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Maternal Clinic Attendance: Does Husbands' Knowledge about Pregnancy and Childbirth have Influence on Intra-Household Decision-Making?

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Abstract

Husbands are very influential in making decisions for maternal healthcare, and the quality and type of decision depend on the level of understanding of maternity. This study explores how husbands' knowledge about key signs of pregnancy and childbirth translates into wives' involvement in decision-making and the type of decisions made towards care-seeking. These qualitative data were generated from individual interviews involving thirty husbands whose spouses were receiving maternity care in the Yendi Municipality of the Northern Region of Ghana. Purposive and quota sampling were used to reach the participants. Irrespective of husbands' knowledge about maternity, cultural beliefs and traditional gender role expectations had a far-reaching effects on wives' involvement in decision-making and the type of decisions made towards care-seeking. Though most husbands with adequate knowledge about maternity were more liberal by involving their wives and respecting their views in the decision-making process, others tended to be more conservative by considering decision-making as men's space. Most decisions were individualistic and male-centred. Healthcare promotion programmes should be directed towards changing the mind-set of men about cultural beliefs and gender roles in relation to maternity care. There should be provision of education on pregnancy and childbirth and the associated benefits and dangers to equip men on how to recognise pregnancy-related complications to enable them to reach informed decisions for care-seeking.

Keywords: Knowledge; Pregnancy and childbirth; Husbands; Decision; Care-seeking; Gender roles; Cultural beliefs.

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1. Background

Studies in maternal healthcare services utilisation have consistently indicated that decision-making is an essential component of maternal clinic attendance (Babalola and Fatusi, 2009; Bougangue, 2017; Ghana Statistical Service, 2009;2015; Ghana Statistical Service Ghana Health Service and Macro International Inc, 2008; Hagman, 2013; International Center for Research on Women, 2008;2010; Tsikata, 2007). Husbands are very influential in decision-making towards healthcare seeking for their spouses. With education as a proxy variable, some researchers have concluded that the quality and type of decision reached between spouses on care-seeking often depend on the level of education of the spouses (Bougangue and Ling, 2017; Ghana Statistical Service, 2009;2015; Ghana Statistical Service Ghana Health Service and Macro International Inc, 2008).

Joint decision-making at the household level is a necessary act for making informed decision for care-seeking in maternity. However, in most African patriarchal societies, women who carry pregnancy and experience the symptoms of its related complications are marginalised in decision-making towards maternity care-seeking (Bougangue, 2017; Hagman, 2013). This is because decision-making is regarded as an act of protection which is men's space (Bougangue and Ling, 2017; Bougangue, 2017). In traditional Ghanaian society, though some men may engage their spouses in intra-household decision-making, the final decision on care-seeking is usually reached based on the man's own assessment of severity of the woman's condition and need for professional care (Ampim, 2013; Bougangue, 2017).

Research indicates that most men are not much closer to maternity issues which could be interpreted to mean that they may lack the knowledge to make informed decisions for their spouses. This presupposes that some men are most likely to make wrong decisions which may have a far-reaching implications for maternal foetal and neonatal health. Involvement of women in decision-making for their healthcare yields positive outcome (International Center for Research on Women, 2008;2010). Besides, female autonomy in decision-making facilitates positive behaviour towards maternity care-seeking which is a necessary pre-condition for improved maternal and neonatal health (Babalola and Fatusi, 2009; Hagman, 2013). In the light of this, this paper explores how husbands' knowledge about maternity and its related complications influences decision-making towards maternity care-seeking and the type of decisions made at intra-household level vis-a-vis clinic attendance. The paper provides insight into how healthcare decision-making affects women's health during the pregnancy-postpartum period in connection with the choice of healthcare services, timing and number of clinical visits. This has become necessary because gender inequality and

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women's low social status and disempowerment relative to men significantly impact women's healthcare decisions, their health and the demand for maternal healthcare services (African Union Commission, 2006; Bougangue and Ling, 2017; Nwokocha, 2007).

2. Research Methods

2.1. Study Setting

The Yendi Municipality (YM) is a Muslim dominated setting in the Northern Region of Ghana. The Dagombas of the Mole-Dagbani ethnic group form the largest proportion in the municipality. About 89 percent of households in YM are headed by men Yendi Municipal Assembly (2015). The compound house system forms the predominant housing system in these areas where couples live together with members of the extended family who are usually relatives of the husbands. The YM hospital, which serves as referral centre to the eastern corridor of the country has only 4 medical doctors including the medical superintendent (Yendi Municipal Assembly, 2015). YM has only one government hospital, one private clinic, with only 4 CHPS compounds functioning. The municipality is about 75 percent rural and characterised by high illiteracy rates of which women outnumber men (Ghana Statistical Service, 2015).

2.2. Study Design

This was a qualitative study that employed a culturally appropriate approach in the data collection and analysis. The primary aim of the study was to assess the relationship between husbands' knowledge about maternity and the involvement of spouses in intra-household decision-making towards maternal healthcare. The design enabled husbands whose wives were receiving maternity care to share their candid views on how they involved their spouses in decision-making towards care-seeking based on the knowledge and the experiences they had about pregnancy and childbirth.

2.3. Sampling and Data Collection

The data was solely collected by the lead author. The participants for the study involved men whose spouses were receiving maternity care in the Yendi Municipality. Background of participants was considered to ensure full representation of various variables such as age, location, level of education, experience of pregnancy and childbirth to provide a comprehensive data for discussion. Non-proportional quota sampling and snowball sampling techniques were used to select the participants from their respective communities. Based on thematic data saturation, 34 husbands whose wives were receiving maternity were sampled and interviewed individually in the Yendi Municipality of the Northern Region of Ghana.

2.4. Ethical Consideration

Ethical clearance was sought from the Postgraduate Research Committee of the Faculty of Social Sciences, Universiti Malaysia Sarawak. As research ethics and the Ghanaian custom demand, permission was sought from the chiefs and assembly members of the selected communities and the husbands who were the participants before data collection. The purpose and importance of the research outcome were explained to both the community leaders and the participants. Each participant was given consent form to sign or thumb-print with assurance of anonymity and confidentiality before the interview sessions. Consent of the participants was also sought for publication of the study findings for public consumption in both electronic and print format. However, for fear of legal implications, some participants refused to sign or thumb-print the informed consent forms. Upon their request, they were given verbal informed consent with witnesses.

2.5. Analysis

The study was programmed to allow for expansion of field notes and transcription of recorded data to be done after each interview session within 24 hours. This served as a guide for subsequent data collection as the initial analysis suggested changes in questioning. Participants were easily contacted for clarity in cases where important information was missing. It also helped the research to establish thematic data saturation to determine the sample size for the study. To ensure trustworthiness and dependability, the research was subjected to reflexivity during the preparation of the research design and questions, data collection process and the stages of analysis. The research was strategised to make sure that only participants willing to offer appointment were considered for interviewing to avoid false information. Iterative questioning was employed to ensure that deliberate lies were uncovered during the interactions.

The data generated from interviews that were conducted in local language was transcribed in local language and later translated into English whilst the data generated from interviews conducted in English Language was directly transcribed with ethical conscience to avoid distortion of information. Inductive thematic analysis was the major framework for analysing the data. The data were recorded with a tape recorder during the IDIs sessions. Inter-coder analysis was employed, using the results of ATLAS t.i.v.7 software application and manual coding system. Final coding was done by assessment of the outcomes of the two techniques. Similar thoughts experienced across the participants were identified, coded and grouped together. Out of each group of similar thoughts, a unifying concept or underlying theme was derived. Key points, phrases and illustrations were also identified to back up the findings. Finally, themes that appeared similar were grouped together to generate major themes through a consultative process amongst authors.

2.6. Results

The husbands who had adequate knowledge about maternity were able to identify the critical periods in pregnancy as well as obstetric complications such as bleeding, severe waist pain/abdominal pain, persistent severe vomiting (hyperemesis gravidarum) leading to weight loss and dehydration, severe morning sickness and general body weakness with a few of them mentioning symptoms of pre-eclampsia such as blur vision, frequent headaches and fatigue. Conditions associated with labour such as labour dystocia, prolonged labour and retention of the placenta were also mentioned by these participants as dangerous to the health of women. However, the causes of these conditions were received with mixed ideas inclined to women's physiology and spiritualism. They were also well informed about postpartum haemorrhage as well as puerperal and neonatal infections.

Some other husbands did not have adequate knowledge and experience about signs and complications of pregnancy and childbirth. However, signs such as nausea/vomiting, cessation of menses and weight gain were commonly known to them. They had limited or no idea about the physiological causes of labour dystocia, prolonged labour and retention of placenta as well as post-partum haemorrhage (PPH). Though some of them were informed about early postnatal care for preventing PPH, they did not have knowledge about infections that women and babies contract during and after delivery.

2.7. Interplay of Husbands' Knowledge, Culture and Gender

Husbands' knowledge about pregnancy, childbirth and the associated conditions was very instrumental in intra-household decision-making towards care-seeking. Husbands' knowledge was particularly influential in the involvement of their wives in decision-making as well in giving women the liberty to take autonomous decisions. Most of the husbands with adequate knowledge about maternity considered their wives in the best position to make decisions towards maternity care. This statement cuts across the data from husbands of this category:

"I don't have the eyes to see what is in the woman's womb. I can only see the seriousness when my wife tells me. I cannot decide for my pregnant woman regarding where and when she should seek care. It is even better for women to decide for themselves." (Husband, 34 years old, SSS Graduate).

The husbands of this category believed that it is women who get pregnant or give birth and therefore, they have the best experience, knowledge and feel the symptoms of any complication. They explained that the views of women must be respected and treated with urgency because some signs may not show up for men to see but women may feel the symptoms of the condition and determine the severity of such conditions. Most of the men with higher level of education and those with media exposure or experiences in health education programmes fell within this category. In a rural community, a husband said:

"I think we have learnt a lot from radio and TV programmes that should influence us to allow women play active role in decision-making regarding their own health because we are not medical doctors to determine what should be done at a particular time. We need to put tradition aside and listen to the voices of women sometimes." (44 years old, No formal education)

Joint decision-making was the commonest adopted by these men and their spouses and final decision was usually reached either on mutual agreement or based on the women's feelings of the complication she was experiencing. However, some husbands with in-depth knowledge about pregnancy and childbirth were not guided by their knowledge and experiences to involve their spouses in decision-making towards care-seeking. They were influenced by cultural beliefs and traditional gender role expectations which together considered decision-making as men's space.

"You see, certain things are best done by men and some by women. Would you allow your son or daughter to decide for you? We are supposed to act as fathers to our wives and we must be accountable to any decision or action taken about their welfare including health issues. Decision-making is a sole responsibility of the family head. Yes, I listen to my wife but I make my decisions and implement them with her." (42 years old, A' Level Graduate).

Some of these men connected decision-making to spiritual consultations and solely based on their own judgement. That is, the final decision on care-seeking was reached based on the outcome of spiritual research which was regarded as an act of protection for the pregnant woman and her foetus. Some of these men mentioned that some maternal conditions may result in the death of the woman or stillbirth if they were taken to the hospital for professional care. They noted that this could only be realised through a comprehensive spiritual research which is the role of the husband or the family head.

"It is difficult to allow women make decisions especially in pregnancy because some conditions will provoke the woman to move to the health facility where she would end her life. Certain pregnancy related conditions can best be treated with spiritual eyes or with herbs. Traditionally, women are not supposed to make spiritual consultations and therefore cannot be part of decision-making that is based on spiritual consultation outcomes." (39 years old, Bachelor degree).

They believed that such conditions could best be treated with a spiritual eye or herbs. Most of the husbands did not involve their wives in decision-making because women were not supposed to consult spiritualists for solution of problems. The decisions were culturally-driven and male-centred and the wives were made to seek spiritual healing or herbal treatment upon the husbands' instruction. So, it was the husbands who decided for the timing, number and regularity of maternal clinic attendance for their wives.

2.8. Husbands' knowledge and Type of Decision

As mentioned earlier on, most of the husbands with adequate knowledge about maternity created a liberal environment for their spouses to be fully involved in decision-making. Some of them allowed their wives in most cases to take decisions on care-seeking without consulting them. Mostly, it was the wives who decided when to seek care, whom to seek care from and how many times to seek care. According to some of the husbands, their wives had complete autonomy in taking decisions for maternity care and they supported them because they believed that women know more about maternity than men because it is women who bear pregnancy and feel the pains or symptoms of any related complications. Some of the men noted that apart from personal experiences, women also get education on maternity issues from professionals in healthcare facilities and through community sensitisation programmes. Decisions made by couples involving this category of men were mainly joint decisions, female-dominated, non-tentative and devoid of cultural and gender influences. Most husbands in this bracket said something related to this statement that was made by one of them:

"I believe women are not slaves to culture or gender roles and my wife is not an exception. Healthcare decisions should not be informed by culture or gender factors because whether we admit it or not, our wives are in the best position to determine whether they need care or not."(35 years old, Bachelor degree).

Others with limited knowledge or lack of knowledge about maternity relied on the report by their wives to take decisions. However, most of them did not involve their wives in the decision-making process. They thought it was only health professionals and herbalist who could understand what a woman was going through with pregnancy. Based on this, they did not consider it important to act or decide based on what their wives said about symptoms of complications. They either made their own judgement or relied on what the traditional practitioners around them told them. The decisions made by these men were culturally or spiritually driven, male-centred or gendered.

'... Oh yes, I only consulted a herbalist and asked my wife to go to him for herbs. No, I did not involve my wife because that is the work of a man." (38 years, JSS Graduate).

The husbands without adequate knowledge about maternity were observed to be in two groups. These were those who were liberal and used their wives' experiences and knowledge for decisions (the dynamic); and the conservative who never engaged their spouses in decision-making. The dynamic mentioned that they used the information given to them by their wives to take decisions about maternity care in terms of where, when and what care to seek. Almost all of them made a similar statement like this:

"Women should make their own decisions. If she consults me or needs my assistance I will help but I cannot solely decide on something that I don't feel its symptoms when the person experiencing it is available. If you ask her she will tell you. My wife has the autonomy to take decisions at any time about her health and I always support her concerns." (40 years old, No formal education)

To the dynamic, decision-making was more women-centred as most decisions were dominated and finalised by women. Even some women were at liberty to decide and only informed their husbands for financial support without any barriers. However, the spouses of the conservative had no space in the decision-making process. They took decisions based on their own assessment of their wives conditions. Their decisions were individualistic and male-centred or gender-driven.

2.9. Background of Husbands and Intra-Household Decision-Making

The study examined background influences in wives involvement in decision-making. Apart from level of education and media exposure which was major sources of knowledge to the men and led to informed decisions amongst most couples, other factors such as religion, location of participants, age and experiences of wives, occupation and husbands experiences in maternity were important in determining the involvement of wives in decision-making towards care-seeking.

Most Muslim husbands were more conservative and did not involve their spouses in decision-making though some of them had enough knowledge and several experiences of maternity from their wives.

"I am the man and head of the family. I have to take family decisions. Women only decide on what to cook for the family. ... She only told me she felt like giving birth. So, I took it upon myself to make a good decision about where to go and the day she should seek care." (52 years old, Muslim, A'level Graduate)

As indicated earlier on, members of traditional religion were also conservative and delayed decision-making as well as denying their wives access to modern maternity care as the primary choice of care amongst them was traditional practitioners. However, they were more liberal compared with the Muslim husbands because most of them involved their wives in decision-making than the Muslim husbands. Most Christian husbands were more liberal and granted their wives autonomy in taking decisions and implementing such decisions compared with their traditional and Muslim counterparts. Irrespective of the knowledge the husbands had, urban husbands were more liberal and their wives were more autonomous compared with rural husbands. Most of them involved their wives in decision-making and used their wives contributions compared with the rural husbands. Husbands in the rural areas were less gender responsive and dominated in decision-making. This had a link with their occupation as well. It was observed that farmers had inadequate knowledge and were more conservative as they were mostly influenced by gender norms and culture. Though most of them worked together with their spouses, they did not make time to discuss issues with their wives. Husbands whose wives had several pregnancy experiences were more liberal and their wives had opportunities in making decisions about care-seeking compared with their counterparts without experiences. The men noted that, they were comfortable with such women because they had both knowledge and experience to make informed decisions. Also husbands with several experiences of pregnancy were more democratic

by seeking and using the views of their wives in intra-household decision-making compared with their colleagues with less experience.

2.10. Implication for Maternal Clinic Attendance

Data from the dynamic showed that their wives had the opportunity of taking prompt decisions for care-seeking which resulted in early antenatal care attendance, mostly in the first month of the first trimester; timely attendance for institutional supervised delivery and postnatal care within the critical period as well as increased number of ANC and PNC visits. One of them said:

"My wife made several ANC visits. The visits were timely as well including PNC visits. Because she knew I would not worry her she was able to go to the clinic as early as possible when she felt like giving birth in my absence. I only received a phone call from the clinic and joined her there till she delivered." (48 years old, No formal education)

However, the conservative who were male-centred delayed both the decision-making process and maternal clinic attendance of their wives. This translated into poor clinic attendance in the form of low ANC visits, late ANC, delivery care and PNC. One conservative husbands said:

"... from the herbalist then we decided to carry her to the clinic but when we got there the midwife said it was too late so the baby died and my wife sustained some injuries. Later, they had to clean her womb." (45 years old, MSLC).

Similar views were expressed across the various participants with the same background characteristics in the interviews.

3. Discussion

3.1. Informed Decisions

One key implication observed in this study was the making of well-informed decisions by husbands who had knowledge about maternity. They made informed decisions towards care-seeking through active involvement of their wives in decision-making and granting their wives total autonomy in taking decisions and implementing such decisions. They used their knowledge to influence their wives to make informed decisions and seek early care from health professionals. One of the participants noted:

"I know what women normally go through in pregnancy. So, I allow her to be part of the decision-making or decide for herself to avoid delays in clinic attendance. Though I am aware of most signs of pregnancy and childbirth complications, she feels the symptoms and can better determine what is right for her based on the condition and what she has been told in the hospital." (35 years, Diploma).

Involvement of wives in decision-making and women's empowerment supported with resources to seek professional care enabled the women to seek timely and regularly care. This concurs with the observation that gender role affects women's autonomy to make decisions about healthcare at the household level which in turn play out at the agency level (Bougangue, 2017; International Center for Research on Women, 2008;2010; World Health Organisation Commission on Social Determinants of Health, 2008;2010). The timely and regular clinic visits positioned the women well for better chances of maternal screening for health dangers as compared with their counterparts who had to wait for their husbands to decide for them. These women made early antenatal care (ANC) visits mostly within the first month of the first trimester with more ANC visits and timely postnatal care (PNC) visits. Also, most of the husbands with maternity knowledge accompanied their wives to health facilities for professional care during ANC, delivery and the post-delivery visits. This demonstrates that husbands' knowledge about maternity translates into informed decisions and positive attitudes towards care-seeking. This maintains the assertion that men who have knowledge are able to stand dominant against gender norms to improve maternal health (International Center for Research on Women, 2008;2010;2014).

"Oh Sir, as early as within the first month she started making ANC visits. She made not less than 7 visits before delivery. I carried her on my motor bike to the health centre for delivery and made sure that she did not miss PNC within 48 hours as they usually encourage us to do." (54 years, Bachelor degree).

Women's autonomy and active involvement in care-seeking decision-making led to positive behaviour towards clinic attendance and their health. This is supported by the fact that only two husbands reported that their spouses had some complications during the maternity period which they were aware before occurrence through clinical examination. This shows that respect for the views of women during pregnancy and childbirth is very essential to improve maternal healthcare because it is women that experience the symptoms of pregnancy and related complications. Therefore, they can best determine the severity of the conditions they experience and help in making a better care-seeking decision. The informed decisions reached by these couples were due to the liberal and autonomous environment created for the women by their spouses which enabled them to make decisions about healthcare and implement them without their husbands' interference by which they acted quickly without waiting for men's approval.

3.2. Uninformed Decisions

Some husbands who had knowledge together with most husbands with limited knowledge were conservative, culture-centred and gender-driven, which prevented them from actively involving their wives in decision-making, and consequently resulted in male-dominant decisions and the consequential poor clinical visits. The husbands relied on their personal assessment of their wives' conditions based on the reports given to them by their spouses and the

outcome of spiritual consultations for some of them. This resulted in late and lower number of clinic attendance. Others did not allow their wives to seek professional care at all. A participant stated:

"Yes, women carry pregnancy and feel its complications but decision-making is men's case. Unlike women, men have their own way of deciding on issues. It is not an issue of a woman going for check-up early but whether that check-up will not harm her. This is the position of a man as the head of the family." (40 years, SSS graduate).

The wives of this category of men had a higher risks of developing maternal complications or aggravating existing ones (Ghana Statistical Service, 2009;2015; Ghana Statistical Service Ghana Health Service and Macro International Inc, 2008). Timely and regular clinical visits are necessary for improved maternal healthcare because professionals are able screen women to identify and guard against health risks (Ghana Statistical Service, 2009;2015; Ghana Statistical Service Ghana Health Service and Macro International Inc, 2008; World Health Organisation, 2013). Entrenched gender norms had a serious repercussion on the type of decisions made at the household level and clinic attendance. This concurs with previous observations that there are still gender inequalities in decision-making towards maternal healthcare seeking (Ghana Statistical Service, 2011; International Center for Research on Women, 2008;2010;2014; Tsikata, 2007).

3.3. Gender Discrimination, Marginalisation and Women's Reproductive Rights Violation

As discussed above, gender discrimination, marginalisation of women and violation of women's reproductive rights were evidential in the intra-household decision-making process. In most cases, decision-making power was entrusted to the hands of the husbands rather than being a joint responsibility of spouses. To the disadvantage of women's health, some of the husbands did not count women's experiences of symptoms as important for decision-making. Marginalisation of women in decision-making had serious maternal health implications. Some women developed serious complications and injuries during delivery whilst two of them lost their lives in pregnancy whilst they were receiving traditional treatment. A husband noted:

"I decided where to seek care for her. She was not able to deliver for more than 30 minutes. So we took her to an herbalist but it was not possible with the herbs. After about one hour we looked for a motor bike to carry her to the health centre. They told us that we came too late so both the mother and the baby died." (49 years, MSLC).

As direct objects of pregnancy and its related complications, women should be given autonomy to take non-tentative decisions regarding their health at the household level. Fundamental human rights guarantees women the right to make decisions and to access healthcare services of their choice (African Union Commission, 2006; Republic of Ghana, 1992). When women have the power to decide they can make meaningful decisions that can positively affect their lives (Babalola and Fatusi, 2009; Hagman, 2013). However, differences in the status of women and men as observed in this study lead to differences in opportunities to claim, benefit from, and enjoy human rights including the right to decision-making and health (World Health Organisation, 2013;2014). In many parts of Africa, women's decision-making power is extremely limited, particularly in maters of reproduction and sexuality. In this regard, decision about maternity care are often made by husbands or other family members usually, males thereby compromising maternal and neonatal health (World Health Organisation, 2001).

3.4. Background Factors

Regardless of the influence of culture, religion and traditional gender norms, there is a changing pattern of husbands' behaviour in relation to intra-household decision-making. There is a gradual shift from the hitherto male-centred decision-making to joint and female autonomous decision-making which is necessary for improved maternal healthcare (International Center for Research on Women, 2010;2014). This enabled some pregnant women to take quick and informed decisions which translated into timely clinic attendance and increased number of visits in the maternity period. This pattern of men's behaviour was evident particularly amongst the Christian husbands and the believers of traditional religion.

"I know household decision-making is men's space but I cannot experience what my wife goes through in pregnancy. I think it is about time we put some traditional norms aside especially when it has to do with human life. Many times the radios and TVs organise health programmes to alert us on what to do to help our wives and that is what I try to do." (37 years, Diploma, Christian).

Observation of dominant gender norms was still strong and evidential amongst some Muslim husbands as indicated below:

"A husband loses his position as a head of family the moment he entrust decisions to the hands of his spouse. Allah knows it is men who should made decisions and He prepares us and gives us wisdom to deal with it." (45 years, SSS graduate, Muslim).

The norms and principles governing marriage and religious institutions particularly regarding gender ideologies were very strong and resilient

Media exposure had a far-reaching impact on the illiterates and rural dwellers particularly. Illiterate husbands without experiences of pregnancy learnt about maternity signs and complications from local radio programmes which were accessible to them even in their farms. The illiterate husbands in urban communities had more knowledge than their rural counterparts due to more exposure to the media (TV and Radio) and the opportunity to interact with literates and experienced people from whom they taped knowledge. Also, husbands to a very young women regarded their wives as not capable of taking good decisions and solely decided for them. Besides, most of the participants had higher education as compared with their wives. Most of the participants with age ranges between 25 and 35 years had at least basic education and were in support of joint decision-making and female autonomy more than those aged 36 and above. However, regardless of age and experience, female educational attainment was

influential in women's involvement in intra-household decision-making. Husbands whose wives had formal involved their wives in decision-making as compared with their counterparts who were married to illiterates. This observation maintains the importance of formal education which is often used as a proxy for knowledge, informed decisions and empowerment as well as positive behaviour towards care-seeking though there are exceptions (Bougangue and Ling, 2017; Bougangue, 2017; Ghana Statistical Service, 2009;2015; Ghana Statistical Service Ghana Health Service and Macro International Inc, 2008; McAlister and Baskett, 2006; Preston, 1989; United Nations Fund for Population & International Center for Research on Women, 2013;2014).

4. Conclusions

This study discovered that though knowledge of husbands about maternity could influence them to involve their spouses in care-seeking decision-making, cultural beliefs and traditional gender role expectations had a far-reaching effects on wives' involvement in decision-making and the type of decisions made towards care-seeking. Besides, exposure to media and healthcare promotion programmes and locational factors were observed as crucial variables that influenced husbands to involve their spouses in healthcare decisions. Male-dominant, culture-driven and gender biased decisions at the intra-household level resulted in poor maternal clinic attendance whilst female-centred, female autonomous and joint decisions promoted maternal clinic attendance in the form of early care-seeking and increased number of clinical visits.

Healthcare promotion programmes should be directed towards changing the mindset of men about cultural beliefs and gender roles in relation to maternity care. There should be provision of education on pregnancy and childbirth and the associated benefits and dangers to equip men on how to recognise pregnancy-related complications to enable them to reach informed decisions for care-seeking. Besides, men should be encouraged to actively engage their spouses in care-seeking decision-making for timely clinical visits. Whilst husbands' knowledge is necessary for informed decisions, other background variables such as education level and media exposure, traditional gender norms and cultural beliefs may interact with knowledge to inform the type of decision.

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