KNOWLEDGE, ATTITUDE AND PERCEPTION OF MARRIED MEN TOWARDS SAFE MOTHERHOOD IN IBADAN NORTH LOCAL GOVERNMENT AREA, OYO STATE, NIGERIA

BY

Zaynab Aramide ALABI
B.Sc (ED) HEALTH EDUCATION (ILORIN)
MATRIC NO: 181931

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DEDICATION

This study is dedicated to the Almighty Allah, the most gracious, most merciful.

Zaynab Aramide ALABI

ABSTRACT

Safe motherhood is one of the interventions proposed to reduce maternal mortality rate. Majority of the deaths can be prevented if women receive adequate care and make informed decision about their health. Since men are the major decision makers in the home and it is believed that their involvement in safe motherhood can lead to good maternal health. This study was designed to assess the knowledge, attitude and perception of married men towards safe motherhood in Ibadan North Local Government Area.

This study was a descriptive cross-sectional study which employed a multi stage-sampling technique. The twelve wards in Ibadan North local government was stratified into three zones based on their level of development, two wards were randomly selected from each zone to get a total sampling frame of six wards. Proportionate sampling technique was used to select the number of respondents from each community. Pre-tested semi-structured questionnaire was administered on three hundred and ten respondents to document their socio-demographic characteristics, awareness and knowledge of safe motherhood, attitude towards safe motherhood and their perception about safe motherhood. Factors influencing their involvement in safe motherhood was also investigated. Knowledge, attitude and perception were measured on 35-point, 10-point and 8-point scales respectively. Knowledge scores of ≤11, 12-23, ≥24 were rated poor, fair and good respectively. Attitude scores of ≤ 5 and >5 were rated negative and positive attitude respectively while perception score ≤ 4 and > 4 was rated negative and positive perception respectively. Data was analysed using SPSS version 20 using descriptive statistics and Chi-square test at 5% level of significance

Age of respondents was 43.7 ± 7.9 years, 85.5% were Yoruba and 54.5% were Muslims, the highest educational qualification of majority of the respondents was secondary education (47.1%), slightly more than half (51.6%) make a joint decision with their wives on where they seek maternity care. A good number of the respondents (64.2%) had safe motherhood awareness but the knowledge of safe motherhood was poor (74.8%). About one-third (33.1%) understood safe motherhood as taking care of women throughout pregnancy. Knowledge about danger signs in pregnancy and childbirth was low with mean scores of 1.2± 0.9, 0.8± 0.8 respectively. The overall mean knowledge score was 8.97±3.48 out of a 35- point knowledge scale.

Occupation, level of education were statistically significant with respondents' knowledge of safe motherhood. Majority of the respondent (72.6%) and (76.8%) has positive attitude and perception towards safe motherhood respectively. There was no significant relationship between respondent's knowledge and attitude, knowledge and perception about safe motherhood. Reported reasons for non participation was time factor (30.3%), men do not consider it necessary (25.3%) and knowledge deficit (20.9%).

Although awareness of safe motherhood, perception and attitude was high among the respondents, their knowledge about safe motherhood is poor. Their is need to enlighten married men about safe motherhood and involvement in maternal health.

Keywords: married men, safe motherhood, maternal health.

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Zaynab, Aramide ALABI

CERTIFICATION

I certify that this study was carried out by Zaynab, Aramide Alabi under my supervision at the department of Health Promotion and Education, Faculty of Public Health, College of Medicine, University of Ibadan, Ibadan, Nigeria.

SUPERVISOR

Titiloye A. Musibau

B.Sc (UNAAB), MPH (Ibadan), PhD (Ibadan)

Department of Health Promotion and Education

Faculty of Public Health, College of Medicine,

University of Ibadan.

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CHAPTER ONE

INTRODUCTION

1.1 Background Of Study

The lifetime risk of maternal mortality of women in sub- Saharan Africa is 1 in 39 live births, which is the highest when compared to other world regions (Tilahun, Coene and Luchters, 2013). The World Health Organization (WHO) estimated in 2012 that 287,000 maternal deaths occurred in 2010; sub-Sahara Africa (56%) and Southern Asia (29%) accounted for the global burden of maternal deaths (WHO 2012).

Nigeria accounts for 1 in 6 maternal deaths globally. Approximately 50,000 Nigerian women die each year from largely preventable pregnancy-related complications (Erim, Resch, and Goldie, 2012). According to Somé, Sombié, and Meda, (2013) certain avoidable factors (biomedical, reproductive, health service factors, socioeconomic and cultural factors) increase the risks of severe complications or maternal death.

A majority of the deaths related to pregnancy and childbirth can be prevented if the women receive adequate and timely medical care at the crucial moments, evidence suggests that providing expectant mothers with adequate maternal care, birth supervision by skilled attendants, and access to emergency obstetric care in pregnancy and delivery can save lives (Oyeyemi and Wynn, 2014). He further stated that complications that can potentially lead to death exist in about 9-15% of pregnancies, 75% of maternal deaths are as a result of direct causes from severe haemorrhage (bleeding), maternal sepsis (infection), obstructed labour, high blood pressure with fits in pregnancy (eclampsia) and unsafe abortion (Oyeyemi and Wynn, 2014).

Most cultures, especially in Africa, regard all issues related to pregnancy or childbirth as a female domain; therefore, men are often not expected to be involved in any health seeking behaviour during pregnancy (Kwambai, Dellicour and Desai, 2013). Safe motherhood has been conceptualized as a means of ensuring women's accessibility to needed care through antenatal programme in order to facilitate their safety and optimal health throughout pregnancy and childbirth (Price, 2002 as cited by Igbokwe and Adama, 2011). According to Jatau 2014, it is a means of saving the lives of women and improving the health of millions of others.

Safe motherhood is aimed at preventing maternal and prenatal mortality and morbidity. It also enhances the quality and safety of women's life through the adaptation of combination of health and non- health strategies (Igbokwe and Adama, 2011). It was further stated that the initiative is achieved through a programme of inter-linked steps which strive to provide family planning services to prevent unwanted pregnancies; safe abortions (where abortion is legalized, efficient management and treatment of complication of unsafe abortions are accessible); prenatal and delivery care at the community level with quick access to first-referral services for complication and postpartum services, promotion of breastfeeding, immunization and nutrition services. Safe motherhood services must be integrated into the health care delivery system and necessary inputs such as drugs, equipment, facilities and appropriately trained staff supplied.

Maternal mortality is a major public health problem in the world, and ensuring safe motherhood with access to necessary health care including antenatal care, emergency obstetric services, post natal care is a prerequisite for reducing maternal mortality. Men are important stakeholders in Safe Motherhood and can be possible barriers to women's health care seeking behaviour in pregnancy, delivery and post-partum period, thus their involvement is essential for safe motherhood.

1.2 Statement of Problem

Report has shown that of the 585,000 annual maternal deaths reported globally, 526,500 (90%) occur in sub-Saharan Africa; where Nigeria is a part, and the other 58,500 (10%) is shared among other developing and developed countries. In this regards, one of the target for achieving the MDGs 5 was to "reduce the maternal mortality ratio to 125 per 100,000 live births by 2010 and to 75 by 2015". However, as drawn from Nigeria Demographic Health Survey NDHS (NPC 2014), the estimated maternal mortality ratio in 2013 (576) is higher than that in 2008 NDHS which is 545; despite the aim of the MDGs to reduce maternal mortality by three quarter by the year 2015. Just less than two years to the propose time frame for the attainment of MDGs-5, it can be suggested from NDHS that there is no evidence to suggest the reduction in maternal mortality (NPC, 2014).

As reported by Jose, (2010), Nigeria has one of the worst maternal health indicators in the world. Worrisome, as praiseworthy as safe motherhood initiative is, it is tragic that

1 in 12 Nigerian women die as a result of pregnancy despite the 21st century technologies. This bizarre phenomenon is not the lack of man power or technical knowhow but may have resulted from poor knowledge, involvement and practice of safe motherhood among pregnant women significant others.

Over the years, issues relating to maternal health has been predominantly seen and treated as a purely feminine matter. The hugely disproportionate representation of men, and their resulting dominance, among those responsible for the planning and provision of health care has had serious consequences for the health status of women and girls, particularly in developing countries (Adenike, Esther, Adefisoye, Adeleye, and Olanrewaju 2013).

1.3 Justification for the study

While it has been reported that men's behaviour influences the reproductive health of women and the health of their children, it is known worldwide and in Africa in particular that men tend to be responsible for important choices relating to the care-seeking behaviours of women; and this directly impact on the health of women and newborns. Despite this, most maternal and child health programs focus on engaging and educating women and mothers, to the exclusion of men. Considering that engaging men in maternal and child health has been slow in most developing countries contexts, hence this justifies the selection of married men for this study. So far, studies on men's reproductive health have mainly focused on basic measurement of fertility, contraceptive use and reproductive preferences leaving scanty information on their involvement in safe motherhood, especially their perception and attitudes towards the topic. Researches in the past decade has mainly focused on women, the magnitude of men's attitude and perception is not echoed in such studies.

The importance of safe motherhood to the overall development of a country or a nation cannot be over-emphasized and it has to be acknowledged at the highest levels. Without improving women's health care seeking behaviour through men involvement regarding safe motherhood, the overall development of the country will be hindered. Therefore, this study is aimed at assessing the knowledge, attitude and perception of married men on issues related to safe motherhood and by implication, this will help in understanding men's disposition and serve as a guide in designing targeted programs and in the long run contributing to the reduction of the country's maternal mortality and the realization of MDGs -5.

1.4 Research Questions

1. What is the level of knowledge of married men about Safe Motherhood?
2. What is the attitude of married men towards Safe Motherhood?
3. What is the perception of married men about Safe Motherhood?
4. What are the factors influencing involvement of men in Safe Motherhood?

1.5 Broad Objective

The broad objective of this study is to investigate the knowledge, attitude and perception of married men towards Safe Motherhood Initiatives in Ibadan North Local Government Area of Oyo state, Nigeria.

1.6 Specific Objectives

1. To assess the level of knowledge of married men about Safe Motherhood
2. To determine the attitude of married men towards Safe Motherhood
3. To determine the perception of married men about Safe Motherhood
4. To identify factors that influence men involvement in Safe Motherhood

1.7 Variables

The dependent variables include knowledge, attitude and perception of married men. The independent variables include socio demographic variables; age as at last birthday, religion, ethnicity, occupation, educational level, number of children/ parity, years in marriage, types of marriage.

1.8 Hypotheses

There is no association between:

1. Respondents' knowledge of safe motherhood and their attitude towards safe motherhood
2. Respondents' level of education and their knowledge of safe motherhood
3. Respondent's occupation and knowledge of safe motherhood
4. Respondents' age and their perception of safe motherhood
5. Respondents' knowledge of safe motherhood and their perception of safe motherhood.

CHAPTER TWO

LITERATURE REVIEW

2.1 Historical Overview Of Safe Motherhood Initiatives

The global Safe Motherhood Initiatives (SMI) would be 30 years in 2017 since its launch in 1987 in Nairobi Kenya, it is an international effort to raise awareness of the scope and dimensions of maternal mortality and to stimulate commitment among governments, donors, UN agencies, and other relevant stakeholders to take steps to address this public health tragedy (McCaw-Binns, 2005). It was aimed at reducing the burden of maternal death and ill health in developing countries. The conference was co-sponsored by a group of international agencies that founded the Safe Motherhood Inter-Agency Group (IAG), namely: the United Nations Children Emergency Fund (UNICEF), the World Bank, the WHO, UNFPA, the International Planned Parenthood Federation (IPPF) and the Population Council (Onwurah, 2013).

The Safe Motherhood Inter-Agency Group (IAG) was established to realize the goal of the Initiative which was to draw the world's attention to the thousands of deaths and millions of serious complications that occur every year in association with motherhood, these agencies raised international awareness about safe motherhood, set goals and programmatic priorities for the Initiative, stimulated research, mobilized resources, and shared information to make pregnancy and childbirth safer (McCaw-Binns, 2005).

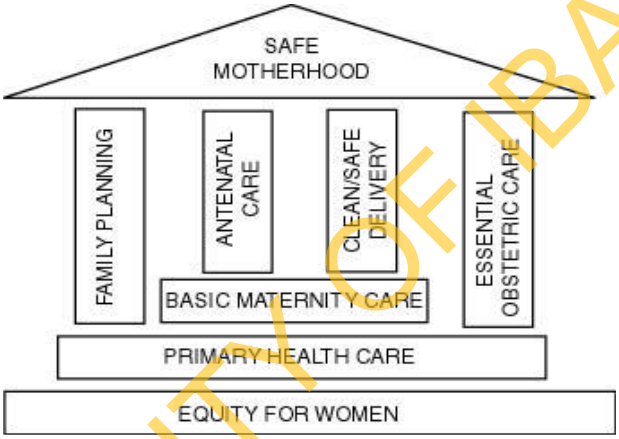
Discussing the importance of safe motherhood, Daly, Azefor, Nasah (1993), Jatau (2000) and NPSM (2003) as cited by (Igbokwe and Adama, 2011) affirmed that the health risk that confront childbearing mothers particularly teenage mothers both the mother and child are serious, which include eclamptic toxaemia, anaemia, malnutrition, cephalopelvic disproportion, obstetric fistulae, obstructed labour, low birth weight and prenatal mortality. They further attested these abnormalities could be averted through health education MCH clinics.

Safe motherhood is one of the important components of Reproductive Health, it means ensuring that all women receive the care they need, to be safe and healthy throughout pregnancy and childbirth. It is the ability of a mother to have a safe, healthy pregnancy and child birth. It means that no woman should die or be harmed

by pregnancy or childbirth. It is a state of well-being in which a woman approaches childbirth with confidence in her abilities to give birth to and nurture her newborn (Aktar, 2012). Knowledge about safe motherhood is important for an expecting mother's physical and emotional health.

2.2 Components of safe motherhood initiatives

Safe motherhood encompasses a series of initiatives, practices, protocols and service delivery guidelines designed to ensure that women receive high-quality gynaecological care, family planning, prenatal, delivery and postpartum care. The pillars of safe motherhood are family planning, ANC, clean/safe delivery and essential obstetric care. In an act to preserve health of the mother and baby (Banda, 2013). It is substantial to implement Safe motherhood in a vertical and coordinated manner and form part of a broad strategy to improve reproductive health through primary health care as illustrated in Figure 2.1 below.



Source: Banda, (2013)

Figure 2.1 The four pillars of safe motherhood

Partnership for transforming health care system in Nigeria (2005) elucidated the components of safe motherhood, which comprised prenatal care, clean and safe delivery, and postpartum care, including family planning, emergency obstetric care and child care, sexually transmitted infections (STI), prevention of mother to child (PMTCT) transmission of HIV/AIDS and post abortion care. Women most especially child bearing mothers (15-49 yrs) should be the important target in any government's policy formulation and implantation with reference to SMI because the maintenances of adequate health particularly of infants children and mother is critical to attainment of optimum maternal health and national development (Banda, 2013).

To ensure safe motherhood, WHO has recommended the following major initiative;

- Antenatal Care
- clean and safe delivery
- Essential Obstetric Care
- Family Planning

2.3 Antenatal Care

Antenatal care (ANC) one of the four pillars of safe motherhood is a basic component of reproductive health, it refers to the regular medical and nursing care recommended for women during pregnancy. It is a type of preventive care with the goal of providing regular checkups that allow doctors or midwives to prevent, detect as well as treat potential health problems that may arise in a pregnant woman, (WHO 2005). ANC offers advice and information about appropriate place of delivery, depending on a woman's condition and status, It also offers opportunity to inform women about the danger signs and symptoms which require prompt attention from a health care provider (Banda, 2013). She went further to say that, ANC may assist in abating the severity of pregnancy related complications through monitoring and prompt treatment of conditions aggravated during pregnancy, such as pregnancy induced hypertension, malaria, and anaemia which put at risk both the life of the mother and unborn baby.

ANC is a strategy for ensuring the well-being of the mother and foetus through early detection of risks in pregnancy, prevention of pregnancy and labour complications and ensures the safe delivery of mother and child, it exposes pregnant women to counselling and education about their own health and the care of their children. According to Lule 2011, ANC contribute indirectly to the reduction of maternal mortality. Furthermore, a woman is expected to book early and attend adequate number of ANC prior to delivery, Although ANC attendance has been measured based on the proportion of women who have attended ANC at least once during pregnancy; WHO in 2002 recommends that pregnant women should attend ANC at least 4 times starting from the first trimester (Lule, 2011). In addition, pregnancy must be supervised by a trained health personnel and labour attended to by a skilled birth attendant (WHO, 2012). In Nigeria, the current ANC schedule recommends that a pregnant woman should book for ANC during the first trimester, thereafter attend

ANC clinic as follows; every four weeks until 28 weeks gestation, every 2 weeks until 36 weeks gestation and weekly until delivery.

According to a study conducted in South Eastern Nigeria by (Emelumadu, Ukegbu, Ezeama, Kanu, Ifeadike and Onyeonoro, 2014), 58.4% of them visited the ANC clinic at least 4 times prior to delivery even though only about 19% of them booked within the first 3 months of pregnancy, (19%) of them attended ANC for the first time during their most recent pregnancy in the first trimester. Also, about 30% of them attended ANC less than 4 times prior to the delivery which is less than the minimum number of attendance recommended by WHO. ANC provides an important opportunity for healthcare providers to inform women about the advantages of delivering their babies with the help of a Skilled Birth Attendant (SBA), it also teaches pregnant women about the danger signs of pregnancy, enabling them to recognize early symptoms and go to a health facility as soon as possible (Choulagai, Onta and Subedi, 2013). ANC contributes to good pregnancy outcomes depending on the timing and quality of care provided.

2.4 Clean and Safe Delivery

The World Health Organization has identified six measures that are critical for helping to reduce maternal mortality, these include: ensuring clean hands of the attendants, cleaning the delivery surface, clean delivery blade/medical apparatus, clean cord tie, clean towel to dry and wrap the baby and finally, clean clothes to wrap the mother (WHO, 2015).

2.5 Essential Obstetric Care

Essential obstetric care (EOC) is the term used to describe the elements of obstetric care needed for the management of normal and complicated pregnancy, delivery and the postpartum period. Emergency obstetric care refers to life-saving services for maternal and neonatal complications provided by skilled health workers. Emergency obstetric care(EmOC) is one of the strategies for reducing the maternal mortality as pregnancy related complications are unpredictable. However, many women in developing countries do not have access to essential health care services including emergency obstetric care. Basic emergency obstetric care by skilled birth attendants or timely referral for further comprehensive emergency obstetric care can reduce

maternal deaths and disabilities significantly. Maternal mortality and stillbirth are highly correlated with the access of emergency obstetric care services (Bhandari and Dangal, 2014). Fundamentally, EOC and EmOC are different approaches of obstetric care. EOC focuses on all pregnant women and is based on the idea that obstetric complications can be predicted and prevented by employing the concept of "high risk" and on the other hand EmOC focuses on the identification, referral and treatment of women with obstetric complications and regards equal risk to all pregnant women. Emergency obstetric care is necessary to save lives of pregnant women and neonates, It is divided into basic emergency obstetric care and comprehensive emergency obstetric care. Basic emergency obstetric care refers to lifesaving services for maternal complication being provided by a health facility or professional. It includes administration of parenteral antibiotics, oxytocin and anticonvulsants drugs for pre-eclampsia and eclampsia, manual removal of placenta and retained products and assisted vaginal delivery. Similarly, comprehensive emergency obstetric care covers all above basic care plus two other services i.e. performance of caesarean section and blood transfusion (WHO 2013). By emergency obstetric care all women must be ensured of basic as well as comprehensive emergency obstetric care services for all kinds of complications during pregnancy, childbirth and early postpartum period and their neonates (Bhandari and Dangal, 2014). Majority of maternal deaths could be avoided if women have access to essential obstetric care.

The United Nations estimates that 15% of pregnant women develop obstetric complications that require emergency obstetric care. Therefore, out of the total deliveries at least 15% women should attend health facilities for emergency obstetric care services (WHO, 2013).

2.6 Family Planning

Family planning according to Rosliza and Magdah (2010) is one of the main pillars of Safe Motherhood Initiative, The public health importance of family planning is quite enormous, without family planning, the rate of childbearing will be high and so also will maternal mortality and morbidity, maternal health services and obstetric care would be overstretched. lack of family planning is also linked to shorter spaces between births which could result in low birth weight babies and also fetal deaths. it is therefore a very crucial area that needs continuous strengthening and improvement in order to reduce maternal morbidity and mortality. Family planning is meant to ensure

that individuals and couples have the information and services to plan the timing, number and spacing of pregnancies (Onwurah, 2013).

Onwurah further explained that family planning has modern contraceptive methods and traditional methods which includes the following:

1. Coitus interruptus (withdrawal method) is the method involving waiting until ejaculation occurs at which point the male withdraws his penis from the vagina.
2. Injectables contraceptives such as Progestin-only Injectables (Medroxy progesterone acetate (DMPA), Norethisterone enanthate), Combined Injectables (Cyclofem, Mesigyna) which are all synthetic hormone that act like a natural hormone progesterone.
3. Pills (oral contraceptive), Intra Uterine Contraceptive (IUCD)/ Copper-T,
4. Fertility Awareness (The Safe Period), here the couples abstain from sexual intercourse at certain times during the woman's menstrual cycle. It is sometimes called "natural family planning".
5. Condom is also another method of family planning, made of thin rubber and covers the penis thereby preventing the semen from entering the vagina. There are male and female condoms.
6. Diaphragm or Cervical caps, Jellies, Creams, Foams, and Vaginal tablets are spermicidal.
7. Vasectomy and Tubal ligation, they are also known as permanent methods of family planning for both men and women. Vasectomy is the cutting off or the blocking of the tubes through which the sperm from the testis travels to the penis while Tubal ligation is also a permanent family planning method for women; the fallopian tubes are blocked so that the female eggs are prevented from travelling to meet the sperm; this is done surgically using bands, clips or cutting off and tying. It is more effective than other methods of contraception.

2.7 Male Involvement In Safe Motherhood

The International Conference on Population and Development in Cairo in 1994 and the Fourth World Conference on Women, Beijing 1995 pointed towards the need for involving and encouraging men to take responsibility for their sexual and reproductive behaviour, advocating that men are in a position to change attitudes and practice through their positions as community, religious and political leaders. However, they should also take individual responsibility as husbands and fathers to become involved in changing social attitudes including taking responsibility for reproductive health issues (Kwambai et al., 2013).

In some parts of Nigeria, a study by Adeyemi et.al. as cited by Somé et al., 2013, has described that spousal permission is important before a woman in emergency obstetric conditions attends to health care. In the absence of the chief of the household, any male must accompany the woman to the clinic; but it seems that women wait for the husband. Furthermore, it has also been pointed out that culture, which in most African societies is defined by men, determines habits related to food, which in turn has some implications for the health status of individuals in the community (Ajiboye and Adebayo, 2012).

Many pregnant women are dying in Nigeria not because of pregnancy as a biological function, but because of the neglect they suffer in the management of the events particularly from home, these include having to take permission from their husbands before seeking care, even in emergencies when their husbands may not be available, having to do strenuous work during pregnancy (Orji, Adegbenro, Moses, Amos, and Olanrenwaju, 2007). It was further elucidated that some family or culture dictates that even when this is dangerous to their health in pregnancy women in Sub-Saharan Africa are in a disadvantaged position in terms of decision making at home and they are not in control of their sexuality. From research evidences, women have little or no control at all when it comes to decision making. They may have to have as many children as possible even when their health would not be supportive.

Men hold social and economic power and have tremendous control over their partners, especially in developing countries. They decide the timing and conditions of sexual relations, family size, and whether or not their spouses will utilize available health care services (Iliyasu, Abubakar, Galadanci, and Aliyu, 2010). According to

Bhatta (2013), involving male in Safe motherhood enables them support their wives to utilize services aimed at reducing maternal mortality (for example; obstetric care, antenatal care e.t.c.) by preparing them adequately for birth complications or any unforeseen situation that could arise. Bhatta (2013) further stated in his study that, strategies for involving men in maternal health services should aim at raising their awareness about emergency obstetric conditions, and engaging them in birth plans and complication readiness. As such, this would lead to a reduction in all three phases of delay, namely; delay in the decision to seek care; delay in reaching care and delay in receiving care. The male partner can play a crucial role especially in the first and second phases of delay in developing countries and thereby positively impact birth outcomes (Bhatta, 2013).

Men involvement has been slow, and the lack of progress is a likely contributor to the sub-optimal advancement towards the achievement of the United Nations Millennium Development Goal (MDG) 5: reduce maternal mortality by 75% between 1990 and 2015. In order to improve men's participation, reasons for their poor or reluctant involvement need to be explored. Men could be involved in maternal health care in the following ways: supporting contraceptive use by women, helping pregnant women to stay healthy, arranging for skilled care during delivery, avoiding delays in seeking medical care, helping after the baby is born, and being responsible fathers or effective parents (Adenike, Asekun-Olarinmoye, Adefisoye, Adeleye, and Olanrewaju, 2013)

According to Adenike et al., 2013, the wives of 193 (53.2%) respondents had used family planning (FP) methods before, but only few 105 (29.0%), 87 (24.0%), 98 (27.1%) had ever followed their wives to family planning clinics, antenatal care and to the labour room respectively. The categorized involvement of men in maternal health care after scoring of the outcome variables showed that 194 (53.6%) had poor involvement, while 168 (46.4%) had good involvement.

Men's presence and their participation at the health facilities during antenatal care visits and also during delivery of their wives will help boost the morale of their wives and it also bring about a greater sense of commitment of both parents to having healthy mothers and babies (Adenike et al., 2013).

2.8 Factors Influencing Male Involvement

Marital status, level of education, occupation, age are some of the factors associated with male's participation in safe motherhood as it can be seen in the study of (Adenike et al., 2013),"The categorized knowledge about maternal health care (MHC) was found to be significantly associated with the respondents' marital status , with the ever married having a better knowledge than the single. The involvement of men in maternal health care was also found to be significantly associated with the respondents' age ($p = 0.0001$), marital status ($p = 0.0001$) and occupation ($p = 0.009$), such that those older than 40 years, ever married and professionals were more involved in MHC. The categorized attitude was found to be significantly associated with the occupation ($p = 0.015$) and educational status (0.001) of the respondents, with professionals and those with tertiary education having more positive attitude" (Adenike et al., 2013).

2.9 Knowledge Of Married Men About Safe Motherhood

Knowledge is critical to men's quality of life because everything we do depends on knowledge (Igbokwe and Adama, 2011). WHO (1996) asserted that knowledge is prerequisite for any health action. WHO further maintained that many of the ailments people suffer from are to large extent, self inflicted by anti-health practices due to lack of knowledge.

Adenike et al., 2013 ascertained that Family planning which is one of the essential interventions in improving maternal health is known by majority of the men in her study and nearly all of them accepted that men have roles to play in family planning.

Studies from East Africa shows that women have inadequate knowledge of obstetric danger signs as well as a lack of birth preparedness plans. However, involvement of men in re- productive and maternal health education may contribute to a reduction of preventable fatalities as demonstrated in previous studies in Tanzania and Nepal (Kabakyenga, 2011). When men were engaged in different reproductive health programs, it resulted in positive outcomes such as increased condom use, more couples adhering to the program of prevention of mother-to-child HIV transmission and the use of skilled birth attendants (Kululanga, 2011). A number of researches has been done in the area of knowledge, attitude and perception of women towards safe motherhood as indicated in the table below

Table 2.1 Previous studies on Safe Motherhood targeted at women

AUTHOR	STUDY POPULATION	KEY FINDINGS
Igbokwe and Adama (2011)	Childbearing mothers	From the findings of the study, it was concluded that; 1. childbearing mothers had high knowledge of various components of safe motherhood initiative 2. childbearing mothers practice safe motherhood initiative. 3. age of childbearing mothers did not influence their practice of safe motherhood.
Andrew Audu Jatau (2014)	Pregnant married women	The findings of the study revealed that factors associated with maternal health problems of semi-urban and rural pregnant married women were: pelvic inflammatory diseases, cultural beliefs and traditional practices, maternal mortality and vesico-vaginal fistulae. The factors associated with maternal health problems among age 15 – 30 and 31+ pregnant married women were: poverty, hypertension in pregnancy and prolonged labour. The perceived strategies for promoting safe motherhood were: improving the skills of community health workers, screening of high risk pregnant mothers, even distribution of health care.
Ekechi Okereke et. Al (2013)	Nursing mothers	This study found generally poor knowledge about safe motherhood practices among female respondents within selected rural communities in northern Nigeria.
Nwala K Emmanuel et al., (2013)	Women of child bearing age	There was low knowledge on the availability of maternal and child health care services.
Manju Sharma and Sudhanshu Sharma (2012)	Pregnant women	Low knowledge of safe motherhood and also high parity influences women's vulnerability There is a relationship between education and level of awareness.

2.10 Attitude Towards Safe Motherhood

Many women conceive and give birth to children without their consent. While becoming mother is a pleasant experience for most women, a forced conception without their consent can have a negative effect on their physical and emotional health. According to the findings of a study conducted by Aktar in 2012, 81 percent of women conceived a child without their consent at some point in their reproductive life. This can have a long-term effect on mothers. For safe motherhood, it has to be ensured that every woman is ready for childbearing and enjoys the freedom-+ to decide when she will bear a child. Men should communicate with their wives and reach a consensus as to when the woman wants to conceive a baby as this attitude could improve safe motherhood.

Adenike et al., 2013 reported that nearly half of the respondents agreed that men should accompany their wives for antenatal care visit whereas only 2 out of 10 respondents follow their wives for antenatal care visits and also to the labour ward. Most of the respondents agreed that men should encourage prenatal care, encourage family planning and that men should support exclusive breast feeding. However, some still felt that family planning encourages promiscuity. Overall 43.4% were found to have negative attitudes, while 56.6% had positive attitudes towards maternal health care.

2.11 Perception About Safe Motherhood Practices

According to the findings from the study of Kwambai et al., 2013, pregnancy, attendance of ANC, delivery are all female roles and thus responsibility of care lies on mother-in-laws or co- wives rather than the male. Secondly, as head of household and provider, men's focus was on economic activity which was more important for them to concentrate on at this time than participating in any safe motherhood practice. it was also reported that health care workers have a negative attitude towards men who accompany their wives for ANC or delivery.

In another study by Adenike et al., 2013, Perception of ANC amongst men showed that about four-fifth believed it entails taking care of pregnant women and their unborn child while few believed it involves giving drugs and injections to pregnant women and detecting complications and less than half of the respondents saw their role as providing emotional and moral support while 2 out of 10 felt financial support

is their only role. Also half of the respondents agreed that men should be involved in obstetric care and also encourage family planning.

2.12 CONCEPTUAL FRAMEWORK

The Theory of Planned Behaviour (TPB). This theory was proposed by Ajzen (1985), Theory of planned behaviour posits that individual behaviour is driven by the individual's intention to perform that behaviour, where behaviour intentions are functions of:

1. An individual's attitude towards the behaviour (i.e beliefs about the outcome of the behaviour and the value of these outcomes),

2. The subjective norms surrounding the performance of the behaviour (the influence of the person's social environment -beliefs about what other people think the person should do as well as the person's motivation to comply with the opinions of others)

3. The individual's perception of the ease with which the behaviour can be performed.(behaviour control).

In other words, to predict whether a person intends to carry out an action, we need to know:

I. Whether the person is in favour of doing it (attitude)
II. How much the person feels socially pressured to doing it (subjective norm)
III. Whether the person feels in control of the action in question (perceived behavioural control)

In relation to this study, to determine the perception of married men about being involved in safe Motherhood Initiatives, there is need to know;

1. Whether a man believes he can participate in any of the components of the safe motherhood initiative (attitude). This will be determined through the assessment of his perception of safe motherhood initiatives
2. Whether and how much he feels pressured by the society and significant others by his involvement in safe motherhood initiatives (subjective norms) i.e if his friends or his siblings feels it is a good idea to be involved in the practice then it increases his chances of engaging in it.
3. Whether he feels in control of the action (behavioural control). This refers to his perception of performing behaviour. If he thinks he can perform and maintain the behaviour. A man's willingness to be involved in safe

motherhood initiatives could therefore be influenced by finance, time and social factors.

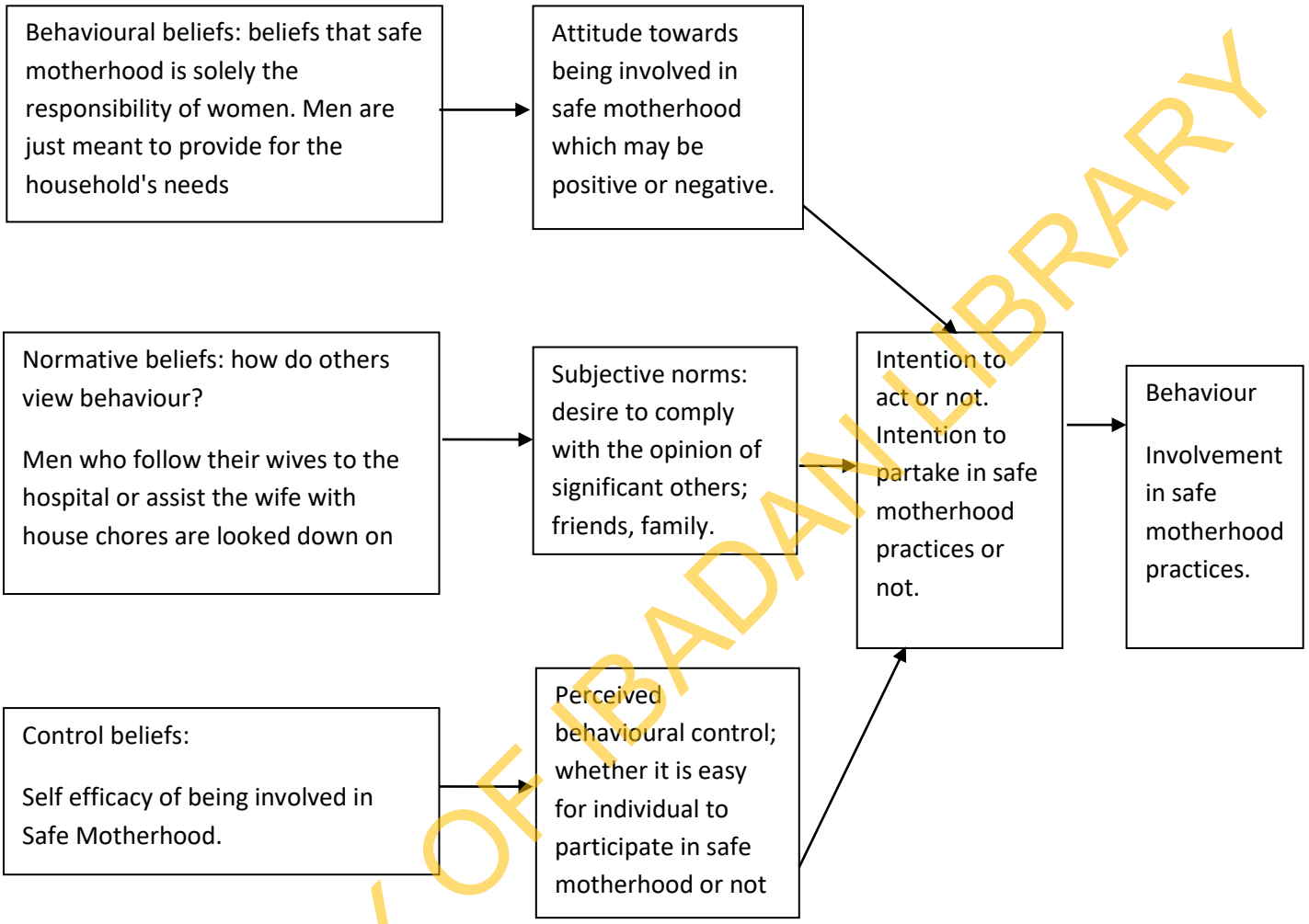


Figure 2.2 Application of the Theory of Planned Behaviour to the study

CHAPTER THREE
METHODOLOGY

3.1 Study Design and Scope

The study is a cross-sectional descriptive study. The study accessed the knowledge, attitude and perception of married men towards Safe Motherhood, the study is designed to determine the level of knowledge of respondents on safe motherhood initiatives and its components, the attitude of married men towards safe motherhood and the perception of married men about safe motherhood.

3.2 Description Of Study Area

As obtained from Ibadan North Local Government secretariat, Ibadan is located in the South-western part of Nigeria. It is the largest city in West Africa and the capital of Oyo state. Ibadan was formally called Igbori- Ipara that is the forest of Ipara, this is because the forest acted as the boundary between towns where the Ijebus, Egbas and the Oyos occupied. The name changed to Ibadan as more people settled and live there.

Ibadan occupies a large area of 3132.30 km^2, 15% 0f which falls within the urban sector, the remaining 85% are in the rural setting. 11 local government areas were created in Ibadan in 1991 by the then Military Head of State Major General Ibrahim Gbadamosi Babangida (Rtd) during the nationwide general reforms. Five of the local government areas are urban based while the remaining six are rural based. Ibadan North Local Government area falls within the urban based local government areas.

The study was carried out in Ibadan North Local Government Area, Ibadan North Local Government is situated in Ibadan metropolis which was carved out of the defunct Ibadan Municipal Government by the Federal Military Government of Nigeria on 27th September 1991. The Local government is bounded by Akinyele Local Government in the North, in the east, it is bounded by Ibadan North East and Lagelu Local Government, it is bounded by Ido Local Government, Ibadan South West and Ibadan South-East Local Government in the West.

Ibadan North Local Government Area covers a large expanse of land with an area of about 132.5 square meters. It is multi-ethnic and it is dominated by the Yoruba. The Igbo, Edo, Urobo, Itsekiri, Ijaw, Hausa, Fulani and some foreigners who are from Europe, America, Asia and other parts of the world are resident in the local

government (Oyo State Ministry of Health, 2008). The local Government Area has a population of 308,119 people; 152,608 males and 155,511 females.

Majority of people living in the local government area are in the private sector, they are mainly traders and artisans i.e they are self employed. A good number of workers in the LGA are civil servants who live predominantly around Bodija Estate, Agbowo, Sango, Mokola, the Polytechnic Ibadan and the University of Ibadan. The notable tertiary institutions in the local government Area are the University of Ibadan, the Polytechnic Ibadan and the University College Hospital, Ibadan. Ibadan North Local Government has the following health facilities; University College Hospital, Adeoyo Teaching Hospital, Secretariat Medical Clinic, Idera-de Primary Health Centre, Government House Clinic, The Polytechnic Clinic and host of other private owned health facilities that offers maternal and child health services.

Ibadan North Local Government area is stratified into 3developmental zones; inner core, Transitional and peripheral with a total of 52 communities. Table 3.1 shows the categorisation of wards and communities Ibadan North Local Government Area.

Table 3.1 Categorisation of Zones And Wards In Ibadan North Local Government Area

ZONES	WARDS	COMMUNITIES
Inner core	1	Beere Kenike, Agbadagbudu, Oke Are,Odo Oye
	2	Ode-oolo, Inalende, Oniyanrin,Oke Oloro
	3	Adeoyo, Yemetu, Oke Aremo, Isale Alfa
	4	Itutaba, Idi Omo, Oje-Igosun, Kube, Oke Apon, Abenla, Aliwo/ Total Garden and NTA Area
Transitional	6	Sabo Area
	7	Oke Itunu, Cocacola and Oremeji Areas
	8	Sango, Ijokodo
	12	Agbowo, Bodija market, Oju Irin, Barika, Iso Patako, Lagos Ibadan Express way.
Peripheral	5	Bashorun, Oluwo, Ashi, Akingbola, Ikolaba and gate
	9	Mokola, Ago Tapa and Premier hotel areas
	10	Bodija, secretariat, Awolowo, Obasa, Sanusi
	11	Samonda, Polytechnic, University of Ibadan

3.3 Study Population and Inclusion Criteria

The target population for this study was married men living in the community selected from all the three developmental zones in the Local Government Area whose wife has had at least a child or currently pregnant and who consented to participate in the study.

3.4 Exclusion criteria

Men who are not married, men whose wife are yet to give birth and whose wife are not pregnant was not recruited for the study.

3.5 Determination of Sample Size

The sample size (n) was determined by using sample size formula:

$$n = \frac{Z^2 P(1-P)}{d^2}$$

Where n= minimum sample size required

Z= confidence limit of survey at 95% (1.96)

p= prevalence of male participation 72.5% (Iliyasu et al., 2010) = 0.725

d= absolute deviation from true value (degree of accuracy) =5%

n= [1.96^2 x 0.725 x (1- 0.725)] / 0.05^2

n = 306.37, approximately 306

However, a total of 310 respondents participated in this study.

3.6 Sampling Procedure

A five stage multi-stage sampling technique was used in selecting respondents that participated in the study. There are three developmental zones with a total of about 52 communities in Ibadan North Local Government Area, each consisting of a number of households/ compounds. The procedure for the selection of respondents are highlighted below:

Stage 1: Stratification of wards into zones: the twelve wards in the local government area were stratified into three zones based on the level of development

Stage 2: Two wards was randomly selected from each of the three zones by balloting to have a total of six wards.

Stage 3: A list of all the communities in the selected ward was made and 50% of the total number of the communities was randomly selected by balloting from each of the zones

Stage 4: Proportionate sampling technique was used to determine the sample size from each selected community. Number of respondents from each community was calculated by dividing the number of respondents per ward by the number of communities in the ward (Table 3.2) and a total of 310 respondent was selected.

Stage 5: Houses were systematically selected using a class interval of three from each of the community i.e questionnaires was administered in every third house. In houses where there were more than one household, balloting was done to select a household where the married man for the study was picked.

Table 3.2 Calculation of the number of respondents from each community.

Zones	Ward	Communities	Sample size determination	Number of respondents
Inner core	1	Beere Kenike, Agbadagbudu, Oke Are, Odo Oye	$\frac{4}{23}$ x 310	54
	3	Adeoyo, yemetu, Oke Aremo, Isale Alfa	$\frac{4}{23}$ x 310	54
Transitional	6	Sabo	$\frac{1}{23}$ x 310	13
	12	Agbowo, Bodija market, Oju Irin, Barika, Iso Patako, Lagos Ibadan Express way	$\frac{6}{23}$ x 310	81
Peripheral	10	Bodija, Secretariat, Awolowo, Obasa, Sanusi	$\frac{5}{23}$ x 310	67
	11	Samonda, Polytechnic, University of Ibadan	$\frac{3}{23}$ x 310	41
	Total	23		310

3.7 Research Instrument

A semi-structured interviewer administered questionnaire which comprised open and closed ended questions was used to collect data from respondents. Information from literatures and corrections from my supervisor guided the development of the research instrument which consisted of five sections. The first section explored the socio-demographic information of respondents. Section B assessed the level of knowledge of respondent about safe motherhood where a 35-point knowledge scale was developed. Section C and D explored attitude and perception of safe motherhood where a 10-point and 8-point scale were developed respectively. Section E assessed factors influencing male involvement in safe motherhood.

3.8 Validity and Reliability Of Instrument

Validity: validity is the degree to which an instrument measures what it is supposed to measure, to ensure the validity of the instrument, relevant literatures was consulted. A draft of the instrument was developed after extensive literature search on knowledge, attitude and perception of men towards safe motherhood initiatives, the drafted instrument was reviewed by research supervisor. The questionnaires was written in English language and also translated to Yoruba for respondents that do not understand English, not educated and for better understanding. It was subsequently back translated to English language to ensure that the translation has not affected or changed the context of the question.

Reliability: the reliability of an instrument is the degree to which it yields constant result on repeated trials. Before the questionnaire was used, it was pretested among 10% of the total sample size in Ibadan North West Local Government Area (IBNWLGA), a population that has similar characteristics with actual study population. Findings from the pre-test was used to revise the questionnaires for necessary adjustment in the main study. The Cronbach Alpha coefficient analysis was used to measure its internal consistency that is to confirm its reliability, results that show correlation coefficient greater than 0.05 are considered reliable. For the pre-test, the correlation coefficient was 0.730 which is greater than 0.05 thereby confirming it reliable.

3.9 Data Collection Procedure

Four research assistants were recruited for the study since interviewer administered questionnaire was used for the study. They were trained a day prior to commencement of data collection to ensure that they have good understanding of the instrument. They were trained on the objectives and importance of the study, sampling process, how to get respondent's informed consent, detailed review of the questions to ensure familiarity and interviewing techniques. Data collection commenced on 7th September 2015 and ended 6th October; it lasted for approximately 4 weeks. Data was collected in 23 communities in the Ibadan North Local Government, namely; Beere Kenike, Agbadagbudu, Oke Are, Odo Oye , Adeoyo, yemetu, Oke Aremo, Isale Alfa, Sabo, Agbowo, Bodija market, Oju Irin, Barika, Iso Patako, Lagos Ibadan Express way, Bodija, Secretariat, Awolowo, Obasa, Sanusi, Samonda, Polytechnic, University of Ibadan. Approval to interview respondents was gotten from the head of each community after explaining to them the purpose and benefits of the research. Thereafter informed consent was sought from the participants before being recruited into the study and the questionnaires were administered to them in seclusion to give room for privacy. Respondents were selected from every third house, in houses where there were more than one household, balloting was done to select a household where the respondent was picked. A total of 323 questionnaires were collected but 310 was used for the study. Thirteen questionnaires were discarded as some information was not completely given.

3.10 Data Management and Analysis

All questionnaire were reviewed after completion for accuracy and serial number were written on each for easy identification and recall. Coding guide was then developed to facilitate the entry of the responses into the computer. The responses were then entered into the computer after coding using the SPSS software. Descriptive statistics involving frequency counts, percentages, mean and standard deviation were carried out. Inferential statistics (chi square) was used to test the hypotheses. The knowledge section was calculated for each respondent using a 35-point knowledge scale, each correct answer was scored 1 and the incorrect answers were scored 0, the scores 1-11, 12-23, 24-35 were subsequently categorized poor, fair and good knowledge respectively. The attitude section was categorized using a 10-point attitude scale, scores between 1-5 was categorized as negative attitude while 6-

10 was categorized as positive attitude. The perception section was categorized on a 8-point scale, negative perception was categorized 1-4 while positive perception was 5-8.

3.11 Ethical Consideration

Approval to carry out this study was obtained from the Oyo State Ministry of Health Ethical Review Committee prior to the commencement of the study. Informed consent by participant was paramount in this research, participation was voluntary and there was no form of coercion of respondents to participate in the study, they were informed of their rights to decline or discontinue with participation if they so wish. Respondents were assured of confidentiality as there was no form of identifier on the questionnaire.

CHAPTER FOUR

RESULTS

The results from this study is presented in this chapter, distribution tables and charts are used to present the results in details. Relevant statistical tests were used to test the knowledge of safe motherhood among married men, their perception and attitude. The chapter was organised into five sections:

- Socio-demographic characteristics
- Knowledge about safe motherhood
- Attitude towards safe motherhood
- Perception about safe motherhood
- Factors influencing involvement in safe motherhood

4.1 Socio-demographic characteristics

The ages of respondent ranged from 25 to 64 years with a mean age of 43.66 ± 7.89 years. Almost half (45.8%) fell between the 35 to 44 years age group. More than half of the respondents (54.5%) were Muslims and majority of the respondents were Yoruba (85.8%). The highest educational qualification of almost half of the respondents (47.1%) was secondary education, (38.1%) acquired tertiary education, 11.9% completed primary education while 2.9% did not acquire any formal education. A greater percentage of the respondents (43.9%) have spent between 10 to 19 years in their marriage (Table 4.1). On respondents occupation, (35.2%) were traders, (29.3%) were civil servants followed by artisans (23.9%) (table 4.2). More than half of the respondents(51.6%) make a joint decision with their wives about where they seek maternity care while (38.4%) of the respondents make the sole decision about where the wife seeks maternity care, (8.7%) of the respondents wives decides where she wants to deliver and family decides for the remaining (1.3%). Majority of the respondents (87.4%) has just one wife while (12.6%) are polygamous with (89.7%) having two wives and 10.3% married to three wives.

Table 4.1 Socio-demographic characteristics of respondents (N=310)

Socio-demographic characteristics	Freq	%
Age (grouped) in years		
≤ 34	33	10.6
35-44	142	45.8
45-54	100	32.3
55-64	35	11.3
Mean age	**48.66±7.89**	
Religion		
Christianity	141	45.5
Islam	169	54.5
Ethnicity		
Yoruba	266	85.8
Igbo	20	6.5
Hausa	18	5.8
Others	6	1.9
Level of Education		
None	9	2.9
Primary	37	11.9
Secondary	146	47.1
Tertiary	118	38.1
Type of marriage		
Monogamy	271	87.4
Polygamy	39	12.6

Table 4.2 Respondents' Occupation

Occupation	Freq	%
Civil servant	91	29.3
Artisan	74	23.9
Trader	109	35.2
Driver	30	9.7
Self employed	6	1.9

4.2 Respondents' knowledge about safe motherhood

Majority of the respondents 199 (64.2%) have heard about safe motherhood while 111(35.8%) have not heard about it. According to the respondents, safe motherhood was understood as taking care of a pregnant woman throughout pregnancy (33.1%), going to the hospital for antenatal checkups (17.6%), less stress for a woman (17.1), good nutrition (11%), less chores (8.8%). Other responses (12.4%) include taking prescribed drugs, adequate rest after delivery, exercise, lot of sex, no violence, exclusive breastfeeding, safe delivery, financial assistance, family planning (Table 4.4).

The two highest source of information of the respondents are Media (37.7%), Hospital (21.9%). Table 4.3 shows the details on source of respondent's information. When asked on what they considered safe motherhood practices, (26.3%) mentioned Ante natal care, 19% mentioned Nutrition, (14.6%) mentioned family planning (See table 4.3). (81.3%) reported they have participated in one or more of the practices, (18.1%) said they have never participated in any of the practices while less than one percent said they participate sometimes. (56.1%) of the respondents has ever used any method of family planning before while (43.9%) claimed never to have used family planning before. According to the respondents, the family planning method they or their wives used included injection (46.6%), condoms (23.5%), IUD (9.6%), withdrawal method (7.7%), drugs (7.7%), others (4.9%). Others include; bilateral tubal ligation, safe period, lactation amenorrhea, my wife knows.

Majority of the respondents (91.0%) were sure that their wives take their medications regularly during pregnancy and most of the respondents' wife (96.8%) seek care in the hospital during pregnancy. Majority (86.1%) of the respondents reported correctly that problems related to pregnancy and childbirth can endanger the life of a woman while (5.2%) reported it cannot. (8.7%) admitted they don't know if problems related to pregnancy and childbirth endanger the life of a woman. On the danger signs in pregnancy, (16%) of respondents mentioned bleeding, (15.3%) said weakness and tiredness,(12.8%) mentioned swollen legs and faces, (9.8%) mentioned malaria, other responses are represented on the table 4.6. When the respondents were asked if a woman can die from any of the problems, 61.9% responded in the affirmative,

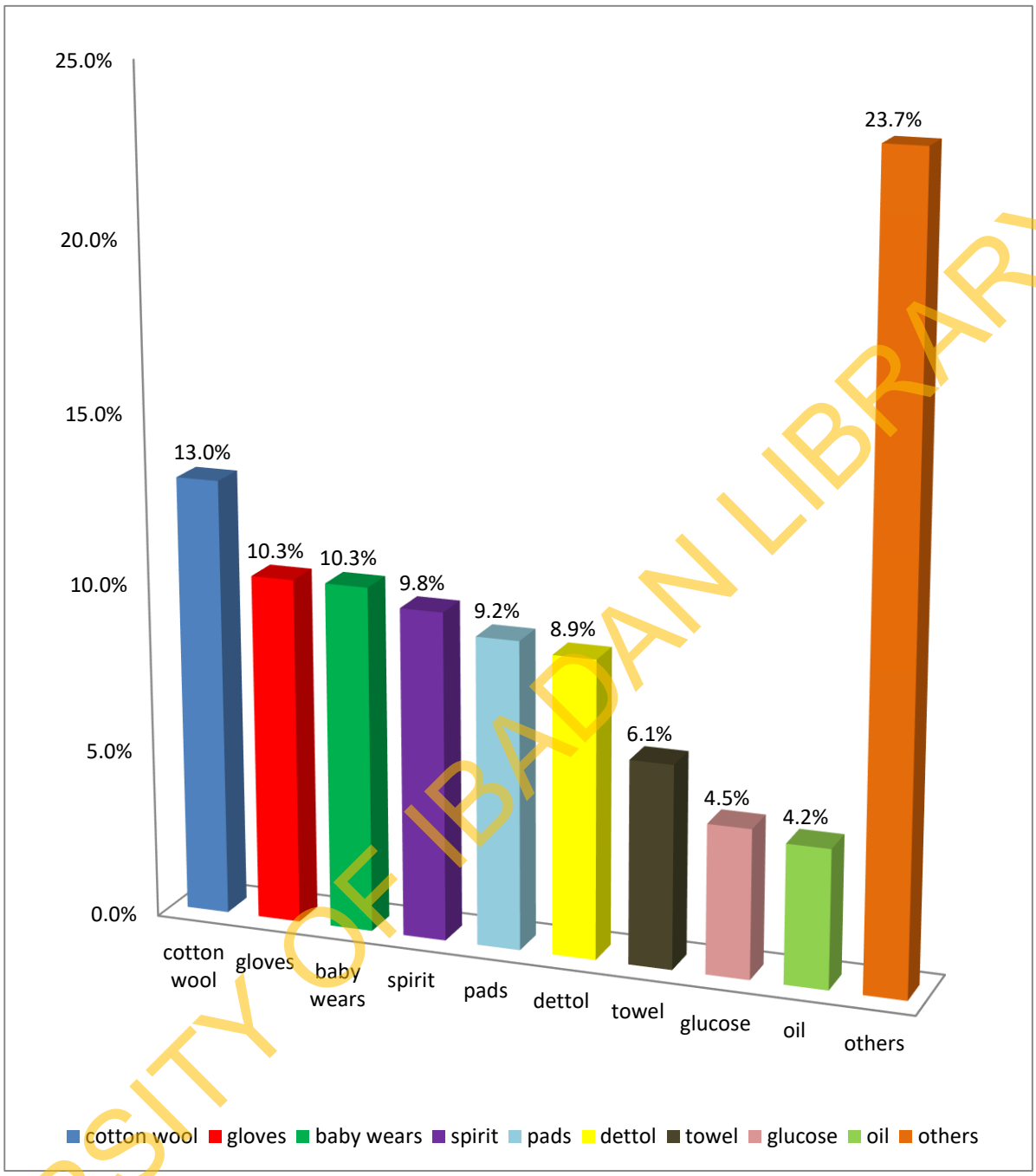
(16.8%) responded No while (21.3%) admitted they don't know if a woman can die from the problems.

On danger signs during labour, (21.9%) reported severe bleeding, (10.6%) mentioned severe headache, (9.9%) said prolonged labour while (16.1%) admitted they don't know the danger signs in labour, others are represented on the (table 4.7). 61.6% reported that a woman can die from these problems during labour, (6.8%) answered No while (31.6 %) does not know if it a woman can die from the problems. When asked what is needed to be put in place before delivery, (13%) mentioned cotton wool,(10.3%) mentioned Gloves, another (10.3%) mentioned baby's wear, (9.8%) mentioned spirit, (9.2%) mentioned pads other items are represented on Figure 4.1.

Table 4.3 Respondents' sources of information about safe motherhood (N=199)

Source of information	Freq	%
Media	117	58.8
Hospital	68	34.2
Friends	4	2.0
Parents	4	2.0
Others*	6	3.0

***Others include; personal information, religious places, office, school.**



Others include; provision, diaper, flask, mother's cloth, cord clamp, sponge, food, razor blade, injection, jik, toilet roll, soap, dusting powder, mackintosh, kerozene, feeding bottle, bandage, mucus extractor, potty, blanket, money**.**

Figure 4.1 Materials needed to be put in place for delivery.

Table 4.4 Respondents' understanding of safe motherhood

Respondents understanding of safe motherhood*	Freq	%
Taking care of a woman throughout pregnancy	124	33.1
Going to the hospital for ANC/checkups	66	17.6
Less stress for a woman	64	17.1
Good nutrition	42	11.0
Less chores	33	8.8
Others*	46	12.4

***multiple responses included**

*others = taking prescribed drugs, adequate rest after delivery, exercise, lot of sex, no violence, exclusive breastfeeding, safe delivery, financial assistance, family planning.

Table 4.5 Respondents' knowledge of safe motherhood practices

Safe Motherhood practices*	Freq	%
Family planning	83	14.6
Ante natal care	149	26.3
Safe and clean delivery	55	9.7
Essential Obstetric care	35	6.2
Nutrition	108	19.0
Use of medication	49	8.6
Good exercise	30	5.3
Others*	58	10.3

***multiple responses included**

*Others= Not walking in the sun**, less stress, counselling, i don't know**, post natal care, less chores, monitoring, wellbeing and safe practice in pregnancy, no tight cloth**, adequate rest, avoiding local herbs**, prayer**, scan, regular sex**, shelter**.

**= wrong answers

Table 4.6 Respondents' knowledge of danger signs in pregnancy

Knowledge of danger signs in pregnancy*	Freq	%
Bleeding	106	16
Severe headache	55	8.3
Weakness/tiredness	102	15.3
Swollen legs and face	85	12.8
Malaria	65	9.8
Wrong position of baby	46	9.6
Back pain	33	5.0
I don't know**	39	5.9
Hypertension	26	3.9
Preterm labour	18	2.7
Others*	72	10.7

***multiple response included**

*Others =malnutrition, loss of appetite**, stomach pain, low pcv, miscarriage, ectopic pregnancy, severe pain/discomfort, dizziness, stillbirth, insomnia, diabetes, hard breathing, prolonged pregnancy, no fetal movement, overweight baby, infection, anaemia.

** Wrong answers

Table 4.7 Respondents' knowledge of danger signs in labour

Knowledge of danger signs in labour*	Freq	%
Severe bleeding	132	29.1
Severe headache	48	10.6
Convulsion	15	3.3
High fever	38	8.4
Loss of consciousness	35	7.7
Obstructed labour	6	1.3
Prolonged labour	50	10.9
Placenta previa	8	1.8
Delayed placenta	8	1.8
Weakness/tiredness	8	1.8
I don't know**	73	16.1
Wrong position of baby	11	2.4
Severe pains**	6	1.3
Others*	22	3.5

***multiple responses included**

Others= pushing when cervix is not fully dilated, low pcv, outburst of fluids, preterm labour, inadequate pelvis, restlessness, high blood pressure, no fetal heartbeat, hard breathing.

** Wrong answers

Knowledge of safe motherhood was calculated for each respondent using a 35-point knowledge scale assessing understanding of safe motherhood, knowledge of safe motherhood practices, and knowledge of danger signs in pregnancy and labour, knowledge about whether a woman can die from the pregnancy and labour related dangers. Each correct answer was scored 1 and incorrect answers were scored 0, then each respondent's score was summed up to give the total knowledge score for each respondent. The scores were now categorised into poor, fair and good knowledge. A score above 24 was categorised as good knowledge score, while a score from 12-23 was categorised as fair and scores below 12 was categorised as poor.

Table 4.8 Knowledge categorisation of the respondents

Category	Range	Freq	%
Poor knowledge	1-11	232	74.8
Fair knowledge	12-23	78	25.2

4.3 Attitude of respondents towards safe motherhood

A total of 10 questions were used to assess the attitude of the respondents towards safe motherhood. Slightly more than half (54.8%) of respondents agreed that men should accompany their wives to the Antenatal clinic while 28.1% disagreed, 48.1% agreed that men should accompany their wives to the delivery room if allowed while 36.1% disagreed. Majority of the respondents' (92%) agreed that men should assist their wives with household chores during pregnancy, (68.4%) disagreed that men should only help their wives with chores if she asks, majority of the respondents (90.3) agreed that men should discuss and plan with their wives on having a new baby, (83.5%) of the respondent can comfortably help their wives with chores even when they are not asked. Almost all the respondents (95.8%) agreed that men should encourage their wives to attend clinics during and after delivery, (90.8%) of the respondents agreed that delivery in the health facility is safer than delivery outside a facility while (6.5%) were undecided. It was deduced from this study that 65.2% of the respondents disagreed that giving birth is a woman's matter; husbands have nothing to do with it while (20.3%) agreed to the statement. About two-third of the respondents (64.8%) agreed that as the head of the family, they make decision about family planning, where the wife gives birth or whether she attends antenatal (table 4.9).

Table 4.9 Attitude of respondents towards safe motherhood

Variables	Agree (%)	Disagree (%)	Undecided (%)
Men should accompany their wives to the ANC	170 (54.8)	53(17.1)	87 (28.1)
Men should accompany their wives to the delivery room if allowed	149 (48.1)	49 (15.8)	112 (36.1)
It is important that men assist their wives with household chores during pregnancy	286 (92.3)	14 (4.5)	10 (3.2)
Men should only help their wives with house chores if she asks	44 (14.2)	54 (17.4)	212 (68.4)
Men should discuss and plan with their wives on having a new baby	280 (90.3)	17 (5.5)	13 (4.2)
I can comfortably help my wife with chores even if i am not asked	259 (83.5)	29 (9.4)	22 (7.1)
Men should encourage their wives to attend clinics during and after pregnancy	297 (95.8)	9 (2.9)	4 (1.3)
Delivery in the health facility is safer than delivery outside a facility	280 (90.3)	20 (6.5)	10 (3.2)
Giving birth is a woman's matter, husband's have nothing to contribute	63 (20.3)	45 (14.5)	202 (65.2)
As the head of the house, I make decision about family planning, where she gives birth or whether she attends antenatal	201 (64.8)	53(17.1)	56 (18.1)

Attitude towards safe motherhood was categorized using a 10-point attitude scale, appropriate answers for each question had a score of 1, while other options were scored 0. The scores were summed up to get each respondent's attitudinal score which was then categorized into poor attitude and good attitude. Scores between 0-5 was categorized as negative attitude or bad attitude while 6-10 was categorized as positive or good attitude. Few (27.4%) of the respondents have negative attitude towards safe motherhood while 72.6% had positive attitude to safe motherhood.

Table 4.10 Attitudinal categorisation of respondents

Category	Freq	%
0-5 (Negative attitude)	85	27.4
6-10 (Positive attitude)	225	72.6

Mean= 6.18±1.56

4.4 Respondents' perception about safe motherhood

Majority of the respondents (86.5%) disagree to the statement 'I prefer that my wife delivers with the traditional birth attendants than at the health facility i.e they would prefer their wives to deliver at the health facility than with the TBAs while (9.4%) of the respondents were undecided. Very few (5.2%) of the respondents considers men who assist their wives with household chores during pregnancy as weaklings while (83.2%) disagrees. Less than half (41%) of the respondent agrees that accompanying their wives to the antenatal clinic is likely to ensure good pregnancy outcomes, (32.6%) were undecided while the others disagreed. About three quarter (73.9%) of the respondents agreed that it is important that men participate more in pregnancy planning, 17.7% were undecided while the remaining respondents disagreed. Many (72.9%) of the respondents believe husbands should be more involved in pregnancy and childbirth, 20.6% were undecided. More than half (54.5%) of the respondents encourages their wives to do family planning while 23.2% were undecided. Majority of the respondents (95.2%) agrees that it is safer to deliver in a hospital, 93.9% of the respondents encourages their wives to practice exclusive breastfeeding, 21.9% of the respondents agreed presence of men in the delivery room delays the birth of a baby while 57.1% disagrees.

Table 4.11 Respondents' perception about safe motherhood

Variables	Agree (%)	Disagree (%)	Undecided (%)
I consider men who assist their wives with household chores during pregnancy as weak	16 (5.2)	36 (11.6)	258 (83.2)
Accompanying my wife to ANC is likely to ensure good pregnancy outcome	127 (41.0)	101 (32.6)	82 (26.5)
I think it is important that men participate more in pregnancy planning	229 (73.9)	55 (17.7)	26 (8.4)
I believe husbands should be more involved in pregnancy and childbirth	226(72.9)	64 (20.6)	20 (6.5)
I encourage my wife to do family planning	169(54.5)	72 (23.2)	69 (22.3)
I think it is safer to deliver in a hospital	295(95.2)	10 (3.2)	5 (1.6)
I encourage my wife to practice exclusive breastfeeding	291 (93.9)	11(3.5)	8(2.6)
Presence of men at the time of delivery delays the baby	68 (21.9)	65(21.0)	177(57.1)

Perception of respondents about safe motherhood was scored on a 8-point scale, appropriate response for each statement was scored 1 while the wrong was scored 0. The scores were summed up to get each respondent's perception score which was then categorized into negative perception and positive perception. Score between 0-4 was scored negative perception while 5-8 positive perception. Majority of the respondents (76.8%) has positive perception while (23.2%) of the respondents has negative perception towards safe motherhood.

Table 4.12 Categorisation of respondent's perception

Category	Freq	%
Negative perception	72	23.2
Positive perception	328	76.8

Mean= 5.72±1.59

4.5 Factors influencing involvement in safe motherhood

When asked whether they ever accompanied their wives to the antenatal 55.8% responded in the affirmative while 44.2% has never accompanied their wives to the ANC, reasons given for non attendance include the following; 26.9% reported they think it is unnecessary, 33.1% reported they have very busy schedule, another 33.1% said they have to go to work, 2.3% said the health facility is too far, other responses are represented on Table 4.13.

When asked if people in their community accompany their wives to the antenatal 34.2% of the respondents said Yes, 35.5% of the respondents said No, 30.3% responded that they do not know, (48.7%) said men in their community does not accompany their wives to the labour room, 17.4% said Yes while 33.9% said they do not know. Slightly above half (53.9%) of the respondents do not practise male family planning and reasons given includes the following; 31.3% thinks it is the responsibility of the woman, 20.7% do not practice it because religion forbids , 16.8% do not practice it because they do not like it while 16.2% do not practice because they want more children (Table 4.14).

When respondents were asked about the factors that can prevent men from involving in safe motherhood generally, the reasons given are reported as follows; 30.3% said time factor was responsible for non involvement, 25.3% responded that some men do not consider it necessary, 20.9% said non involvement is as a result of knowledge deficit10.3% responded that financial issues is responsible for non involvement (Table 4.15).

Table 4.13 Factors responsible for non attendance of antenatal clinic

Factors	Freq	%
Very busy schedule	86	33.1
I have to be at work	86	33.1
I do not think it is necessary	70	26.9
Health facility is too far	6	2.3
No means of transportation	3	1.2
I consider it embarrassing	2	0.8
It is her duty	2	0.8
Since she is not incapacitated	2	0.8
She never went for antenatal	1	0.4
I trust her	1	0.4
Societal beliefs	1	0.4

Table 4.14 Factors responsible for non-practise of family planning

Factors	Freq	Percentage
It is the responsibility of the woman	56	31.3
Religion forbids	37	20.7
I do not like it	30	16.8
Want more children	29	16.2
No reason	9	5
It has side effects	6	3.4
Not my culture	4	2.2
I do not know where to procure it	3	1.7
I am not promiscuous	2	1.1
It is not effective	2	1.1
It is not necessary	1	0.6

Table 4.15 Reasons why men do not participate in safe motherhood generally

Factors	Freq	%
Time factor	200	30.3
Men do not consider it necessary	167	25.3
Knowledge deficit	138	20.9
Financial issues	68	10.3
Relationship issues	34	5.2
Negative attitude of health workers	27	4.1
No human feelings	7	1.1
Cultural restrictions	6	0.9
Individual differences	4	0.6
Women's responsibility	4	0.6
Fear	2	0.3
Communication gap	2	0.3
Government Negligence	1	0.2

TEST OF HYPOTHESES

HYPOTHESIS 1

The null hypothesis states that there is no association between the level of knowledge of married men and their attitude towards safe motherhood. Knowledge was categorized into good, fair and poor knowledge. Chi square was used test for association and the result is presented below:

Table 4.16 Association between respondent's level of knowledge and their attitudes towards safe motherhood

Variables	Attitude		X^2	Df	P-value
	Poor	Good			
Knowledge					
Poor	69	163	2.498	1	0.114
Fair	16	62			

p-value is 0.114 which is more than 0.05, therefore there is no significant association between respondent's level of knowledge and their attitudes towards safe motherhood. Hence we fail to reject the null hypothesis.

HYPOTHESIS 2

This states that there is no relationship between respondent's level of education and knowledge about safe motherhood, Chi square was used to test for the association and the result is presented in the table below.

Table 4.17 Association between respondent's knowledge and level of education

Variable	Knowledge		X^2	Df	P-value
	Poor	Fair			
Level of education					
None	8	1	13.354	3	0.04
Primary	29	8			
Secondary	120	26			
Tertiary	75	43			

P-value is 0.04 which is less than 0.05, we can therefore say that there is significant association between the level of education and level of knowledge of respondents about safe motherhood. Hence we reject the null hypothesis

HYPOTHESIS 3

This states that there is no association between the respondent's occupation and knowledge of safe motherhood, the occupation is categorized into civil servants, artisans and self employed. Chi square was used to test for the association and the result is presented in the table below:

Table 4.18 Association between respondent's occupation and knowledge of safe motherhood

Variables	Knowledge		X^2	Df	P-value
	Poor	Fair			
Occupation					
Civil servant	56	35	15.415	2	0.000
Artisan	65	9			
Self employed	111	34			

P-value is 0.000 which is less than 0.05. therefore there is a significant relationship between respondent's occupation and their level of knowledge about safe motherhood. Hence we fail to reject the null hypothesis.

HYPOTHESIS 4

There is no significant relationship between respondent's age and perception about safe motherhood

Table 4.19 Association between respondent's age and perception about safe motherhood

Variables	Perception		X^2	Df	P-value
	negative	Positive			
Age in group					
25-34	3	30	8.282	3	0.041
35-44	30	112			
45-54	26	74			
55-64	13	22			

P= 0.041 which is less than 0.05. therefore there is a significant association between age and perception and hence we reject the null hypothesis

HYPOTHESIS 5

There is no significant relationship between respondents' knowledge of safe motherhood and the perception about safe motherhood.

Table 4.20 Association between respondents' knowledge of safe motherhood and their perception

Variables	Perception		X^2	Df	P-value
	Negative	Positive			
Knowledge					
Poor	53	179	0.075	1	0.784
Fair	19	59			

P = 0.784 which is greater than 0.05, therefore, there is no significant relationship between respondents' knowledge of safe motherhood and their perception about safe motherhood. Hence, we fail to reject the null hypothesis.

CHAPTER FIVE

DISCUSSION, CONCLUSION AND RECOMMENDATIONS

This cross sectional study was conducted to understand the knowledge, attitude and perception of married men in Ibadan North local Government towards safe motherhood. This chapter will focus on the discussion of the findings of the study. It is organized into the following sub sections: socio-demographic information, knowledge relating to safe .motherhood, attitude towards safe motherhood, perception towards safe motherhood and factors preventing respondent's from involvement in safe motherhood. Other sub sections include; implication of the findings for health promotion and social policy, conclusion, recommendation and suggestion for further research.

5.1 Socio-demographic characteristics of respondents

The ages of respondents ranged from 25-64 years, greater number of the study participants were within the range of 35-44 years, those within the 45-54 age bracket were the next most numerous. The mean age of 43.66±7.89 found in this study was observed to slightly vary from an earlier study carried out in Northern Uganda conducted by Tweheyo, Kondelule, Tumwesigye, and Sekandi (2010) . The implication of this mean age is that majority of the men are still in their reproductive ages and they are agile enough to participate in safe motherhood. It is therefore necessary to enlighten men of this age group on the importance of participation in safe motherhood.

More than three quarter of the respondents were from the Yoruba ethnic group as revealed from the study, this is expected since the study is carried out in Ibadan North, a local government in the South-western part of Nigeria. The proportion of the respondents who practised Islam is higher compared to those who practiced Christianity and traditional religion which was similar to a research conducted in Osogbo by Adelekan et. Al., 2014 where more than three quarter of the respondents were Muslims. The educational status of men in the community can be considered to be less than average since less than half of them had at least secondary education. Respondent's with secondary education were the highest followed by tertiary education, this can be attributed to the fact that the study was carried out in a community setting where all categories of people can be found. A higher percentage

of the respondents were self employed, this is expected since most people in the local government are in the private sector.

5.2 Knowledge of the respondents about safe motherhood

Safe motherhood means different things to different people, respondents understood safe motherhood as different things; taking care of pregnant woman throughout pregnancy, going to the hospital for antenatal check up, less stress and chores during pregnancy, good nutrition. The finding from this study shows that there is poor knowledge of safe motherhood initiative/ practices while some of the respondents understood it as taking prescribed drugs, exercise, adequate rest after delivery, lot of sex. Few of the respondents recognised Antenatal care as a safe motherhood practice, fewer said nutrition while even fewer recognized family planning, safe and clean delivery and essential obstetric care as safe motherhood practices. Majority of the respondents agreed that problems related to pregnancy and childbirth can endanger the life of a woman. Despite the high level of awareness, only few of the respondents could identify the danger sign in pregnancy and danger signs during labour. The mean knowledge score of danger signs in pregnancy and danger signs during labour are 1.20±0.874 and 0.75±0.796 respectively. However, on birth preparedness, few of the respondents were able to identify items needed to put in place before delivery i.e birth kits as cotton wool, Gloves, spirit and sanitary pads. This agrees with a study conducted by (August et al, 2015) among similar respondents in Tanzania. Respondent's overall mean knowledge score about safe motherhood was 8.97±3.48 out of a 35 point knowledge scale which accessed understanding of safe motherhood, knowledge of safe motherhood practices, knowledge of danger signs in pregnancy and labour and materials needed for birth preparedness. This implies a poor knowledge of safe motherhood, however to ensure effective and increased participation, men should possess relevant knowledge of safe motherhood.

This finding (high awareness, poor knowledge) is consistent with several similar studies; Butawa et al, 2010, among men and women of reproductive age in Zaria, Kaduna state, Nigeria; Iliyasu et al, 2010, among men in Ungogo, a community in Northern Nigeria; Adenike et al, 2013 in a study carried out in Osun state among men of reproductive age;

The respondents' major source of information on safe motherhood is the media, followed by the hospital. From this study, there is significant relationship between respondent's level of education and knowledge of safe motherhood. This agrees with the findings from the study conducted by Butawa et al., 2010. Respondents with tertiary education showed more knowledge of safe motherhood, this is expected because of the training and exposure in the tertiary institution. Those with secondary and primary education showed lesser knowledge, this could be as a result of school curriculum at that level is been limited to. It is therefore important to include issues relating to maternal health in school curriculum so that an average Nigerian can have basic knowledge about safe motherhood practices. People with primary education showed the least knowledge. Other independent variable found to be statistically significant with knowledge in this study is occupation with civil servants showing highest level of knowledge.

5.3 Respondents' attitude towards safe motherhood

A little more than half of the respondents agreed that men should accompany their wives to the antenatal clinic while the others either disagrees or are undecided with a mean score of 0.55±0.49, this could be because they are unaware of the benefits inherent in accompanying their wives to the ANC and also because it is not the practice in the community to accompany wives to the ANC, reasons given for non attendance included busy work schedule, ANC is for women, proximity to health facility, a good number of them considered it unnecessary, some even considered it embarrassing. This is in consonance with the study conducted by Adelekan et al, 2014 conducted among similar respondents in Osogbo, Osun state Nigeria, Nkuoh et al 2010 in a study conduct among similar respondents in cameroun, Africa; Adenike et al., 2013 in Osun state Nigeria; Andrews 2012 in a similar study about the roles of partners during maternity; Bhatta, 2013 among similar respondents in Nepal.

Less than half of the respondents would accompany their wives to the delivery room if allowed, while majority of the respondent wouldn't accompany them if allowed, reasons given for this was majorly that they could not stand seeing their wives in pain or they couldn't stand the sight of blood, a mean score of 0.48±0.5 was recorded for this question. This agrees with the study conducted by Helleve, 2010 on men's involvement in care and support during pregnancy and childbirth.

Interestingly, majority of the respondents agreed that it is of utmost importance to assist their wives with household chores during pregnancy and that they can comfortably render assistance not necessarily waiting for her to ask for help. Nevertheless some men said they would only assist their wives if she asks for help. Majority of the respondents also agreed that men should discuss and plan with their wives on having a new baby i.e they agreed that pregnancy planning with their spouses is important.

Majority of the respondents agreed that delivery in the health facility is safer than delivery outside health facility, also men should encourage their wives to attend clinics during and after pregnancy, A large proportion of the men disagreed that giving birth is a woman's issue and husband have nothing to contribute, this contradicts the study of Nanjala and Wamalwa, (2012) where husbands claim that giving birth is entirely a woman's issue. A good proportion of the respondents also claimed that as the head of the house, they make the decision about where the wife gives birth, family planning or whether she attends ANC.

Overall, there is no statistical relationship between knowledge and attitude, it was recorded that majority of the respondents have positive attitude to safe motherhood. Though their knowledge about the concept is poor, they have good attitudes towards it. The mean attitude score is 6.18±1.56

5.4 Respondents' perception about safe motherhood

A very few of the respondents considered men who assist their wives with household chores as weak, the large majority disagreed, 41.0% of the respondents of the respondents agreed that accompanying wife to antenatal clinic is likely to ensure good pregnancy outcomes while the remaining proportion disagreed or were undecided about the fact. 73.9% thinks that men should be participate more in pregnancy planning and almost the same proportion 72.9% beliefs that husbands should be more involved in pregnancy and childbirth. This agrees with the study conducted by (Adenike et al., 2013); (Opeyemi et al, 2014)

Slightly more than half of the respondents would encourage their wives to practice family planning, the others disagreed or were undecided. This finding disagrees with the finding of Adenike et al., 2013 where majority of the men encourages family

planning. Interestingly, majority of respondents encourage their wives to practice exclusive breastfeeding, this agrees with the study conducted by Adenike et al., 2013. More than half of the respondents disagrees that presence of the husband at the time of delivery delays the birth of the baby, the remaining respondents belief that if the husbands are present while the wives are giving birth, the labour tends to be prolonged. There was no statistical relationship between respondents' knowledge of safe motherhood and their perception about safe motherhood.

5.5 Factors influencing male involvement in safe motherhood

Bhatta, (2013) has shown in his study among men in Kathmandu, Nepal that ignorance, employment, belief that it is a woman's duty, being preoccupied with work and feeling of embarrassment are reasons given by men for not accompanying their wives to the ANC. The same trend is observed in this cross-sectional study,33.1% of the respondents reported that they have very busy schedules, 26.9% think it is unnecessary, others consider it embarrassing, some said it is the duty of women and some actually mentioned societal beliefs that it is not been practiced in their culture. This is in keeping with the findings from the study of Kabagenyi et al., (2014). Findings from this study pointed to the fact that cultural norms could hinder some men actually from involving in safe motherhood as some of the respondents reported that people in their community do not accompany wives to ANC and to delivery rooms.

A high percentage of the respondents do not practice family planning because they think it is the responsibility of women, because they do not like it, some claimed not to know whre to procure it, some siad it is not in their culture, a number of the respondents gave religious reasons that their religion forbids it,some of the respondents don’t practice it because they claimed it is not effective others do not practice it because they want more children while some claims it has side effects. This is also documented in the study conducted by Nanjala & Wamalwa, 2012 in a study conducted in Kenya among married couples.

However, 30.3% of the respondents mentioned that time factor was prevented a lot of men from participating in safe motherhood generally, 25.3% of the respondents said some men do not consider it necessary and see it as women's responsibility, 20.9% of the respondents think it is as a result of knowledge deficit, very few claim

communication gap, individual differences,no human feelings could be the reason males do not participate. This finding agrees with the finding of Nanjala and Wamalwa, (2012)

5.6 Implication For Health Promotion And Education

The findings from this study provide important information on the knowledge, attitude and perception of married men towards safe motherhood initiatives. The study revealed poor knowledge among married men in Ibadan North Local Government which indicates the need to strenghten existing health education programs. Men need to be enlightened on the issue of safe motherhood and the importance inherent in it. The health promotion strategies that could be useful to mitigate levels of poor knowledge of married men towards safe motherhood initiatives are training and public enlightenment.

Training

Training is one of the health promotion strategies that can be used to disseminate knowledge and skills. It could be useful in addressing the poor knowledge of safe motherhood among married men in the Ibadan North Local Government Area. The relevant associations in the community e.g Landlord Association, youth groups could initiate a training program targeted at male groups in the local government by employing the services of an expert in health promotion. The training program could be facilitated with a well designed training curricullum to increase the awareness of the men. The curriculum will contain program objectives, contents, methods, materials and evaluation. Contents of the training program could include; meaning of safe motherhood, components of safe motherhood, importance of male involvement in safe motherhood. This training methods could involve both active and passive methods. Active methods such as demonstration and role play could be used while passive method could include lectures training materials such as projectors, charts, lecture notes could also be used and the evaluation can be done by using question and answer method, return demonstration and the training venue held in the community town hall.

Public enlightenment and effective communication

Public enlightenment is one of the health promotion strategies to achieve behvioural change, it aids in the promotion of healthy behaviours and involves the use of Behavioural Change Communication (BCC) materials such as hand bills, fliers, pamphlets etc. The impact of communication and information on behavioural change can not be overemphasized, BCC materials should be designed to address the knowledge gap about safe motherhood and the importance of participation. Fliers or pamphlets containing messages depicting what safe motherhood is and the importance of male participation in safe motherhood can be put in strategic places in the community e.g market places with the aim of enlightening the general populace on the issue of safe motherhood and male involvement. Information on safe motherhood can also be displayed on billboards in public places and even on the pack of daily household materials and such fliers could be designed by a health promotion specialist with expertise in BCC. Messages should be designed to suit the level of comprehension of the respondents to faclitate assimilation. Pictures illustrating the importance of safe motherhood could be used on the flier for example the picture of a man accompanying his wife to the antenatal clinic.

5.7 Conclusion

This study highlights the need for men in Ibadan North Local Government to have more knowledge about safe motherhood and involvement in safe motherhood practices as their knowledge about the issue has been found to be deficient even though they have positive attitude and perceptions. It is obvious that a huge knowledge gap needs to be filled in terms of understanding of the concept of safe motherhood, knowledge about safe motherhood practices, knowledge about obstetric danger signs (danger signs during pregnancy and during labour). Men especiallly married men should be knowledgeable about issues relating to maternal health such as safe motherhood so that they can have a happy and healthy family because when women in the households are incapacitated, the whole household would be affected since women have an enormous impact on their families's welfare.

5.8 Recommendations

From the findings obtained from this study, the following reccomendation were made;

1. Men should be taught about safe motherhood and the importance of male participation in safe motherhood starting from an early age, it should be included in secondary school curriculum and also in the general studies curriculum in the University.
2. There is need for increased media advocacy to promote maternal health and enlighten the public on safe motherhood and the importance of male involvement in safe motherhood.
3. Also religious houses such as Churches and Mosques with the influence of religious leaders are good health promotion setting. Religious leaders in both Mosques and Churches should be reached and persuaded to deliver messages on safe motherhood and reduction of maternal deaths through male participation.

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QUESTIONNAIRE

KNOWLEDGE, ATTITUDE AND PERCEPTION OF MARRIED MEN TOWARDS SAFE MOTHERHOOD IN IBADAN NORTH LOCAL GOVERNMENT AREA, OYO STATE, NIGERIA

Dear Respondents,

My name is **ZAYNAB ARAMIDE ALABI,** a Postgraduate Student of the Department of Health Promotion and Education, Faculty of Public Health, College of Medicine, University of Ibadan. I am carrying out a research on the **knowledge, attitude and perception of married men towards safe motherhood.**

The findings from this study will help in the design of programmes and formulation of policies aimed at reducing maternal morbidity and mortality. The survey should only take about 10 minutes to complete, but participation is voluntary and can be discontinued. By participating, you will not experience any risk. If you decide to complete the survey, your identity will be kept strictly confidential and will be used for the purpose of this research only. Please note that you do not have to write your name on this questionnaire. Please give honest answers to the questions asked as your maximum co-operation will assist in making this research a success. Thank you for your interest in this study.

Survey identification number…… Interview date……

Ward…… Community……

SECTION A: SOCIO-DEMOGRAPHIC CHARACTERISTICS

Instructions: In this sections please tick (√) in the appropriate boxes that correspond to your answers or complete the spaces provided.

1. Religion: 1.Christianity 2.Islam 3.Traditionalist. 4.Others(specify)……
2. Ethnicity: 1.Yoruba 2.Igbo 3.Hausa 4.Others(specify)……..
3. Level of Education: 1. None 2. Primary 3. Secondary 4. Tertiary
4. Age as at last birthday:……
5. Years in marriage……..
6. Number of children: …….

7. Occupation:1. Civil Servant 2. Trader 3. Driver 4.Artisan 5.Unemployed

9. Who makes the decision about where your wife give birth?

1.Wife 2.Husband 3. My wife and I 4. Others(Specify)……

10. Type of marriage: 1. Monogamy 2. Polygamy

11. If polygamy, how many wives? ……..

SECTION B: Knowledge about Safe Motherhood Initiatives

12. Have you ever heard of the word 'safe motherhood'? (1) Yes

(2) No → Go to Q 15

13. If 'YES', what was your source of information? 1. Media 2. Hospital 3. Friends 4. Others(specify)……..

14. From the options below, choose the one that best describes your understanding of what Safe Motherhood is?

S/N	Statements	Tick
i.	Taking care of a pregnant woman throughout pregnancy	
ii.	Less stress for a woman	
iii.	Less chores	
iv.	Good nutrition	
v.	Going to the hospital for ANC/ checkups	
vi.	Taking prescribed medications	
vii.	Adequate rest after delivery	
viii.	Others(specify)	

15. What would you consider a safe motherhood practice? (No prompting)

S/N	Safe motherhood practice	Tick
i.	Family planning	
ii.	Ante natal care	
iii.	Safe and clean delivery	
iv.	Essential obstetric care	
v.	Nutrition	
vi	Use of medication	
vii	Good exercise	
viii.	Others	

16. Have you ever participated in any of these before? 1.Yes 2.No

17. Have you (your wife) ever used any method of family planning before? 1. Yes 2. No

18. Which one did you (your wife) use? 1.Condom 2.IUD 3.Injection 4.Withdrawal method 5.Drugs

19. Do you know if your wife takes her medications regularly during pregnancy?
1. Yes 2.No 3. I don't know

20. Where does your wife usually seek care during pregnancy?

21. Can problems related to pregnancy or childbirth endanger the life of a woman?
1.Yes 2.No 3.I don't know

22. What are the key danger signs in pregnancy? (No prompting)

S/N	Danger signs during pregnancy	Tick
i.	Bleeding	
ii.	Severe headache	
iii.	Weakness/tiredness	
iv.	Swollen legs and face	
v.	Back pain	
vi.	Malaria	
vii.	Wrong position of baby	
viii	Preterm labour	
ix.	Breech baby	
x.	Hypertension	
xi.	I don't know	
xii.	Others(Specify)	

23. Can a woman die from any of these problems? 1. Yes 2. No 3. I don't know

24. What are the key danger signs during labour?(No prompting)

S/N	Danger signs in labour	Tick
i.	Severe Bleeding	
ii.	Severe headache	
iii.	Convulsion	
iv.	High fever	
v.	Loss of consciousness	
vi.	Others (Specify)	

25. Can a woman die from any of these problems? 1. Yes 2. No 3. I don't know

26. What are the materials one need to put in place before delivery? 1. Cotton Wool 2.Gloves 3. Pads 4. Glucose 5. Spirit 6. Dettol 7. Oil 8. Towel 9. Razor blade 10.Others(specify)……..

SECTION C: Attitude towards Safe Motherhood Initiatives

27. Please indicate whether you agree, are undecided or disagree with the following statements;

	Attitudinal statements	**Agree**	**Undecided**	**Disagree**
i.	Men should accompany their partners to the ANC			
ii.	Men should accompany their wives to the delivery room if allowed			
iii.	It is important that men assist their wives with household chores during pregnancy			
iv.	Men should only help their wives with house chores if she asks			
v.	Men should discuss and plan with their wives on having a new baby			
vi.	Men should accompany their wives to the immunization of their children			
vii.	I can comfortably help my wife with chores even if I am not asked			
viii.	Men should encourage their wives to attend clinics during and after pregnancy			
ix.	Delivery in the health facility is safer than delivery outside a facility			
x.	I can allow my wife undergo caesarean section (CS)			
xi.	Giving birth is a woman's matter, husbands have nothing to contribute.			
xii	As the head of the house, I make decision about family planning, where she gives birth or whether she attends antenatal			

SECTION D: Perception about Safe Motherhood Initiatives

28. Please indicate whether you Agree, are Undecided or Disagree with the following statements

s/no	Statements	Agree	Undecided	disagree
i.	I prefer that my wife delivers with the TBAs than at the health facility			
ii.	I consider men who assist their wives with household chores during pregnancy as weak			
iii.	Accompanying my wife to ANC is likely to ensure good pregnancy outcome			
iv.	I think it is important that men participate more in pregnancy planning			
v.	I believe husbands should be more involved in pregnancy and childbirth			
vi.	I can use any method of contraception			
vii.	I encourage my wife to do family planning			
viii.	I think it is safer to deliver in a hospital			
ix.	I encourage my wife to practice exclusive breastfeeding			
x.	Presence of men at the time of delivery delays the baby			

SECTION E: Factors influencing involvement in Safe Motherhood initiatives

29. Have you ever accompanied your wife to ANC 1.Yes 2.No **If Yes, go to Q31**

30. If NO, can you tell me the three top reasons why you did not?

S/N	Reasons	Tick
i.	Don't think it is necessary	
ii.	Health facility is too far	
iii.	No means of transportation	
iv.	There is no time	
v.	I have to be at work	
vi.	Others	

31. Do people in your community accompany their wives to ANC? 1. Yes 2.No

32. Do people in your community accompany their wives to labour room?

1.Yes 2.No

33. Do you practice male family planning? 1.Yes 2.No **If Yes, go to Q35**

34. If No. Why?

S/N	Reasons	Tick
i.	It is the responsibility of the woman	
ii.	Need more children	
iii.	Religion forbids	
Iv	I do not know where to procure it	
v.	Others: specify	

35. What are the reasons why men do not participate in safe motherhood generally?

S/N	Reasons	Tick
i.	Negative attitude of health workers	
ii.	It doesn't make sense	
iii.	Nonchalant attitude of men	
iv.	No time for such	
v.	Busy work schedule	
vi.	Financial issues	
vii.	Lack of education	
viii.	Others (Specify)	

THANKS FOR YOUR PARTICIPATION IN THIS STUDY.

Iwe ibeere

IMO, IWA ATI ERO AWON OKUNRIN TO TI GBE IYAWO SI IDABOBO AWON ABIYAMO NI AGBEGBE IJOBA IBILE ARIWA, IPINLE OYO, NIGERIA.

Mokiyin o eyin oludahun,

Orukọ mi ni ALABI ZAYNAB ARAMIDE, moje akeko agba Health Promotion And Education Department, FacultyHealth, College of Medicine, University of Ibadan.

Mo n se iwadi lori imo, iwa ati ero awon ọkunrin to tini iyawo si ọna idabobo awon abiyamo.

Awon nkan ti a ba ri kojo ninu iwadi yii yoo je ki a le seto idanileko ati awon ona lati dekun iku abiyamo to ro mo ibimo, a ko ni gba akoko yin pupo.

O ṣeun fun gbigba lati kopa ninu iwadi yi.

Nomba idanimo..... Ojọ iwadi .....

Ward ..... Community .....

IPIN A: Awon Nkan Idanimo Nipa Yin.

1. Esin: 1. Igbagbo 2. Musulumi 3.ibile
   4.Omiran(daruko)……
2. Eya: 1.Yoruba 2.Igbo 3.Hausa
   4.Omiran(daruko)……..
3. Iwe melo leka to ga ju lo? 1.nko lo ile iwe rara 2. Iwe mefa 3. Ile iwe girama 4.ile iwe giga
4. Omo odun melo ni ese ni ojo ibi yin to koja?.....
5. Oto odun melo ti e ti wa ninu igbeyawo yin?.....
6. Omo melo ni olorun bun yin?
7. Ise wo le n se?
9. Ta ni o ma n se ipinu ibi ti iyawo yin a bimo si? 1. Iyawo 2.oko 3. Emi ati iyawo mi 4.elomiran(daruko) ……
10. iyawo melo le ni? 1.oniyawo kan 2. Oniyawo pupo

IPIN B: Imo Nipa Idabobo Awon Abiyamo

12. Nje eti gbo nipa ona idabobo awon abiyamo 1. Beeni 2. beeko → go to Q 15
13. Ti e ba ti gbo nipa ona idabobo awon abiyamo, nibo leti gbo? 1.ero igbe ohun safefe 2.ile iwosan 3.ore 4.omiran (daruko)
14. ewo ninu awon asayan yi ni o se apejuwe oye yin nipa idabobo awon abiyamo

S/N	Statements	Tick
i.	Itoju alaboyun ninu oyun	
ii.	Didin wahala ku	
iii.	Didin ise sise ku	
iv.	Jije ounje to dara	
v.	Lilo ile iwosan fun itoju igbadegba awon alaboyun	
vi.	Lilo awon oogun tiwon ko fun alaboyun	
vii.	Isinmo leyin ibimo	
viii.	Omiran(Daruko)	

15. daruko awon ona ti a le gba dabobo awon abiyamo tio mo

i.	Ifeto somo bibi	
ii.	Itoju ninu oyun	
iii.	Ibimo to mo ti ko mu ewu dani	
iv.	Aboju to topeye fun obinrin	
v.	Jije ounje to peye	
vi.	Ogun lilo	
vii.	Idaraya	
v.	Omiran	

16. Nje e ti kopa ninu eyikeyi awon nkan wonyi ri? 1. beeni 2. beeko

17. Nje e ti lo ona kankan fun ifeto somo bibi ri? 1. beeni 2. beeko

18. Iru ewo le lo?

19.Nje e mo boya iyawo yin man lo awon ogun won deedee ninu oyun. 1.beeni 2. beeko

20.ibo ni iyawo yin ti ma n gba itoju ninu oyun?

21. se awon isoro to jemo oyun abi ibimo le mu ewu ba alaboyun?

22. kini awon koko ami to tokasi ewu ninu oyun?

i.	Eje yiya	
ii.	Efori to lagbara	
iii.	Ki o maa re alaboyun	
iv.	Ese ati oju wiwu	
v.	Eyin riro	
vi.	Iba	

vii.	Ki omo o dabu	
viii.	Riro bi lai to ojo	
ix.	Ige	
x.	Eje riru	
xi.	N ko mo	
xii.	Omiran(daruko)	

23. Nje alaboyun le ti ara awon isoro wonyi ku?

24. . Kini awon koko ami to tokasi ewu nigba irobi?

i.	Eje yiya	
ii.	Efori to lagbara	
iii.	Giri	
iv.	Ara gbigbona	
v.	Didaku	
vi.	Omiran	

25. Nje alaboyun le ti ara awon isoro wonyi ku?

26. Kini awon nkan ti alaboyun ni lati pese sile de ibimo?

……

IPIN C: Iwa Si Ona Idabobo Awon Abiyamo

27. E jowo e so boya e fara mo, e ko fara mo abi e ko mo si awon gbolohun yi

	Gbolohun	Mo fara mo	Mi o mo	Mi o fara mo
i.	Okunrin gbodo maa tele iyawo won lo si ile iwosan itoju alaboyun			
ii.	Awon okunrin gbodo maa tele iyawo wo yara ibimo ti wonba gba won laaye			
iii.	O se pataki ki awon okunrin o maa ran iyawo won lowo nipa sise ise ile ninu oyun			
iv.	Igbati iyawo ba beere fun iranlowo nikan nikiwon o ran lowo			
v.	Awon okunrin gbodo jiroro pelu iyawo won nipa bibi omo miran			

vi.	Awon okunrin gbodo maa tele iyawo won lo si ibi abere ajesara			
vii.	O ro mi lorun daadaa lati ba iyawo mi sise ile koda bi ko ba bimi			
viii.	Awon okunrin gbodo maa gba iyawo won niyanju lati maa lo gba itojunile iwosan ninu oyun ati leyin ibimo			
ix.	Bibimo si ile iwosan fokanbale ju bibimo si ibomiran			
x.	Mo le gba ki iyawwo mi bimo pelu ise abe			
xi.	Ibimo je ise obinrin, ko si kan oko rara			
xii	Gege bi olori ile, emi ni mo man se ipinu nipa ifeto somo bibi, ibi ibimo abi boya iyawo mi yoo lo si ile iwosan itoju alaboyun			

IPIN D: ero nipa Ona Idabobo Awon Abiyamo

28. **: Iwa Si Ona Idabobo Awon Abiyamo**

s/no	Gbolohun	Mo fara mo	Mi o mo	Mi o mo
i.	Mo feran ki iyawo mi bimo si odo awon baba abiwere ibile ju ile iwosan lo			
ii.	Mo ri awon okunrin to ba n ran iyawo won lowo nipaise ile ninu oyungege bii gbewu dani okunrin			
iii.	Mima tele iyawo mi lo si ile itoju alaboyun yoo fa ki iya o bi were			
iv.	Mo lero pe ose pataki ki awon okunrin o maa kopa ninu igbaradi fun oyun nini			
v.	Mo gbagbo pe awon okunrin gbodo ma kopa daadaa ninu oyun ati ibimo			
vi.	Mo le lo eyikeyi ona lati dena oyun			
vii.	Mo ma n ro iyawo mi lati se ifeto somo			

	bibi			
viii.	Mo lero wipe o fokanbale lati bimo si ile iwosan			
Ix	Mo ro iyawo mi lati fun omo ni omu fun igba pipe			
x.	Wiwa nibe oko nigba ibimo lee fa ki irobi o pe ju bo she ye lo			

IPIN E: awon nkan to n dena ikopa okunrin ninu idabobo awon abiyamo

29. Nje eti tele iyawo yin lo si ile iwosan itoju alaboyun ri? 1. Yes 2. No

30. Bi eko ba tele won ri, nje e le so idi meta pato ti e ko fi tele won?

i.	Mi o lero pe ose pataki	
ii.	Ile itoju ti jina ju	
iii.	Nko ni oko	
iv.	Ko si aaye	
v.	Maa lo si ibise	
vi.	Omiran	

31. Se awon ara agbegbe yi a maa tele iyawo won lo si ile itoju alaboyu? 1.Yes 2.No

32. Se awon ara agbegbe yi a maa tele iyawo won wo yara ibimo

33. Nje e n se ifeto somo bibi fun okunrin?

34. Bi e ko ba she, kini idi?

i.	O je ojuse obinrin	
ii.	Mo n fe omo si	
Iii.	Esin o faye gba be	
iv.	Nko mo ibi ti moti le se	
v.	Omiran:daruko	

35. kini awon idi to awon okunrin kii fin kopa ninu idabobo abiyamo?

S/N	Idi	Toka
i.	Iwa odi awon eleto ilera	
ii.	Ko ni itumo	
iii.	Ailakakun awon okunrin	
iv.	Ko si aye fun irufe nkan be	

v.	Ise ma n gba akoko mi	
vi.	Oro lori owo	
vii.	Ai kawe	
viii.	Omiran (daruko)	