opinions were raised by most men that women were expected to seek the advice of their husbands before most undertakings which included their decision to seek health care. This was seen as religious obligation and believed to be within the teachings of Islam. Consequently, most women were warranted to seek permission from their husbands before visiting the clinic. In instances where husbands travel or not available for other reasons, women visit to the clinics were also delayed. The quotes below alluded.

"Your wife is just like your child....she (wife) should take permission from her husband before doing anything....even before going to the clinic to seek care...this is in line with our religion (Islam) and our tradition and culture" (A 40 year old husband ,in-depth-interviews one, informant -7).

Similar perspective was explained by a female midwife:

"Most women will even start antenatal care late....and the main reasons they say is...my husband travel.... I needed to take permission...I was waiting for my husband to give me money and the business is not working... Men provide and decide for women to seek health care" (a female midwife, in-depth interviews three, informant-4)

A few men explained that, *'Despite how much education a woman may have, she should be behind men...men should decide in everything in the house hold [.....] (58 year old husband quoted).* Such conventional views of men seem to contribute to limitations of women's decision making powers. This could suppress women's freedom of expressions that could further limit their emancipation to liberate their rights to health. However, Men's influence on decision to seek care in the process of delivery was largely restricted; as this part was seen as domain of women and women were to decide. The TBA was the first to be consulted by either the mother in-law or elderly female relatives. Upon assessment of the woman, she mostly decides for the next level of care. When

decisions are made, men are then consulted to arrange for transport and offer support to access the nearest health facility. However, sometimes TBA'S tended to work beyond their limitations and at times try cases that were beyond their scope thereby delaying referrals.

A 47 year old husband shared an experience:

"my last child ...when my wife was in labour... my mother calls the TBA and I was sent out of the room...when I stayed outside for hours without any progress (did not hear the baby cry) ..I called their attention by knocking the door and begged them for us to go the health centreBut my mother insisted..... And I tried to convince her for us to go... Guess what happened? When we arrived at the health centre we were further referred to the Hospital and she was operated...If we had stayed home she (wife) would have died" (A 47 years old husband, In-depth interview two, Informant -2).

This chapter concludes that women initiated to seek antenatal care, but also that they only sought care following male approval. Decision making powers of men were mostly base on religious obligations, cultural and traditional reasons and husbands been main providers and custodian of money for transport fares for women to access antenatal care. However, women's decision to seek delivery care was largely determined by TBAs, mothers and mothers in-laws and elderly women in the communities. Decision about delivery care was influenced by women and women mostly take decisions. This has explained a seemingly division of responsibility in terms of decision making regarding decision to seek antenatal care and decision to seek delivery care. In a clearer note, decision to seek antenatal care was said to be influence by men, whereas decision to seek delivery care mostly determine by women. However, at times TBAs sought advice from the community health nurse village health services if available. Once decisions were taken, men were then contacted to arrange for transport and some times pay for the transport cost for women to access delivery care.

10.1.2 REPRODUCTIVE COMMUNICATION BETWEEN COUPLES

Essentially, few respondents saw decision making and care seeking as a process that requires communication between couples, but this was restricted by culture and individual disposition, which seemingly rendered men's limited understanding of reproductive needs of women. Some informants felt ashamed to talk to their partners about pregnancy and child birth issues and this further spurred women's perceived difficulties in informing their husbands about their proposed visit to seek antenatal care. Few informants perceived restricted reproductive communication between couples as a good morale in some cultures and adaptation of this morale depended on how one was culturally brought-up. A few others felt they were just ashamed to talk to a man about reproductive issues. Lack of communication often resulted to men been oblivious of women's health care seeking intentions as few men also kept to them selves waiting for the woman to make a request. Limited communication between couples was also obvious in women's experienced in seeking family planning services. Women hide from husbands to received family planning services because they perceived husbands to be reluctant to support women's initiatives to received family planning services. Men's perceived reluctance was may be a sign of limited understanding of women's reproductive needs due to limited husband wife reproductive communications. A 58 years old husband explained.

"When my wife is pregnant....She never tells me... I only know by observing her menstruation pattern....A tree flowers before bearing fruits (literally look for sings of pregnancy)...most women do hide reproductive issues from their husbands... and you know one can offer help on something one know about...that's why we (men) keep our selves too" (A 58 years husband narrated, in-depth interview - two, Informant -6)

Similar feeling was explained by a female midwife.

"I do perform IUCD insertion (contraceptive method) for women here in the clinic....but many times women will meet me in the clinic and saymy friend told me that you performed IUCD insertion for her and is very good ...I am interested but I don't want my husband to know about it ...if I had informed him he will never allow me to come for the service and if he knows about it he will insist for me to remove it....men decide mostly so they need to be involved" (In-depth interview three, informant -4).

Discomfort experienced in husband wife reproductive communication was not only limited to men. Some women expressed similar feelings suggesting some cultural

influenced, which to some extent further influenced individual dispositions regarding husband - wife reproductive communication and care seeking attention. *'I never discuss pregnancy and child birth issues with my husband...I do feel ashamed...In our culture is very hard for a man and woman to discuss pregnancy and child birth which is a good morale' [.....] (A 30 year old woman)*, However, despite the limited reproductive communication between couples, husbands were also reminders of pregnant women to take their iron supplement tablets during pregnancy. Men sometimes reported that most women often hesitate to take their iron tablets because of side effects such as nausea and vomiting. As one 28 year old pregnant woman explained. *'my husband reminds me to take the red tablets (ferrous sulphate) am normally given from the clinic...which is very difficult to swallow. It nauseates me...Some women even throw it away [.....] (A 28 year old woman, in her 3rd pregnancy)*. Studies conducted in rural Gambia has identified anaemia as one of the contributing factors to maternal deaths and iron deficiency anaemia is prevalent among antenatal mothers in the Gambia(26). Essentially, antenatal care services covered supply of iron tablets to antenatal mothers to help them boost their haemoglobin level before delivery, but in this study non compliance of pregnant women to routinely ingest their routinely supplied iron tablets unfolded. Additionally, few women expressed men's concern to get feedback from women's experienced in the clinics. At times men were even interested to know the nutritional advice given to women in clinics while showing intentions to provide nutritional support *'Any time I visit the clinic and back home...my husband will ask me about what the midwife saidhe (husband) will even ask me about the type of food they advice me to eat' [.....] (A 24 year old woman in her 3rd pregnancy, in-depth interview one, informant -/4)*. Interestingly, some of the interviewees also alluded to men support and encouragement for women to attend antenatal care and their support in accessing care in emergency obstetric situations. Such responses were frequent among women who had a history of obstetric complication and needed men's physical, morale and economic support to access care. A woman in her 8th pregnancy explained.

'My husband repeatedly advises me to joint antenatal clinic early....not to suffer my previous problem in my last pregnancy...In my last pregnancy I fitted at home and become unconscious.... Thank God my husband was at home at that moment...He (husband) rushed me to the hospital...Though I was unconscious but I had them (doctors and nurses) taking about operation...my husband was sent out but

he insisted that whatever is to happen will be in his presence" (A 36 year old woman in her 8th pregnancy, in-depth interview one, informant-10)

In conclusion, reproductive communication between couples was restricted by cultural beliefs and individual dispositions. Some women found it difficult to talk to their husbands to discuss reproductive issues and this has resulted to impediments in women's care seeking attentions. Despite limited reproductive communications men were at times reported to show interest in reminding women to take their iron tablets and also men's interest to know about women's experience in the clinics was also reported. This implies that partnership care and support of women could be enhancing if couples are sensitised on their reproductive roles which could further facilitate couple reproductive communication.

10.1.3 COMMUNICATION BETWEEN SERVICE PROVIDERS AND ANTENATAL MOTHERS.

Some interviewees expressed views that women's care seeking attention for antenatal care was influence by increased sensitization of antenatal care services such as IPT. The antenatal period presents important opportunities for reaching pregnant women with a number of interventions that may be vital to their health and well-being and that of their infants. A better understanding of foetal growth and development and its relationship to the mother's health has resulted in increased attention to the potential of antenatal care as an intervention to improve both maternal and new born health (20). Coverage of antenatal care by skilled personnel (Doctor, Nurse or Midwife) is high in the Gambia with 97.8 per cent of women receiving antenatal care at least once during last pregnancy(20). Despite this high percentage of women receiving antenatal care most used to book for antenatal care in late trimesters. In this study opinions were expressed that women booked early for antenatal care mostly in the first trimester and early part of the second trimester. This was attributed to increased sensitization of women on intermittent preventive treatment (IPT). This is a strategy adapted and sponsored by the Global Fund to reduced incidence of malaria and malaria related morbidity and mortality. In this process fansidar (sulphadoxine and perimethamine) is recommended to be administered in the second and the third trimester.

A TBA explained.

‘pregnant women used to visit the clinic late at six and even eight months of gestation, when they are just about to deliver....but in recent days there are lot of sensitization on IPT and most women start antenatal care early at three or four months of gestation to take their fansidar (sulphadoxine and perimethamine) to prevent them from malaria’ (A TBA narrated, in-depth interview two, informant - 12).

In contrast, most of the informants reported limited communication between service providers and antenatal mothers. This resulted from limited time and opportunity for mothers to ask questions during antenatal visit and get their doubts cleared. A missed opportunity antenatal care study conducted in the Gambia in 2006 indicated that 70.5% of the respondents spent 3 minutes or less with the service provider(16). Such results suggest that limited time is available for pregnant women to be educated and informed about their health needs and get the opportunity to ask questions and get their doubts cleared. Therefore, they resort to the TBA to get their doubts cleared; this sometimes warranted the TBA to work beyond her limitation. A 38 old woman explained.

‘my last pregnancy ended as still birth.... I lost foetal movement for weeks and I was never told on antenatal visit ...I told the nurse (midwife) and she said is okay...while calling the next woman in the queue....When I was more and more worried I visited the TBA, who told me that my child was dead in my abdomen and I was never told at the clinic.....I went into labour and she (TBA) helped me deliver at home but the baby did not survive....the TBA later took me to the health centre and told the midwife that I delivered at home but the child died...I was given drugs and discharged home at the same time’ (FGD 1, a 38 years old woman ,informant -5).

This chapter concludes that pregnant women seem to be booking for antenatal care in the first and second trimester. This was attributed to increased IPT sensitisation that advocates for antenatal booking in the first trimester, but focus on sensitisation on other areas of reproductive health like men’s involvement should be considered. However, interpersonal communication between pregnant women and care providers (midwives) during antenatal care was reported limited and this contributed to pregnant women’s limited opportunities to ask questions during antenatal visits and get their doubts cleared. They are as well not privilege to be given relevant reproductive information. Therefore they at times resorted to the TBAs to confide with them to get their doubts cleared. In this process inappropriate information are given or information given is misconstrued. Eventually the woman became limitedly informed

about reproductive issues surrounding her life and may not identify the need to discuss with her husband and this may seemingly contribute to husbands limited understanding about women's reproductive needs.

10.1.4 OBSTETRIC DIAGNOSIS- ULTRA-SOUND SCANNING

Limited access to diagnostic tools like ultrasound scanning featured, as twin pregnancies were mostly undiagnosed and abnormalities not detected. Abdominal ultrasound scanning should be a birth right of all pregnant women, but scanning services were only available at the main referral hospital RVTH during weaker days and inconsistently offered at one major health centre in western region. Though, ultrasound scanning services are available at private clinics, but a bit more expensive for an average Gambian. Therefore accessing ultrasound scanning services were reported to have involved time, cost and sometimes multiple visits before acquiring the services. Women needed the support of men (husbands) to realise such important services to save their lives. A woman in her 3rd pregnancy explained.

"my last delivery was a twin delivery ...I never knew that I was carrying twins and my mother and mother in-law who escorted me to the health centre were both surprised when I delivered twins.....interestingly when I delivered the first baby and my abdomen was still bigI wondered...that was the time the nurse (midwife) told me that it remain a another one. Then I asked her Is it twins? She said you never knew...I replied. I was never told" (A 21 year old woman in her 3rd pregnancy, in-depth interview one, informant -5).

Similar experience was shared by a female midwife.

"Last week I had an antenatal client who was anaemic and not feeling her foetal movement and her foetal heart was not heard too on auscultation...then I requested for scanning to be done at the main hospital RVTH ..It was Friday getting into weekend , making it only possible the following week because of high demand of this services.....luckily the woman was escorted by her husband who asked for other possible ways ? Which are the private clinics? the woman was further escorted by the husband to the private clinic and he (husband) paid for the services...upon getting the results the same daywhich showed that the foetus was dead in uterusthe woman was directly referred to RVTH for induction" (A female midwife, in-depth interview three, informant -5).

The need to decentralised diagnostic services like ultrasound scanning and training of midwives to offer such services was opined in some of the interviews.

A male Midwife explained

“This is an experience I will never forget ...just recently I met a woman that booked for antenatal care at seventh month of gestation...then I asked the reasons and came to understand that she is a non Gambian and was not able to afford the cost of antenatal carethe husband was poor to afford the cost ..I later attended this lady in labour and she delivered a premature with very small head, cleft palate and very big eyes...abnormalities would have been detected by scanning which is free at the main referral hospital RVTH...but access to the services is the problem, going to Banjul involved transportation cost, money to buy food to eat and possibly having two or more visits before getting the services..... that’s why it’s ideal to trained midwives on ultrasound scanning and make the resources available so as to render such services accessible and affordable to save the lives of women and children” (A male Midwife ,in-depth interview three ,informant-2).

Significantly, evidence from WHO randomised studies concluded that quantity of antenatal visit does not determined quality, but rather the quality of services rendered (42;43). This however, is the basis of focus antenatal care strategy; which dictates four round quality antenatal visits. Evidence further advised that, a model with reduced number of antenatal visit with or without goal oriented components could be introduced into clinical practice without risk to mother or baby, and reduction of cost related to antenatal care could be attained, but some degree of dissatisfaction by the mother could be expected (42-44). Therefore women should be sensitized on focus antenatal care to save time, money and resources of families.

This chapter concludes that access to obstetric diagnosis test like ultrasound scanning featured some difficulties and at times factored multiple visits before getting the service. This has reported growing demands of husband’s assistance in terms of decision and monetary support for women to access such services. However, ultrasound scanning services are provided free of charge in public health facilities but the cost involved to access the service was difficult to afford by women. Therefore decentralisations of obstetric services like ultra-sound scanning and possibly training midwives to offer such services was advocated. Sensitisation of men on the relevance of such obstetric services to capture their attention to offer help to women was reported as well.

10.2 ARRANGEMENT OF TRANSPORT AND TRANSPORT FARES TO SEEK CARE.

10.2.1 TRANSPORT FARES PROVISION AND ARRANGEMENTS - RURAL URBAN VARIATIONS.

Variation in the study area in terms of its urban and rural characteristics has resulted in difference in how men were involved in arrangement of transport and transport fares for women to seek antenatal and delivery care in different areas. This difference were mostly attributed to difference in economic status as 61% of the rural population are poor compared to 48% in the urban areas(45). However, for the urban area, most of the interviews revealed that men mostly provided transport fare for women to seek antenatal care and even at times extra money to buy food while seeking care at the clinic. Men also took the responsibility to arranged for transport (commercial taxi) and mostly paid for the cost of the transportation in the urban areas. Husbands who were some times away from home because of the nature of their jobs did kept money with shop keepers in the neighbourhood for women to use as transport fares to access delivery care when the need arose. However, circumstances delaying access of such monies at the time needed were raised. Some women expressed views that shop keepers at times close their shops and were out to run business errands. Most women felt they should be trusted to keep such monies to ascertain its use in the right time. At the other hand few husbands felt that if such monies were kept by women it may end up be spend on a different purpose. A woman in her 5th pregnancy explained.

"When am in my ninth month of pregnancy my husband does leave some money with the shop keeper ...that any time I have labour pain, I take the money and pay for a taxi to rush to the health centre.... Also any time am coming to the clinic he gives me GMD 50 or 100 GMB to pay for my fares and buy food ...sometimes we spent long hours in the clinic and nurses (midwives) will be just going in and out" (A 29th year old woman in her 5th pregnancy, in-depth interview one, informant -8).

Instances were reported in which husbands provided money for antenatal mothers to seek antenatal care but women stayed home and did not want to go to the clinic because they felt lazy and bored by repeated numerous antenatal visits during the pregnancy period. Another impeding use of antenatal care is that women did not want to reveal that they were pregnant until later in their pregnancy. This has resulted to some misunderstanding amongst couple.

A 34 year old woman shared a neighbour's experienced.

" Just recently my neighbour's wife was pregnant and her husband gave her money on two occasions to attend antenatal care...But she decided to stay home and ate the money ...the husband was not happy with her and they quarrelled bitterly and she later went.....some men are very caring really but some women never want to help them selvesThey feel lazy to go to the clinic" (FDG 2, A 34 years old woman, informant -3).

In contrast to urban areas, most of the informants reported that men (husbands) hardly provide fares for pregnant women to access antenatal care. Most husbands were conscious of their role to provide fare for women to visit the clinic and even to buy extra food while at the clinic but money was reported to be limited. Most respondents felt they are farmers and not paid monthly salaries. Most men felt they were restricted to annual earnings by selling their annual produce and interviewees further explained that the money they earned following sales of their annuals proceeds last for only few months. Some informants said that men are just not caring and supportive, but rather take opportunity of their limited annual earnings as excuse. A 40 years old husband posited.

"Men should provide food, clothing, shelter and health care for their wivesI know its my responsibility to provide fare for my wife to go the clinic to seek care and even to buy extra food when in the clinic but the money is not available...we are poor people not paid monthly salary and totally rely on farming which is not producing much nowadays" (A 40 year old man, in-depth interview two, informant -11.).

Therefore, in the rural areas where 61% of the population are poor, women resort to selling charcoal, firewood, practicing gardening ,engage in micro-finance programs and local contributions known as "OSUSU" to generate income to use for their own health and fare to access health care. A 40 year old husband explained.

"Women sell charcoal and firewood to get money to access the clinic for care.....they even sometimes take care of the fish money... Women should be help by men to get good health [...]" (A 40 year old husband, in-depth interview two, informant -10).

A Similar perspective was expressed by a 47 year old husband

' Men and women should help each other in care of the family...but pregnancy and child birth as I have seen in this village and many other villages in the Gambia is largely seen as responsibility of women ...which should not be the case....we are even thought by Islam to help women, provision of food and

means of seeking health care should be the responsibility of the man....but instead most of it are done by women.. If a woman should tell her husband to give her even 10 GMD ((US\$0.38)...the husband will say I have no money.... go away!!.....trust me, women here, even provide the fish money and men are just there to eat and complaint...they (women) even pay school fees of their children" (A 47 year old husband, in-depth interview two, informant -2).

There was a shift in respond in terms of access to delivery care in the rural part. Husbands some times but in rare occasions paid for cost of transportation for women to access delivery care. They were as well involved in arrangement of transport for women to access delivery care but mostly stayed home to keep the security of the compound. A 38 years old husband explained.

"My last child was delivered at the health centre...When my wife started feeling labour pain I informed my mother who sent for the TBA... the TBA came and examined her (wife) and after some hours my mother told me to looked for a car for them to go the health centre.... I looked for a taxi and paid for the charges.....then she was escorted by my mother and the TBA.....I was prepared to join them but my mother said what are you going to do at the health centre? This is a woman show, stay home to keep the security of the compound... I stayed home very sleepless and the last telephone call I made was at 4.20 am..... They eventually called me at 5.20 am, an hour later that she (wife) delivered a baby boy....I became relieved" (A 38 years old husband, in-depth interview two, informant -5.).

This chapter concluded that men in the urban areas mostly provided transport fares for women to seek antenatal care and even at times provided extra money for women to buy food while at the clinic seeking care. And men in the urban areas mostly arranged and paid for transport for women to seek delivery care. By contrast, in the rural areas men rarely provided fares for women to seek antenatal care but were involved in arrangement of transport for women to access delivery care. Though, reproductive and maternal health services are declared free of charge for Gambians, but efforts to access the services remains largely the responsibility of the woman especially in the rural areas. Therefore, women resorted to selling charcoal, firewood and engaging in gardening and micro-credit finance programmes to generate income to access health care. Some women expressed views that husbands who were mostly away from home due to the nature of their jobs kept money with shop keepers in the neighbourhood to be use by pregnant women to access delivery care, but concerns were raised for women to be trusted to keep such monies as shop keepers were at times reported to be out on business errands at a point such monies were needed most. A Few informants suggested that if such monies were kept by women or wives,

it may end up serving a different purpose. Instances were reported where husbands provided money for women to seek antenatal care but few women decided to stay home and ate the money without going to seek antenatal care and this was reported to have erupted some misunderstanding between few couples. However, women's resistance to seek care at this point was attributed to women being ashamed to expose their pregnancies in the early months and been bored by repeated antenatal visits suppose antenatal clinic attendance were started in the first trimester. Practice of focus antenatal care strategy by care givers and sensitisation of women on the same strategy may have an impact.

10.2.2 SOCIAL PROGRAMMES - WEDDING AND NAMING CEREMONIES.

Few interviewees expressed views that men spend money lavishly in social programmes like wedding and christening ceremonies rather than giving priority to health of women. A woman in her 6th pregnancy explained

"I always walk to the clinic because I have to pay fare twice before reaching the clinic....Any time I asked my husband he will say I don't have money and I cannot force him to give me moneywhen am pregnant he does give me normal fish money to cook the lunch and dinner but never buy me extra food to make my pregnancy more viable... and he will spend lot of money during the christening ceremony....I think its better to take care of a sick person ...spend your money and resources and get her wellthan to spend money on her burial" (A 30 year old woman in her 6th pregnancy, in-depth interview one,informant-16).

Similar perspective was shared by a 42 year old woman in a focus group discussion.

"Men hardly provide fare and extra food needed for the good health of the pregnant woman...my husband has two wives and as am talking to you my co-wife is pregnant too....my husband never provides extra food for her ..For me am working and do help my self....Any time I tell him (husband) to provide extra food for her (co-wife), he says it's always my intention but I have no money, the little I have is for the fish money...she (co-wife) sometimes takes only lunch and plucked some mangoes to eat" (FDG 2, a 42 year old woman, informant-6).

Social programmes were as well highly cherished by women and women accrue lot of money to spend on such occasions. Such programmes were widely seen as social obligations and men also expressed views that women encourage them on such expenses. Women use such occasions to show their prestige to friends and relatives by wearing expensive clothing and jewelleryes.

In the other hand some women saw men to be caring and views expressed that men bought extra protein foods for their pregnant wives when coming back from work. In instances where it was forgotten to buy such foods, monies were provided for the woman to buy her choice of food as a supplement to the supper already taken. Though it's important to note that such support was some times influenced by women's nutritional education received from midwives.

A 28 years pregnant woman explained.

"my first visit to the clinic....the midwife advice me to be eating good food like beans, meat and fruits and avoid lifting very heavy things. When I went home I explained this to my husband and any time he is coming from work he will buy me roasted chicken or beef.....sometimes if he forgot, he does give me money to buy my food of choice and soft drink.....and he always wants me to eat it alone, despite that I always want to share it with him" (A 28 years old woman, in-depth interview one, informant-3).

Social programmes are social obligations that are practice and accepted by most people. However, in such programmes like wedding and christening ceremonies lot of monies are spend by both men and women and monies spend are budgeted long since before the actual programme. For instance during pregnancy, money is accrued to be spend in the christening ceremony. However, men are alleged of lavish spending in such programmes but women also appeared to support such spending as they used such programmes to show prestige to their female counterparts and other relatives. Therefore men try to satisfy their wives and relatives demands in such programmes as a social obligation. This led few of them exhausted their budgets and some even indebted. Despite men been reported of lavish spending and uncaring by not providing extra food for women during pregnancy, there were also a few positive reports of men providing nutritional support to women especially during pregnancy. Men and women should give priority to their own health rather than lavish spending in social programmes. A year or two budgets is squandered in a day.

10.2.3 PREFERENCE OF THE MALE CHILD

Gender difference and preference of the male child featured prominently in this study. Women who delivered a male child reported to have been provided good nutrition by their husbands during the postpartum period. This shows some sort of gender inequality and some women who delivered a baby girl felt not getting the required support from their husbands. Women who delivered baby girls in health facilities felt discomfort to inform their husbands who were most often not available at clinics. However, women who delivered a baby boy were reported happy to satisfy their husbands' wish. Such women were as well reported to have been supported by men with money as fares to access infant welfare clinics for immunisations and weight monitoring of their babies following the christening ceremony.

A 29 year old woman in her 5th pregnancy shared an experience.

"Normally when I delivered a baby boy, my husband is very happy and he provides me chicken every day through out the first seven days of postpartum' and he gives me fare to take the child for immunization" (A 29 year old woman in her 5th pregnancy, in-depth interview one, informant -8).

Gender difference and preference of the male child seems to start right from birth. Women who delivered baby boys were reported happy for satisfying their husbands wish. Such women received nutritional support from their husbands during the postpartum period and were often supported with transport fares to attend infant welfare clinics for the immunisation of their babies. Husbands at homes being communicated sex identities of babies delivered at health facilities were reported happier where the delivery is a baby boy. It is important to educate men on gender equity and the important of both sexes in development.

10.3 MEN'S ESCORT AND COMPANY OF WOMEN TO SEEK ANTENATAL AND DELIVERY CARE.

10.3.1 COMPANIONSHIP TO CLINICS

Men's company and physical support of women to seek antenatal and delivery care was merited by most informants but largely restricted by myriad of factors. Some men felt it is their responsibility to escort women to clinics and offer physical support when needed, but this was deterred by men's job responsibility. Men were seen and felt that they are the providers. It was further expressed by men that their absence from work and been present in the clinic together with their partners could left children without food, as many felt an hour absence from work will mean a struggle for the next day fish money. Most informants reported having limited income and needed more hours of work to meet their survival. A 28 years old husband narrated.

"when my wife is pregnant I do give her money and advice her to joint the antenatal clinicbut I don't have the time to escort her to the clinic because I have to go for work to look for our survival.....most of my colleagues including my self (interviewee) , if stayed out of work for even an hour will left the children stay with bare stomach the next day (hungry)...We live from hand to mouth" (A 28 years old husband, in-depth interview two, informant -14).

Some of the men saw women to be mature enough to visit the clinic alone or to be escorted by their fellow women but not men. Some men expressed opinions that very sick women should be cared by their fellow women and not men for privacy reasons. This explained how pregnancy and childbirth was viewed as women responsibility and mostly seen as a women show. A 40 years old husband expressed contention.

"women should be escorted to the clinic by their fellow women but not men...A blind man has another game to play different from jumping over a hole...Laugh..." This proverb literally means, Men have more appropriate responsibility than escorting women to clinics"[researcher] (A 40 year old husband, in-depth interview two, informant -7).

Most of the interviews revealed that women were mostly escorted to clinics by mothers and mother's in-law. A few educated men, men with travelling experience abroad, foreign nationals living in the Gambia mostly fullas from Guinea and Nigerians escorted women to clinics. Most of the interviews opined that foreign nationals escorted their wives to clinics to get the opportunity to negotiate for what was regarded as high charges of antenatal and delivery care and served as an interpreter

between service providers and their own wives. Besides, they mostly don't have a close female family member to offer such service. It is important to mention that antenatal and delivery services are free of charge for Gambians and according to a tariff document acquired from the drug revolving fund unit of the Gambia Ministry of Health, the charges for non Gambian for antenatal care stood at 225 GMD, which is approximately (US\$ 9) and delivery care charges were 1800 GMD, which is also approximately equivalent to (US\$ 69). Educated men that escorted their wives were stereotype and subjected to gossip by their male counterparts and interestingly by women found in the clinics while in the process of seeking pregnancy care. This resulted to prejudicial views like, husband's too much love for the wife, the clinic been a domain of women and women should escort women to clinics and not men. A 28 year old husband who escorted her wife to the antenatal clinic explained.

"Am here in the clinic today to escort my wife to seek antenatal care. She is in her 7th month of pregnancy and she started the clinic in her 3rd month. We were told by the nurse in our last visit that she should visit the clinic at least four times during pregnancy. When am in the clinic with her, I do escort her to the lab and check on her appointments to remind her of her appointments visits, she is not educated.... When her appointments are due I do call my office a day before to let them know that I will be coming to work late the next day because am suppose to escort my wife to the clinic, but I do have lot of pressure from my friends, telling me that I love my wife too much and the clinic is a domain for women. This I think is just out of ignorance, I am educated up to grade 12 and during my junior secondary school days I use to attend family life education classes ,though the classes were optional but I had interest in it and this has given me the knowledge about the importance of helping women especially when they are pregnant. This is why am providing the best help for my wife. Husband and wife should compliment each others efforts... Many find it hard to escort their wives to the clinic, one should even be ready to offer your wife a bath when the need arise. I think men should be educated on their reproductive role" (A 28 year old husband who escorted his wife to the antenatal clinic narrated, in-depth interview two, and informant -1).

A few men who escorted their spouse to the antenatal clinic were at times health educated by midwives and given priority in receiving services. This is a form of encouragement to get them back and further convince their male counterparts to emulate them. A female midwife explained.

"As for me, I give priority to men who escort their wives to the clinic for antenatal care...this is a form of encouragement for them, but if you leave them to queue for so long they become discouraged and you will never see them in the clinic again...men claim to be very busy at work" (A female midwife, in-depth interview three, informant -7).

A large age gap within couples was another factor that restricted men from escorting women to clinics. Old men married the young girls and felt ashamed to visit clinics together with their partners despite the status attached to marrying a young wife.

A 58 years old husband explained.

"With my age now ...I am ashamed to escort my wives to the clinicand if I do it for one, I have to do it for the others ...though one of them never had a childyou know such women are castigated in our communities ...I supported her to seek both traditional and conventional medicine but to no avail...we even went to Dakar (Senegal)... Now we taken what God destined" (A 58 years old husband, in-depth interview two, informant -6).

Besides, opinions were also expressed that polygamous men and women were as well restricted by what was referred to as one rule apply to all, thus ones a husband has offered an escort and support to one of the wives he has to do the same for the co- wives and this was regarded tedious.

10.3.2 LONG WAITING TIME OF ANTENATAL AND LABORATORY SERVICES.

Husband's limited time availability to be in clinics together with their spouses was further complicated by long waiting time for antenatal and laboratory services. Many expressed feelings that they spent long times in clinics to receive antenatal and laboratory services and husbands cannot just waste their precious times in clinics for hours waiting for services. A 30 years old woman in her 6th pregnancy explained.

"Am back to the clinic today to the lab to get my blood tested...yesterday I spent 6 hours here but did not receive any service because they (lab staff) said there was no electricity... I had to eventually go home to cook lunch for my kids to have something to eat when they come from school...how can my husband be with me in the clinic for such a long time (6 hours)...I even don't know what will happen today"(A 30year old woman in her 6th pregnancy, In-depth interview one informant-10).

Some of the interviewees expressed opinions that limited hours of electricity supplies and limited human resource such as midwives are contributing factors to long waiting time of antenatal and laboratory services . A few midwives felt the work load is too much on them as many midwives left for the private sector. A midwife explained.

"This job (midwifery) is very stressful and the work load is heavy....because many midwives left for the private sector or Europe in search of greener pastures" (A female midwife, in-depth interview one, informant -7).

Lessons were drawn from most informants that men were mostly not present when women seek antenatal and delivery services. This made them unavailable when their support is needed to donate blood in emergency obstetric situations. Men's reluctance to donate blood even if they were present was conspicuously noticed in this study. Women's needs for blood transfusion to save their life were obvious but made oblivious by men. A maternal mortality study conducted in 2003 in central region of the Gambia including Bansang Hospital has reported general reluctance of people to donate blood, operational deficiencies and women been escorted by old women leaving men behind as potential blood donors, despite their unwillingness as donors (26).

A 24 year old woman shared an experience in a focus group discussion.

"Just recently my sister was admitted in Bansang Hospital....and the husband was called to donate her blood because her blood was very low...when he received the call while was standing with his friend ..He (husband) told his friend that she (wife) will die but I will never donate my blood outand she eventually died. Some men are very heartless" (FDG 2, A 24 old woman, informant -2.).

A female midwife shared similar feelings.

"In my experienced, men are not responding that's why we get problems in blood donation and even signing consent forms....they (men) in fact prefer to buy blood than to donate, even if there spouses are in dire need of blood...they should be sensitized well on blood donation ..Donating Blood will not end ones life but will instead safe life" (A female midwife, in-depth interview three, informant -1.).

This chapter illustrated that most women were escorted to clinics to seek antenatal and delivery services by mothers and mothers in-laws. Opinions were expressed that most men hardly escorted their partners to seek antenatal and delivery care. Reasons of men's limited escort of women to seek care at clinics were grounded in men's job responsibilities, long waiting time of antenatal and laboratory services, husband-wife large age difference as the old men married the young girls, and individual dispositions of just being ashamed to be with their partners in the clinics. This resulted in often missed opportunities of getting men's timely support in emergency obstetric situations especially when they are absolutely needed to donate blood. Use of mobile phones helped considerably in getting the attention of men to offer help; hence they were mostly away and thanks to technology. However, it was further acknowledged

that, even if men were present they were mostly reluctant to donate blood but rather preferred to buy blood. Furthermore, men felt they spent most of their time looking for the survival of the family and had little or no time to be in clinics together with their spouse to seek antenatal care. Expressions further alluded that if men had to be in the clinics together with their spouses then the children at home will go hungry. Men's limited time available to be in the clinics together with their spouse was further complicated by experience of long waiting hours of antenatal and laboratory services. Few men expressed views that women were seen mature enough to seek care on their own and not suppose to be escorted. Whereas parallel feelings unfolded views that even if women were to be escorted, it should be the responsibilities of their fellow women but not men. Imperatively, few educated men, men with travelling experience abroad and foreign nationals like Guineans and Nigerians were mostly reported to have escorted their spouse to clinics to seek antenatal and delivery care. Educated men who escorted their partners were subjected to gossip of too much love for their partners by their male counterparts and interestingly women found in the clinic while seeking care .While foreign national like Nigerians and Guineans escorted their partners and relatives to get the opportunity to negotiate for what was regarded as expensive cost of antenatal and delivery services They also served as interpreters to facilitate communications between their spouses or relatives who were mostly recently migrated in the Gambia and were often inept to understand or speak the main local languages which were mostly the medium of communication between care providers and clients.

10.3.3 USE OF MOBILE PHONES

Essentially, the advent of electronic mobile phones was acknowledged to greatly help in getting men to the clinics in situations where their support were needed in emergency obstetrics care situations. They were mostly not present to offer assistance like donation of blood. Therefore women had their husband's telephone numbers written on pieces of papers tied at the edge of their wrappers and mostly seek help from midwives to call husbands when in dire need of their assistance. Cost to pay for telephone calls was even expensive for many. A female midwife narrated

'I had an experience just last week... when a woman delivered in the labour ward and was crying bitterly...I was very surprised ... I just got near her to console her and went further to gently asked her about what made her crying bitterly? Is it pain? She replied nodding her headThen I further asked

...and she said...I was escorted to the health centre by my mother in-law and this is our second night heremy husband never called or sent me any money. He just told me when I was coming, to call him when I deliver and he never gave me any money...can you help me to call him...I have his telephone number here" (A female midwife, in-depth interview three, informant -9.).

Similar poignant feelings were shared by a female midwife:

"The mobile phones are of great help now to get men informed of serious problems suffered by women while seeking care in health facilitiesthere was an incident were a woman delivered at the hospital and eventually died 3 days postpartum ...and it was rather unfortunate that the husband visited the wife after seven days...let only to be told that your wife died three days ago. The husband was living in the provinces and there were no mobile phones by then „messages take days before they reach their intended targets....technology is making life a bit easy for people now" (A female midwife ,in-depth interview one, informant -1).

This chapter explained the importance of technology in getting men involved and offer support to their partners while in dire need of their assistance in the process of seeking health care. More difficult moments were reported when efforts to reach men took days because of the rudimentary communication system that was earlier used. Messages were communicated and relayed from one person to the other and its takes longer times to reach their intended targets. However, despite the privilege to reach men by means of electronic communication there is absolute need to get them present and offer needed support at the right time. Therefore men should be sensitised on their reproductive responsibilities including providing escort for their partners to clinics.

10.4 PRESENCE DURING DELIVERY

This chapter discuss the perspective of men's presence during the delivery process. Different views of informants captured lot of interest and reported intriguing opinions. Most women welcomed their husband's presence and support during the delivery process. However, husband's presence and support of their spouse during the delivery process were restricted by variety of factors that includes health service and structural factors, socio-cultural factors and religious factors, and men's presence during delivery process seen as non-customary.

10.4.1 HEALTH SERVICE AND STRUCTURAL FACTORS

- **LIMITED SPACE- NON CUBICLE STRUCTURED LABOUR WARDS AND LIMITED PRIVACY.**

Most interviewees reported difficulties of being in clinics together with their partners during the delivery process. One of the reasons was the limited space to accommodate both parties in the labour ward. Most labour wards were open and not constructed in cubicles. It was reported that if husbands were allowed in labour wards to be with their labouring partners, they will possibly see other labouring women different from their own wives. This was mostly regarded as something against the teaching of Islam. However, few husbands who escorted their wives to clinics were at times asked out of the labour ward and they hung outside waiting for outcome of labour. A 24 years old woman in her 3rd pregnancy explained:

"I delivered my last child in this health centre... when the labour pain started my husband drove me together with my mother in-law to the health centre., I was admitted and he (husband) was asked to stay out and he hung within the health centre complex, and what ever I needed he will just rushed home and bring it . He stayed outside until I delivered a baby boy and my mother in-law went outside to inform him (husband) that I delivered a baby boy and he cried, he is a very caring husband.....interviewee cried too at this point....sorry!! (Researcher)...what makes you carry?I know if this was in Europe, my husband would have been by my side giving me all the support I needed....women here should be given the option to choose whether to be together with their husbands during labour or not" (A 24 years old woman in her 3rd Pregnancy ,in-depth interview one, informant - 14).

❖ ATTITUDE OF MIDWIVES .

Most women and some men expressed views that some of the attitudes of midwives towards labouring women were unacceptable, especially female midwives. They used abusive languages against their female counterparts in labour and at times reluctant to answer to labouring women's call for help. Men were as well at times sent out of the labour ward. In instances where men mistakenly entered labour wards while in the process of seeking care they are shouted at by nurses (midwives) and they became bewildered. A female midwife explained.

"Its a good thing to allow husbands to be present when their spouse deliver...but many midwives including my self will sent them out of the labour ward ...even if men mistakenly entered labour wards while in process of seeking health care ...they are shouted at by midwives ...making them confused looking" (A female midwife, in-depth interview three,informant-5).

Instances were also reported when husbands wanted to be with their labouring wives and been restricted by nurses (midwives) which resulted to some misunderstanding. A 36 years old woman shared an experience.

" Just last week one soldier man's wife was in labour at the health centre and the soldier man wanted to be with her labouring wife in the labour ward ...the midwife insisted and sent the man outhe appealed and she (midwife) still insisted...he (soldier) force his way and sat besides the wife while fanning her...the woman was happy and comfortable ...this is what is required but midwives need to be sensitised about it so that they allow men to help women" (A 36 years old woman, FDG 2, informant -1)

Similar perspectives revealed that, a husband with travelling experience escorted his wife to deliver at the health centre and wanted to be with his labouring wife but was denied by midwives. He had to convince midwives using his experienced abroad. A female midwife shared her work experience in public hospitals.

"A man with travel experienced abroad escorted her wife to deliver at the health centre and he found me and my colleague on dutywe admitted the woman and asked the man to wait outside ...and the man appealed to be with her wife but we both strongly insisted... but the man eventually convinced us to be with his wife.....when the woman delivered safely...the man told us that when his first child was been delivered in England he was never prepared to witness it but was encouraged and invited by the midwife to attend the delivery and he (husband) wept that day. Men should be allowed to be present when their wives deliver so that they will become more caring " (A female midwife narrated her worked experience in public hospitals, in-depth interview three, informant -10).

In this particular experience the labour ward was cubicle structured but the midwives were just reluctant and felt it was a rare practice to allow men in the labour ward. This implies that even if privacy of women is restored in labour wards midwives need to be sensitised on men's involvement so as to capture their response to better accept and involve men in care and support of women.

Similar perspective was expressed by a 33 year old husband who carried food and hot water for his labouring wife at the health centre.

"My last child delivered at the health centre...my wife was escorted by my mother and sister ...I later prepared food and hot water (tea) and followed them at the health centre...when I arrived I greeted nurses (midwives) seated round a table....then a very arrogant female nurse just got up and said what is this? (Food and hot water) is for who? I said my wife and mentioned the name ...she said bring it ,this place is not for men...I really wanted to be with her and gave her all my love and support but made very angry by that young nurse...what can I do about it" (A 33 years old husband, in-FDG 3, informant - 4).

Most women shared experience that male midwives are more sympathetic and caring than female midwives. Some women further expressed preference of attendants by a male midwife to a female midwife. A 42 year old woman shared her view in a focus group discussion.

" I prefer male midwives than female midwives ...I have an experienced recently at the health centre, when my friend's wife was in labour ...she called the female nurse (midwife) and she insisted and continued chatting with friends round a tableand after some times a male midwife came and she made the same request and he offered good help....can you imagine? She is her female counterpart and she (female midwife) should have been in a good position to help women " (A 42 years old woman, FDG 2, informant -6).

Similar experience was captured by a 47 years old husband.

" My wife told me female midwives should be even stopped!my wife was also told by her friend that when she was in labour...she (friend) told the nurse (midwife) to give her some water to drink and the nurse (midwife) told her (friend) to get up fetch water on her own to drink...when she was thirsty...With all the pains of labour....she later told a male midwife who rushed and got her some water to drink.....this is something just crazy...I think they are not monitored at work"(A 47 year old husband, in - depth interview two, informant- 2).

However, despite feelings of appreciation of male midwives, most interviews saw midwifery as a domain of women and advocated that deliveries should be performed by females and men can take up responsibility in the absence of women. Education of

the girl child to take up responsibility of midwifery practice including delivery attendants featured in most interviews. Secondary school net attendant ratio of girls in the study area is more than 40%(20). Women expressed feelings that they felt ashamed to be delivered by male midwives and a few religious ones preferred even to deliver on their own than been delivered by a male midwife. They felt women should be given the rights to make a choice of a midwife to attend to them in labour.

A 28 years old woman in her 6th pregnancy explained.

"I am happy to have been attended by female midwives in all children I delivered....many women do tell me that male midwives are more caring ...this may be true but I prefer my female counterpart. I can recall visiting the health centre together with my sister who bend her head down when we met a male nurse (midwife) and I asked her what is the problem ?...she replied that nurse (midwife) delivered my last child ..He (midwife) may not recognise me but I feel very uncomfortable where ever I see him in the clinic.....in instance where a male midwife want to deliver meI will ask for a female midwife and if there is none...I rather prefer to deliver by my own" (A 28 years old woman in her 6th pregnancy, in-depth interview one, informant -12).

A female midwife shared experience that Male midwives are not practicing midwifery in the main referral hospital (RVTH) and actual reasons for this was not clear in this study but perhaps linked to hospital policies. However, opinions further revealed that some male midwives have taken up the profession of midwifery just only to be promoted and get brighter opportunities to work for the private sector. A Few midwives felt opportunities are greater with the midwifery speciality compared to other areas of nursing speciality. A female midwife explained.

"Male midwives are not practicing in the labour ward RVTH (the main referrals hospital)...they are only interested to study midwifery to be promoted or get more opportunity to work in the private sector....most of them are leaving for the private sector and lot more gone abroad in search of greener pasture. And they were doing a very good job; many women even prefer to be delivered by a male midwife" (A female midwife, in-depth interview three, informant-8).

There were examples of private health facilities that accommodated men (husbands) to be with their labouring wives and offered both physical and psychological support. Such support in the private health facilities was one reason that women expressed preference of private to public health facilities. A 28 year woman in her 6th pregnancy explained.

"I delivered my last child at the private clinic....this was in 2002...my husband was allowed to be with me and he held my hand reassuring mebut unfortunately I ended up delivering a still birth...he continued to encourage and company me which further gave me a peace of mind ...could you imagine how painful and stressful it is to be pregnant for 9 months and eventually losing itHis support was highly cherished....there is privacy in the private clinics. Each labouring woman to a room...but in the public health facilities the labour wards are open and if men (husbands) are allowed in they can easily see other labouring women's privacy ..This is against Islam" (A 28th year old woman in her 6th pregnancy, in-depth interview one, informant -17.).

Significantly, there seems to be more privacy in private health facilities as women reported allocation of separate rooms during labour, delivering in cubicle structures or screened area during the process of labour. Husbands were some times reportedly encouraged to be with their labouring wives in private clinics and this was cherished by some women and midwives. A few men expressed appreciation to be with their partners during the delivery process and this was reportedly said that it may result to partners admiring each other more. Most women also expressed views that men should have an experience of witnessing the difficulties involved in child birth and this could result to men becoming more sympathetic to their partners. Women need to be supported by their husbands during the difficult process of childbirth.

10.4.2 MEN'S INVOLVEMENT NON CUSTOMARY

Some men expressed views that involvement and presence of men during the delivery process is a western practice culture that should not be adopted. Pregnancy and childbirth as well as care of the children in the family were seen as women's responsibility. Men who offered birth to their children, help them change their clothing and cuddled them were seen as renegade by some men. Attitude of men with travelling experience were at times positively influenced by their travel experience abroad. A 47 year old husband with travelling experience explained.

"I have many years travelling experienceand used to go to the market to buy condiments for my wife ...besides it was my responsibility to prepare the break fast and she prepares the lunch, any time we are out together, I held our child.....when I came back home to the Gambia ,I encountered lot of problems with many people just because I was fetching water for my wife and cuddling my youngest child from time to time....one fine day my father called me and said to me that it is rumoured in the village that you fetch water for your wife and cuddle your child too much, you are introducing a western culture in the village and you got to stop this now. Are you afraid of your wife? I smile and could not speak my opinion because he is my father ...it is against our culture to go against the opinion

of an elderly person...culturally in this village, it is believed that women should do the cooking, take children to the clinic, and wash childreneven if an innocent child wants to sit on his/her father's laps, he (father) will just say go to your mother as if the child is only own by the mothermen feel children should be cared by women and they grow to benefit men" (A 47 year old husband with travelling experience, in-depth interview two, informant-2).

Interestingly, another man shared a negative feeling from his experience abroad. This man happen to travelled abroad and eventually got married. He was then exposed to witnessing her wife deliver, which he was obliged to. In some western practice the husband is present during the delivery process and takes the responsibility to cut-off the umbilicus to separate the child from the mother following the birth of the child. This man's experience in witnessing his wife delivers resulted to a divorce. He said he no longer accepted his wife following his experience.

A 42 year old husband who witnessed her wife delivers abroad.

"I experience witnessed my wife deliver when I was abroad, but this happened to break my marriage because I can no longer admire her following my experience and we divorced....this was something I never knew ...totally alien of my culture but I was called by the midwife to attend ...it was really a terrible experience ...not nice at all" (A 42 year old husband, FDG 3, informant -3).

10.4.3 CULTURAL AND RELIGIOUS BELIEFS

Culture can be defined as an integrated system of socially acquired values, beliefs, and rules of conduct which delimit the range of accepted behaviours in any given society(46). Culture is also philosophically viewed as the way of life of a people, including their attitudes, values, beliefs, arts, sciences, modes of perception, and habits of thought and activity. Cultural features of forms of life are learned but are often too pervasive to be readily noticed from within(46). Cultural difference distinguishes societies from one another. In this study cultural and religious belief of people were major issues that restricted men (husbands) from been involved and present in the delivery process of their spouse. These beliefs include a belief that a man can become sick and swollen before they die when they witness a labouring woman, men becoming impotent when they see delivery blood, men losing the spiritual protection of their amulets (jujus) when they enter the labour ward or a delivery place. There are other cultural prescriptions to protect men from such dangers. For instance, men not supposed to enter the house of a postnatal mother within one week of postpartum. Some interviewees expressed views that it is against

Islam that a man be present when his spouse delivers. Some of these beliefs run across different cultures and ethnicities and some were specific to certain cultures and ethnicity. Though it was not a main objective of this study to specify what cultural practice was specific to which ethnic group, but rather the focus is to generally establish the socially constructed cultural beliefs and practices related to the subject. That is why the interviews in this study covered seven different ethnicities with respondents between the ages of 21 and 58 years, which further assisted to contextualize some of the findings. However, it will be of great importance if an anthropological or ethnographic study follows in order to better make cultural meanings in relation to involvement of men in maternal and reproductive health issues in the Gambia. Some of these beliefs have featured in some interviews to have obstructed men from helping women who needed obstetric attention.

A TBA explained an experience.

"It was one fine day when a young girl of 18 years of age was in labour , escorted by a 52 year old husband .They knocked at my door around 4am. The girl was shouting and screaming but the husband insisted to touch her because his belief was if he touches the girl he will have a very bad ending and his amulet (jujus) will spoiled. My own husband (TBA) had to help me to take the lady inside my house.....Then I examined her and found out that she had mal-presentation (shoulder presentation). This was beyond my capacity, then we were given mobile phones by one project that used to facilitate obstetric referrals, I called the obstetric team right away and they quickly came with the ambulance and I escorted the girl to Brikama health centre but the husband never followed us. She delivered a baby boy and was discharged two days after....saddest part of all she stayed with me in my house (TBA) for a week because the husband belief that she should not see the wife in the first 7 days of postpartum. Men should be educated on their reproductive roles especially those who are not educated. Education is very good, as for me am educated in non formal, I can read and write in non formal education" (A TBA, in-depth interview three, informant-12).

Women who got the opportunity to be with their husbands during the delivery process expressed satisfaction and support received from their husband's, and husbands who were privilege as well expressed concerns that their presence made them sympathized their wives more and became more concerned with their health.

A TBA explained.

"It is very important for men to be present when their spouse are delivering, it will make them sympathetic and more caring. I will take myself as example, when I delivered my last child in the hospital, I was very dizzy and felt very bad and my husband stood besides me and gave me some water,

this is an experience I will never forget in life and that's the time I knew that she has concern for me...I do even remind him of that still" (A TBA, in-depth interview three, informant -11).

A 54 year old husband shared similar feelings:

"I experienced witnessing my wife deliver her second child ...then the midwife we found on duty was my neighbour and she encouraged me to witness the delivery... this was a great experience and I wept afterwards... this made me care for my wife more and became more sympathetic to her....men should be sensitized and encourage to help their wives....women need to be supported" (A 54 years old husband, in-depth interview three, informant -13).

An experience was reported where a midwife encouraged a husband to attend his wife's delivery process at the hospital and wonderful experience was shared. However, this man was reported to have strongly rejected the request to witness his spouse delivery when the initial request was made. He insisted because he was found wearing amulets (jujus) and never wanted to lose the spiritual protective spirit claimed to be obtaining from the amulets. With ardent encouragement by the midwife he eventually accepted and took off his amulets (jujus) kept outside the labour ward and got into the labour wards to be with his labouring wife. The Labour ward where this experience occurred was cubicle structured and relatively spacious. This man was reported to be very happy after successful delivery of his wife to a baby boy and he held the baby with pride and joy.

A female midwife explained her experience.

"I had an experienced in the hospital recently; a man escorted his wife to the labour ward. I examined the wife and told him that your wife is in labour and later invited him to witness the delivery process but he initially insisted that the place is for women and he was wearing amulet (jujus)...I further encouraged him to take the amulets off and he finally did and came in the labour ward ... and his wife delivered a baby boy and he was very happy and held the child...men are just not involved and encouraged....They need to be sensitized about their reproductive roles".(A female midwife, in-depth interview three, informant -8).

Most men expressed views that pregnancy and childbirth is a risk that can end a woman's life. *'When a woman is pregnant her grave yard is open and when she delivers her grave yard is close [...]* (A husband explained). Some women believed that they are sometimes protected from risk involved in pregnancy and child birth by the prayers and holy water provided by their husbands during pregnancy and child birth. This is believed to

have helped in hastening labour and reducing complications during delivery. A 29 years old woman in her 5th pregnancy shared an experience.

" when ever am pregnant my husband seek prayers and pray for me to deliver in peace....he also prepares holy water to help me hasten my labour and protect me from having any problem during labour....this really help me any time am pregnant" (A 29 years old woman in her 5th pregnancy, in-depth interview one, informant-8.).

This chapter captured lot of interest and intriguing opinions. Most women welcomed their husband's presence and support during the delivery process. This was restricted by what was considered to be health service and structural factors which constituted limited space and fewer cubicles structured labour wards and limited privacy and unacceptable attitude of midwives. Men's presence during the delivery process was also seen as non customary and was further restricted by cultural and religious belief. Though most of these beliefs were coming from elderly men and women but younger men and women had seemingly opposed such beliefs and further expressed concerns to offer support and companionship of their spouses during labour if permitted by midwives. Men who were reported to attend the delivery process of their wives after being encouraged by midwives, expressed concerns that their presence made them more sympathetic towards their wives. Women with similar experiences also expressed satisfaction and support received from their husbands. Some of these beliefs ran across different ethnicities and some were specific to certain ethnicity. My primary interest as a researcher was not to study different cultural beliefs and practices to different ethnicity, but rather to establish a general construct associated with the subject in question. Notwithstanding, variations of cultural diversity was considered and interviews held in this study covered informants from seven ethnicities to further contextualise the subject. Future anthropological or ethnographic studies will help in delineating the issue of culture and involvement of men in maternal and reproductive health issues in the Gambia.

11.0 DISCUSSION

This chapter will discuss the findings of this study according to the study objectives in sub-headings. This is intended to better relate the evidence generated to what was targeted. It will also help facilitate better understanding of the findings of the study.

➤ **DECISION MAKING AND CARE SEEKING.**

This study found that women mostly initiated to seek antenatal care but men eventually decide. Decision making powers of husbands were posited on religious obligation, cultural and traditional factors and conventional views of husbands being main providers and custodians of money. In instances where men travel or are not available due to other reasons women's visits to clinics are delayed. Thaddeus and Maine identified three levels of delays that lead to maternal deaths thus, (A) Delays in initial decision to seek care (B) Delays in woman's arrival at hospital or clinic and (c) Delays once a woman has arrived within a health facility(47). However, many of the factors that contribute to delays in initial decision to seek care or the timing of a woman's arrival at a hospital or clinic are the results of interplay of socio-cultural and economic factors at levels of families within the community(48). Most interviews also expressed opinions that women were culturally and traditionally expected to be submissive to men especially their husbands and this contributed to limitations of women's decision making powers. Aspects of every day life such as woman's decision making power, their perception of risk associated with pregnancy and childbirth, and the degree to which they are bound by cultural norms and traditional practices that harm their health have all been identified as factors that limits women's access to health care and ultimately maternal health outcomes(48;49). Some male informants expressed opinions that no matter how much education a woman may acquire, she should always be behind a man. Men decide and this includes decision to seek health care. Literatures suggest that men are key decision makers for women choice of health care services despite their limited knowledge on reproductive needs of women, and women depend heavily on men to access health care(50). Contrary to this assertion this study found out that decision to seek delivery care were mostly determined by TBAs, mother's in laws and elderly female relatives at home. Strikingly, 70% of deliveries in the Gambia take place out side health institutions mostly attended by a TBA(51). Decision-making and care seeking were also seen as a process that

requires communication between couples, although such communication can be restricted by cultural belief and individual dispositions. However, limited couple reproductive communication was seen as a good morale in some cultures. This seemingly resulted in limited reproductive communication between couples which was believed to have contributed to men's limited understanding about reproductive needs of women. Men's discomfort to discuss reproductive issues and their limited reproductive knowledge have been reported in Bangladesh and Guatemala(36;52). Men's understanding of danger signs was limitedly reported in this study but interest of men to learn about danger signs was expressed. However, bleeding was mostly recognised as a danger sign and most opinions suggested for urgent medical attention if noticed during pregnancy or child birth, but all other danger signs were mostly oblivious. This was not a surprise because bleeding is largely seen as a life threatening issue and therefore compels one for urgent medical attention. The findings of my study resonate with those of other studies about knowledge of danger signs. A Knowledge of danger sign studied among 457 pregnant women attending six urban and six rural clinics in the Gambia was reported low with bleeding as a danger sign known by only 12.9% of the sample studied(53). And in another study, the prominent danger signs that are the major causes of maternal death were not known and bleeding as danger sign was only known by only 4% of 391 women studied(54). Men's influence on decisions to seek care in the delivery process was largely restricted, as this part was mostly seen as women responsibilities. Traditional birth attendants were often the first to be consulted either by the mother in-law or elderly female relatives. Once decision to seek care was made, husbands were then contacted to arrange and at times pay for transport for women to access health care. However, men usually stayed home to keep the security of the compound while women accompanied the pregnant women to deliver at health facilities. It's important to note that at times TBAs tended to attempt cases beyond their scope thereby delaying referrals. Review of TBAs' roles have been recommended by studies conducted in the Gambia(55). TBAs are in closer contacts with individuals, families and communities and can serve as important community agents linking women to the general health system and the community's thereby increasing access to skilled birth attendant. The roles and limitations of TBAs have been recommended by such studies to be clearly delineated and communicated. Limited time and communication between service providers and mothers who were seeking antenatal care resulted to

limited opportunities for mothers to ask questions during antenatal visits to get their doubts cleared. Therefore, women resorted to TBAs, mothers In-law and elderly women who were closer to them in the communities and confided with them to get their doubts cleared. In this process inappropriate information was offered or information offered was mostly misconstrued and this influenced women's decision to seek care.

➤ **ARRANGEMENT OF TRANSPORT AND TRANSPORT FARES.**

Transportation is an important medium to access health care. Though western health region, the area where this study was conducted has easier means of communication and fairly reachable health services. This study found that husbands in the urban areas were largely involved in arrangement of transport and provision of transport fares for women to seek antenatal and delivery care. And in contrast to the urban areas, husbands were limitedly providing transport fare but were involved in arrangement of transport for women to seek delivery care. This difference could be attributed to difference in economic status and level of education, as 61% of the rural population are poor compared to 48% of the urban areas(16). Most respondents expressed concerns about low economic earnings as many were subsistence farmers and mostly depended on annually earned agricultural proceeds and not paid monthly salaries. To supplement men's low income in the rural areas, women resorted to selling charcoal, firewood, practicing gardening; engage in micro-credit finance programmes and local contributions to generate funds to access health care and other subsistence needs. Despite the poor economic status some women viewed men to be profligate and not committed to help women to access health care, even though they were prepared to spend lot of money in wedding and christening ceremonies. This however, was largely seen as social obligation and such practices were reported to be supported by women as opinions were raised that most women used these ceremonies to show prestige and encouraged men's lavished expenses. Women as well, were reported to have accrued money to spend on social programmes rather than giving priority to their own health. Men and women should give priority to their own health rather than lavish spending on social programmes, a year or two budget squandered in a day.

➤ **ESCORT, COMPANY AND SUPPORT TO CLINICS.**

Escort and physical support of women to clinics to seek antenatal and delivery care was welcomed by most women but restricted by myriad of factors like husband's job responsibilities, husband too much love for the wife, long waiting time of antenatal and laboratory services, repeated antenatal visits, cultural restrictions and husband-wife large age differences as the old men marriage the young girls. However, having a young wife brings status but in this study husbands with younger wives expressed discomfort to be with their partners in the clinics. Most women were reported in this study to have been escorted to clinics by mothers, mothers' in-law, TBAs and elderly relatives to seek antenatal and delivery care. A Few educated men, men with travelling experience abroad and foreign nationals living in the Gambia thus, Guineans and Nigerians escorted their partners to the clinics as well. Educated men who escorted their partners to clinics to seek antenatal care were subject to gossip by both their male counterparts and women found in clinics seeking care. They were some sort of stigmatised. Erving Goffman argues that stigma is an attribute that is deeply discrediting and special between attributes and stereotypes and need to be demystified(56). He went further to identify three types of stigma (a) Blemish of perceive individual character thus rigid beliefs, treacherous and passion (b) Tribal stigma ,race and religion (c) Abomination of the body and various physical deformities (56). The need to sensitised men on their reproductive responsibilities echoed numerously in most of the interviews and the equal need to sanitised women and service providers should be considered. A randomised control trial with a large sample size of 442 women attending antenatal clinic in one of the hospitals in Kathmandu in Nepal, concluded that women learn and retained most of the information when they are educated with their partners(57). Most women and some male informants expressed absolute need to sensitise men on their reproductive roles and responsibilities as men were mostly seen as being oblivious of reproductive needs of women. Furthermore, non-Gambian national like Guineans and Nigerians escorted their wives to the clinics to get the opportunity to negotiate for cost of antenatal and delivery care and serve as an interpreter between service providers and their own wives as many were reported not able to speak the main local languages in the Gambia and found it difficult to explain them selves during the process of antenatal registration. Besides, most of them expressed concerns of not having a

close family relative in place to offer such services. Additionally, private clinics were viewed to have offered more privacy to labouring women as each labouring woman was assigned to a room or cubicle. This was in the reverse in public health facilities as expressed, women mostly delivered in non cubicle structured labour wards and this was further reported to compromise women's' privacy and restricted husbands to be together with their labouring wives. However, their care seeking attention were gradually shifting to the private clinics because of what were referred to as expensive cost of antenatal and delivery care offered in public health facilities in compares to the services received. It unfolded in this study that, most women seem to book for antenatal care early, mostly in the first or second trimester which was attributed to increased IPT sensitisation. Also limited access to diagnostic test like abdominal ultrasound scanning featured as twin pregnancies and other obstetric abnormalities were mostly undiagnosed during antenatal visits. Abdominal ultrasound scanning services should be a birth right for all antenatal mothers, but scanning services were only available at the main referral hospital during weaker days and sporadically offered in one major health centre within this study area. Abdominal scanning services were also offered by private clinics but at a cost mostly regarded as expensive for an average Gambian. Contentions were expressed that accessing abdominal ultrasound scanning services involved time; cost and multiple visits before getting the services and the demand for the services were high. Most women expressed concerns for husbands to be sensitised on their roles to company and support their partners to access such services. A few women showed husband's support for their spouse to access such services at weekends when it was most difficult to acquire such services. Long waiting time of antenatal and laboratory services was acknowledged in this study as a factor that limits men's escort of women to clinics. Interviewees felt that men are busy to work for the survival of the family and therefore can't spent long hours in clinics together with their partners. However, long waiting times fo antenatal and laboratory services were largely attributed to limited human resources and limited hours of electricity supplies. Availability of human resource in the area of health in the Gambia has been reported to be under the level required thus, 1 Physician per 5000 population, 1 nurse per 1300 population and 1 midwife per 7000 population(18;55). The ministry of Health and Social Welfare has also reported high attrition of skilled health workers and Low staff production from health training institutions contributing to inadequate skilled and competent health workers. This warranted a five year policy

plan frame work to facilitate attractive remuneration packages for health staff, outlined operational human resource development plan including postings and transfers, and expand and upgrade the capacity of the training institutions for health service providers(27). Recently, health workers are benefiting from a seemingly attractive incentive payment package, which includes hardship and on call allowances meant to serve as motivation to keep skilled personnel to continue to serve in the public sector and attract the services of others. This effort was hailed by many but still there is need to consider housing of health staff especially in the rural areas. Some of the informants made known that the job demand for midwives was very high and some felt the job were stressful and there is need to motivate and trained more midwives for effective service delivery.

➤ **PRESENCE DURING DELIVERY.**

Husbands' presence during labour was mostly restricted by cultural and traditional beliefs, such as the belief that men became sick and swollen when witnessing their spouse deliver, that men became impotent when they see delivery blood and men losing the potential spiritual powers of their amulets (jujus) when witnessed their spouse deliver. Some of these beliefs ran through different ethnicities and some were specific to certain ethnicity. Some cultures even restricted physical contact of men and the newly born baby in the first seven days of postpartum. Religious beliefs were another factor that restricted men from been involved in the delivery process of their spouse. However, most opinions linked to such beliefs were expressed by the elderly men and women, but the younger men and women were seemingly protagonist to involvement of husbands in the delivery process which could be attributed to modernisation and level of education. This study interviews covered respondents between the ages of 21 and 58 years. Women who got the opportunity to be with their spouse during delivery expressed satisfaction and support received from their husbands. And husbands encouraged by midwives to witnessed delivery of their spouse expressed concerns that their presence during the delivery process made them sympathised their wives more. This may imply that if men are sensitised encourage and involved especially the younger generation their attitudes could be positively influence towards their involvement in care and support of women during pregnancy and childbirth. Men were recognised to be involved in the delivery process by providing prayers and holy waters which were believed to have prevented prolong

labour and complications during delivery. This may be some of the factors that influence women care seeking attention and could eventually delay self referrals which could increase risk of pregnancy and child birth. This further justifies the need to educate men on danger signs and men's limited knowledge on danger signs was reported in this study. Male midwives were largely seen more sympathetic and caring and at times presents the choice of care attendant for most women. Despite the choice of male midwives expressed by many informants, midwifery was viewed as domain of women and female midwives were mostly recognised to take the lead and in the absence of female midwives then male midwives became an option. However, opinions on this issue was not clearly understood, but it seems male midwives became a choice of care giver due to uncooperative attitudes of female midwives. Few religious women preferred to be delivered by female midwives and concerns were raised for women to be given choice of care attendant during labour, as few women felt ashamed to be delivered by male midwives despite male midwives been seen more caring and sympathetic. Imperatively, men's physical and companion support of women who suffered obstetric conditions while at home and required urgent obstetric attention were acknowledged in this study. However, men's support in such situations was sometimes restricted by cultural beliefs, as few belief that touching a labouring woman will render bad ending in their lives. Additionally, men were mostly unavailable to offer support to women in need of emergency obstetric care to donate blood or run errands, even if they were present they were reluctant to donate blood but rather prefer to buy blood. Though the used of electronic mobile phones were acknowledged to have helped greatly in getting men respond to women's request while in dire need of their support in health facilities. A Few female respondents went further to indicate inadequate nutritional support of men offered to women during pregnancy, but it was interestingly noted that men provided good nutrition during the postnatal period to women who delivered a male child. This implies gender preference of the male child which could further presupposed decision making powers which has already unfolded earlier. The need to sensitise men on their reproductive responsibilities was mostly advocated for and many felt reproductive needs and problems of women were obvious but mostly not known by men.

12.0 CONCLUSION

This study concluded that the involvement of men in pregnancy and child birth in the Gambia was restricted by myriad of socio- economic and cultural factors including men's limited knowledge on danger signs, and health service and structural factors. Men were mostly not involved in escorting their wives to clinics and the reasons were grounded in myriad of factors including husband job responsibilities and health service and structural factors among others. Controlling such factors requires an ardent action oriented approaches that could help in attracting men to come onboard the conveyor of reproductive health programmes. This could help in abating difficulties encountered by women during pregnancy and child birth. Services also need to be augmented, staff oriented, train and re-trained on strategies like focus antenatal care. Repeated and numerous antenatal visits were largely seen as boredom and seems to have caused discomfort for both men and women and not cost effective as well. Both men and women should to sensitise on their reproductive roles and responsibilities. It was even fascinating to notice that women even gossip and kind of stigmatised men who escorted their partners. Men should be encouraged and educated to offer more to women during pregnancy and childbirth. This study has shown that, there could be a plus if the younger generation are sensitise and involved as their interest in care and support of women was seemingly captured. However, provision of timely and quality obstetric services which requires staff responsiveness and respect for ethics and etiquette is greatly advocated. This further embraces provision of accessible obstetric diagnostic services like ultra sound scanning and all necessary resources relevant to facilitate such services are also advocated. Improvement of the human resource and motivation of staff, most especially facilitation of their accommodation within or near health facilities could have a positive impact and make them more readily available to offer services. This may further limit longer times reportedly spent in clinics by women to seek antenatal care. Besides, supervision is fundamental in the whole process and should not be seen as fault finding but rather a mean of providing continues ways of training.

13.0 RECOMMENDATIONS

Understanding issues and developing effective interventions that address contemporary public health issues, requires credible research findings that could help in planning, implementation and evaluation of public health programming and activities. Therefore, this study apart from fulfilling an academic requirement bore the following recommendations that beckon for both public and private attention to promote involvement of men in care and support of women during pregnancy and childbirth.

- Sensitization of nurses and midwives on men's involvement in reproductive health in general including care and support during pregnancy and childbirth is recommended in this study. Considerations should be also made to include men's involvement in midwifery training programmes to better prepare midwives on their roles in getting men more involved in reproductive health care.
- Most men were oblivious of their reproductive responsibilities and only few men were informed on danger signs during pregnancy, delivery and the puerperium, though they were seemingly receptive to learn about danger signs. Women were as well kind of stigmatised men who offered escort and support for their partners to clinics. This study recommends education of both men and women on their reproductive responsibilities and danger signs during pregnancy, delivery and the puerperium.
- This study recommends sensitisation of community health workers such as traditional birth attendants, village health workers and community base distributors on men's involvement, roles and responsibilities and referral procedures. Development of referral protocols for the primary and the secondary level of the health delivery system in the Gambia are also advocated in this study.

- Sensitisation of community members' especially elderly women, mothers and mothers' in-laws on men's involvement in reproductive health including care and support during pregnancy and child birth through traditional structures such as women kafoos and village development committees are recommended.
- Most labour wards especially in public health facilities were open pallor's and non cubicle structured which to some extent compromise women's privacy and contributed to limited husband companionship during labour. Recommendation are therefore suggested in this study to restructure labour wards possibly in cubicles or to initiate mechanisms that would ensure women's privacy during the delivery process which may as well attract men's participation.
- Long waiting times of antenatal and laboratory services were reported to keep men away and contributed to men's limited involvement during pregnancy and child birth. However, long waiting times were attributed to limited hours of electricity supplies and limited human resource most especially midwives and laboratory assistance. This study advocates for more hours of electricity supplies, Improvement in recruitment of midwives and lab assistants and facilitate their accommodation in health facilities to make them more readily available and accessible to deliver service. This will possibly reduce long waiting time of antenatal and laboratory services which may eventually capture men's attention.
- A repeated antenatal visits which was reported as boring and non-cost effective tend to limit men's participation. Training of nurses and midwives on focus antenatal care strategy and applying the skills learnt is suggested in this study to may have an impact.

- Difficulties in blood donation were reported as most men were reluctant to donate blood and preferred to buy blood. Sensitisation of men on blood donation and possibly conduct research on why are men reluctant to donate blood is recommended
- Anthropological or ethnographic study to provide better understanding of cultural beliefs and practices related to men's involvement in reproductive health issues is advocated in this study.
- Educated men were seemingly involved in care and support of women during pregnancy and childbirth; this could spur interest to conduct a quantitative study to look into husband education on receipt of antenatal and delivery care.

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APPENDIXES

Scientific Coordinating Committee
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West Africa
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Leading Research For Better Health

23rd June 2009

Mr Ebba Secka
University of Oslo

Dear Mr Secka,

SCC 1161, version 2, 14th May 2009: Men's involvement in care and support during pregnancy and childbirth

Thank you for submitting the revised proposal for the study on 'Men's involvement in care and support during pregnancy and childbirth' to the SCC, along with the interview guides, CV and consent form. I appreciate the consideration you have given to the comments from the SCC, and your helpful explanations of the changes you have made.

I am pleased to approve this proposal for consideration by the Ethics Committee.

With best wishes

Yours sincerely,

A handwritten signature in blue ink, which appears to read 'David Conway', is written over the typed name.

Dr David Conway
Chair, Scientific Coordinating Committee

Cc: Mr Sekou Omar Toure

The Gambia Government / MRC Laboratories Joint

ETHICS COMMITTEE

c /o MRC Laboratories Fajara P. O. Box 273, Banjul The Gambia, West Africa Fax: +220 – 4494498 or 4496 513

Tel: +220 – 4495442-6 ext. 2308

2 September 2009

Mr. Ebba Secka
University of Oslo
Department of general Practice and Community Medicine, Section for International Health
Faculty of Medicine
P.O. Box 1130 Blindern
0318 Oslo,
Norway

Dear Mr. Secka,

SCC 1161v2, 16 April 2009: Men's involvement in care and support during pregnancy and child birth, a qualitative study intended for The Gambia

Thank you for your letter dated 23 July 2009, in response to our letter dated 17 July 2009.

I note with approval your response to each of the itemized queries that were raised at the 26 June 2009 meeting of our Ethics Committee.

These are satisfactory and I am happy to record our committee's full approval for the project to proceed.

With best wishes

Yours sincerely,



Mr. Malcolm Clarke
Chairman, Gambia Government/MRC Joint Ethics Committee
Cc: Mr Sekou Omar Toure

Additional documents submitted for review:

- CV of Ebba Secka
- Consent form, Version 1 – 16 April 2009
- Interview guide, Version 1 – 16 April 2009

IN-DEPTH INTERVIEW GUIDES

IN-DEPTH INTERVIEW GUIDE -1 (WOMEN)

QUALITATIVE STUDY ON MEN'S INVOLVEMENT IN CARE AND SUPPORT DURING PREGNANCY AND CHILD BIRTH.

SECTION 1 - ANTENATAL CARE

1.1 DECISION TO SEEK ANTENATAL CARE

A. what is your reason of being in the clinic today?

B. How old is your pregnancy?

C. when have you started receiving care in this pregnancy?

D. Did you discuss your visit with any one before you started the clinic? Whom do you talk to?

E. What did you discuss?

F. Who decides for you to join antenatal care?

G. What time of her pregnancy do you feel a woman should start antenatal care?

H .What is your reasons?

- -socio cultural beliefs
- -Religious
- -Health system

I. Did you perceived any benefit in seeking antenatal care?

1.2 TRANSPORT, TRANSPORT FARES AND COMPANY

- A. How did you travelled to the clinic?
- B. who provided transport and transport fares?
- C. Who escorted you to the clinic and why?
- D. what is your feeling about been escorted by your husband?
- E. would you share with me any good or bad experience in reaching the clinic for care?

1.3 REPRODUCTIVE INFORMATION SHARING

- A. Did you discuss with any body about pregnancy and child birth?
- B. whom have you talk to and where?
- C. what is your feeling discussing pregnancy and child birth issues?
- D. Did you discuss such issues with your husband?
- E. What are the reasons of discussing it or not discussing it?
- F. Did you perceived any benefit in couples discussing pregnancy and child birth?

1.4 DANGER SIGNS (PREGNANCY)

- A. Did you perceived any risk in pregnancy?
- B. What is the risk involved?
- C. What do you perceived as danger signs during pregnancy?
- D. what do you think can be done to minimize the risk?
- E. what care and support do you need during pregnancy?
- F. what care and support do you received from your husband?

SECTION 2- BIRTH EXPERIENCE

2.1- DECISION TO SEEK DELIVERY CARE?

- A. Where was your last child born?
- B. what motivated you to deliver in this place?
- C. Did you discuss it with any body?
- D. who decided for your place of delivery?

2.2-TRANSPORT, TRANSPORT FARES AND COMPANY

- A. Who provided or arrange for the transport?
- B. who paid for the transport?
- C. Who escorted you and why?
- D. what is your feeling of been escorted by your husband?
- E. would you please share with me a good or bad experience in reaching a palce of delivery?

2.3- HUSBAND'S PRESENCE DURING LABOUR

- A. Was your husband present when you were giving birth?
- B. why was he not present?
- C. Did you perceive any benefit if he was present?
- D. what is your feeling if it is to be encourage?
- E. Did you perceived any challenges
 - -socio cultural
 - -Religious

- -Health system

2.4-DANGER SIGNS (DELIVERY)

- Did you perceived any risk in child birth?
- what are the risk involved?
- what do you perceived as danger signs during child birth?
- what do you think can be done to minimized the risk?
- what support and care do you need during delivery?
- what care and support do you received from your husband?

2.5 MALE MIDWIVES

- What is your opinion about practice of male midwives?
- Should it be encourage?

DEMOGRAPHIC DATA

INFORMANT NUMBER-----AGE-----TRIBE.....

GRAVIDA-----PARITY-----

LEVEL OF EDUCATION-----

MONOGAMOUS/ POLYGAMOUS-----RELIGION-----

DATE, PLACE AND TIME OF INTERVIEW-----

IN-DEPTH INTERVIEW GUIDE -2 MEN (HUSBANDS)

QUALITATIVE STUDY ON MEN'S INVOLVEMENT IN CARE AND SUPPORT DURING PREGNANCY AND CHILD BIRTH

SECTION 1-ANTENATAL CARE

1.1 DECISION TO SEEK ANTENATAL CARE

- A. Did you perceived any benefit in pregnant woman seeking antenatal care?
- B. what time of her pregnancy do you think is accepted for pregnant woman to seek antenatal care?
- C. what are your reasons
- socio cultural
 - religious
 - health system
- D. How did you know when your wife was pregnant?
- E. Did she seek antenatal care from the clinic?
- F. who decided for her to seek care?

1.2 TRANSPORT, TRANSPORT FARES AND COMPANY?

- A. who provided or arrange for transport?
- B. who paid the transport fares?
- C. Who escorted her to the clinic and why?
- D. what is your feeling about escorting your wife to the clinic to seek antenatal care?

E. would you share with me any good or bad experience in trying to help your wife seek antenatal care?

1.3 REPRODUCTIVE HEALTH INFORMATION SHARING

A. Did you discuss with any one about pregnancy and child birth?

B. Whom have you talk to and where?

C. How do you feel discussing pregnancy and child birth?

D. Did you discuss it with your wife?

E. what are the reasons discussing it or not discussing it?

F. Did you perceived any benefit in couples discussing pregnancy and child birth

1.4 DANGER SIGNS (PREGNANCY)

A. Did you perceived any risk in pregnancy?

B. What are the risks involved?

C. What do you perceived as danger signs during pregnancy?

D. what do you think can be done to minimize the risk?

E. what care and support women need during pregnancy?

F. what care and support do you give your wife?

SECTION 2-BIRTH EXPERIENCE

2.1 DECISION TO SEEK DELIVERY CARE

A. Where was your last child born?

B. what are the reasons for the place of delivery?

C. who decided for the place of delivery?

2.2 TRANSPORT, TRANSPORT FARES AND COMPANY

- A. Who provided or arrange for transport?
- B. Who paid the transport fares?
- C. Who escorted her and why?
- D. what is your feeling about accompanying your wife to deliver in the health facility?
- E. would you share with me a good/bad experience in reaching a place of delivery?

2.3 HUSBAND'S, PRESENCE DURING LABOUR

- A. Were you presence when your wife was giving birth?
- B. why were you not present?
- C. Did you perceived any benefit of being present when your wife is giving birth?
- D. what is your feeling if it is to be encouraged?
- E. Did you perceived any challenges?
 - socio cultural
 - Religious
 - health system

2.4 DANGER SIGNS (DELIVERY)

- A. Did you perceived any risk in child birth?
- B. what are the risk involved?
- C. what do you perceived as danger signs during child birth?
- D. what do you think can be done to minimize the risk?

E. what care and support women need during delivery?

F. what care and support do you give your wife during delivery?

2.5 MALE MIDWIVES

A. What is your opinion about practice of male midwives?

B. Should it be encourage?

DEMOGRAPHIC DATE

INFORMANT NUMBER-----AGE-----TRIBE-----

LEVEL OF EDUCATION-----

MONOGAMOUS/ POLYGAMOUS-----RELIGION-----

DATE, PLACE AND TIME OF INTERVIEW-----

IN-DEPTH INTERVIEW GUIDE -3 (FOCUS GROUP DISCUSSION)

1.1 DECISION TO SEEK ANTENATAL CARE

- A. Did you perceived any benefit in pregnant women seeking antenatal care?
- B. what time of her pregnancy do you think is accepted for pregnant woman to seek antenatal care?
- C. what are your reasons
- socio cultural
 - religious
 - health system
- D. who decide for pregnant women to seek antenatal care and why?

1.2 TRANSPORT, TRANSPORT FARES AND COMPANY?

- A. who provides or arrange for transport to seek antenatal care?
- B. who pay the transport fares?
- C. Who escort pregnant women to the clinics to seek care and why?
- D. what is your feeling about husbands escorting their wives to the clinic to seek antenatal care?
- E. would you share with me any good or bad experience in trying to help your wife seek antenatal care?

1.3 REPRODUCTIVE HEALTH INFORMATION SHARING

A. what are your feelings about husband and wife discussing pregnancy and child birth?

D. can we share any experience?

E. what are the reasons of couples discussing or not discussing pregnancy and child birth issues.

F. Did you perceived any benefit in couples discussing pregnancy and child birth?

1.4 DANGER SIGNS (PREGNANCY)

A. Did you perceived any risk in pregnancy?

B. What is the risk involved.

D. what do you think can be done to minimize the risk?

E. what care and support women need during pregnancy?

F. what care and support do you give/received from your wife/husband?

SECTION 2-BIRTH EXPERIENCE

2.1 DECISION TO SEEK DELIVERY CARE

A. who decides for place of delivery?

B. what are the reasons for the place of delivery?

2.2 TRANSPORT, TRANSPORT FARES AND COMPANY

A. Who provide or arrange for transport?

B. Who mainly pay for the transport fares?

C. Who mainly escort the woman to the clinic and why?

D. what is your feeling of being accompanied by your husband to deliver in the health facility?

E. would you share with me a good/bad experience in reaching a place of delivery?

2.3 HUSBAND'S PRESENCE DURING LABOUR

C. Did you perceived any benefit of being present when your wife is giving birth?

B. can we share any experience

D. what is your feeling if it is to be encouraged?

E. Did you perceived any challenges?

- socio cultural
- Religious
- health system

2.4 DANGER SIGNS (DELIVERY)

A. Did you perceived any risk in child birth?

B. what are the risk involved?

D. what do you think can be done to minimize the risk?

E. what care and support do women need during delivery?

F. what care and support do you give your wife during delivery?

2.5 MALE MIDWIVES

A. What is your opinion about practice of male midwives?

B. Should it be encourage?

DEMOGRAPHIC DATA

DATE	INFORMANT NUMBER	AGE	SEX	PARITY	RELIGION	EDUCATIONAL STATUS	MONOGAMOUS OR MONOGAMOUS	DIVORCE

IN-DEPTH INTERVIEW GUIDE -4 (MIDWIFE, TBA, VHW)

QUALITATIVE STUDY ON MEN'S INVOLVEMENT IN CARE AND SUPPORT DURING PREGNANCY AND CHILD BIRTH

SECTION A -ANTENATAL CARE

A. How many years experience do you have and were do you work?

B. What is your opinion on men's involvement in pregnancy and child birth?

C. What is your experience in women attending clinic in the first 3 months of gestation?

D. What are the reasons? What is your experience in men escorting their spouse to the clinic for antenatal care?

E. what problems do women encounter in accessing antenatal care?

F. what do you think can be done to encourage men participation?

DELIVERY

A. what is your experience in obstetric referrals?

B. what is your feeling about men's participation in referrals?

C. Are men escorting their wives to deliver in health facilities? Are they present when their wives are labouring?

D. what are the reasons?

- religious
- socio cultural
- health system

E. what is your opinion about practice of male midwives?

F. Should it be encourage?

F. How can we improve men's involvement in pregnancy and child birth?

G. Any last words.

UNIVERSITY OF OSLO, INSTITUTE OF GENERAL PRACTICE AND COMMUNITY
 MEDICINE, SECTION FOR INTERNATIONAL HEALTH.

INFORMED CONSENT FORM

NAME OF INTERVIEWER.....

INFORMANT NO-----

PLACE OF INTERVIEW-----

DATE-----

TIME-----

You are invited to voluntarily participate in a study that is done through the University of Oslo in Norway. The purpose of the study is to explore men's care and support during pregnancy and child birth. The findings of this study would be helpful in future reproductive planning and implementation. Your participation in this study is purely voluntary and based on your own independent decision and you can withdraw from the study at any time you wish without any intimidation. If you agree to participate you will be asked a number of questions and we discuss about it. The interview will be tape recorded to help me remember some important points that we talk about. The information given will be treated confidential and will not be disclosed in association with your name. If you choose to participate in the study upon reading the information provided or hearing what is explained you may give a verbal consent or sign in the space provided below.

INTERVIEWER'S SIGNATURE/DATE

INFORMANT'S SIGNATURE/THUMB PRINT

THANK YOU