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SOCIO-CULTURAL PRACTICES AND MALE INVOLVEMENT IN REDUCING MATERNAL MORTALITY IN RURAL GHANA. THE CASE OF SAVELUGU/NANTON DISTRICT OF THE NORTHERN REGION OF GHANA

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ABSTRACT

Passive male involvement in combating maternal mortality is rooted in socio-cultural practices and attempts to increase male participation in reducing maternal mortality have proven to be a daunting task. This study examined the effects of socio-cultural practices on male involvement in reducing maternal mortality in rural Ghana. Both qualitative and quantitative data were collected for the study. The main methods used in data collection were structured interviews, focus group discussion and direct observation. The research revealed that male involvement in reducing maternal mortality was low. Polygamous marriages, the practice of "Dog kuli" and social stigma, are among the key socio-cultural practices that inhibit male involvement in reducing maternal mortality. The research notes that intensive public education, an increase in couple-friendly maternal health care services and increased engagement with traditional authorities on the need to modify some socio-cultural practices would help whip up male partners' interest in promoting maternal health.

Key Words: Socio-cultural practices, Maternal mortality, Rural, Ghana

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INTRODUCTION

Most maternal deaths are entirely preventable. Yet, while the world is making progress in fighting maternal mortality, far too many women are still losing their lives. Maternal mortality is defined as "the death of a woman while pregnant or within 42 days of termination of pregnancy, regardless of the duration of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental and incidental causes" (WHO, 2005).

According to estimates made for the 2005, half a million women – most of them in developing countries – die each year of complications during pregnancy or childbirth (WHO, 2010). About half of maternal deaths occur in Sub-Saharan Africa and about a third in South Asia. Together the two regions accounted for 85 per cent of maternal deaths in 2005 (World Bank, 2010).

The international community in 1987 launched the Safe Motherhood Initiative (SMI). The aim was to urge national governments, funding agencies and Non-Governmental Organizations to make maternal health an urgent health priority and ensure that the necessary political and financial support is dedicated to this effort. This call was echoed by subsequent international conferences such as the International Conference on Population and Development in Cairo in 1994 and more recently, by the Millennium Summit in New York in 2000 that endorsed the Millennium Development Goals of which Goal Five is targeting the reduction of maternal mortality by two-thirds by the year 2015 (WHO, 2007).

In spite of the implementation of the SMI in 1987 and Making Pregnancy Safer initiative in 2000, maternal mortality ratio in Ghana is still high. The ratio was 580 maternal deaths per 100,000 live births in 2004 and decreased slightly to 500 per 100,000 live births in 2005 (UNICEF, 2007). In Northern Region of Ghana, maternal mortality ratio is higher than national average and has been fluctuating from 590 maternal deaths per 100,000 live births, 520 maternal deaths per 100,000 live births and 600 maternal deaths per 100,000 live births in 2003, 2005 and 2006 respectively (Northern Regional Health Directorate, 2007).

Maternal mortality is caused by a number of factors. These factors have been categorized as obstetric, health service, reproductive, socio-economic and transportation factors (McCarthy and Maine, 1992). Thaddeus and Maine (2005) have conceptualized the causes of maternal mortality in the 'Three Delays Model'. This model identifies individual decision making power, access to affordable health services and provision of skilled personal as main factors which delay access to effective interventions to prevent maternal deaths.

Owing to the still high levels of maternal mortality in developing countries and especially Africa, it is now increasingly being recognized that actions required to achieve improvements in maternal health should involve communities in the process and encourage active male participation. Men

have a crucial role to play in reducing maternal mortality. Male in this context include husbands/partners, fathers, brothers, in-laws and other male relatives. Around the world, men play critical roles in women's ability to seek health care, yet more often than not, they are uninformed about women's reproductive health needs. Service providers' biases and sometimes just the lack of space in facilities can discourage men from participating in services that have been aimed primarily at helping women, such as antenatal and post abortion care. In some cases, service providers have not thought about ways to include men. It is a fact that for all steps leading to maternal survival as defined in *Mother-Baby Package*, there is always a man standing by the side of every woman knocking the "gate" before, during and after each pregnancy (WHO, 1995).

Women generally do not make decisions about their own reproductive health in a vacuum. Rather, their husbands as well as other family members influence them. Men are instrumental in providing the necessary physical, financial and emotional support to give women access to reproductive healthcare, or conversely represent obstacles for many women who wish to protect their reproductive health. For example, men play the dominant role in providing financial and logistical support for women in need of emergency obstetrical care, as well as post abortion care (Greene, 1999). Many who advocate for male involvement in reproductive health programs believe that involving men leads to greater gender equity and the transformation of men's and women's social roles (Adamson, 2006).

Efforts by the Savelugu-Nanton District Health Directorate to increase male involvement in promoting maternal health have proved futile. In 2000, the District Health Directorate made concerted efforts to involve men in their Safe Motherhood Initiative. The results indicated that women had challenges getting their partners' emotional and financial support for antenatal and postnatal care services. The general perception of the people is that men who escort their wives to attend antenatal services are ridiculed by their peers as "weak men" and women themselves fear to be subject of gossip and to be seen as having control over their husbands. In view of this, antenatal and postnatal care services attendance is very low and many maternal deaths in the district that take place outside the hospital and clinics are not often reported.

The aim of the study was to assess the effects of socio-cultural practices on male involvement in reducing maternal mortality in Savelugu-Nanton District. The study examined in detail the extent to which men are involved in maternal health issues and the socio-cultural barriers to male involvement in promoting maternal health so as to reduce maternal mortality in the district.

MATERNAL HEALTH: MEN AS CRITICAL PARTNERS

Male involvement in maternal health is rooted in the programme of action that was agreed to at the International Conference on Population and Development (WHO, 2007) which included male responsibilities and participation as critical aspects for improving reproductive health outcomes,

achieving gender equality and empowering women. This mandate grounded male involvement programs in reproductive health (USAID, 2003).

Maternal and child health present many opportunities for involving men in reproductive health of women and children. Pregnancy is a time when both parents have similar interest in the survival and health of their babies. Even though men do not bear the physical burden of carrying pregnancy, they can still be active partners in this life cycle provided they have the information about prenatal and postnatal care and symptoms of childbirth requiring emergency care (Greene, 1999).

Male involvement in Safe Motherhood is a new approach compared to other areas of sexual and reproductive health, such as family planning, prevention and management of sexually transmitted diseases and management of sexual and gender-based violence. Companionship during labour involving a female relative or husband is being introduced in some facilities and it is seen as a very effective intervention for improving delivery outcomes, including a reduced need for caesarean section. Even though this practice is reported to have an overwhelming positive experience, there are no clear-cut guidelines on how far the husband/partner participation can go on (Ntabona, 2001).

In patriarchal societies, where men hold the decision making power in matters including use of family income, access to health care and reproductive and contraceptive choices, involvement of male partners in reproductive health services have a crucial impact on women's and family's reproductive health (Singh et al, 1998). Yet, public health services still tend to exclude men when counseling women about childcare, contraception and sexually transmitted diseases preventive behavior. In South Africa, men traditionally have not been involved in many aspects of their partners' maternity care and that involving men in maternity was a process that required several stages of implementation, and that each stage required health professionals to take on different roles, as trainers, motivators, and counselors (USAID, 2003).

Men can help women stay healthy by planning their families with their partners, limiting and spacing their children, encouraging good nutrition, ensuring that a trained attendant is present at the time of delivery and paying for professional services. Other responsibilities they can take to enhance their partners' health are to seek immediate care when their partner requires it; provide or make necessary arrangement for transportation to the clinic; accompany their partners' on prenatal and postnatal visits; and help with household chores especially those requiring heavy lifting such as collecting wood and carrying water (UNFPA, 2000).

Although men have a unique role to play in improving maternal health, too often in the past, they were presented as obstacles and not as solutions to women's reproductive health. Majority of the interventions and services designed to promote sexual reproductive health, including care during pregnancy and childbirth, have been exclusively focused on women. Yet men and women live in the same society and are influenced by the same beliefs about the roles and responsibilities that are

appropriate for each gender. Men should not be the only ones to blame for the slow changes in gender-based imbalances. In society where maternal mortality and morbidity are high, men and women face similar challenges related to social, cultural and political complexities.

Since the issue of male involvement in sexual and reproductive health including safe motherhood is built on gender-based roles within the entire society, some aspects can achieve dramatic changes within one generation whilst others may take longer time. As a first step, there is the need to develop strategies to implement the International Conference on Population and Development recommendation which urges governments and their partners to "support public health education to create awareness of the risks of pregnancy, labour and delivery and to increase the understanding of the respective roles and responsibilities of family members, including men, as well as civil society and governments, in promoting and protecting maternal health" (Ntabona, 2001).

SOCIO-CULTURAL FACTORS THAT AFFECT MATERNAL HEALTH

A qualitative study conducted in Katmandu Nepal, revealed that the most prominent social barriers to male involvement in maternal health included low levels of knowledge, social stigma, shyness/embarrassment and job responsibilities. Other barriers identified were hospital policy, manpower and space problems. Based on these findings, a major shift in hospital policy was seen as an important first step in introducing couple-friendly antenatal or delivery services (Mullany, 2005).

Men and women play key roles in reproductive health but increasing male participation in reducing maternal mortality has been a challenging task to policy makers, health personnel and advocates of maternal health. The cause of passive male involvement in combating maternal mortality is rooted in the socio-cultural practices that single out pregnancy and childbirth as women's burden (Adamson, 2006). The conceptualization of childbirth as "the woman's battle" was found to be prevalent in West Africa, where maternal mortality was explained as "she fell on the battle field in the line of duty". However, the view that childbirth demonstrates courage and power of women is common in societies where women command much less power than men in the public domain (Adamson, 2006).

Among the Bariba of Benin, women take pride in giving birth unassisted and are in turn "silently admired" by their courage. To the people, birth represents a rare opportunity for a woman to demonstrate a proverbial virtue of courage and bring honor to her and her husband's family by her stoic demeanor (PRB, 2005). In view of this conception, Carter (2002) found that pregnant women in Benin would rather suffer days of obstructed labour than ask for help during childbirth and risk being seen as weak.

Lack of communication between couples on matters of sexuality and a desire to maintain male dominance within the household are primary contributory factors to unwanted pregnancies and consequently maternal death. Pregnant teenagers may be dependent on the decisions of older members of the extended family for economic reasons. Decisions to seek care are often made not by the women but by their husbands or other family members (in-laws) because of their economic power. For example, in Botswana, when men migrate for work, they keep their wives in a continuous state of pregnancy and lactation as a way of keeping their possible infidelity to a minimum (Family Care International, 1991).

Violence against pregnant women is a contributory factor to maternal mortality. Studies have shown that women who are battered during pregnancy are twice as likely to experience miscarriage and four times more likely to have a low birth weight baby than those who are not beaten. Battering during pregnancy has a great impact on women who are malnourished and overworked. Young unmarried mothers may be particularly vulnerable to violence during pregnancy even leading to death. In Matlab, Bangladesh, homicides and suicides which were motivated by stigma over unwanted pregnancy, beatings or dowry accounted for six per cent of all maternal deaths in 1986 (Heise, 1993).

Gender norms that act as barriers to women's involvement in reproductive health programs also act as barriers for men. Socio-cultural definitions of masculinity may make is difficult for men to seek reproductive health information or services. Men who wish to limit their family size often face gender norms that equate number of children with virility and that discourages men from using reproductive health services of any kind (Foreman, 1999). Similarly, African Health and Development International (AHADI), in their research published by African Health Monitor (2004) on general attitude towards male participation in maternal health programs, found out that men who escort their wives to attend antenatal clinics are ridiculed by their peers as not being "men enough". Women themselves fear to be subject of gossip and to be seen as having bewitched their husbands in order to make them humble and respectful of their reproductive rights and therefore do not ask for their husbands' companionship during antenatal visits and delivery.

METHODS

Overview of Study Area

Savelugu/Nanton District is one of the eighteen (18) political and administrative districts of the Northern Region of Ghana. It was established by PNDC Law 207 under the Legislative Instrument of 1988. It was carved out of the then Western Dagomba Council, which included Tolon/Kumbungu and Tamale Metropolitan Assembly. The district shares boundaries with West Mamprusi in the North, Karaga to the East, Tolon/Kumbungu in the West and Tamale Metropolitan Assembly to the South (Figure 1). The district covers a total land mass of 1790.70 sq. km (Savelugu/Nanton District Profile, 2007).

The population of the district was 91,415 (GSS, 2001). With the growth rate of 3%, the projection as at March 2007 was 109,442. The population density is about 61 persons per sq. km. The total number of communities in the district was 149. The high population growth rate of 3% in the district as against national rate of 2.6% is partly due to the low family planning acceptance rate in the district (GSS, 2003). In 2005 for example, family planning acceptance rate was only 9% (Savelugu-Nanton District Profile, 2007). The population is made of 49% males and 51% females (Savelugu-Nanton District Profile, 2007). The average household size which is predominantly male-headed is 8.7, with the smallest household comprising one person and largest household comprising about 47 people. The people are predominantly farmers.

The existing condition and distribution of health facilities in the district are poor leading to poor access to quality health care delivery. Health facilities comprise Savelugu Hospital, Nanton Health Centre, Pong-Tamale Health Centre, Tampion Health Post, Moglaa Health Post, Janjorkukuo Clinic, Zoggu Clinic and Pigu Health Facility. The staffing situation is equally poor. Mortality rate in the district is increasing especially for children under-5 years. However, maternal deaths have declined over the past two years (Table 1) due to increase in antenatal attendance (Savelugu-Nanton District Health Directorate, 2007).

Data Collection and Analysis

The data for this study was collected from a combination of primary and secondary data sources. Both qualitative and quantitative methods were employed in primary data collection and include structured interview of household heads (using interview schedule), Two Focus Group Discussions were held for each of the ten communities sampled, based on gender while in-depth interviews were held with key informants including Traditional Birth Attendants (TBAs), nurses and traditional rulers. Secondary data sources included content analysis of documents relating to socio-cultural practices affecting maternal mortality. The household was the key unit of analysis where heads of households were interviewed. A household as used here takes its definition from Ghana's 1984 Population Census, which defines a household as a person or a group of persons who live together in the same house or compound, share the same house-keeping arrangements and are catered for as one unit.

Using a simple random sampling technique, ten (10) communities were selected covering the six councils into which the district is divided. These include Ziong, Nabogu, Tarikpaa, Zosalli, Savelugu, Nanton-Kurugu, Zogaw, Nanton, Kpalung and Gbungbun. A total of 210 household respondents were interviewed which made up of 107 females and 103 males. Key informants were purposively sampled. Data gathered from structured interviews were coded and analyzed using Predictive Analytical Software (Version 7.0). The results were displayed in graphs and tables. Qualitative data was tape-recorded, transcribed. Using the techniques for content analysis the transcribed interviews were read and re-read and themes identified. Field notes were also used to provide contextual information about the data. Results are presented in the test as direct quotations.

RESULTS AND DISCUSSIONS

Socio-cultural Impediments to Male Participation in Promoting Maternal Health and reducing Maternal Mortality

The key objective of the research was to assess the socio-cultural factors that undermine male support for their spouses and the implications for maternal health and mortality in the Savelugu-Nanton District. Five major themes emerged during the field interview process and it is on these themes that the discussions that follow are based. The research shows that male involvement in maternal issues is considerably low; a development occasioned by the interplay of the following factors (Figure 2).

Polygamy

Polygamy creates a condition that affects maternal and child health in diverse ways. Polygamy is the norm in the Savelugu-Nanton District. This is not surprising because the dominant religion in the district is Islam with 98% of all the respondents being Muslims. From an Islamic perspective, there are several rules that must be followed by men who choose to practice polygamy. The *Koran* says 'Marry women of your choice two, or three, or four; but if you fear that you shall not be able to treat justly with them, then only one… That will be more suitable to prevent you from evil' (*Koran*, 4:3). Another verse says 'You will never be able to deal justly between wives however much you desire [to do so]. But [if you have more than one wife] do not turn altogether away from [from one] leaving her in suspense' (*Koran*, 4:129). If a man cannot treat each of his wives equally, then he should only take one wife (Bewely, 1999 quoted in Al-Krenawi, 2010).

In the Savelugu-Nanton District, an average of 3 wives per man with the number ranging from 1 to 6 wives per man. It is evident from the field research that polygamist husbands have generally failed to give equal love, care or treatments to their wives. In these polygamous homes the reality is that men had their favorite wives. The study also shows that in cases where polygamist husbands were rich enough to feed and clothe all the wives, the love, care and affection each wife needs during childbirth could not be provided by their husbands. Among Palestinian polygamous marriages in the Gaza Strip for instance, there is compelling evidence that senior wives are often less favored by their husbands, have fewer economic resources, and receive less conjugal support and attention than junior wives. Within this particular society, senior wives are typically married to men through arranged marriages based on exchange, while subsequently, junior wives are chosen by the husbands and their marriages are based on love matches (Al-Krenawi et al., 2001). Furthermore, most of the studies conducted in the UAE, Kuwait, Egypt, Jordan, the Gaza Strip (Bedouin-Arabs in Israel) and Turkey showed that the senior wives in polygamous marriages reported more psychosocial, familial and economic problems compared to their counterparts from monogamous families (Al-Krenawi and Slonim-Nevo, 2008; Al-Shamsi and Fulcher, 2005). A recent Turkish study found that the participants from polygamous families, especially senior wives, reported more psychological distress (Ozkan et al., 2006). A study conducted in Egypt found that

following their husbands' second marriage, senior wives in polygamous families experienced a major psychological crisis, which manifests itself in somatic complaints and psychological symptoms such as anxiety, depression and irritability. Following this finding, the author suggested the generation of a new cultural-specific psychiatric diagnosis, the 'First Wife Syndrome' (Al-Sherbiny, 2005). Abdul-Salaam (1997) quoted in Al-Krenawi (2010) pointed out that 71% of Kuwaiti women respondents reported that men could not do justice or be fair between their wives. The same study showed that 50% of the men agreed that they cannot do justice between the wives**.** This may be the result of men acting without reference to the teachings of Islam particularly the imperative to treat all wives equally and to assume a second wife only if economically feasible.

The economics of polygamy are particularly problematic. This is supported by the case of oil-rich Persian Gulf region where Al Toniji (2001) quoted in Al-Krenawi (2010) found that 75% of the study participants agreed that the polygamist husband faced economic problems due to the need to pay rent for two houses. The situation in Savelugu-Nanton District does not deviate from the literature discussed above. In the study area about 80% of the population depends on rain-fed agriculture for survival. Incomes are generally low with the incidence of poverty high. Polygamy thus exacerbates economic problems among polygamous families most of whom are already economically distressed. Since most husbands are economically constrained they are unable to meet their financial obligations towards their female spouses. Both male and female focus group discussants did identify polygamous marriages as an obstacle in promoting maternal health in the district. This is what a pregnant woman in Savelugu had to say about the adverse effects of polygamy on her health:

"Since I became pregnant for my husband he has shifted all his attention to my two younger rivals and each time I ask for financial assistance from him for medical care, he always turned me down with the excuse that he had other responsibilities".

She continued:

"Even when the nurses requested for my husband to come with me to the hospital for some counseling on the likelihood of complications of my pregnancy, he declined with a reason that accompanying me to hospital for maternal care will mean setting a precedence for all the three wives which he cannot fulfill in his life time".

This often led to unhealthy competition and intense rivalry in the family and resulted in poor maternal outcomes. Polygamy's evident characteristic of competition and jealousy among co-wives is commonly observed within plural marriage communities (Al-Krenawi et al., 2001; Madhavan 2002). This seems predictable, as co-wives are likely to have very limited private time with the lone husband they share, and thus might vie for his attention and favor. In some polygamous communities, women's self-worthiness is linked to the number of children they bear and, therefore, having time with their husband is also critical to promote their status within the family and community (Al-Krenawi, 1998). In some instances jealousy between co-wives can escalate to intolerable levels, resulting in physical injuries sustained by the women and even suicide attempts. In addition, in polygamous spousal relationships, it is quite commonly reported that the patriarchal

nature of polygamy leads not only to women's subordination, but also to their sexual, physical and emotional abuse at the hands of their husbands (Hassouneh-Phillips, 2001).

Accusation of Marital Infidelity and Women's Confession

The research has shown that infidelity on the part of a woman is considered a serious violation and does not go unpunished when it comes up. It is a common belief among rural people in the district that when a woman flirts behind her husband during pregnancy, she may not have smooth and safe delivery. Adulterous woman is refused assistance during delivery until she confesses to the infidelity or adultery by mentioning the name of the man involved. Men neglect their suspected flirting wives during pregnancy on the notion that the unborn child may not be theirs. This practice in most cases results in maternal and child deaths. In most cases too, such accusations are false. This is what Habiba had to say about her experience during a Focus Group Discussion in Savelugu:
"I was falsely accused by my husband of having extra-marital affair simply because of occasional visits and phone calls from my former male schoolmate. It was a moment of neglect and vilification. It was a tough moment for me because I was pregnant then. No amount of explanation could convince my husband that I was innocent. It nearly cost my marriage hut I stood firm and put all my trust in Allah. Eventually when I had a smooth and safe delivery of my first born I was vindicated. The sad aspect is that I was made to suffer unduly".

This practice was however not common in the urban communities in the study area because they have ready access to professional delivery care. In the urban communities, pregnant women who show signs of labor are often rushed to the health centres for professional delivery services. This is in accord with Ascadi (1991) who asserts that in many African societies, prolonged labour is ascribed to marital infidelity with the consequential effect of maternal death. If she survives, the long term risks include ectopic pregnancy, infertility and chronic pelvis inflammatory disease. It is believed that women who bleed for long are those who have committed offences. It is very difficult to stop such bleeding until confessions are made. After the confessions, some cleansing rituals are undergone before the bleeding can be stopped. Without confession, the woman is left to bleed helplessly (Okolocha et al, 1998). In some parts of Ghana, troubled labour is seen as a sign of infidelity, so in such conditions, instead of family members calling for emergency care they rather rely on elders to appease the gods to help with the delivery (Carter, 2002).

Male Dominance in Household Decision Making

Male dominance in decision making at household level was also identified as one of the socio-cultural practices in the study area that hinders active male involvement in reducing maternal mortality in the area. The research shows that men and for that matter husbands are the main and final decision makers and whose decisions traditionally are not opened to challenge. He is the head of the family and wields so much authority and power. It is the man who decides how, when and on what to spend household resources. Farm produce of family for instance is largely controlled by men who determined what quantity should be sold for cash and what quantity to feed on. Pregnant

women in rural communities depend on the decisions of their husbands to seek medical care because they have the economic power. If he says 'no' that is it. Women are frequently not consulted when a man opts to assume additional wife. Male dominance is evident in all facets of life - social, cultural and economic - and there is that every effort is made to maintain this male dominance.

These gender-based inequities thus contribute to lack of effective communication among couples on a broad range of issues including maternal, sexual and reproductive health. With Islamic religion being the norm, family planning does not arise. The decision regarding the number of children couples could have rests solely with the man. For as long as it favors the man it is fine. It is strictly not negotiable regardless of the health consequences. This supports the research findings by Family Care International in Botswana in 1991 that implicates the desire to maintain male dominance among other factors as a primary contributory factor to unwanted pregnancies and consequently maternal death. A study in Egypt by Philips (2001) found that while permission is required from the first wife, few women actually give the husbands their consent to marry a second wife. In Islam, it is important that the husband tells his first wife whenever he plans to marry again (Al-Kobesi, 2001 quoted in Al-Krenawi (2010).

Unequal power in sexual relationships gives rise to gender-based violence. This has a multitude of negative effects on women's sexual and reproductive health in the district under study. Research revealed some form of physical and sexual abuse of women whose voices in most cases are not heard due the culture of silence. Similar results from almost 50 population-based surveys worldwide show that between 10 and 67 percent of women report being physically harmed by a male partner at some point in their lives; and these do not include psychological or sexual abuse (Heise et al., 1999). The damage to women's physical and mental well-being can be greater than the immediate injury and can include depression, anxiety, gynecological problems such as chronic pelvic pain, miscarriages and pregnancy complications (Kapoor, 2000).

Health outcomes for pregnant women and newborns are thus determined largely by the actions and decisions made by the men in the area. Pregnant women are dependent on the decisions of their husbands because of their extended family structure and their economic power. Since men's perception of risk in pregnancy and childbirth was limited, their involvement in reducing maternal mortality was low. An interaction during focus group discussion with men in Tarikpaa revealed that maternal deaths were generally regarded natural, leaving men with no option when in fact these are preventable. Evidence however suggests that as power relations between the couple become closer to equal, the likelihood for discussion increases. For example, as women's involvement in domestic decision-making increased in Ethiopia, the likelihood that they had discussed family size and family planning with their husbands increased (Hogan et al. 1999), a situation which was largely lacking in the Savelugu-Nanton District of Ghana.

Early Marriage by Girls and the Problem of Age Incompatibility

Early marriage is the norm in Savelugu-Nanton District Like and other districts in northern Ghana. The reason for this practice was that teenage pregnancies were still high in the area and so early marriage is seen as a panacea to this. Also, early marriages were considered by the people to maximize childbearing, particularly those who preferred male children to carry forward their family name. Children are also of economic value where they support their parents on farms.

Since the practice favored men most, it was a big challenge for men who were decision-makers in the families to campaign against it; in spite of its health implications for the young girls' reproductive health. Since most of these girls get married to men who are by far older than them, 'master-servant' or 'head-tail' relationship is the norm. The master/head herein the husband would not stoop so low as to accompany the servant/tail (wife) for instance to ante-natal and post-natal services. The fact that most of these young female partners were not gainfully employed, further subjects them to control by their older husbands. The difference in age also undermines effective communication among couples in the study area. As noted by Drennan (1998), married women who are much younger (and presumably less powerful) than their spouses are less likely to communicate with them. In a study of the feasibility of including men in reproductive health services in Kenya, women and providers identified poor communication between partners as a serious barrier to men's participation and emphasized that commitment in relationship is a primary determinant of the level of communication between partners (Muia et al., 2000).

An interesting revelation from the household survey shows that majority of respondents (95%) did not see the connection between early marriage and maternal health issues. However 5% of the household interviewed indicated a linkage between the two. The age at which girls or women first marry has an influence on maternal outcomes and varies greatly between countries. For example in Botswana and Namibia, the average ages at first marriage are around 24 and 25 respectively, whereas in Mali, Niger and Yemen, half of their women marry before their 16^{th} birthday. In Ghana, the average age at first marriage is 19.6 (GSS, 2003). The younger women are married, the more likely it is that they will not have fully developed pelvis and therefore will be at risk of obstructed labour which causes maternal deaths (WHO, 1995).

Social Stigma against Caring Husbands

Men like women face barriers that arise from norms about appropriate gender roles. Social stigma of men engaged in domestic chores was identified as a social practice in the district that hinders male active participation in reducing maternal mortality. An interaction with a male focus group in one of the remote communities in the district (Gbungbun) revealed that men in that community who supported their wives in domestic work were being ridiculed by their colleagues that women controlled them ('woman's remote control'). They are called "weak men". This hindered male participation in domestic chores in the community. A middle age man shared this with us:

"*I used to help bath my children and prepare them for school every morning but I was ridiculed by my brothers that I was a maid servant to my wife because such chores are exclusively meant for women. I was compelled to stop because I did not want to be seen as a maid to my wife".*

Even if women are pregnant, men feel reluctant to assist in domestic chores due to social stigmatization. Pregnant women will have to bear the heavy responsibility at home, a condition that can be detrimental to their health. Negative reactions from other men and family members when male partners attempt to become involved in women's or children's health have been mentioned as a barrier in several studies (Marindo, 1999; Raju and Leonard 1999). In Turkey, for example, men reported that family members ridiculed them when they attempted to help with housework in order to assist their wives who had recently given birth (Pile et al, 2000). Men mentioned similar concerns in a study conducted in Zambia (Muvandi et al., 2000).

"Dog kuli" as a Practice

Also identified is the practice of "dog kuli" with only15% of the household respondents seeing this as a problem (Figure 3). This is a practice whereby a woman who gives birth goes back to live with her parents for three months immediately after the naming ceremony. This practice reduces the burden of the male partner in catering for the physical and emotional needs of the wife and baby for the first three months when their support is needed. Although women who have had more than two children in the area hardly went back to their parents for this care, it was still common among young families in the area. This is what a young father in Nanton-Kurugu said in a focus group discussion:

"When my wife gave birth to our first born, I could not get a decent sleep for days because the child used to cry a lot at night. I was greatly relieved when she went back to live with her parents for three months after the naming ceremony. Even though I missed them a lot when they were away the fact that I was relieved of some expenses and stress paid off"

Even though the practice relieves men of financial and emotional pressures for three months, its adverse affects on maternal health cannot be underestimated. This practice compelled women to travel long distances with their newly born babies on open trucks to their parents and some unfortunately develop complications such as hemorrhage because of stress from traveling on long and bumpy roads. In situations where the parents of the woman are poor and cannot provide quality food for her within the period, mother's complete recovery and growth of the baby is affected.

CONCLUSION AND RECOMMENDATIONS

In general, male involvement in reducing maternal mortality in the district was low. This was attributed among other factors to men's low level of knowledge on maternal health, men seeing pregnancy and childbirth as women's burden, polygamy, social stigma against men engaged in

domestic chores, the practice of "*Dog kuli*", early marriages, male dominance in decision making at household level and domestic violence against pregnant women.

The low male involvement in reducing maternal mortality in the area led to unplanned pregnancies, malnutrition of pregnant women, low patronage of antenatal and postnatal care services and high illegal abortions. Consequently maternal mortality in the district is still high. To encourage active male involvement in reducing maternal mortality in the district it is recommended that:

1. An increased engagement with traditional authorities on the need to modify the socio-cultural practices that hinder active male involvement in promoting maternal health is necessary.
2. Intensive public education on the importance of male involvement in the Safe Motherhood Programme. The Safe Motherhood Initiative through which health personnel in the district try to increase male level of awareness on maternal health and the need to get involved in maternal health issues is a step in the right direction.
3. Monogamous marriages should be encouraged through public education involving all stakeholders. This however would be a daunting task since the area is predominantly a Muslim community.
4. Strict adherence to the teachings the Holy Koran should be promoted by Islamic religious leaders. The requirement that wives in polygamous homes are treated equally must be emphasized while teenage pregnancy (rationale for early marriage) is discouraged.
5. Provision of couple-friendly maternal health services is a key to getting men involved in matters of maternal health. This will require both government and private initiative.
6. Improvement in transportation services through government and private initiative.

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Fig.-1. A Map of Savelugu-Nanton District showing Sampled Communities

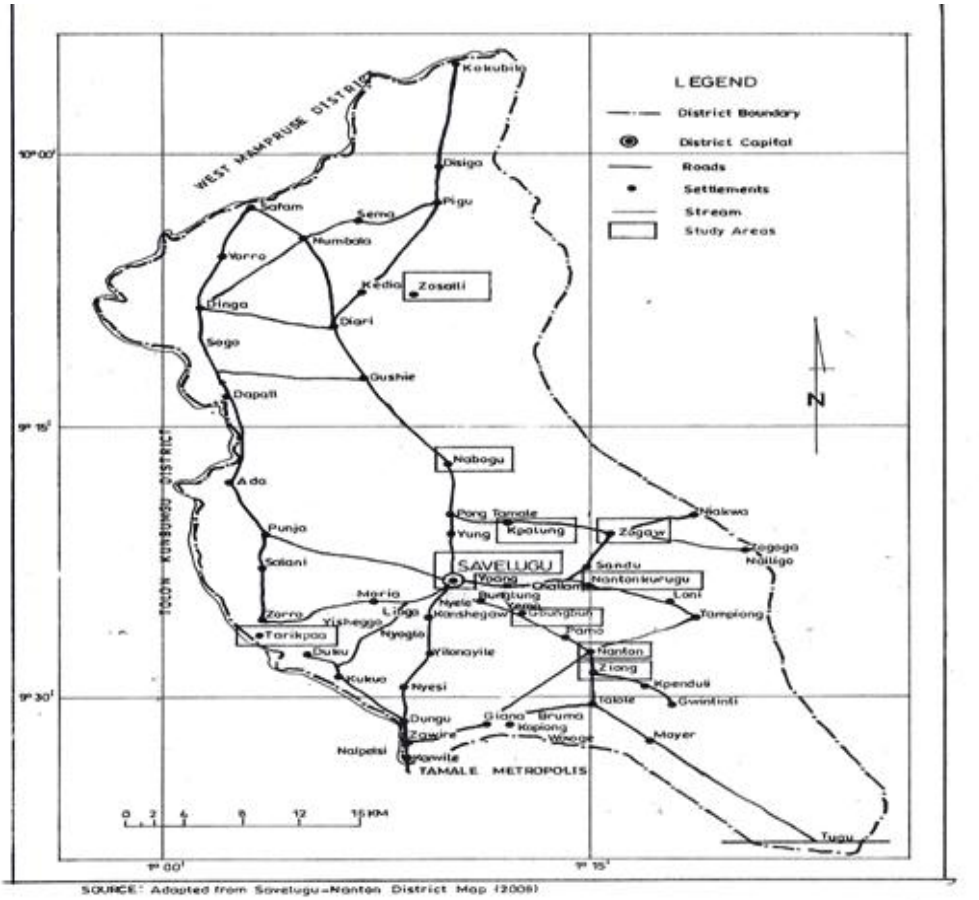

Table-1. Trend in maternal deaths in Northern Region and Savelugu-Nanton District

Number of deaths recorded at health facilities	Northern Region	Savelugu-Nanton District
2002	87	12
2003	75	6
2004	66	6
2005	72	9
2006	91	7
2007	115	9
2008	91	2
2009	96	3

Source: Northern Regional Health Directorate (2010)

Table-2. Common causes of maternal mortality in Savelugu/Nanton district

Common causes of maternal mortality	Absolute	Percentage
Poor medical services	32	15.3%
Poor patronage of prenatal and postnatal services	35	16.9%
Poor transportation services	39	18.7%
Ill health of pregnant women	33	15.6%
Traditional beliefs and practices	22	10.3%
Adolescent pregnancy	17	7.9%
Domestic violence against pregnant women	8	3.6%
Poverty (low incomes of the people in the area)	24	11.5%
Total	**210**	**100%**

Fig.-2. Socio-cultural practices that prevent male involvement in reducing maternal mortality in **Savelugu/Nanton district**