Male Involvement and Accommodation During Obstetric Emergencies in Rural Ghana: A Qualitative Analysis

CONTEXT: *Although men potentially play an important role in emergency obstetric care in Sub-Saharan Africa, few studies have examined the ways in which men are involved in such emergencies, the consequences of their involvement or the degree to which health facilities accommodate men.*

METHODS: *Qualitative interviews were conducted with 39 mothers and fathers in two districts in Northern and Central Ghana who had experienced obstetric emergencies, such as severe birth complications, to obtain narratives about those experiences. In addition, interviews with six health facility workers and eight focus group discussions with community members were conducted. Transcripts were analyzed using an inductive analytic approach.*

RESULTS: *Although some men had not been involved at all during their partner's obstetric emergency, two-thirds had provided some combination of financial, emotional and instrumental support. On the other hand, several men had acted as gatekeepers, and their control of resources and decisions had resulted in care-seeking delays. Although many respondents reported that health facilities accommodated male partners (e.g., by providing an appropriate space for men during delivery), others found that facilities were not accommodating, in some cases ignoring or disrespecting men. A few respondents had encountered improper staff expectations, notably that men would accompany their partner to the facility, a requirement that limits women's autonomy and delays care.*

CONCLUSIONS: *Policies and programs should promote supportive behavior by men during obstetric emergencies while empowering women. Health facility policies regarding accommodation of men during obstetric emergencies need to consider women's and men's preferences. Research should examine whether particular forms of support improve maternal and newborn health outcomes.*

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Providing access to skilled birth attendants and emergency obstetric services is crucial to reducing infant and maternal mortality.[1] Most maternal health programs address the need for obstetric care by educating pregnant women about such care and encouraging them to obtain it. However, decisions about the allocation of household resources and the use of health care are often made, individually or collectively, by men.[2] Although these decisions directly affect women's health, to date very little research has examined the ways in which men are involved in emergency obstetric care or men's experiences during obstetric emergencies.[3]

Male partners' involvement during pregnancy and childbirth varies according to cultural perceptions of gender roles. During the 1970s and 1980s, the United States and the United Kingdom experienced a rapid increase in male partner involvement during childbirth.[4] Much of this growth happened during the "natural childbirth" movement, which viewed the male partner as an important source of emotional support in the delivery room. Moreover, changes in social norms related to the cultural ideals of family togetherness, being seen as a "good" father and strengthening the infant-father bond led to greater involvement of male partners during childbirth.[4]

In Sub-Saharan Africa, however, men were considered a major obstacle to women's using maternal health services. For example, men often restricted women's access to resources necessary for safe delivery and were generally viewed by health promoters as uncaring and negligent.[5] Reproductive health programs typically focused on empowering women to make decisions about their health care, and paid little attention to the prevailing gender dynamics in the household, where men were the primary decision makers.[6] In the 1990s, greater recognition of gender and power dynamics led the international development community to acknowledge men as potentially useful contributors to sexual and reproductive health promotion.[3,5] However, little was known about the implications of involving men in reproductive health programs, especially those related to pregnancy and childbirth.[5]

The extent to which these findings are relevant today is not clear. Given the range of men's attitudes and practices (only some of which are considered supportive) during pregnancy and childbirth, it is important to examine their behaviors–both positive and negative–to identify those that are most helpful to women in need of obstetric care. Maman and colleagues noted that in

South Africa, male partners' involvement in pregnancy and postpartum care extends beyond the typical indicator of accompaniment to the hospital.[7] A study in a non-African setting (rural Guatemala) documented positive forms of male involvement, such as a husband's providing access to transportation during an obstetric emergency or money to visit a qualified provider.[8] However, if the husband has exclusive control over those resources, then his involvement may be more ambiguous and may not lead to the same positive outcomes. Such is the case in parts of Ghana, where typically men are the key decision makers in all aspects of reproduction and women have to ask for permission to go to a modern health facility or pay for maternal health care.[9,10] This "gatekeeper" mentality, in which the male head of household controls economic resources and is ultimately responsible for decisions about the use of maternal and other health services, is common in many patriarchal societies.[11] Thus, it is important for program planners to consider family structure and the community's perception of male involvement during childbirth to identify the most effective ways to involve men and their families during labor and delivery, especially during an obstetric emergency, which can have severe, and sometimes fatal, consequences.

In Ghana, where the current study was conducted, family structure differs substantially across regions. In Northern Ghana, family structure is organized along patriarchal lines, which can lead to subordination of women;[9–11] polygamy, which may reduce male involvement in delivery,[11] is also common (47% of all women in our study area are in polygamous marriages). In Central Ghana, families follow a matrilineal system that promotes greater female autonomy in making decisions related to reproduction,[9] and polygamy is less common (14% of all women in our study area are in polygamous marriages). In both regions, marriage is often viewed as the union of two extended families, which has implications for the involvement of men and other family members in decision making related to reproductive health.[12]

Identifying ways in which men can be supportive during an obstetric emergency will not lead to better health outcomes unless health facilities make accommodations that allow men to fulfill their roles. Most hospitals and health centers in Africa cannot accommodate a woman's request that her husband accompany her during delivery because they are not equipped to maintain the privacy of other female patients.[7,13–16] Furthermore, men may hesitate to accompany their partner during labor and delivery because they think they will be treated poorly by health care workers.[13,15] In studies conducted in Ghana and Malawi, men who accompanied their wives to the hospital reported feeling marginalized by health care workers and being excluded from the decision-making process during childbirth.[13,16] It is important that hospitals not only improve relationships between male partners and health workers, but also create a "space" for men in maternal health care units, such as couple-friendly health services.[13,17]

Research is needed to better understand how to accommodate both women who desire the presence of their male partners during delivery and those who do not, as well as how to effectively involve men during obstetric emergencies and how men and women perceive male involvement to be most helpful. In this article, we explore various types of male involvement and health facility accommodation—and their respective consequences—during obstetric emergencies in rural Ghana from the perspectives of men, women and health care providers. Furthermore, we introduce a spectrum of male involvement and health facility accommodation to better understand how these practices affect the health of mothers and their children.

METHODS

Study Design

The data used in this analysis were collected to inform the design of an intervention to improve community support for referrals for birth complications. We collected data in May and June 2012 in two districts of Ghana: the Nanumba North District of the Northern Region and the Assin North District of the Central Region. Data were collected as part of the Maternal and Newborns Referral Project, which was implemented by the Institute for Healthcare Improvement, the National Catholic Health Service and the Ghana Health Service.

To obtain perspectives of women and men on obstetric emergencies, we conducted in-depth interviews with 21 mothers and 18 fathers who had experienced a severe birth complication—defined as an ailment affecting the woman or newborn (e.g., severe bleeding, infection, obstructed labor) that required an urgent visit to a health facility. Health workers in the two study areas identified women who had experienced complications during pregnancy or delivery and had been referred either from a lower-level health facility (e.g., a community health post) or by a traditional birth attendant to a higher level of care, such as a hospital within or outside of the district. With the assistance of a community health worker or assemblyman, we requested an interview with either the mother or the father. To avoid creating any tension or vulnerabilities between partners, we did not interview both parents, particularly given that in some cases severe complications and even the death of the child had occurred. Of the 40 men and women recruited for interviews, 38 (95%) participated.

During the interviews, we elicited birth narratives—in-depth descriptions of participants' personal experiences with childbirth, and in particular birth complications—in an attempt to situate the experiences in their social and structural context. To assess male involvement during the obstetric emergencies, we asked mothers to elaborate on the father's role in their experience, and we asked fathers to describe their role during their partner's crisis. We also asked about any additional support that women would have wanted, as well as suggestions for strategies to improve or facilitate partner support during obstetric emergencies.

In addition to the birth narrative interviews, we conducted six key informant interviews with health facility workers, and eight focus groups with a total of 59 community stakeholders. We selected three health workers (community health officers and midwives) from referral health facilities in each district to participate. During the interviews, we elicited participants' experiences with and opinions about obstetric emergencies. Participants also discussed their perceptions of how men in the community support their partners during pregnancy, labor and delivery.

Focus group participants were community health volunteers, traditional birth attendants, pharmacists, transport workers and community leaders; they were recruited by community assemblymen and other community mobilizers. Participants' age, occupation, tribal affiliation and education level varied, reflecting the diversity of residents in each study district. Focus group discussions explored participants' perceptions of how men in the community support women during pregnancy, labor and delivery, as well as the process of responding to obstetric emergencies.

As previously described,[18] we used semi-structured interview guides for both the individual interviews and the focus group discussions. Interviews were conducted by trained research assistants who had experience conducting qualitative research. All interviewers were fluent in the language in which they conducted the interviews (*Twi* in the Central Region and *Konkonba* in the Northern Region). Prior to data collection, the lead qualitative investigator and the field coordinator led training sessions for interviewers on the study protocol and on qualitative interviewing techniques. During these sessions, the interviewers reviewed the interview guides and engaged in collaborative translation to ensure that the meaning of the guides' questions was consistent across languages. Interviewers were trained to cover all of the content areas in the guides while following the lead of the participants regarding order of topics and use of probes.

Before the start of each interview, the interviewer described the study's procedures, content, risks and benefits and allowed participants to ask questions. All participants provided written informed consent.

Data Analysis

We audio-recorded and transcribed all interviews and translated them into English. Our inductive analytic approach was informed by Maxwell and Miller's theory of qualitative analysis in which they differentiate between connecting (i.e., narrative) and categorizing (i.e., thematic) approaches.[19] We started with a connecting approach by writing a summary of each birth narrative to capture the main "story" of the birth complication experience.[20] This exercise promoted a holistic and contextualized analysis of the birth experience. We then engaged in a categorizing approach by developing a coding scheme and systematically coding all transcripts from birth narratives, focus groups and key informant interviews using Atlas.ti software. Because the coding process was iterative, the codebook evolved as we uncovered new themes. We used the coded text segments together with the narrative summaries to create analytic matrices and compare men's and women's perspectives and experiences related to the obstetric emergencies.[21]

This project was approved by the Ghana Health Service Ethics Review Board and was deemed exempt from a full board review by the University of North Carolina's Internal Review Board.

RESULTS

We identified two types of male involvement: interpersonal involvement and health facility accommodation. We defined interpersonal involvement as the father's social interactions (or lack thereof) with the mother, family members and health care workers during the obstetric emergency. We defined health facility accommodation as the way in which a health facility was organized to accept (or not accept) men during obstetric emergencies, and the appropriateness (or inappropriateness) of these accommodations. Although respondents frequently spoke of both types, interpersonal involvement was more common than health facility accommodation in the birth narratives. Each operated along a spectrum encompassing three categories, as we describe below.

Interpersonal Involvement

For this type of involvement, we classified men as not involved, as supportive or as gatekeepers.

• *Not involved.* Approximately one-quarter of the male partners were not involved (i.e., they did not provide financial or emotional support) in the obstetric emergency. For example, a 32-year-old woman reported that her mother-in-law had accompanied her to the hospital during the obstetric emergency and had taken out a loan of approximately US$76 to cover the hospital fees, but her husband had yet to pay it back:

Interviewer (I): Was [your husband] not giving you money for the pregnancy?

Respondent (R): This is what he usually does whenever he impregnates me. He does not take care of the children. He later comes to be with me when the children are grown.—*32-year-old mother, Central Region, birth narrative*

Not only was her husband absent during the obstetric emergency, but he also was not involved during the pregnancy and the early years of their children's lives. In addition to not providing financial support during the obstetric emergency, the husband did not appear to provide emotional or informational support to his wife before or after she gave birth.

In some cases, lack of support during obstetric emergencies may have been related to marital status. In two cases, the mother was not married to the father and relied primarily on her own parents for support. In two other instances, the man had more than one wife and

was not able to financially support the mother. As one woman explained:

"My husband had another wife who had given him children, so he [was] unconcerned [about my situation], knowing that he was already having children. I had to deal with all these things alone."—*34-year old mother, Central Region, birth narrative*

Some fathers' lack of involvement was due to their not being nearby or available during labor and delivery. In two cases, a family member helped in place of the father, who was traveling or working when complications arose. A polygamous father explained that he was not available when one of his wives had complications during childbirth, so his younger wife found a bus to take the laboring wife to the hospital:

I: Why was she transferred to [the] hospital?

R: I cannot tell, because I was not there when it all happened. I was called on [the] phone when she went into labor, and by the time I arrived there, they had taken her away.—*Father (age unknown), Central Region, birth narrative*

Regardless of who had helped during the obstetric emergency, mothers consistently mentioned that they had desired support from their husband. One woman who expressed this sentiment was a 49-year-old mother from the Northern Region, who said that although she still lived with her husband, she had not communicated with him very often during her pregnancy. He had supported her during the prenatal period by providing nutritious food, but he was not involved during childbirth. When asked about her desire for her husband's support during childbirth, the woman laughed and said, "I wish for [his support], but the man has not [provided it]."

In focus group discussions, men said that even if they wanted to be involved in the delivery process, they were hesitant to do so because of expectations about the male role during childbirth:

"[A man] is afraid that [people] will say...the woman has turned [him] into an imbecile because of [his involvement]. The man may want to help the wife, but he cannot do so because the neighbors, siblings and friends may pass all kinds of negative comments about his attitude, and he may not like to hear them say so about him."—*Male respondent, Central Region, focus group*

Although this man felt that helping one's wife during childbirth was a positive action, he believed that men feared the way they would be perceived by other family and community members.

• ***Supportive.*** Despite the possibility of encountering negative attitudes about their involvement during childbirth, nearly two-thirds of the male partners were supportive during obstetric emergencies. Many men reported providing informational and emotional support to their partners throughout the pregnancy (e.g., by discussing symptoms, promoting use of prenatal care and discussing delivery preferences). During the obstetric emergency, however, respondents primarily provided instrumental support—tangible assistance that directly helps a person in need.[22] The most common form of instrumental support that men offered was facilitating or providing transportation to the hospital, which they accomplished by sending money to pay for fuel, providing the vehicle to transport their partner, negotiating with taxi drivers to lower their fare or driving their partner to the hospital themselves. In one case, a father walked with his wife to the health center, which eventually referred her to the hospital because of prolonged labor. He drove with his wife on his motorbike 12 miles to the referral hospital:

"My motorbike was [one], and we begged for another motorbike, so we used two motorbikes. Somebody [drove] behind her to protect her, because the health facility here does not have any vehicle that can go to hospital."—*21-year-old father, Northern Region, birth narrative*

In another case, a 28-year-old father in the Northern Region described how he hired a taxi to take his wife from the health center to the referral hospital. He negotiated with the taxi driver to reduce the cost from about US$24 to US$14 and paid the fare.

In many cases, men who provided instrumental support were not present at the time of the emergency because they were working away from home. Once these men learned of the complication, they drove home to pick up their partner, met her at the health facility or had a family member or neighbor assist her in his absence. In addition, approximately half of the male partners whom we classified as supportive provided other instrumental support, such as paying hospital fees or searching for money to do so. For example, a 23-year-old mother reported that her husband, who worked in another town as a fisherman, had not been home when she went into labor:

I: What did your husband do to support you?

R: He was not here when it all happened. So we called him on the phone to inform him about it. After the surgery, they brought money [from him] for them to discharge me.—*23-year-old mother, Central Region, birth narrative*

In another case, a father who was traveling for school had planned to be available to take his wife to the hospital, but when she went into labor he was too far away to provide the necessary support:

"In January, I...travelled to Cape Coast, and while there I received a call that my wife was in labor and they were taking her to the hospital. When she got there, [the hospital staff] said...they cannot assist her to deliver on that day. So when [the staff] called me, I asked them to get a taxi and take her to [the referral hospital]."—*37-year-old father, Central Region, birth narrative*

Although such men were not physically present, they were still able to provide support to their female partner during the obstetric emergency.

Another common form of instrumental support was looking for individuals to donate blood. This was reported in three individual birth narratives and was also mentioned by focus group participants and health facility personnel. For example, a male focus group participant stated that men are expected to "take care of [the mother's] needs

and also prepare to help with finding someone who can transfer blood." This is a critical role, because service provision was frequently delayed until an appropriate blood donor was identified and the blood was procured. The search for an appropriate blood donor was described as expensive, time consuming and stressful. One father, who was especially supportive throughout his wife's pregnancy because she had had two prior adverse pregnancy outcomes, accompanied his wife to the hospital for delivery. When they arrived, they were told that the wife needed to have a cesarean section and that the father needed to find a blood donor. After offering to donate his own blood, which was not suitable, the father tried to find other donors, a time-consuming and frustrating experience. As it turned out, the blood was never used for his wife, yet he still had to pay for it:

"During the process, we were asked to bring blood and so I had to call the people I knew to come and donate. But [their blood type did not match] hers.... We later came into contact with someone whose blood matches with hers. The person asked for 300 Cedi [US$76] before he [would] do it...I had to pay him the money, because I needed to save the life of my wife and the child."*—34-year-old father, Central Region, birth narrative*

A small number of men also provided emotional and informational support. The form of emotional support most often reported by women was prayer by men who were not physically present during the obstetric event. Informational support, such as explaining the location of a referral facility, was provided when decisions had to be made.

Instrumental support was not synonymous with accompaniment to the hospital. In fact, men went to the hospital with the mother or met her there in only 10 of the 25 cases of supportive male involvement. If her partner had not accompanied her to the hospital, a woman was sometimes unaware of the role he had played during the obstetric emergency. For example, a 29-year-old mother from the Central Region said she had not known of her husband's involvement until her mother told her that he had been looking for someone whose blood type matched hers so that the medical staff could replace the blood the hospital provided to her during delivery.

• *Gatekeeping.* Gatekeeping—the control of economic resources and household decisions—was reported in four of the birth narratives. For example, women described asking their partner for money to go to the hospital or for his permission to get care at a particular hospital. One mother described how her husband often withheld financial resources that she needed to obtain prenatal care, health insurance and delivery care. She explained that her husband had not been expecting another child and asked her to terminate the pregnancy. When she refused, he became frustrated and withheld resources from her.

"So when...[the father] was not there for me and supporting [me] in various ways like he should, I was worried, since I was placing my money in such a place that he could take some to do something when he needed money. For him, he does not make you know when he is having [money]. He only gives you money if he feels like doing so, and these things were painful for me to handle."*—36-year-old mother, Central Region, birth narrative*

Gatekeeping also led to care-seeking delays during obstetric emergencies and to ill-advised decisions about care. In one case, a father of unknown age in the Central Region reported that he had been away from home when his wife went into labor. He paid for her to take a taxi and met her at the hospital. The baby was delivered safely, but after the birth the medical staff was concerned about the condition of the infant's brain. When asked if he or the mother had taken the baby to the hospital for a consultation, the father simply responded, "I did not allow [the mother] to take the child there." Instead, he asked the mother to take their daughter to see someone who could give her traditional medicine.

Health facility workers mentioned similar problems with obtaining permission from the father. When discussing the referral process, several health workers reported that finding male partners and convincing them to accept the referral was time consuming and contributed to delays in providing care. Obtaining such approval was important because hospitals were often reliant on men's logistic support to send mothers to referral sites. One midwife described the potential delays that could be caused by traditional gender norms:

"I think that the long tradition of the man being the head [of the household] is problematic. I say so because if the man refuses to accept the referral, the wife will be the one to suffer from it,...even to the point of losing her life. So the men should become more understanding or enlightened."*—58-year-old midwife, Central Region, key informant interview*

In some cases, men withheld money for health services, demanded the use of certain health facilities or prioritized traditional medicine over modern health care. Each of these actions led to a delay in their partner's obtaining appropriate care, and some had harmful effects on the health of the mother and child.

Health Facility Accommodation

We examined whether health facilities accommodated men (e.g., they provided an appropriate "space" for them during delivery) or were not accommodating (e.g., they ignored or disrespected them). We also examined whether facility staff had improper expectations—in particular, whether they required male accompaniment, which can lead to underutilization of or delays in care, and whether they blamed poor outcomes on the man's absence during the obstetric emergency.

Three health facility workers discussed their general expectations that men should be involved in maternal health care and should accompany women to the health facility. They reported that family members and husbands commonly went to the facility; however, the extent of

their involvement varied. A midwife in the Central Region reported that she often urged men to accompany their wives to provide emotional support and encouragement during childbirth. She said that she attempted to involve fathers by trying "to get the man to do something in the ward while I assist the woman to deliver." However, this approach was not universal. Another midwife, also in the Central Region, responded to a question about husbands' involvement by stating, "Don't come and talk about husbands here at all, because I don't see the role that they play. They only impregnate the women."

Approximately one-quarter of the birth narratives indicated that the father had accompanied the mother to the hospital. However, once they arrived at the hospital, the degree of acceptance men experienced varied.

• *Not accommodating.* In many narratives, respondents said that facilities had not accommodated the male partner. For example, a 38-year-old father in the Central Region reported dropping his wife off at the hospital and immediately returning to his house because "they do not allow men to go in there." Another father was permitted to help, but described looking for blood donors for his wife as "incredibly frustrating" because he felt unable to talk to health care workers.

I: So after [your partner] had delivered, did you go to find out why they did not give her the blood?

R: If you inquire about this issue at [the hospital], you will be insulted.—*31-year-old father, Central Region, birth narrative*

More frequently, men felt helpless at hospitals because they did not have a particular role to play. Male partners were often excluded from major decisions about the care of the mother, and one was not allowed to see his baby until the day after delivery.

• *Accommodating.* Hospitals that were more accommodating toward men gave them a space where they could wait, treated them with respect and considered them a partner in the childbirth process. In two cases, men were given the task of finding blood donors for the mother. One woman recalled that she had needed surgery and the doctor asked her husband to get blood because the doctor had been able to obtain only one pint of blood that matched her type:

"When [the doctor] came, I was pale and he said that he was going to perform another surgery to take the blood out of my stomach. He requested my husband to go upstairs in the hospital to get some pints of blood. [The doctor] could only get one for them to give to me."—*31-year-old mother, Central Region, birth narrative*

In this case, the male partner was given a specific role during the obstetric emergency and was viewed as a partner in the childbirth process rather than as a hindrance. However, even in hospitals that were accommodating to male partners, men did not always have a specific role to play.

Moreover, hospitals that were accommodating did not necessarily make space for male partners in the delivery room, as it is not always culturally appropriate to allow men into the room and some mothers may not want their partner to be present. Indeed, a 32-year-old mother in the Northern Region laughed at the idea of her husband helping her after delivery because she said it would be inappropriate.

• *Improper expectations.* At some facilities, health workers accommodated men, but improperly expected that the men would be present for prenatal care and childbirth. Such expectations can delay access to care; indeed, some health workers even blamed absent partners for delays in care-seeking and for adverse outcomes. One father explained that prenatal care was delayed because the health workers demanded that husbands attend:

I: But why did she start [antenatal care] during the fifth month?

R: The reason is that [she] went to [the hospital] on several occasions, and during those occasions [she needed] health insurance.... But they demanded that the husband should be there, so they [waited to] register...us.—*30-year-old father, Northern Region, birth narrative*

This type of delay is especially detrimental to women who are not married to the father or who do not have a good relationship with him.

In two other cases, fathers who were not present at delivery were blamed by health care workers for delays in obtaining delivery care and for the ensuing death of the child. In one case, a father in the Central Region (age unknown) was told to return home with his wife because she was not ready to deliver. Four days later, when his wife was in labor, the midwife came to his home and told them that their insurance had expired. While the father was renewing their insurance, his wife had complications and was referred to the hospital, where the child died. According to the father's account, "the midwife at [the hospital] was the one who explained the whole thing to me. This is what she told me: 'If the delivery is delayed for some time and the child is unable to come out, it defecates and vomits, causing the death of the child.'" Although the father was not to blame for the delays, he was made to feel responsible for the child's death. Similarly, a 37-year-old father in the Central Region felt blamed for the death of his child by the nurses who brought the deceased infant to him. Upon going into labor, his wife went to the local clinic for delivery, but the staff said they could not help her because they were leaving for a party and referred her to a hospital for delivery. The father said he felt as though he had "no option" but to follow the clinic staff's referral orders, because he had not been present when she went into labor. The baby was stillborn, which left the father frustrated with the clinic staff; he believed that "if the clinic here was serious about their work, all that happened would not have happened."

DISCUSSION

As men become a greater focus in maternal health programs, it is critical to understand the implications of involving them in antenatal care and childbirth, especially during emergencies, given the vulnerability of the mother

and child in this situation. We identified spectrums of male involvement and accommodation during obstetric emergencies in rural Ghana. At the interpersonal level, some men were not involved during the emergency and provided no financial or emotional support; at the other extreme, some acted as gatekeepers and caused delays in care seeking. Most men, however, were supportive: They provided instrumental support, usually money and transportation, to help their partner obtain care during the emergency. Similarly, at the facility level, we found a spectrum of male accommodation, from ignoring or even disrespecting men to accommodating them by providing appropriate spaces for them or improperly expecting them to be present (which led to delays in care).

Financial support was the form of interpersonal involvement most commonly reported—as both a positive and a negative aspect of male involvement. Help in paying the costs associated with hospital care, medicine, blood transfusions and transportation is critical for women to obtain timely access to emergency obstetric services. In our study, the absence of financial support from the father led to additional stress on the mother, delays in obtaining care and financial burdens on other family members. Our findings are consistent with findings from Guatemala, where women reported that men's involvement in pregnancy care and childbirth included providing money and transportation.[8] However, the author cautioned that "the level of male involvement does not reveal its character."[8(p.448)] For example, male partners who acted as gatekeepers during obstetric complications sometimes caused delays in care-seeking by refusing to give their partner access to critical household resources. Similarly, we found that women who had to seek permission from their male partner during an obstetric emergency experienced delays in care. This gatekeeping mentality has been found in previous studies in Ghana, where men act as the primary decision makers concerning contraceptive use[9] and make decisions about their partner's use of modern health services.[10] Therefore, maternal health programs and policies should not merely encourage male involvement and view such involvement as an intrinsically desirable outcome. Instead, supportive behavior by men during obstetric emergencies should be promoted—in combination with initiatives that encourage female empowerment, such as programs to improve women's autonomy and education—and should be measured to determine if particular forms of support (e.g., financial and logistic assistance, emotional support) improve maternal and newborn health outcomes.

At the health facility level, interactions (both positive and negative) with health workers were related to male involvement. Because of tension with health workers and space limitations, some men felt that they did not belong at the hospital. Prior studies have shown that adverse relationships with health workers created facility-level barriers to male involvement during childbirth.[14,16,17] Kwambai and colleagues suggested that hospitals with space limitations establish waiting rooms that are close to the delivery rooms so that men are available to take part in decisions, perform useful tasks (such as procuring blood for a transfusion) and otherwise participate in childbirth without violating hospital policy or infringing on women's preferences.[15] When establishing policies to accommodate men, it is important for facilities to consider both women's and men's preferences by creating a space where men can accompany their wives if both partners desire; however, policies should not require male presence at the hospital because it may compromise quality of care and women's safety and confidentiality.[23] Moreover, we found that many men made positive contributions during obstetric emergencies without being physically present.

At both the interpersonal and health facility levels, we found gender norms to be salient to male involvement during obstetric emergencies. Men were first and foremost expected to play the role of financial and logistic provider. Most discussion of men's actual presence during the labor process reflected the idea that men should be "bystanders," not active supporters.[24,25] Mbekenga and colleagues found that in Tanzania, norms concerning feminine and masculine roles during the postpartum period reduced male involvement.[26] It is important to recognize the potential tension between the masculine provider role and the expectation that men will be present during labor and delivery. This tension—which may be especially problematic for men who rely on agriculture or migration for work and are often far from home providing for their family—may result in masculine gender role strain: the stress associated with adhering to the norms of a gender role.[27] In particular, our findings reflect what Pleck refers to as discrepancy strain,[27] which occurs when an individual fails to meet the predominant notion of masculinity (in this case, the provider role). Taken together, our findings and those of other studies highlight the importance of addressing gender norms and strain in the context of promoting male involvement.[26,28,29]

Finally, we found that partnership dynamics—among both married and unmarried parents—prior to delivery shaped the involvement of men during obstetric complications. Previous studies have shown that the quality of family relationships[30] and partners' household decision-making patterns[31] are important factors in the utilization of maternal health services. Identifying partnership dynamics during the prenatal period and creating a plan to address the challenges posed by unsupportive partners could help providers ease care-seeking during an obstetric emergency. However, it is important not to require male partners to be involved if the mother does not perceive his participation as helpful.

Limitations

The findings of this study must be considered in light of various limitations. First, the results and patterns of behaviors we observed were obtained from a small, purposive sample of respondents and may not be generalizable to other Ghanaian contexts or to other countries

in Sub-Saharan Africa. However, the conceptualization of male involvement as a spectrum of behaviors at the interpersonal and health facility levels can be applied to a variety of contexts in which men are involved in decisions about maternal health care, especially during an obstetric emergency. Another limitation is that we did not interview couples, so we were not able to compare women's birth narratives with their male partner's account. We intentionally avoided interviewing both partners to reduce the potential risks to couples in which partners had conflicting perspectives on this sensitive subject.

Conclusion

Recognizing the myriad forms of involvement and accommodation is critical for understanding how and why men are involved during obstetric complications. Such understanding can be used to design effective quality improvement efforts aimed at creating a positive and supportive place for men throughout pregnancy and delivery. Furthermore, understanding male involvement may require challenging patriarchal notions of male and female roles and "spaces" in both communities and health facilities. It is important to recognize the role of gender norms as determinants of male involvement and as a potential source of stress for men striving to adhere to multiple roles. Future research and programming should use a holistic approach to measuring and promoting male involvement that addresses these contextual factors.

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RESUMEN

Contexto: *Aunque en África subsahariana los hombres juegan potencialmente un rol importante en la atención obstétrica de emergencia, pocos estudios han examinado las formas a través de las cuales éstos se involucran en tales emergencias, las consecuencias de su participación, o el grado en el que las instituciones de salud los toman en cuenta.*

Métodos: *Se condujeron entrevistas cualitativas con 39 madres y padres que habían experimentado emergencias obstétricas–tales como complicaciones graves en el parto–en dos distritos de las regiones Norte y Central de Ghana, con el propósito de obtener narraciones sobre dichas experiencias. Además, se llevaron a cabo seis entrevistas con trabajadores de instituciones de salud y ocho discusiones en grupos focales con miembros de la comunidad. Las transcripciones se analizaron utilizando un enfoque analítico inductivo.*

Resultados: *Aunque algunos de los hombres no habían estado involucrados en absoluto en la emergencia obstétrica de su pareja, dos tercios de ellos habían provisto alguna combinación de apoyo financiero, emocional y facilitador. Por otra parte, varios hombres habían actuado como controladores, y su manejo de los recursos y las decisiones había resultado en retrasos en la búsqueda de atención médica. Aunque muchas de las personas entrevistadas reportaron que las instituciones sanitarias tomaban en cuenta a las parejas masculinas (ej., proporcionando un espacio apropiado para los hombres durante el parto), otras encontraron que las instituciones no tomaban en cuenta a los hombres, en algunos casos ignorándolos o tratándolos de forma irrespetuosa. Algunas personas entrevistadas lidiaron con expectativas impropias por parte del personal, especialmente con la expectativa de que los hombres acompañen a sus parejas a la institución de salud, lo cual limita la autonomía de las mujeres y retrasa la atención.*

Conclusiones: *Las políticas y programas deben promover una conducta de apoyo por parte de los hombres durante las emergencias obstétricas, a la vez que empoderan a las mujeres. Las políticas de las instituciones de salud relativas a la participación de los hombres durante las emergencias obstétricas deben tomar en cuenta las preferencias tanto de las mujeres como de los hombres. Las investigaciones deben examinar si determinadas formas de apoyo mejoran los resultados de salud de las madres y los recién nacidos.*

RÉSUMÉ

Contexte: *Bien que les hommes jouent potentiellement un rôle important dans les soins obstétricaux d'urgence en Afrique subsaharienne, peu d'études ont examiné la façon dont ils interviennent, les conséquences de leur participation ou le degré d'accueil que leur réservent les structures de santé.*

Méthodes: *Des entretiens qualitatifs visant à recueillir le récit de leur expérience ont été menés avec 39 mères et pères ayant vécu une situation d'urgence obstétricale, telles que de graves complications à l'accouchement, dans deux districts du Nord et du Centre du Ghana. Des entretiens avec six agents de structure de santé et huit discussions de groupe avec des membres de la communauté ont également été organisés. Les transcriptions en ont été analysées selon une approche inductive.*

Résultats: *Bien que certains hommes ne soient pas intervenus du tout dans la situation d'urgence obstétricale de leur partenaire, deux tiers avaient apporté une combinaison d'assistance financière, affective et instrumentale. En revanche, plusieurs s'étaient posés en gardiens, entraînant un retard des soins du fait de leur contrôle des ressources et des décisions. Si beaucoup de répondants rapportent l'accueil des partenaires masculins dans les structures de santé (qui leur réservent par exemple un espace approprié pendant l'accouchement), d'autres ne qualifient pas les structures d'accueillantes, estimant parfois qu'elles les ignorent même ou leur manquent de respect. Quelques répondants s'étaient trouvés confrontés à des attentes inappropriées de la part du personnel, exigeant notamment que les hommes accompagnent leur partenaire à la structure et imposant ainsi des limites à l'autonomie des femmes et un retard des soins.*

Conclusions: *Les politiques et les programmes doivent, tout en autonomisant les femmes, encourager un comportement solidaire de la part des hommes lors des situations obstétricales d'urgence. Les politiques des structures de santé concernant l'accueil des hommes lors de telles urgences doivent tenir compte des préférences des femmes et des hommes. La recherche doit examiner si certaines formes particulières de soutien améliorent les résultats de santé maternelle et néonatale.*

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