

## **Male Partner Involvement In Antenatal Care Services In Mumias East And West Sub-Counties, Kakamega County, Kenya**

Sally Jepkosgei Kiptoo<sup>1</sup> Dr. Mary Kipmerewo<sup>1</sup>

<sup>1</sup> *School of Nursing and Midwifery, Masinde Muliro University of Science and Technology, Kenya*

---

**Abstract:** Male participation in the Antenatal Care is essential for realization of socio-cultural and economic development. The significance of the male was noted as he is the head of the house and has strong influence on decision making in his family. This research was guided by use of cross-sectional survey in which both qualitative and quantitative data was collected. Data was obtained by means of questionnaires, interview guides and observation schedules. Questionnaires were used to collect primary data. Secondary data was collected from documented information to support primary data. The men who accompanied their wives/partners were also engaged in an in-depth interview to examine their reasons for coming to the clinic. The data collected was processed, coded and analyzed using Statistical Package for Social sciences (SPSS). The study results showed that the clients were impressively aware of the services offered and other activities carried out in the clinic but there was need for the facility especially the clinic area to improve in terms of space and sitting arrangements to accommodate all mothers and their spouses comfortably and add more doctors to facilitate quick and quality services to the clients. Additionally, there is need to advocate for policy change so that the government can pass laws which oblige men to be responsible for their unborn babies and their pregnant partners especially financially and emotionally.

**Keywords** – *Anti-natal care, Male partner involvement,*

---

### **I. Introduction**

Antenatal care (also known as prenatal care) refers to the regular medical and nursing care recommended for women during pregnancy. Prenatal care is a type of preventative care with the goal of providing regular check-ups that allow doctors or midwives to treat and prevent potential health problems throughout the course of the pregnancy while promoting healthy lifestyles that benefit both mother and child (Aarnio *et al.*, 2009). During check-ups, women will receive medical information over maternal physiological changes in pregnancy, biological changes, and prenatal nutrition including prenatal vitamins. Recommendations on management and healthy lifestyle changes are also made during regular check-ups. The availability of routine prenatal care has played a part in reducing maternal death rates and miscarriages as well as birth defects, low birth weight and other preventable health problems (Backstrom & Wahn, 2009).

The behavior of men, their beliefs and attitudes affect the maternal health outcomes of women and their babies. The exclusion of men from maternal health care services could lead to few women seeking maternal health services and as a result worsening the negative maternal health outcomes for women and children. Increasingly, recognition is growing on a global scale that involvement of men in reproductive health policy and service delivery offers both men and women important benefits (Amou *et al.*, 2011).

Male involvement in reproductive health is a complex process of social and behavioral change that requires men to play a more responsible role in reproductive health. It not only implies contraceptive acceptance but also refers to the need to change men's attitude and behavior towards women's health, to make them more supportive of women using health care services and sharing child-bearing activities (Anderson & Caldwell, 2011). Participation of men in reproductive health leads to better understanding between husband and wife, it reduces not only unwanted pregnancies but also reduces maternal and child mortality in connection with pregnancy and labor by being prepared in obstetric emergencies (Babalola & Adesegun, 2009).

In South Africa, as in most other African countries, family planning, pregnancy and childbirth have long been regarded as exclusively women's affairs (Wassie *et al.* 2014). Men generally do not accompany their partners to family planning, antenatal or postnatal care services and are not expected to attend the labour or birth of their children. However, male dominance socially and in sexual relations can put women at serious risk of unwanted pregnancy and infection; in pregnancy, male sexual behaviour can affect the health outcomes of both mother and baby (USAID, 2010). Their lack of participation at family planning, antenatal and postnatal consultations

means that they do not benefit from any information given by health providers, regarding the health of mother and baby, or about their role in it. In addition, men are rarely exposed to clinic reproductive health services as they tend to seek care for sexually transmitted infections (STIs) in the private sector, and condoms can be obtained from clinics without contact with providers. The issue of accessibility of reproductive health (RH) services to men in South Africa is a logistical and cultural problem. The exclusive use of services by women has, to a great extent, made RH services unfriendly for men.

Male involvement in the antenatal care (ANC) clearly goes against prevailing gender norms in many places in Sub-Saharan Africa (SSA) (Lotching, 2010). Reproductive health seeking was seen by men as “women’s work”. Men saw the antenatal clinic as women’s space, and the definition and organization of the program as fundamentally female oriented (Reece, *et al.* 2010). Predictably, men thought that antenatal clinic activities fell outside their area of responsibility. Consequently, men perceived that attending the antenatal clinic would be “unmanly”. This paper sought to examine male partner involvement in antenatal care services in Mumias East and West sub-counties in Kakamega County, Kenya.

## **II. Literature review**

It is important to note that to increase male involvement in maternal health care services requires the providers to gain in-depth knowledge and understanding of the men’s health perspectives, behavior and practices (Some, 2013). Although pregnancy is not an illness, it creates a lot of physical and emotional demands on the mother. The husbands as well as other family members need to understand and appreciate the discomfort and tiredness that pregnancy may cause to the pregnant woman. The awareness about the demands of pregnancy on the part of the husband and other family members could result into the necessary support the pregnant woman needs from the family members including the husband (Sapkota *et al.* 2012).

The key elements of the birth plan package include recognition of danger signs, a plan for a birth attendant, a plan for the place of delivery, and saving money for transport or other costs in case the need arises (UNAIDS, 2012). In addition, for birth preparedness, a potential blood donor and a decision-maker (in case of emergencies) need to be identified. This is because complications such as hemorrhage are unpredictable and highly fatal if timely treatment is not obtained. Essential interventions in antenatal clinic include identification and management of obstetric complications such as pre-eclampsia, tetanus toxoid immunization, intermittent preventive treatment for malaria during pregnancy (IPTp), and identification and management of Infections including HIV, syphilis and other sexually transmitted infections (STIs) (WHO, 2012). ANC is also an opportunity to promote the use of skilled attendance at birth and healthy behavior such as breastfeeding, early postnatal care and planning for optimal pregnancy spacing.

Globally, low male involvement in maternal health care services remains a problem to health care providers and policy makers. Since the Cairo International Conference on Population and Development, (ICPD) (1994), and the Beijing World Conference for Women (1995), a lot of emphasis has been to encourage male involvement in reproductive health including maternal health (WHO, 2012). At the 1994 ICPD in Cairo the participating nations (179 nations) agreed on the action plan, which stated that “Changes in both men’s and women’s knowledge, attitudes, and behavior are necessary conditions for achieving a harmonious partnership between men and women on issues of sexuality and reproductive health” (Longworth & Kingdon, 2010).

In sub-Saharan Africa, pregnancy and childbirth continue to be viewed as solely a woman’s issues. A male companion at antenatal care is rare and in many communities, it is unthinkable to find male companions accompanying a woman to the labour room during delivery. However, men have social and economic power, especially in Africa, and have tremendous control over their partners (Mullany, 2009). They decide the timing and conditions of sexual relations, family size, and whether their spouse will utilize available health care services. Hence this situation makes male partner involvement critical if improvement in maternal health and reduction of maternal morbidity and mortality is to be realized.

Strategies for involving men in maternal health services should aim at raising their awareness about emergency obstetric conditions, and engaging them in birth preparedness and complication readiness (Nanjala & Wamalwa, 2012). Male involvement will enable men to support their spouses to utilize emergency obstetric services early and the prepare for birth and ready themselves for complications. This would lead to a reduction in all three phases of delay and thereby positively impact birth outcomes (kakaire, et al, 2011).

Studies have shown that men who are educated about reproductive health issues are more likely to support their partners in contraceptive use, use contraception themselves, and demonstrate greater responsibility for their

children (Grady et al. 1996). More importantly, women express great interest in wanting their partners to be involved in joint reproductive health decision-making. For example, a study in Ecuador surprisingly showed that 89% of women wanted their partner to accompany them on their next family planning visit and 94% would have liked their partner to be present during their family planning session (Roy & de Vargas Pinto, 1999; Mehta, 2002). Studies have suggested that male involvement in maternal health results into positive outcome for not only the pregnant woman but also for the unborn child. Reporting findings of their studies Pagel et al. (1990), and Mutale et al. (1991), concluded that lack of social support; especially from the husbands or family has negative effects on fetal growth.

In much poorer countries many of which have a patriarchal society, increase in male involvement during pregnancy has been seen as a possible factor in reducing the number of children born with low birth weight (Mira and UNICEF, 2000). However despite these benefits of male involvement in maternal health care services, the majority of interventions and services to promote SRH including care during pregnancy and childbirth in most countries have been exclusively focused on women (Ntabona, 2002). Yet it is important to assume that for all the steps leading to maternal survival there is always a man standing by the side of every woman knocking at the gate, before, during and after each pregnancy (WHO, 1995).

Some 24 studies from peerreviewed journals; 21 from sub-Saharan Africa, 2 from Asia and 1 from Europe identified barriers to male involvement as mainly at the level of the societal perception of antenatal care (ANC) as a woman's activity, and it was unacceptable for men to be involved, the health system factors such as long waiting times at the ANCS and the male unfriendliness of ANC services were also identified. The lack of communication within the couple, the reluctance of men to learn their Human Immunodeficiency Virus (HIV) status, the misconception by men that their spouse's serostatus was a proxy of theirs, and the unwillingness of women to get their partners involved due to fear of domestic violence, stigmatization or divorce was among the individual factors.

According to World Health Organizations (WHO, 2007), the Partnership for Maternal, Newborn and Child Health (PMNCH) reports showed that in Swaziland, HIV prevalence among pregnant women attending ANC arose from 4% in 1992 to 43% in 2004 and that each day, 1800 children worldwide become infected with HIV, the vast majority of them newborns (Bhatta, 2013). Therefore, in this regard, PMNCH works to invest, deliver and advance to save lives of women and young children with HIV/AIDS. To achieve all these fundamental goals effectively and quickly, investing in the education and involvement of men during/after pregnancy and in programs for mothers living with HIV/AIDS is very crucial. Moreover, there is need to advance the engagement of men in the ANC as PMTCT efforts may fail without their support. "When men test, adherence to PMTCT may increase" (Ilyasu et al. 2010). One study has demonstrated a reduction in HIV-associated infant mortality and poor feeding options (Feldman et al., 2010). Male-partner involvement may also lower transmission risk to sexual partners, which has been shown to be greatest within established partnerships (Dunkle et al. 2008), and increased during pregnancy (Kainz et al. 2010).

In a study which examined the male spousal participation in Western Kenya, of 2104 pregnant women who accepted voluntary counseling and testing (VCT), 15% of these women and their male spouses received testing, while only 5% of couples received counseling together (Kakire et al. 2011). Male partner support has been shown to be a crucial component in facilitating women's ability to accept preventive interventions. Women who disclosed their HIV status to their partners were more likely to return for post-test counseling, three times more likely to adhere to their ARV prophylaxis/ treatment during pregnancy and at the time of delivery, and five times more likely to adhere to prescribed breastfeeding protocols, accept and modify infant feeding practices and increase condom use in the postpartum period than those who did not (Danforth et al. 2009).

Men are clearly asking for more participation in the childbirth process. It is also interesting to note how, in a recent survey on men and work, 75% of the men would accept slower career advancement if they could have a job that would let them arrange their work schedule to have more time with their families (David, 2012). At the prospect of becoming a father, men are filled with excitement, fear, wonder, worry, love, and confusion. Throughout the pregnancy and birth, the man, who is now becoming a father, is trying to find ways to express and integrate these and many more feelings. In contrast, other programs have been successful in achieving greater participation of couples during expanded weekend hours (Kulunya et al. 2012).

By giving women emotional and instrumental support, men can also clearly positively affect women's attitude towards pregnancy (Nkuoh et al., 2010). During pregnancy and delivery men can give important psychological and emotional support to the women (Early, 2001). There are evidences suggesting that men's presence in the

labor room shortens the period of labor and reduce the number of children ever born with low birth weight (Plantin *et al.* 2011).

### **III. Research methodology**

#### **3.1 Research design**

Since the study was community based, it employed the use of descriptive cross-sectional research design. This resulted in the use of structured questionnaires in collected information from the respondents. Focused group discussions were also conducted separately for male and women.

#### **3.2 The Area of Study**

The study was based in Mumias East and Mumias West sub counties located in Kakamega County in the western part of Kenya. Mumias East covers a surface area of 134.6 Km<sup>2</sup> with a total population of 117,294 people. While Mumias west covers a surface area of 191.8 Km<sup>2</sup> and a population of 129,965 (KNBS, 2009; Census 2009). Administratively Mumias sub-counties have 4 Divisions, 15 locations, 30 sub locations and 370 villages. Mumias East and west sub counties initially was one sub county under one administration till 2013, when Kenya adopted the County administration. Culturally ‘Abawanga’ community in Mumias encouraged polygamy which was interpreted as being wealthy because the man could afford to pay dowry. This has so far reduced because of education, and Christianity. Like Kakamega County, Mumias has rain almost throughout the year with two main rainy seasons, that is one long and another short rainy seasons. This favors agriculture which included planting of maize, sorghum, millet and cassava. Their staple food was “ugali”. Sugar cane was the major cash crop in the area and this has taken more land leaving the community with small pieces of land to plant various kinds of food. The Abawanga community in Mumias has twenty one sub clans. There are two main religions in the area mainly Christianity and approximately 20% Muslims. The Aba Wanga kingdom was visited by Arab and Swahili slave traders during the reign of Nabongo Mumia and this brought about Islam religion in the Wanga community compared to other Luhyas in Kakamega County.

#### **3.3 Study and sample Population**

The study investigated male partner involvement during pregnancy, labor and delivery and postnatal period in Mumias East and Mumias West sub counties, Kakamega County. The study population comprised of couples (man and wife) of 18 years of age and above in the study area, who were married and had a child in the last one year(≤ 1 year) preceding the study.

#### **3.4 Sampling Technique and sample size determination**

##### **3.4.1 Sampling technique**

The research used stratified probability sampling of households in the area of study because it gives` the most representative data (Kothari, 2004). Stratified probability sampling is a technique whereby the researcher divides the entire population into different subgroups or strata, then randomly selects the final subjects proportionally from the different strata (Mugenda & Mugenda, 2003). The subjects were identified through households. The household were systematically selected from one household to the other as long as subjects who meet the criteria were interviewed until the number of required samples of 424 participants were attained.

##### **3.4.1 Sample Size**

Sample size determination was calculated using the fishers’ method formula (fisher *et al.*, 1998)

$$n = \frac{z^2 p q}{d^2}$$

**Where:**

n = the desired sample size (if population is greater than 10,000)

z = the standard normal deviation at the required confidence level.

P = the proportion in the target population estimated to have characteristic being measured.

q= 1-p

d = the level of statistical significance level

If there is no estimate available the proportion in the target population assumed to have the characteristics of interest, 50% should be used as recommended by Fisher *et al.*, 1983.

$$\begin{aligned}n &= \frac{(1.96)^2 \times 0.5 \times 0.5}{(0.05)^2} \\&= 384 (\text{add } 10\% \text{ of } 384) \text{ i.e. } 384.4 \\&= 422.4 (423) \\&= 211.5 \\&= 212 \text{ couples (212 men: 212 women)} = 424 \text{ Participants}\end{aligned}$$

### **3.5 Methods of Data Collection**

The study used both primary and secondary sources in data collection. Primary data was collected through the questionnaires, interview schedules, Focus Group Discussion, and observation. On the other hand, secondary data was collected through document and content analysis guide to ascertain an in-depth analysis on male involvement in antenatal care.

### **3.6 Reliability and Validity of Data Instruments**

#### **3.6.1 Reliability**

The researcher used test and retest techniques, where the same data instrument was administered twice to the same respondents after a period of 2 weeks. To achieve this, a pilot study was carried out in Malava Sub-County which was randomly selected from other Sub-Counties in Kakamega County before the actual collection of data for the study to determine the suitability of the instruments to be used and the procedures for data collection to ascertain their reliability and validity. Thereafter, from the responses using SPSS, a reliability of Pearson correlation co-efficient of 0.5 was taken to imply that the instruments were reliable.

#### **3.6.2 Validity**

The researcher used content validity so as to ascertain whether the tools measured were stated in the objectives. This was done through cross checking with the supervisors. This meant that the researcher content validity measures contained all possible items that were used in measuring the concept. In this study, a valid measure of 0.5 was acceptable as in Spearman correlation coefficient.

### **3.7 Data Analysis**

Data collected was analyzed by assigning numerical values to each response and entered into a code book or coding table. There after the numerical numbers representing responses from the questionnaires were transferred to a code sheet so as to obtain quantitative results from the closed-ended questionnaires. After this, simple statistics was used by the researcher to analyze the data from the questionnaires and interview schedules using percentages, frequency tables, and narrative description of the tables. Later these results was summarized, interpreted, and reported.

## **IV. RESULTS**

A total of 424 respondents consented and participated in the study. From this, 212 were men respondents and 212 women respondents. Most of the male respondents 88 (41.7 %) were between the ages of 25-29 years same as the female respondents between 20-24 years old who were also 88 (41.7%). On the hand, (8) 3.8% of the male and (9) 4.3% of the female respondents marry between the ages of 15-19 years. Majority 183 (89.1%) of the male respondents when grouped into two were between the ages of 15-34 years while minority 23 (10.9%) were between the ages of 35-49 years. The majority 194 (92.0%) of the female respondents were between the ages of 15-34 years, while minority 17 (8.0%) were between 34-49 years (Table 1).

The Male respondents 97 (46%) and female respondents 123 (58.3%) had attained primary level of education. However, a few male respondents 34 (16.1%) and female respondents 12 (5.7%) had obtained the tertiary level of education. It was also noted that 34 (16.1%) of the female respondents and 15 (7.1%) of male respondents had no basic education. Majority of the respondents 168 (79.6%) were in a monogamous type of family and both male and women respondents were in agreement.

In relation to employment, 61 (28.9%) of the male were unemployed while 112 (53.1%) of the female were unemployed. Male respondents who were employed by the Government sector was at 29 (13.7%) compared to 10 (4.7%) of female respondents. Most of the respondents are casual labourers with female respondents leading with 66 (31.3%) compared to 52 (24.6%) of the male respondents. More males 43 (20.4%) were self-employed as compared to 7 (3.3%) of the female respondents who are self-employed.

**Table 1: Demographic characteristic of the respondents**

| Variable             |                            | Male              |                   | Female            |       |
|----------------------|----------------------------|-------------------|-------------------|-------------------|-------|
|                      |                            | N                 | %                 | N                 | %     |
| Age                  | 15-19                      | 8                 | 3.8               | 9                 | 4.3   |
|                      | 20-24                      | 61                | 28.9              | 88                | 41.7  |
|                      | 25-29                      | 88                | 41.7              | 76                | 36.0  |
|                      | 30-34                      | 31                | 14.7              | 21                | 10    |
|                      | 35-39                      | 13                | 6.2               | 11                | 5.2   |
|                      | 40-44                      | 7                 | 3.3               | 4                 | 1.9   |
|                      | 45-49                      | 3                 | 1.4               | 2                 | 0.9   |
|                      | Total                      | 211               | 100.0             | 211               | 100.0 |
| $\bar{X} \pm SD (R)$ |                            | [27.3 ± 5.83(30)] |                   | [26.0 ± 4.83(27)] |       |
| Education            | No education               | 15                | 7.1               | 34                | 16.1  |
|                      | Primary                    | 97                | 46.0              | 123               | 58.3  |
|                      | Secondary                  | 65                | 30.8              | 42                | 19.9  |
|                      | Tertiary                   | 34                | 16.1              | 12                | 5.7   |
|                      | Total                      | 211               | 100.0             | 211               | 100.0 |
| Variable             |                            | Male              |                   | Female            |       |
|                      |                            | Y                 | N                 | Y                 | N     |
| Type of Marriage     | Monogamy                   | 168               | 79.6              | 165               | 78.2  |
|                      | Polygamy                   | 43                | 20.4              | 46                | 21.8  |
| Occupation           | Unemployed                 | 61                | 28.9              | 112               | 53.1  |
|                      | Self-employed              | 43                | 20.4              | 7                 | 3.3   |
|                      | Casual labour              | 52                | 24.6              | 66                | 31.3  |
|                      | Employed private sector    | 26                | 12.3              | 16                | 7.6   |
|                      | Employed government sector | 29                | 13.7              | 10                | 4.7   |
|                      | Total                      | 211               | 100.0             | 211               | 100.0 |
| Religion             | Christian                  | 173               | 82.0              | 160               | 75.8  |
|                      | Muslim                     | 38                | 18.0              | 51                | 24.2  |
|                      | Total                      | 211               | 100.0             | 211               | 100.0 |
| Period of marriage   | ≤10 years                  | 127               | 60.2              | 127               | 60.2  |
|                      | >10 Years                  | 84                | 39.8              | 84                | 39.8  |
|                      | Total                      | 211               | 100               | 211               | 100   |
| Number of children   | 1                          | 12                | 5.7               | 12                | 5.7   |
|                      | 2-4                        | 187               | 88.6              | 187               | 88.6  |
|                      | 5-7                        | 7                 | 3.3               | 7                 | 3.3   |
|                      | Above 7                    | 5                 | 2.4               | 5                 | 2.4   |
|                      | Total                      | 211               | 100.0             | 211               | 100.0 |
|                      | $\bar{X} \pm SD (R)$       |                   | 2.17 ± 5.0.708(8) |                   |       |

A high proportion 172 (82.0%) of the respondents were Christians with majority of them having 2-4 children and 187(88.6%) of the respondents had been in marriage for ten years and below.

**4.2 Antenatal clinic’s environment and its influence on male participation**

When asked their opinion on the antenatal clinic’s set-up, 47% of the women who responded said that the clinic was clean and in perfect condition whereas, the rest gave a few issues which included congestion in the clinic citing that they could not fit in together with their spouses which resulted to men standing throughout the clinic session because of the shortage of seats. This facilitated poor male participation because the men get bored in the process and end up leaving unattended. 12.5% of the mothers also felt the clinic was quite slow with very long queues in every service being provided ending up disorganized. This puts off the men since most of them just get few hours off permission from their employers to attend the clinic which results to a whole day’s agenda. This is further demonstrated in Table 2 below.

**Table 2 Opinion on ANC environment**

|  | Frequency | % of response |
|--|-----------|---------------|
| Small space/congested                  | 34        | 8.0           |
| Less benches/Seats                     | 47        | 11.0          |
| Clean                                  | 21        | 5.0           |
| Few male staffs                        | 17        | 4.0           |
| Delay in clinic/long queues            | 53        | 12.5          |
| Mother going on without being attended | 28        | 6.5           |
| Concerned about clients                | 23        | 5.5           |
| Wanting services                       | 42        | 10.0          |

Three percent of the women said that men are uncomfortable with pregnant women and are shy so they did not want to be around them and more so, in a place with so many of them. This was evidenced also where 15% mothers said that their men often complain of so much of the femininity in the clinic where men’s lavatories are also absent. This forces the few men who participate in the clinic to go seek for washrooms from other clinics. This has therefore been a contributor to men avoiding the clinic. 9% of respondents reported that fear of HIV test outcomes is also a factor as men want to test by proxy, where they assume that whatever HIV status their wives hold reflects to theirs too. Busy schedules, congestion/insufficient space, rude staff, financial constraints and selfishness are other factors that were cited as making the men not come to the clinic.

**4.3 Male partner influence on pregnant women’s decision to seek antenatal clinic service**

Male’s influence involves men accompanying their wives to the health facility for antenatal care. It also involves men being involved in decision on where and whether the wife should attend antenatal care.

**4.3.1 Antenatal Care attendance**

The Pregnant women are expected to attend four focused antenatal visits to ensure quality antenatal care. This enables care and early interventions to promote good maternal health and prevent complications during pregnancy, including labour and postnatal period.

From the analysis of odd ratio, it showed that, type of marriage (OR: 1.3) and living together (OR: 1.9) are more likely to influence the pregnant woman’s decision to seek antenatal care service.

**Table 3: Male partner socio demographic factors and influence on wife attendance for antenatal care**

| Variable  |              | wife attended antenatal clinic |          | Chi-square | df | p-value | Odd ratio | 95% Confidence Interval |       |
|---|--------------|--------------------------------|----------|------------|----|---------|-----------|-------------------------|-------|
|   |              | Yes                            | No       |            |    |         |           | Lower                   | Upper |
| Age   | 15-34        | 183                            | 5        | 0.627      | 1  | 0.429   | 0.973     | 0.75                    | 2.00  |
|   | 35-49        | 23                             | 0        |            |    |         |           |                         |       |
| <b>Total</b>  |              | <b>206</b>                     | <b>5</b> |            |    |         |           |                         |       |
| Type of marriage  | Monogamy     | 168                            | 0        | 20.009     | 1  | 0.001   | 1.132     | 0.95                    | 2.55  |
|   | Polygamy     | 38                             | 5        |            |    |         |           |                         |       |
| <b>Total</b>  |              | <b>206</b>                     | <b>5</b> |            |    |         |           |                         |       |
| Living together with wife at the time of her last pregnancy | Yes          | 183                            | 4        | 0.378      | 1  | 0.539   | 1.989     | 1.25                    | 3.95  |
|   | No           | 23                             | 1        |            |    |         |           |                         |       |
| <b>Total</b>  |              | <b>206</b>                     | <b>5</b> |            |    |         |           |                         |       |
| Education   | Education    | 175                            | 5        | 0.882      | 1  | 0.348   | 0.972     | 0.45                    | 1.75  |
|   | No education | 31                             | 0        |            |    |         |           |                         |       |
| <b>Total</b>  |              | <b>206</b>                     | <b>5</b> |            |    |         |           |                         |       |
| Occupation  | Employed     | 145                            | 5        | 2.083      | 1  | 0.149   | 3.967     | 2.50                    | 7.55  |
|   | Unemployed   | 61                             | 0        |            |    |         |           |                         |       |
| <b>Total</b>  |              | <b>206</b>                     | <b>5</b> |            |    |         |           |                         |       |

**4.3.2 Male partner decision on where the wife attended antenatal clinic**

The study sought to find out whether socio-demographic factors influenced the male partner to be involved in the decision on where the pregnant woman attended the antenatal clinic. It was found out that the male partners age, education and occupation was a significant factor on male partners being involved in the decision on where the wife attended ANC ( $p = 0.001$ ). However, there is no association in the type of marriage and living together to influence the man to be involved in the decision on where the woman attended the antenatal clinic ( $p = 0.469$ ;  $0.154$ ). From the analysis of odd ratio, it revealed that, living together (OR= 2.064), education (OR= 2.030) and occupation (2.103) was two times more likely to influence the male partner to be involved in the decision on where the woman attended the antenatal clinic service than age and type of marriage (OR= 0.480 ; 0.687) (Table 4).

**Table 4: Male partners involved in decision on where the pregnant woman attended antenatal clinic**

|   |              | Involved in the decision on where wife attended antenatal care |    | Chi-square | Df | P-value | Odd ratio | 95% confidence interval |       |
|---|--------------|--|----|------------|----|---------|-----------|-------------------------|-------|
|   |              | Yes  | No |            |    |         |           | Lower                   | Upper |
| Age   | 15-34        | 179  | 9  | 144.396    | 1  | 0.001   | 0.480     | 0.15                    | 1.95  |
|   | 35-49        | 0  | 23 |            |    |         |           |                         |       |
| Total   |              | 179  | 32 |            |    |         |           |                         |       |
| Type of marriage  | Monogamy     | 141  | 27 | 0.525      | 1  | 0.469   | 0.687     | 0.25                    | 1.50  |
|   | Polygamy     | 38   | 5  |            |    |         |           |                         |       |
| Total   |              | 179  | 32 |            |    |         |           |                         |       |
| Living together with wife at the time of her last pregnancy | Yes          | 161  | 26 | 2.036      | 1  | 0.154   | 2.064     | 1.25                    | 3.75  |
|   | No           | 18   | 6  |            |    |         |           |                         |       |
| Total   |              | 179  | 32 |            |    |         |           |                         |       |
| Education   | Education    | 165  | 15 | 44.455     | 1  | 0.001   | 2.030     | 1.35                    | 3.65  |
|   | No education | 14   | 17 |            |    |         |           |                         |       |
| Total   |              | 179  | 32 |            |    |         |           |                         |       |
| Occupation  | Employed     | 150  | 0  | 92.756     | 1  | 0.001   | 2.103     | 1.50                    | 4.50  |
|   | Unemployed   | 29   | 32 |            |    |         |           |                         |       |
| Total   |              | 179  | 32 |            |    |         |           |                         |       |

**4.3.3 Male partner accompanying pregnant women to the antenatal**

The analysis showed that the socio-demographic factors influenced the man to accompany the woman to attend the antenatal clinic. The age, type of marriage, education and occupation of the respondents had influence on the man to accompany the woman to attend the antenatal care but living together does not influence the man to attend the antenatal care. From the analysis of odd ratio, the analysis shows that living together was 1.4 times more likely to influence the man to accompany the pregnant woman to the antenatal clinic than age, type of marriage, education and occupation (OR 1.4).

*Table 4.2: Male partner accompanying wife to antenatal clinic*

|   |              | Accompanied wife to the antenatal clinic during her last pregnancy |     | Chi-square | df | P-value | Odd ratio | 95% Confidence Interval |       |
|---|--------------|--|-----|------------|----|---------|-----------|-------------------------|-------|
|   |              | Yes  | No  |            |    |         |           | Lower                   | Upper |
| Age   | 15-35        | 103  | 85  | 24.619     | 1  | 0.001   | 0.432     | 0.15                    | 1.95  |
|   | 35-49        | 0  | 23  |            |    |         |           |                         |       |
| Total   |              | 103  | 108 |            |    |         |           |                         |       |
| Type of marriage  | Monogamy     | 65   | 103 | 32.821     | 1  | 0.001   | 0.083     | 0.10                    | 0.75  |
|   | Polygamy     | 38   | 5   |            |    |         |           |                         |       |
| Total   |              | 103  | 108 |            |    |         |           |                         |       |
| Living together with wife at the time of her last pregnancy | Yes          | 93   | 94  | 0.554      | 1  | 0.457   | 1.385     | 1.25                    | 2.75  |
|   | No           | 10   | 14  |            |    |         |           |                         |       |
| Total   |              | 103  | 108 |            |    |         |           |                         |       |
| Education   | Education    | 103  | 77  | 34.657     | 1  | 0.001   | 0.428     | 0.25                    | 1.85  |
|   | No education | 0  | 31  |            |    |         |           |                         |       |
| Total   |              | 103  | 108 |            |    |         |           |                         |       |
| Occupation  | Employed     | 103  | 47  | 81.834     | 1  | 0.001   | 0.313     | 0.15                    | 1.75  |
|   | Unemployed   | 0  | 61  |            |    |         |           |                         |       |
| Total   |              | 103  | 108 |            |    |         |           |                         |       |



### 4.3.5 Accompanying wife for ANC

To find out whether accompanying wife to antenatal clinic influenced the pregnant woman decision to seek antenatal care. Linear regression was used to find out whether there is any significant prediction in male's influence on pregnant woman's decision to seek antenatal care. The null hypothesis was tested at 0.05 significance level. From the analysis, at 5% significance level, the null hypothesis was rejected that there is no male's influence on pregnant woman's decision to seek antenatal clinic. Therefore male's partner influence on pregnant woman's decision to seek antenatal care is influenced by occupation ( $P= 0.001$ ) but not the age or educational level of the respondents (Table 5).

**Table 3: Accompanying wife for ANC (Linear regression)**

| Model |                    | Unstandardized Coefficients |            | Standardized Coefficients | t      | Sig. |
|-------|--------------------|-----------------------------|------------|---------------------------|--------|------|
|       |                    | B                           | Std. Error | Beta                      |        |      |
|       | (Constant)         | 4.890                       | .156       |                           | 31.256 | .000 |
|       | Education          | .569                        | .146       | .342                      | 3.892  | .363 |
|       | Occupation         | .279                        | .129       | .185                      | 2.164  | .000 |
|       | age of respondents | -.451                       | .154       | -.230                     | -2.932 | .725 |

a. Dependent Variable: Accompany

The regression model equation is;

Accompanying wife for ANC=4.89 + 0.569\*Education + 0.279\*Occupation -0.451\*Age of the respondents

This shows that accompanying a wife to ANC depends more on level of education (+0.569) and Occupation (+0.279) of the males. On the other hand, accompaniment of the wife to ANC is negatively influenced by age of the respondent (-0.451). The results show that accompanying a wife to ANC is influenced majorly by the level of education and occupation of the males. Age of the males doesn't play a role in the accompaniment of the wives to ANC.

## V. Discussion

Men were identified with masculine role of providing financial support as narrated during FGD. Similarly, in a study done in Northern Nigerian community on birth preparedness by Iliyasu (2010), it was found that the most universal form of male participation during pregnancy was financial support nutrition, psychological support and birth preparedness in terms of material support and transport arrangements.

Men's company and physical support of women to seek antenatal and delivery care was merited by most informants but largely restricted by myriad of factors. Some men felt it was their responsibility to escort women to clinics and offer physical support when needed, but this was deterred by men's job responsibility. This agrees with a study done in Gambia that men wished to escort their wives to ANC but were deterred by their responsibility as providers of families and the type of work they do (Lotching *et al.*, 2010). Men were seen and felt that they were the providers. It was further expressed by men that their absence from work and being present in the clinic together with their partners could have left children without food, as many felt an hour absence from work will mean a struggle for the next day. Most informants reported having limited income and needed more hours of work to meet their survival.

Some of the men saw women to be mature enough to visit the clinic alone or to be escorted by their fellow women but not men. Some men expressed opinions that sick women should be cared by their fellow women and not men for privacy reasons. This concurs with study done in Cameroon by Nkuoh *et al.*, (2013), and in western Kenya (Onyango *et al.*, 2010). This explained how pregnancy and childbirth was viewed as women responsibility and mostly seen as a women issues.

## VI. Conclusion

The participants had the cultural mentality that antenatal clinics are women's places and men needed not interfere. Men above 30 years were the majority. Some men were employed whereas others were in their own business which is evidenced in the findings that they are quite busy making ends meet. This finding is in

agreement with Byamugisha (2010), who reiterates that men frequently perceive ANC services to be designed and reserved for women, thus are embarrassed to find themselves in such “female” places. Some men believe it is not good to follow your wife to the antenatal clinic even though she exposed her privacy to you at home and that male participation in ANC services is superfluous and that ANC is “a woman’s responsibility”. The men acknowledged during FGD that they could decide where the wife would attend ANC clinic and offer transport but lamented that they had no time to escort their wives for the ANC care. In conclusion male partners can influence pregnant women’s decision to seek ANC depending on their socio demographic characteristics

## REFERENCES

- [1]. Aarnio P, Olsson P, Chimbiri A, Kulmala T., (2009) Male involvement in antenatal HIV counseling and testing: exploring men’s perceptions in rural Malawi. *AIDS Care: Psychological and Socio-medical Aspects of AIDS/HIV*, 21:1537-1546.
- [2]. Amosu, A., Adenike, M., Degun, M., Comfort, M., Makinde, T. A., & Babalola, A. O., (2011). An assessment of specific knowledge and attitude of health care providers towards people living with HIV/AIDS in Ibadan, Nigeria. *Annals of Biological Research*, 2(2), 225–264
- [3]. Babalola, S., & Adesegun, F., (2009). Determinants of use of maternal health services in Nigeria – looking beyond individual and household factors. *BMC Pregnancy and Childbirth*, 9 (43), 2393-2943.
- [4]. Bhatta (2013). Involvement of males in antenatal care, birth preparedness, exclusive breastfeeding and immunizations for children in Kathmandu, Nepal. *BMC Pregnancy & Childbirth* 13:14.
- [5]. Byamugisha, R., Aastrom, A., Ndeezi, G., Karamagi, C., Tylleskär, T., & Tumwine, J., (2011). Male partner antenatal attendance and HIV testing in eastern Uganda: a randomized facility-based intervention trial. *Journal of the International AIDS Society*, 14(1), 43.
- [6]. Danforth E.J., Kruk M.E., Rockers P.C., Mbaruku G., & Galea S., (2009). Household Decision – Making about Delivery in Health Facilities: Evidence from Tanzania. *Journal of health population nutrition*, Oct 27(5):696-703.
- [7]. David W. (2012). Determinants of male partner involvement in promoting deliveries by skilled birth attendant in Busia, Kenya. *Global journal of health science. Vol.4:2* Feldman PJ, Dunkel-Schetter C, Sandman CA, Wadhwa P.D., (2010) Maternal social support predicts birth weight and fetal growth in human pregnancy. *Health Care Women Int*, 31(7):621-635
- [8]. Iliyasa Z, Abubakar IS, Galadanci HS, Aliyu M.H., (2010). Birth Preparedness, Complication Readiness and Fathers’ Participation in Maternity Care in a Northern Nigerian Community. *African Journal of Reproductive Health*, 14:21-32.
- [9]. Judith Yargawa., (2015). Male involvement and maternal health outcomes: systematic review and meta-analysis *JECH Online /10.1136/jech-2014-204784*
- [10]. Kainz G, E. Liasson M, von Post I., (2010). The child’s father, an important person for the mother’s well-being during the childbirth: A hermeneutic study.
- [11]. Kakaire, O., Kaye, D. K., & Osinde, M. O., (2011). Male involvement in Birth preparedness and complication readiness for emergency obstetric referrals in rural Uganda. *Reproductive Health*, 8(12). Retrieved from <http://www.biomedcentral.com/content/pdf/1742-4755-8-12.pdf>
- [12]. Kulunya L. I., J. Sundby, E. Chirwa, A. Malata, and A. Malura (2012). Barriers to
- [13]. Husbands’ Involvement in maternal health care in a Rural setting in Malawi:
- [14]. A qualitative study. *Journal of Research in Nursing and Midwifery* 1(1): 1-10
- [15]. Lochting L.L., (2010). The Price to Pay for Maternal Health care in Rural Gambia Master’s Thesis, *Institute of General Practice and Community Medicine, Section for International Health, University of Oslo*.
- [16]. Longworth H, Kingdon C., (2010). Fathers in the birth room: What are they expecting and experiencing? A phenomenological study. *Midwifery* 27: 588-594
- [17]. Mugenda O.M and Mugenda A.G., (2003). Research Methods: Quantitative and Qualitative Approaches, *Africa Centre for Technology Studies, Nairobi*.
- [18]. Mullany, B. C., B. Lakhey, D. Shrestha, S. Becker, and M. J. Hindin, (2009) Impact of Husbands’ Participation in Antenatal Health Education Services on Maternal Health knowledge. *J Nepal Med Assoc*; 48(173):28-34.
- [19]. Nanjala, M., & Wamalwa, D., (2012). Determinants of Male Partner Involvement in Promoting Deliveries by Skilled Attendants in Busia, Kenya. *Global Journal of Health Science*, 4(2), p60 - 67.
- [20]. Nkuoh, G. N., Meyer, D. J., Tih, P. M., & Nkufusai, J., (2010). Barriers to Men’s Participation in Antenatal and Prevention of Mother-to-Child HIV Transmission Care in Cameroon, Africa. *Journal of Midwifery & Women’s Health*, 55(4), 363–369. [University of Ghana http://ugspace.ug.edu.gh](http://ugspace.ug.edu.gh)
- [21]. Plantin L, Olukoya AA, Ny P. (2011) Positive health outcomes of fathers involvement in pregnancy and childbirth paternal support. A scope study literature review. *Fathering*; 9: 87 -102
- [22]. Reece, M., Hollub A., Nangami M. & Lane K. (2010): Assessing male spousal engagement with prevention of mother-to-child transmission (PMTCT) programs in western Kenya. *AIDS Care*, 22(6):743–750.
- [23]. Some, D.T., Sombie, I. & Meda, N., (2013): How decision for seeking maternal care is made—a qualitative study in two rural medical districts of Burkina Faso: *Reprod. Health Journ*, 10:8
- [24]. UNAIDS. (2012). ‘Global Report: *UNAIDS Report on the Global AIDS Epidemic*’
- [25]. United States Agency for International Development, (2010). Men Key to Reducing Maternal Deaths in Developing Countries. *FrontLines*, May. Available at [http://transition.usaid.gov/press/frontlines/fl\\_may10/p08\\_men100517.html](http://transition.usaid.gov/press/frontlines/fl_may10/p08_men100517.html).
- [26]. Wassie, L., Bekele A., Ismael A., Tariku N., Heran A., Getnet M., Mitike M., Adamu A., & Seifu H. (2014): Magnitude and factors that affect males’ involvement in deciding partners’ place of delivery in Tiyo District of Oromia Region, Ethiopia. *Ethiop. J. Health Dev.* 2014; (Special Issue 1).
- [27]. World Health Organization, (2012). Trends in maternal mortality, Available from [www.who.int](http://www.who.int). Accessed on 14th January 2013.

Sally Jepkosgei Kiptoo. "Male Partner Involvement in Antenatal Care Services in Mumias East and West Sub-Counties, Kakamega County, Kenya." *IOSR Journal of Nursing and Health Science (IOSR-JNHS)* 6.4 (2017): 37-46.