

**MALE PARTNER INVOLVEMENT ON MATERNAL CARE SERVICES  
DURING PERINATAL PERIOD IN MUMIAS EAST AND WEST SUB  
COUNTIES, KAKAMEGA COUNTY, KENYA**

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**A Thesis Submitted in Partial Fulfillment of the Requirements for the Award of  
Master of Science Degree in Nursing (Midwifery) in the School of Nursing,  
Midwifery and Paramedic Sciences of Masinde Muliro University of Science and  
Technology.**

**June, 2017**

## **DECLARATION**

This thesis is my original work prepared with no other than the indicated sources and support and has not been presented elsewhere for a degree or any other award.

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## **ACKNOWLEDGEMENTS**

I owe an in debt gratitude to my supervisors Prof. Charles Mutai and Dr. Mary Kipmerewo for their professional guidance throughout the process of my Research. Prof. John Okoth the Dean School of Nursing and Midwifery, Mr. Arudo and Dr. Raballa Research Course Lecturers for their contribution throughout this research.

My appreciation to the Kakamega County Health Records Information Officers Mr. Edward Omusotsi and Mr. Michael Ruto for the Health records from District Health Information System (DHIS2).

My special thanks to the Sub County Health Management Teams in both Mumias East and West sub counties and the Ward administrators for their assistance and giving me access to the community.

Mr. Drinold Mbeti and Mr. Franklin Tireito for their technical guidance during analysis.

My fellow colleague students for moral support and team spirit.

My sincere appreciation to my late brother David Kiptoo for his loving, emotional and financial support.

May God bless them all.

## **DEDICATION**

I dedicate this work to my beloved husband Fredrick Oronje, my Son Kenneth, and daughters Faith, Purity and Winnie for their immense encouragement and loving support during the entire course.

## ABSTRACT

Globally male partner involvement on maternal health services remains a challenge to effective health care. Maternal deaths arise from pregnancy, childbirth and postnatal complications and this can be reduced by involving male partners. Benefits of male partner involvement have been acknowledged in developed countries, however there still continues to be a challenge in creating space for and engaging men in maternal health. In Kenya male involvement in maternity care is one of the strategies for improving the maternal health and reducing maternal mortalities. This study explored socio demographic, cultural and other factors associated with male partner involvement on maternal care services during perinatal period in Mumias East and West sub counties, Kakamega County, Kenya. Specifically it looked into male partner influence on pregnant woman's decision to seek antenatal care, participation of male partner during perinatal period and factors influencing the man to be involved in maternal care. Data was collected using a pre tested structured questionnaire administered to 424 respondents (husband and wife). Four focus group discussions were conducted in groups of nine. Descriptive statistics was used to analyze socio demographic characteristics and inferential statistics using Kappa test, chi-square, odd ratio and Regression analysis using Statistical Package for Social Sciences (SPSS) version 21. Null hypothesis was tested at 5% significance level. The study revealed that women initiated to seek antenatal care, but men eventually decide. Decision making power of men was grounded on education ( $p=0.001$ , OR 2.030), occupation ( $P=0.001$ , OR= 2.103) and living together ( $OR=1.989$ ). Social cultural factors of husbands also had influence on male partner involvement. Kappa test was 0.9945 implying agreement between husband and wife responses. Regression analysis, at 5% significance level predicted that male participated by providing support ( $p=0.001$ ). Space ( $p=0.001$ ) at the health facility had negative influence on whether the man stayed with wife during labour. Improving the levels of education and income of male partners, addressing cultural beliefs and practices, and sensitizing men on their role during pregnancy and child birth can contribute significantly in enhancing male partner involvement in maternity care. There remain a number of maternal health care service challenges such as space and privacy that need to be addressed before maternal health care become more male friendly.

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## **LIST OF ABBREVIATIONS AND ACRONYMS**

<b>ANC</b>	Antenatal Care
<b>CGH</b>	County General Hospital
<b>DHIS</b>	District Health Information System
<b>DPI</b>	Direct Personal Interview
<b>FANC</b>	Focused Antenatal Care
<b>FGD</b>	Focus Group Discussion
<b>KI</b>	Key Informant
<b>MCH</b>	Maternal and Child health
<b>MDG</b>	Millennium Development Goal
<b>MMR</b>	Maternal Mortality Ratio
<b>MMUST</b>	Masinde Muliro University of Science and Technology
<b>MOH</b>	Ministry of Health
<b>SDG</b>	Sustainable Development Goals
<b>TBA</b>	Traditional Birth Attendant
<b>UNFPA</b>	United Nations Population Fund
<b>WHO</b>	World Health Organization

## **CHAPTER ONE**

### **INTRODUCTION**

#### **1.1 Overview**

This chapter gives information about the study which is male involvement on maternal care services during perinatal period. It also looked at global, regional and national view of male involvement on maternal care services.

#### **1.2 Background of the Study**

The issue of maternal health has predominantly been seen and treated as a purely feminine matter over the years. Globally the burden of maternal health is one maternal death per minute and from this, developing countries accounts for 99% of maternal deaths while male in developing countries are chief decision makers and therefore influencing maternal health outcome (Story, 2012). The International Conference on Population and Development in Cairo, 1994 and the Fourth World Conference on Women, Beijing pointed towards the need for involving and encouraging men to take responsibility for their sexual and reproductive behavior, advocating that men are in a position to change attitudes and practice through their positions as community, religious and political leaders (USAID, 2010).

However, male partners should also take individual responsibility as husbands and fathers to become involved in changing social attitudes including taking responsibility for reproductive health issues. In reality, male 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) number five: reduce maternal mortality by 75% between 1990 and 2015 (MDG, 2011).

Throughout sub-Saharan Africa the area of pregnancy and childbirth is recognized as the responsibility of women (Lochting, 2010). Before the onset of male involvement concern, reproductive health issues and services had become synonymous with women's reproductive health, and male were assumed to have no special role in such matters (Kakaire *et al.*, 2011). However, the exclusion of male partners from active involvement in these issues represents a lack of appreciation of the social reality of daily living in most developing societies, particularly in Africa. Studies have reported positive benefits of male involvement in developed and developing countries which include: access to antenatal and postnatal services. Male who were part of ante natal and postnatal care partake in the education given at this clinics. This increases male's knowledge and participation and are able to identify danger signs hence facilitate women's utilization of maternity services (Tweheyo *et al.*, 2010; Backstrom *et al.*, 2009). Additionally, it also results in the reduction in delay in decision making while seeking emergency care. On the other hand, women who do not have company during Labour and childbirth are five times more likely to deliver via caesarean section (C/S), longer duration of active phase of labour and higher pain score (Morshaso *et al.*, 2009).

Traditionally, maternal health issues have predominantly been seen and treated as a purely feminine matter as they are the ones who get pregnant and give birth (Backstrom *et al.*, 2009). Although men's participation in maternal and child health (MCH) care services is low, they play a vital role in the safety of their female partners' pregnancy,

childbirth and postnatal. Most cultures, especially in Africa, regard pregnancy and delivery as a female domain; therefore, men are often not expected to accompany their wives to the antenatal care (ANC) clinic or be present during delivery (Theuring *et al.*, 2009). The exclusion of men from MCH services reinforced the erroneous notion that pregnancy and childbirth was uniquely feminine and maternity units are exclusively meant for women (Iliyasu *et al.*, 2010). From the study done in Kathmantu Nepal, it revealed that that some women's access and utilization of MCH services depend upon their partners (Batta, 2013).

Women in labor have need for companionship, empathy and help. Women's childbirth experience have suggested four dimensions of the support that women want during labor namely; emotional support, informational support, physical support and advocacy (Plantin *et al.*, 2011; D'Aliesio *et al.*, 2009; MIDIRS, 2008). Attempts to encourage male to attend ANC and childbirth have been promoted by individual health facilities in Kenya, with mixed successes and failures similar to reports from other resource poor settings which indicated low male partner involvement (Kululanga *et al.*, 2011). Attempts to involve male in maternal health care especially antenatal care, have managed to attract only few husbands (Aarnio *et al.*, 2009). Strategies that are used to invite husbands to participate in maternal health care by health care providers in different settings are seldom understood. Therefore, there is need to understand strategies that are used to invite men to participate in MCH services. This information is important to formulate policies that remove barriers to male participation.

Few studies have been done in Kenya to determine male involvement in reproductive health and figures are not available on the male partners who accompanied their wives both for ANC and delivery (Kwambai *et al.*, 2013). In Western Kenya (Kakamega County), males are considered not to accompany their wives to maternity care services, a fact attributed to gender norms as one who accompanies the wife is branded as being overpowered by the wife (Onyango *et al.*, 2010). Kakamega County is among the twelve counties in Kenya that has 4<sup>th</sup> ANC attendance less than 50 % (KDHS, 2014). Mumias east and west sub counties in Kakamega County contributes to this low percentage (KDHS, 2014). There is no literature specifically in Mumias, however it contributes to the low 4<sup>th</sup> ANC visits in Kakamega County and this could be attributed to or influenced by gender norms and traditional cultural issues as described by the chief in Mumias as personal information prior to this study. This study, therefore, aims to assess male partner involvement on maternal care services during perinatal period in Mumias East and West sub-counties, Kakamega County, Kenya.

### **1.3 Problem Statement**

Globally maternal mortality Ratio (MMR) is an issue of concern and developing countries continue to have high MMR (240/100,000) live births which is 15 times more compared to developed countries (United Nations, 2010). Sub Saharan Africa is worse with MMR of 500/100,000 live births which is beyond the expected target of 185/100,000 by the year 2015. Western Kenya MMR was at 800/100,000 and Kakamega district at 880/100,000 live births (KDHS, 2008/09). Maternal deaths arise from pregnancy, childbirth or postnatal complications. This can be reduced by

involving men throughout perinatal period (Bhatta, 2013). Finding men in antenatal clinics is very rare and is thought to be unthinkable to find them escort their wives during ANC and delivery. Male partner involvement is a key factor that cannot be ignored to improve maternal health (Story and Burgard, 2012). Low level of Male partner involvement in maternal care services in Kakamega County has persisted despite being one of the reproductive health strategies put in place to improve maternal and Neonatal outcome (DRH, 2007). Less than 50% of pregnant women in Kakamega County attend ANC which is one of the intervention pillars of maternal health (KDHS, 2014). From the County General Hospital (CGH) maternity referrals, it was observed that women referred for obstetric care came late and are escorted by other women as opposed to male partners. Mumias contributed more than 50% (8: 14) of the Maternal deaths at the county Referral Hospital Kakamega (DHIS, 2014). Studies on male partner involvement in Mumias Sub-County have not been clearly elucidated. This study therefore sought to determine the level of male partner involvement in maternal care services during perinatal period in Mumias East and West Sub-Counties, Kakamega County.

## **1.4 Objectives of the Study**

### **1.4.1 Broad Objective**

To determine male partner involvement in maternal care services during perinatal period in Mumias East and West Sub-Counties, Kakamega County.

### **1.4.2 Specific Objectives**

1. To determine Male partner influence on pregnant women's decision to seek antenatal care services.
2. To investigate the participation of Male partners during pregnancy, delivery and postnatal period.
3. To determine factors that influence male partner involvement in maternity care.

### **1.5 Hypothesis**

- i. Male partners do not influence pregnant women's decision to seek antenatal care services.
- ii. Male partners do not participate during their wife's pregnancy, labour, delivery and postnatal period.

### **1.6 Justification**

Male involvement has shown positive results such as improved maternal and neonatal outcome for example increased skilled deliveries, and reduced neonatal problems. Studies have shown how men play key roles in supporting women's and children's health, preventing maternal complications throughout pregnancy, slowing the transmission of sexually transmitted infections, therefore making pregnancy and delivery safer. In addition male also play a key role in antenatal care as he exercises preponderant power in nearly every sphere of life ranging from decisions making regarding antenatal checkups, and nutrition. Involving and improving the way in which male partners participate in maternity care can only have positive influence on

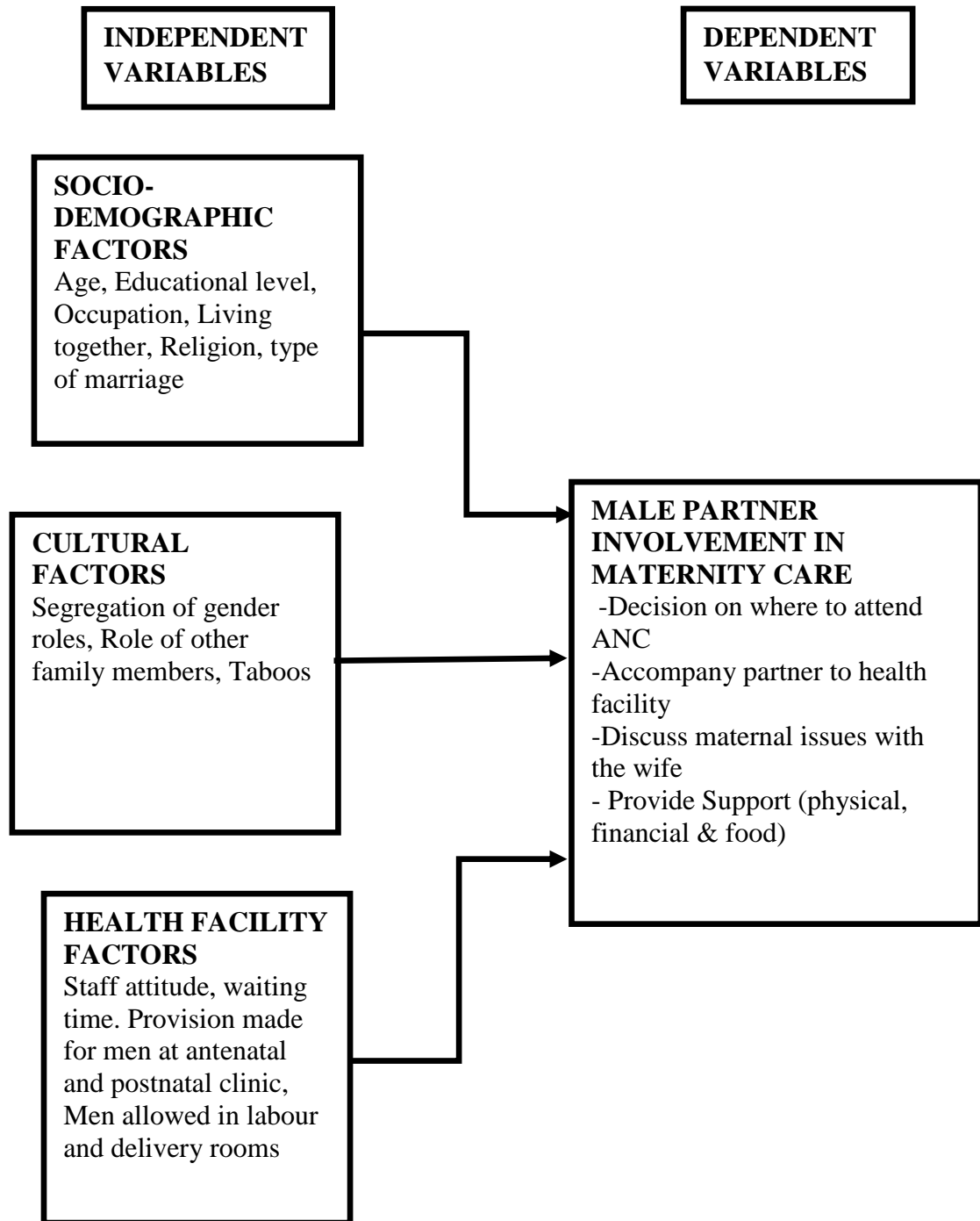
women's and neonatal health outcome. The results of this study will help to inform policy on the challenges women face before, during and after delivery in regard to male involvement in maternity care during perinatal period and possible ways on how to address them. The results of the study will also be submitted to peer review journal for publication. The study will eventually be helpful in improving male involvement in maternity care in Mumias Sub-Counties Kakamega County. The findings from the study will also help the MOH and academicians to use as a basis for further research in issues concerning male involvement in maternity care.

### **1.7 Limitation of the Study**

The study was limited to two sub counties in Kakamega County, hence results cannot be generalized. A sample of above 10,000 was reduced to 424 which is a small population to be generalized. The study design which was cross sectional descriptive study would give information at point in time which may also be influenced by the season and time.

The study included couples that had their youngest child equal or less than one year old to ensure good recall on maternity care and male involvement. However, there was no clear way to ensure accuracy from the respondents, other than trusting their response.

## 1.8 Conceptual Framework



*Adapted with modifications (Dansowaa, 2013)*

In the above conceptual framework Male partner involvement in maternity care services during perinatal period may have been influenced by socio demographic factors, cultural factors and health facility related factors. The age, educational level, being unemployed and religion of male partners may have affected the way their influence and participation in maternity care of their wives. Majority (80%) in this study were in a monogamy type of marriage and staying together which did not have any significance in determining male partner involvement. Cultural factors that include norms, taboos and gender roles played a major role as indication both by male and female during an FGD separately. Health facility factors such as staff attitude, waiting time and availability of space for male partners in the service delivery rooms may have greatly influence male partner involvement.

### **1.9 Operational Definitions**

**Antenatal care:** the care given to women during her pregnancy by a health care professional during pregnancy.

**Intrapartum care:** the care given to a woman during labour and delivery by a health care professional.

**Male involvement:** refers to male participating and having joint responsibility (i.e. discuss together on clinic attendants, accompany the mother both during ANC clinic, for delivery and postnatal care. Discuss maternal health issues and also supporting her wife physically and emotionally including planning for emergency.

**Male Partner:** the man biologically responsible for the pregnancy of a woman and married to the woman by either means.



**Maternal Health:** refers to the health of a woman during pregnancy delivery and postpartum period by a health care professional.

**Maternity care:** the care given to a woman during pregnancy delivery and postpartum period by a health care professional.

**Postnatal care:** the care given to a woman from delivery of the placenta up to six weeks after delivery by a health care professional.

**Prenatal care:** is a type of preventive healthcare 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.

**Skilled Attendance:** refers to childbirth managed by a skilled birth attendant (Nurse Midwife, Doctor or Clinical officer) under the enabling conditions of a functional emergency obstetric care and referral system.

**Skilled Attendant:** refers to an accredited health professional such as a licensed Midwife, Doctor, Clinician who has adequate proficiency and the skills to manage normal (uncomplicated) pregnancies, childbirth and the immediate postnatal care and also in the identification of complications in women and newborns.

**Perinatal Period:** refers to the period when the woman is pregnant, during labour, delivery and after delivery of the baby.

## CHAPTER TWO

### LITERATURE REVIEW

#### 2.1 Introduction Overview

Maternity care which includes antenatal, intrapartum and postnatal care has often been seen as a feminine issue and health care workers, men and even the women viewed it in the same way (Kululanga *et al.*, 2011). Male partners have been identified as key to reducing maternal mortality and improving maternal health in developing countries. It has also been revealed that male partners are key decision makers for women's choice of health care services even though they have limited knowledge (USAID, 2010; Andersson *et al.*, 2011). Therefore, Male partners cannot be left out if we are to accelerate the progress towards the achievement of the millennium development goals (MDGs) i.e. (Reduce neonatal mortality and improve maternal health) currently known as Sustainable development goals (SDG) 3. Involving male partners in various aspects of reproductive health has led to increased uptake of contraception and treatment of sexually-transmitted infections (Mullany *et al.*, 2009).

The level of male involvement in maternity care varies across communities and countries. There are various factors that could determine the level of male involvement. These could be socio-demographic, cultural or even the health facility related factors (Byamugisha *et al.*, 2011; Nanjala & Wamalwa, 2012). Awareness of these factors is important for the formulation of policies and provision of services that encourage male involvement and remove barriers to their participation in maternity care.

## **2.2 Male Partner Influence**

Development of appropriate interventions to increase male partner involvement in pregnancy is vital to strategies for improving health outcomes of women with or without obstetric complications. From a study done in Malawi it indicated that men usually do not accompany their wives on visits to antenatal clinics for fear of being ridiculed by peers (Kulunya *et al.*, 2012). However, it has been shown that when male partners are involved, both partners can get tested for HIV, know their status, and therefore improve the baby's chance of a healthy survival (UNAIDS, 2012). Further, a study conducted by the United Nations Population Fund (UNFPA) in Kenya found that husbands greatly influence women's decisions to use reproductive health services such as family planning (UNFPA, 2009). With regard to maternity care, various studies emphasize how male partner's role can contribute to better outcomes for their pregnant wife (USAID 2010). In most families male partners are empowered financially and are the main decision-makers in all issues including reproductive health (Kululanga *et al.*, 2011). They may use this opportunity to ensure that their pregnant wives seek maternity services or arrange for skilled care during delivery, if delivery takes place at home. For male partners to make the right decision for their wives regarding place of delivery and professional attention, they need to understand the importance of maternal health care.

### **2.2.1 Focused Antenatal Care (FANC)**

Globally and typically in Africa parturition is a time of joy and pride to the woman, family and community as a whole. The birth of a healthy baby is welcomed and therefore the need for the women to be healthy throughout pregnancy, childbirth and postnatal

period. Majority of pregnancies are safe, however in sub Saharan Africa the death of women in pregnancy or within 42 days after delivery is not declining sufficiently to achieve Millennium development goals (MDGs) 4 and 5 (reduce neonatal mortality and improve maternal health (Amosu *et al.*, 2011).

FANC is individualized, client-centered, comprehensive antenatal care that emphasizes disease detection rather than risk assessment. It is an evidence-based intervention which focuses on individual women's needs and concerns and what is appropriate for the gestational period at that time of their pregnancy. The concept of FANC services is a model of preventive health care targeted at primary, secondary and tertiary prevention of diseases and pathological conditions during pregnancy and delivery. It is a model of care that is characterized by a series of health examinations done by health personnel to detect conditions in pregnancy which may threaten the pregnancy and its outcome. FANC emphasizes quality of visits and individualized care rather than quantity of visits.

The FANC package includes continuous care provided by the same midwife and focuses on the involvement of the client's partner or support person in the process of care and preparation for delivery. FANC focuses on the client and unborn baby's needs. This needs include examining of the pregnant mother, involvement of the partner, treating clients as unique individuals (individualized care) with respect, preparing the client for delivery, educating her on what to expect and how to prepare the layout needed for delivery (birth preparedness). Women are also prepared for possible complications (complication readiness). Components such as individualized care, complication

readiness, birth preparedness and prevention of diseases help midwives to proactively detect diseases early and prevent complications; these components are strongly emphasized in the FANC approach (Nyarko *et al.*, 2006). WHO recommends at least four ANC visits or more during a woman's pregnancy, however in Kenya 58% of women reported having four or more antenatal visits for their recent birth while Kakamega County was at 51.3% slightly lower than the National indicators (KDHS, 2014).

### **2.2.2 Antenatal Care**

Development of appropriate interventions to increase male partner involvement in Labour and childbirth a vital to strategy for improving health outcomes of women with obstetric complications. A quantitative study conducted in the Gambia explored the price to pay for maternal health care in rural Gambia, and indicated that only 11% of the women studied were escorted to deliver in clinics by husbands while leaving the rest escorted by in-laws, relatives and friends (Lochting *et al.*, 2010). A study done in Burkina Faso revealed that the traditional necessity for women to have the permission of husband or their relatives before leaving the home predominates (Some *et al.*, 2013). Further, a study conducted by the United Nations Population Fund (UNFPA) in Kenya found that husbands greatly influence women's decisions to use reproductive health services such as family planning (UNFPA 2009). With regard to maternity care, various studies emphasize how male partner role can contribute to better outcomes for their pregnant wives (USAID, 2010).

### **2.2.3 Intrapartum Care**

In most families the men are empowered financially and are the main decision-makers in all issues including reproductive health. They may use this opportunity to ensure that their pregnant wives seek maternity services or arrange for skilled care during delivery, if delivery takes place at home. For men to make the right decision for their wives regarding place of delivery and professional attention, they need to understand the importance of maternal health care (Mullany *et al.*, 2007). A study done in Accra on Male involvement in maternal care revealed that the presence of male partners during labour and delivery greatly effects women satisfaction and enhances maternal outcome (Dansowaa, 2013). Another study on the effect of psycho- social support during childbirth found that women who did not have company were five times more likely to deliver through caesarean section, longer duration of labour during active phase of labour and higher pain scores (Morshaso *et al.*, 2009). Apart from being available to help in times of complications that require referral, Men also provide emotional support (Kakaire *et al.*, 2011).

There are beliefs that male partners company during labour and childbirth delays the process of labour, hence it is a myth that has been passed on from one generation to the other and it has therefore kept spouses away from being involved in maternity care (Mundi, 2013). In Tanzania, strategic decisions regarding delivery in a health facility were influenced by partners and other household members (Allendorf, 2007). Another study in Western Tanzania indicated that couples with their recent delivery found that agreement of partners regarding the importance of delivery in the health facility was

associated with a higher likelihood of women delivering in a health facility (Danforth *et al.*, 2009).

#### **2.2.4 Post-natal Care**

Post-natal period is very critical because this is the time during which there is a lot of Morbidity and mortality both to the mother and the neonate. It is this period that implementation of what was learned in antenatal period, and it includes post-natal checkups, breastfeeding, and family planning. Only 51% of women of child bearing age received Post-natal care checkups in the first two days (KDHS, 2014). Male partner involvement at this stage is also very important for the woman to regain back her strength.

#### **2.2.5 Socio-cultural Factors**

Socio-cultural factors that may affect male partner involvement includes; Segregation of gender roles, Role of other family members and Taboos. The traditional approaches to maternal health care, taken by health systems in most developing countries portray the gendered belief system. The services are female oriented thereby discouraging male involvement (Onyango *et al.*, 2010).

**Gender:** The most basic division of labor is biological, men are physically strong, and women are the only ones able to bear and nurse children. Gendered belief systems foster assumptions about appropriate behavior for men and women and may have an effect on the type of work women and men perform. Gender systems are social

institutions that ascribe the social characteristics of men and women, which provide meaning and guidance with regard to their roles, rights and obligations over the life course. Gender norms have been attributed to lack of male involvement in maternal health care. For instance, men are not expected in some cultures to accompany their wives to the clinic. If they do, this is perceived by their peers as a demonstration of weakness. On the other hand, male involvement in maternal health care has been perceived as loss of women's right to make decisions regarding pregnancy issue; therefore, men should not encroach in their territory (Onyango *et al.*, 2010).

While there are reports of negative experiences such as being ignored or marginalized (Dolan and Coe, 2011), there are reports of positive experiences such as receiving timely attention and adequate support from healthcare providers (Kainz and Liasson, 2010). Negative experiences may lead to difficulty in men's and women's adjustment to pregnancy, childbirth and parenthood, consequently limiting the support men provide to their partners in the postpartum period (Abushaikha and Massah, 2012). With regard to maternity care, various studies emphasize how men's role can contribute to better outcomes for their pregnant wives (UNFPA 2009; USAID 2010).

A study in Malawi, found fathers perceiving themselves on the periphery of events in labor, but the good information from the midwife was significant in helping them to feel involved at the birth. (Longworth, 2010). Another study from Kenya on skilled birth attendant, revealed that where women are supported and accompanied by their male partners, they are more likely to consistently visit antenatal clinics (IRIN/Plus News,



2009). Few men usually accompany their wives on visits to antenatal clinics for fear of being ridiculed by peers. A study from Nigeria indicated that low level of education, poverty, culture, religious, beliefs, health workers negative attitudes contributed to poor male participation in labour and delivery (Mundi, 2013). However, it has been shown that when male partners are involved, both partners can get tested for HIV, know their status and this improves the health of the baby.

**Education:** Male partners with higher education were more likely to be involved in maternal care services since they were more informed on birth plan. They were also socially and financially empowered to make necessary decisions. The study also established that spouses of male partners with formal employment or engaged in a businesses were more likely to seek skilled delivery than those whose partners were unemployed (Babalola, 2009).

**Culture:** Cultural standards is identified as barriers for male partner involvement and have reported negative perceptions towards men attending ANC services (Kulunya *et al.*, 2012). In one report, men who accompanied their wives to ANC services were perceived as being dominated by their wives and therefore demonstrating weakness as male. As noted by Byamugisha *et al.*, (2010), men frequently perceive child bearing as designed and reserved for women, hence they are embarrassed to find themselves in such “female” places. Nepal has culturally dynamic and patriarchic societies and women mainly are of low status, and are culturally referred as second to male therefore cannot make decision on type of health care (Batta, 2013).

A study conducted in Kenya showed that certain male clients trust traditional birth attendants but not hospitals and therefore do not attend ANC clinics therefore, reducing the baby's chances of a healthy survival (UNAIDS, 2012). Another study done in Busia, Kenya demonstrated that male partners did not involve themselves in pregnancy and childbirth because they believe that it is a woman's affair (Wamalwa, 2012). In relation to culture male in Busia preferred their wives to deliver at home for the safety of the placenta, therefore burying the placenta and maintaining the baby indoors for four days for boys and three days for girls before naming. This is believed to prevent bewitching of the baby (Wamalwa, 2012).

#### **2. 2. 6 Health Facility Factors**

The health facility factors that generally affect male partner involvement is both related to service delivery and user related factors (Nkuoh *et al.*, 2010). The most important ones includes physical distance to the health facility, Lack of transport, fixed clinic hours, long waiting time and poor technical interpersonal skills (Kwambai *et al.*, 2013). The health facility factors and infrastructure may not be conducive for male partners and the traditional health workers make no provision for the male partner in antenatal clinics (Nkuoh *et al.*, 2010). Lack of space in maternity units makes men embarrassed to be present during delivery of the baby (Kakaire *et al.*, 2011).

**Staff attitude:** Health facilities especially reproductive care services are dominated by females who are perceived by male partners to shout at pregnant women and portrayed to be harsh to male partners who accompanied to wives to labour ward (Byamugisha *et*

*al.*, 2010). Male partners value being respected, therefore would like to be served by individuals of the health care system who are polite and treat them with due respect as male and not ridicule them (Wamalwa, 2012).

**Time:** Increased male partner participation in the antenatal services occurred in Kinshasa when the MCH services are open in the evenings between 5:00 pm to 8:00 pm and on weekends. Most health facilities offer MCH services only during week days and more so in the morning, when the majority of male partners who are the providers to families are at work. Geographical constraints impact health services uptake and male participation. Lack of decentralized services is a reason for low health services uptake and limited male involvement (Onyango *et al.*, 2010).

### **2.3 Male Involvement**

Male partner involvement refers to men participating and having joint responsibility with women in all areas of maternity care and this influences pregnancy outcomes (Yargawa, 2015). Changes in men's knowledge, attitudes and behaviour are necessary to promote women's health and safe motherhood. It reduces negative maternal health behaviors, risk of preterm birth, low birth weight, fetal growth restriction and infant mortality (Yargawa, 2015). There is epidemiological and physiological evidence that male involvement reduces maternal stress (by emotional, logistical and financial support), increases uptake of prenatal care, leads to cessation of risk behaviors and ensures male's involvement in their future parental roles from an early stage (Feldman *et al.*, 2000).

While there are reports of negative experiences (such as being ignored or marginalized), there are reports of positive experiences (such as receiving timely attention and adequate support from healthcare providers (Dolan and Coe, 2011). Negative experiences may lead to difficulty in men's and women's adjustment to pregnancy, childbirth and parenthood consequently limiting the support men provide to their partners in the postpartum period (Johansson *et al.*, 2012). Uganda's Ministry of Health has a policy that supports male involvement in reproductive health. The ways in which the policy is implemented might discourage men from playing active roles (Longworth *et al.*, 2010). Despite the importance attached to men's involvement in Uganda, there is limited research on male involvement during pregnancy, childbirth and postnatal, particularly from the male's perspective, which hampers development of contextualized appropriate interventions. However, it is noted that Male involvement in pregnancy and childbirth influences pregnancy outcomes. It reduces negative maternal health behaviors, risk of premature birth, low birth weight, fetal growth restriction and infant mortality (Yargawa, 2015). The Level of male involvement measurement is difficult since various communities may rate differently or have different understanding on the same. Therefore, to be able to measure male involvement various points will be adopted as a summary of measure for Male involvement.

Byamugisha *et al.*, (2011) used a six-point involvement index:

1. The man attends ante-natal clinic with his partner
2. The man knows partner's ante-natal clinic appointments
3. The man discusses ante-natal interventions with his partner
4. The man supports partner's ante-natal visits financially

5. The man has taken time to find out what happens in the ante-natal clinic
6. The man has sought permission to use condoms during the current pregnancy

Each activity will be given a score of one (1) if performed and zero (0) if not performed.

A score of 4-6 will be considered as high involvement and a score of 0-3 will be seen as low involvement.

Likewise, Mullany *et al.*, (2005) used four points in their work as follows:

1. Discussion on maternal health
2. Helping with household chores
3. Jointly making arrangement for delivery
4. Being present at the hospital

High involvement: the man performs 2 or more of the above activities.

Low involvement: the man performs one or none of the above activities.

## **CHAPTER THREE**

### **RESEARCH METHODOLOGY**

#### **3.1 Overview**

This chapter describes the specific strategies and procedures that was used in data collection and analysis in order to answer the research questions. The chapter focuses on the research design, the population, sample and sampling techniques, description of research instruments, piloting, data collection procedures and the plan for analyzing data.

#### **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 Study Area**

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 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 (male partner and the wife) of 18 years of age and above in the study area, who were married and had a child in the last one year( $\leq 1$  year) preceding the study.

### **3.4 Inclusion Criteria and Exclusion Criteria**

#### **3.4.1 Inclusion Criteria**

- Couples (Man and wife) 18 years and above
- Married and have a younger child of one year or below
- Permanent Residence and from Abawanga Luhya community
- Had signed consent to participate

### **3.4.2 Exclusion Criteria**

- Study participants who were sick and were unable to sustain an interview
- Participants not willing to participate and had not signed a consent form

### **3.5 Sampling**

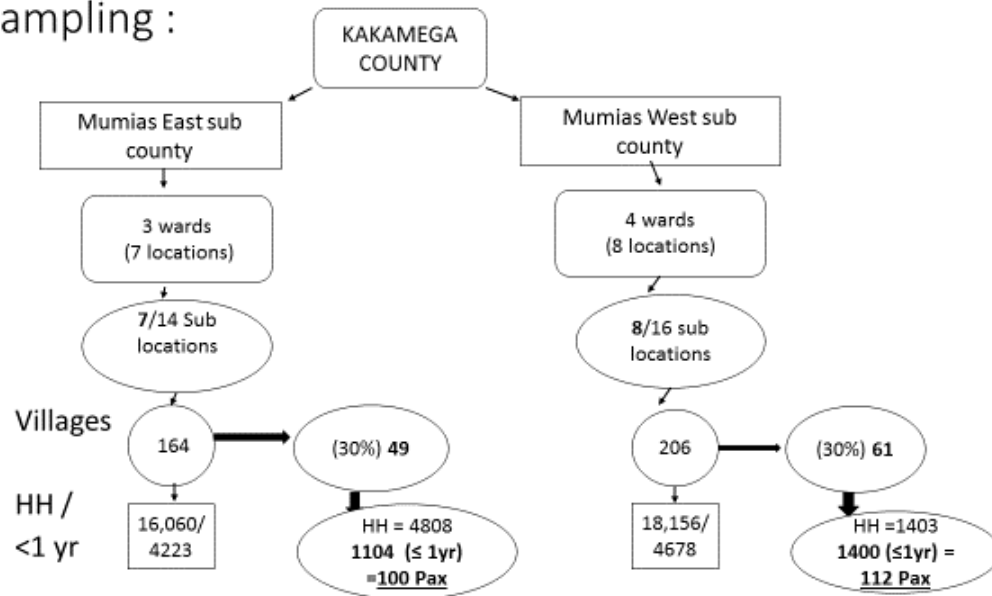
The purpose of sampling was to secure a representative group which enabled the researcher to gain information about population.

#### **3.5.1 Sampling Procedure**

Kakamega county has 12 sub counties which were initially in 6 zones for administrative supervision and one zone was made up of two sub counties. One Zone was selected for the study by simple random sampling. Mumias east and west sub counties has seven administrative wards with a total of 15 locations and 30 sub locations. Simple random sampling was used to select 8 (>50%) locations and 15 (50%) sub-locations. The subjects were identified through households. A list of household with target population was generated hence, having a list frame in place. The first household was randomly selected. This was followed by systematic selection of every 5th household as long as subjects who meet the criteria were interviewed until the number of required samples of 424 participants were attained.



### Sampling :



### 3.5.2 Sample Size determination

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.

$$n = \frac{(1.96)^2 \times 0.5 \times 0.5}{(0.05)^2}$$

=384(add 10% of 384)i.e. 38.4

=422.4 (423)

= 211.5

=212 couples (212 men: 212 women)

= 424 Participants

### **3.6 Data Collection**

In order to answer the research questions, data was collected using structured questionnaires and focus group discussion.

#### **3.6.1 Piloting**

Piloting 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. The Sub-County was not the area of study. The pilot study assisted the researcher to identify areas for correction in the research instruments, checking the clarity of the questions and also make comments from respondents which helped to improve the research instruments.

#### **3.6.2 Questionnaires**

A structured questionnaire was used to collect data from the men and women of 18 years and above. Each item in the questionnaire was developed to address specific research objective adapted from Dansowaa (2013). All the participants who consented were issued

with pretested self-administered questionnaire (Appendix II). For those who were able to read, the questionnaires were given to them to fill and returned immediately after answering the questions. The research assistant administered the questionnaires to those who could not read and marked a tick to the correct response from the subject according to the choices indicated without altering. The questionnaires were serialized starting with one (1) and a household was assigned to one serial number. Both questionnaires for the Male partner and the spouse were stapled together with the male questionnaire on top, a total of 424 questionnaires. Male respondents were a total of 212 (100%) questionnaires administered and 212 (100%) administered to women. Return rate was 422 (99.5%) which were completely filled. According to Kothari, C (1993) over 60% return rate was acceptable return for a study such as this one.

### **3.6.3 Focus Group Discussion**

A pre-tested interview guide of questions to guide the FGD (Appendix III) and the discussions were facilitated by trained research assistants well versed with the native language. Male research assistants conducted FGD's with Men while Female research assistants for the women. The principle investigator served as a moderator. The Research assistant introduced themselves, and explained the purpose of the study including; benefits of the study, risks involved, confidentiality, willingness to participate and whom to contact as the principle investigator. A consent was obtained, both written and verbal and requested them to record the proceedings of the discussion. Each subject was given a unique number. The researcher asked the questions as she/he

probes for more or clear information. The researcher also took notes and recorded the discussions.

#### **3.6.4 Data Storage**

All data collected was stored by the principle investigator. The hard copies were kept under lock and key while the electronic data stored both in the flash disk and computer secured with a password only known by the principle investigator.

#### **3.7 Data Analysis**

Both quantitative and qualitative approaches were used. Quantitative data from the questionnaires was coded and entered into a computer for computation of descriptive statistics. The Statistical package for social sciences (SPSS) was used to run descriptive statistics to produce frequency distribution, and percentages. Inferential statistics such as chi square, Kappa test, odds Ratio, Confidence interval (CI), linear regression and binary logistic regression was used to determine associations between variables, its significance and prediction. Raw data collected was analyzed by assigning numerical values to each response and entering into a code book. Thereafter the numerical numbers representing responses from the questionnaires was transferred to a code sheet so as to obtain quantitative results from the closed-ended questionnaires. The researcher also formulated categories of responses for all open-ended questionnaires and FGD so as to obtain quantitative data. Chi-square linear regression and binary logistic regression was used to analyze quantitative data. Kappa test of association was used to determine whether there was association between the male partners' response and the female

response. All p-values was considered statistically significant when was less than or equal to 0.05 ( $\leq 0.5$ ) Results were summarized, interpreted, reported and presented using percentages, frequency tables, and narrative description of the tables.

### **3.8 Ethical Considerations**

The researcher obtained an approval from the ethical research committee (ERC) of Masinde Muliro University of Science and Technology and permit granted from NACOSTI. The researcher presented a letter from the university to the research site to seek authority to carry out the research and obtain permission from the MOH administration, ward administrators and village elders to conduct the research in each Sub-County. The respondents were educated on their rights in the study. Oral and written Consent was obtained and documented from all the study subjects prior to the interview. The respondents were assured that their participation was voluntary and that the data handled in a confidential manner, their names were not used in any publication or presentation. The research obtained results would not affect the participants directly or indirectly. The participants were asked of their free will to take part in the research without forcing or coercing them after being informed of the purpose of the inquiry. The option to withdraw from the research was also explained to them.

The feedback to the Community, MOH and MMUST will be provided, while the information obtained from FGD and records were treated as confidential.

## **CHAPTER FOUR**

### **RESULTS**

#### **4.1 Introduction**

This chapter deals with data presentation, analysis and interpretation. The presentation is done in tandem with the objectives of this study. A total of four hundred and twenty four (424) questionnaires were given to participants. Four hundred and twenty four (422) were filled and returned while two were rejected because it had errors. Four FGD's were conducted with nine participants each, two for men and the other two for women.

#### **4.2 Socio-demographic Characteristic**

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 4.1).

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.

**Table 4.1: 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
	<b>Total</b>	<b>211</b>	<b>100.0</b>	<b>211</b>	<b>100.0</b>
[ $\bar{X} \pm SD(R)$ ]		[27.3 $\pm$ 5.83(21-49)]		[26.0 $\pm$ 4.83(18-42)]	
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
	<b>Total</b>	<b>211</b>	<b>100.0</b>	<b>211</b>	<b>100.0</b>
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
	<b>Total</b>	<b>211</b>	<b>100.0</b>	<b>211</b>	<b>100.0</b>
Religion	Christian	173	82.0	160	75.8
	Muslim	38	18.0	51	24.2
	<b>Total</b>	<b>211</b>	<b>100.0</b>	<b>211</b>	<b>100.0</b>
Period of marriage	$\leq 10$ years	127	60.2	127	60.2
	$> 10$ Years	84	39.8	84	39.8
	<b>Total</b>	<b>211</b>	<b>100</b>	<b>211</b>	<b>100</b>
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
	<b>Total</b>	<b>211</b>	<b>100.0</b>	<b>211</b>	<b>100.0</b>
	$\bar{X} \pm SD(R)$		<b>2.17 <math>\pm</math> 5.0.708 (1-7)</b>		

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.

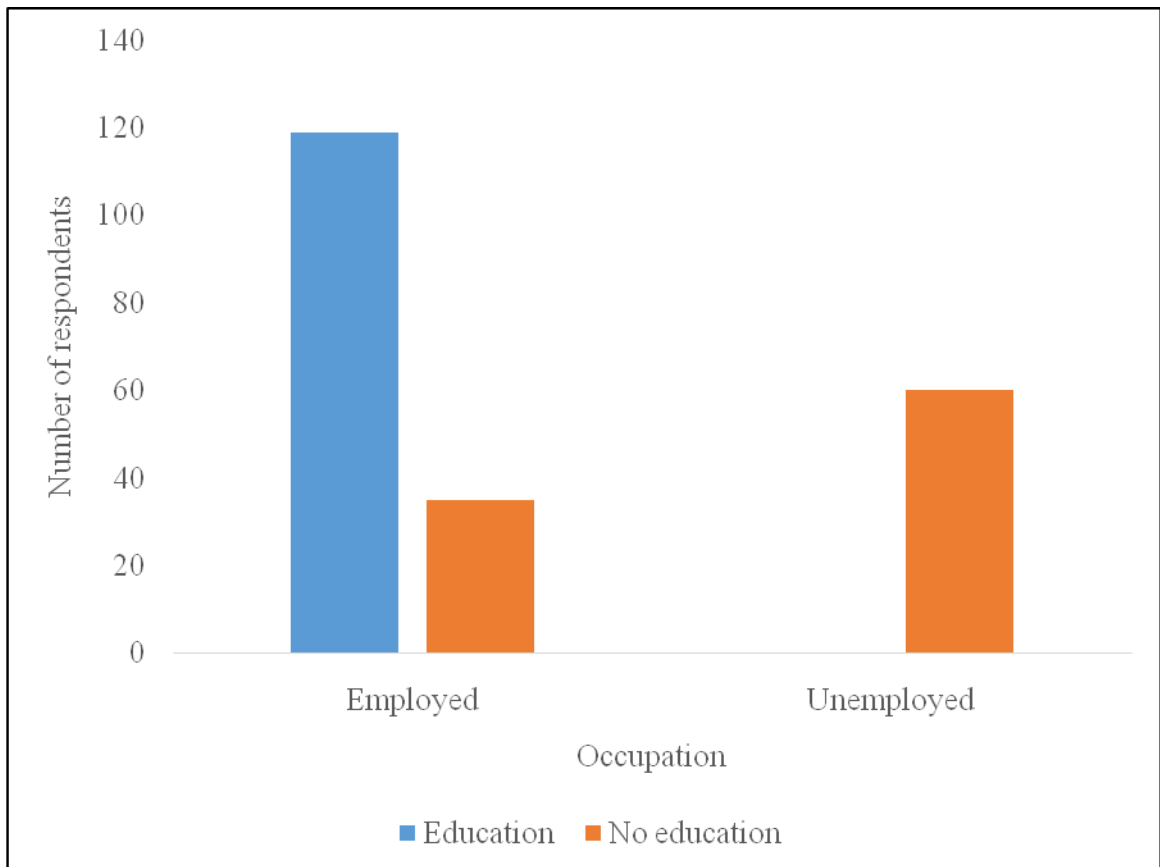


Most of the respondents are casual labourers with female respondents leading with 66 (31.3%) compared to 52 (24.6%) of the male respondents. More males 43 (20.4%) were self-employed as compared to 7 (3.3%) of the female respondents who are self-employed.

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

#### 4.2.1 Relationship of the Occupation and Education

Majority of the respondents who were employed had education compared to those who were unemployed (Figure 4.1).



## **Figure 4.1: Occupation and Education of the Respondents**

### **4.3 Male Partner Influence on Pregnant Women's Decision to Seek Antenatal Clinic Service**

Male partner influence involves male partners 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, type of marriage shows that those who are in monogamous marriage are more likely to influence the spouse ANC attendants as compared to those in polygamous marriage (OR: 1.321;  $p=0.001$ ). Living together on the hand (OR: 1.989;  $p=0.03$ ) are more likely to influence the pregnant woman's decision to seek antenatal care service than those not living together.

**Table 4:2: Male partner socio demographic factors and influence on wife attendance for antenatal care**

		wife attended antenatal clinic		Odd ratio	95% Confidence Interval		p-value
		Yes	No		Lower	Upper	
Age	15-34	183	5	0.973	0.75	2.00	0.429
	35-49	23	0				
<b>Total</b>		<b>206</b>	<b>5</b>				
Type of marriage	Monogamy	168	0	1.132	0.95	2.55	0.001
	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	1.989	1.25	3.95	0.03
	No	23	1				
<b>Total</b>		<b>206</b>	<b>5</b>				
Education	Education	175	5	0.972	0.45	1.75	0.348
	No education	31	0				
<b>Total</b>		<b>206</b>	<b>5</b>				
Occupation	Employed	145	5	3.967	2.50	7.55	0.149
	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 to

influence the male partner to be involved in the decision on where the woman attended the antenatal clinic ( $p = 0.469$ ). 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 as compared to those not living together, those without education and are unemployed. Age of male partners below 34 years or above and type of marriage does not have any contribution towards decision on the facility the wife attends ANC (OR= 0.480; 0.687) (Table 4.3).

**Table 4.3: Male partners involved in decision on where the pregnant woman attended antenatal clinic**

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

#### **4.3.3 Male Partner Accompanying Pregnant Wife to the Antenatal**

The analysis showed that the socio-demographic factors influenced the male partner to accompany the wife to attend the antenatal clinic. The age of 34 years and below ( $p=0.001$ ) is significant and therefore male partners of this age will accompany their wives to the ANC as compared to those above 35 years. Type of marriage, education and

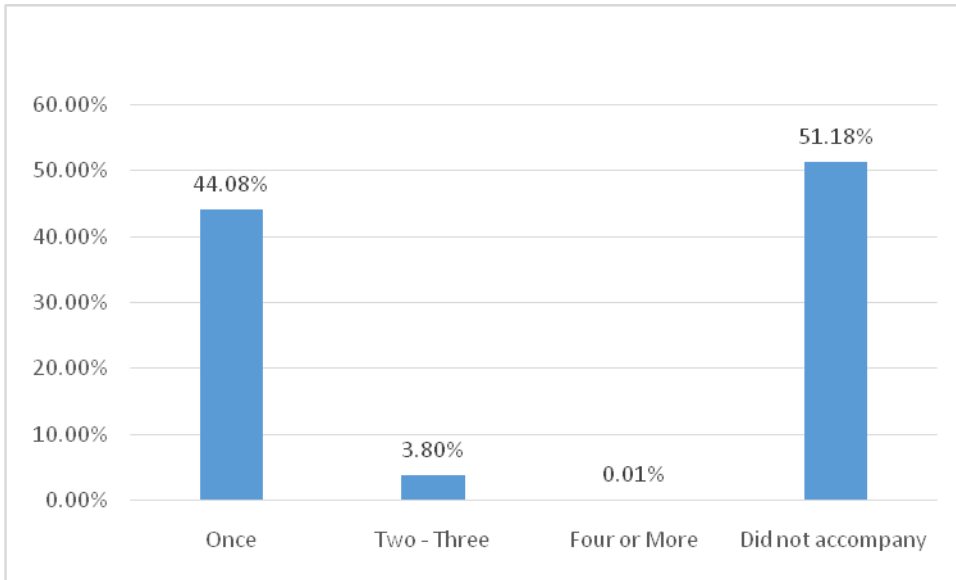
occupation of the respondents were also significant and there was relationship on the male partners to accompany the wives during ANC visits. However, living together does not have any significance as shown by the p value  $> 0.05$ ; therefore, does have influence on the male partners to accompany their wives for antenatal care. From the analysis of odd ratio, the analysis shows that living together as compared to those not 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 1.385).

**Table 4.4: Male partner accompanying wife to antenatal clinic**

		Accompanied wife to the antenatal clinic during her last pregnancy		Odd ratio	95% Confidence Interval		p-value
		Yes	No		Lower	Upper	
Age	15-35	103	85	0.432	0.15	1.95	0.001
	35-49	0	23				
Total		103	108				
Type of marriage	Monogamy	65	103	0.083	0.10	0.75	0.001
	Polygamy	38	5				
Total		103	108				
Living together with wife at the time of her last pregnancy	Yes	93	94	1.385	1.25	2.75	0.035
	No	10	14				
Total		103	108				
Education	Education	103	77	0.428	0.25	1.85	0.001
	No education	0	31				
Total		103	108				
Occupation	Employed	103	47	0.313	0.15	1.75	0.001
	Unemployed	0	61				
Total		103	108				

#### **4.3.4 The Number of Times the Husband Accompanied Wife for ANC**

The majority 109 (51.18%) of the respondents did not accompany the woman to antenatal clinic. However, most respondents 93 (44.08%) of those who accompanied only once (Figure 4.2)



**Figure 4.2 The number of times the male partner accompanied wife for ANC**

#### **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 4.5).

*“Since this was my wife’s first pregnancy, I thought it was very important for me to accompany her to the clinic. So I went with her once and the rest she went on her own because i was sure she and the child she was carrying were safe....”*  
(A father of one)



**Table 4.5: 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	<b>.000</b>
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.

Kappa test was done to measure the degree of agreement which was 0.99. This is equivalent to 99% agreement between the female and male partner responses. This was done to confirm the response of male partners and their wives. The value of 0.9945 shows that there is strong evidence the response of male partners and female were agreeing.

**Table 4.6: Kappa Test**

Step	-2 Log Likelihood	Kappa test	Cox & Snell R Square	Nagelkerke R Square	Chi-square	P-value
1	75.256 <sup>a</sup>	0.9945	.494	.857	143.820	0.000

This results showed that the responses from the subjects could be relied upon since it was agreeing.

#### **4.4: The Participation of Male Partner during Pregnancy, Delivery and Postnatal**

##### **4.4.1 Male Partner Support**

The participation in this section involves the male partner support and discussion of maternal health issues both with the wife and the health care provider of the wife. In order to answer this objective, the study sought to find out whether there was male partner participation during pregnancy, labour, delivery and postnatal. In addition, to find out whether the male partner participated in making joint plans for emergency situations during the wife's last pregnancy and the preparation made. The analysis in the figure below shows that the respondents planned for pregnancy and labour by putting money aside but it also indicates that there was no plan for emergencies during delivery and postnatal.

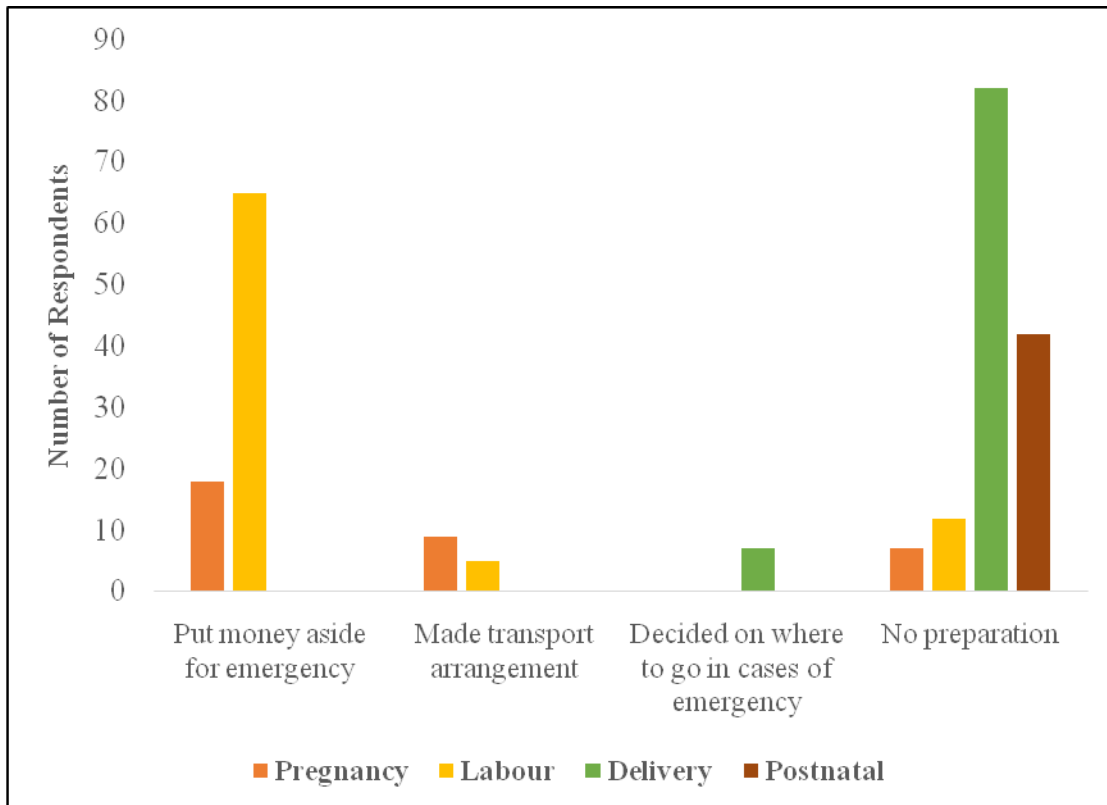
##### **4.4.2 Planning for Emergencies during Perinatal Period**

Emergency preparation and readiness for a woman during pregnancy, labour and postnatal is very important. Therefore the table blow (Table 4.7) indicates that age, type of marriage, education and occupation ( $p=0.0001$ ) is significant and male partners plan together with their wives on emergency plan and the preparation made. Male partner

living together with wife at the time of her pregnancy is 1.3 times likely to be involved in emergency preparation (OR Table 4.7).

**Table 4.7: Planning for emergencies during perinatal period**

		Planning for emergencies during				Odd ratio	95% Confidence Interval		P-value
		Pregnancy	Labour	Delivery	Postnatal		Lower	Upper	
Age	15-34	21	81	79	7	0.463	0.25	1.95	0.001
	35-49	0	0	0	23				
Total		21	81	79	30				
Type of marriage	Monogamy	0	62	81	25	0.079	0.20	1.75	0.001
	Polygamy	21	17	0	5				
Total		21	81	79	30				
Living together with the wife at the time of her last pregnancy	Yes	19	71	73	24	1.327	1.00	2.50	0.518
	No	2	8	8	6				
Total		21	81	79	30				
Education	Education	21	77	69	13	0.439	0.25	1.95	0.001
	No education	0	2	12	17				
Total		21	81	79	30				
Occupation	Employed	21	79	50	0	0.327	0.20	1.80	0.001
	Unemployed	0	0	31	30				
Total		21	81	79	30				



**Figure 4.3 Planning for emergencies and preparation made**

The study sought to find out whether socio-demographic factors made the male partners participate during pregnancy, labour and delivery and postnatal care. The null hypothesis that the male do not participate during pregnancy, labour and delivery and postnatal care was tested at 5% significance level using chi-square test.

#### **4.4.3 Male Partner Discussing Health Issues with Wife**

From the analysis, age, type of marriage, education and occupation ( $p = 0.001$ ) of the respondents influences male partner to participate in discussion of maternal health issues with the wife, but living together ( $p=0.219$ ) does not influence the spouse to participate during this period. From the analysis of odd ratio, the analysis shows that living together (OR = 1.706) which 1.7 times more likely to make the male to participate by discussing

health issues during pregnancy, labour and delivery and during the postnatal period as compared to those not living together.

**Table 4.8: Male partner discussing health issues with wife**

		Discussing health issues with wife				Odd ratio	95 CI		p-value
		Pregnancy	Labor	delivery	Post-natal		Lower	Upper	
Age of respondent	15-34	20	161	4	3	0.266	0.15	1.00	0.001
	35-49	0	0	0	23				
Total		20	161	4	26				
Type of marriage of the respondent	Monogamy	20	123	4	21	0.193	0.50	0.95	0.001
	Polygamy	0	38	0	5				
Total		20	161	4	26				
Living together with wife	Yes	15	148	3	21	1.706	0.50	3.50	0.219
	No	5	13	1	5				
Total		20	161	4	26				
Education	Education	17	150	4	9	0.233	0.21	1.50	0.001
	No education	3	11	0	17				
Total		20	161	4	26				
Occupation	Employed	0	150	0	0	0.080	0.25	0.95	0.001
	Unemployed	20	11	4	26				
Total		20	161	4	26				

#### 4.4.4: Male Partner Discussing Health Issues of the Wife with Healthcare Provider

Table 4.9 demonstrates Male partners participation by discussing health issues with healthcare provider during pregnancy, labor and delivery and postnatal. From the analysis, age, type of marriage, education and occupation of the respondents is significant to the male partners to participate during perinatal period. Living together does not indicate any association for male partner to participate during pregnancy, labor and delivery and postnatal. From the analysis of odd ratio, it shows that living together, age, type of marriage, education and occupation are not more likely to make the man participate in discussion with the healthcare provider on health issues during pregnancy, labour and delivery and during the postnatal period as indicated in Table 4.9

**Table 4.9: Male partner discussing health issues of the wife with healthcare provider**

		Discussing health issues with healthcare provider				Odd ratio	95%CI		p-value
		Pregnancy	Labour	Postnatal	Did not discuss		Lower	Upper	
Age of respondents	15-34	8	18	67	95	<b>0.777</b>	<b>0.420</b>	<b>1.350</b>	<b>0.011</b>
	35-49	0	0	0	23				
Total		8	18	67	118				
Type of marriage	Monogamy	0	0	55	113	<b>0.003</b>	<b>0.150</b>	<b>0.750</b>	<b>0.001</b>
	Polygamy	8	18	12	5				
Total		8	18	67	118				
Living together with wife	Yes	5	17	62	103	0.715	0.750	1.350	0.507
	No	3	1	5	15				
Total		8	18	67	118				
Education	Education	8	18	67	87	<b>0.767</b>	<b>0.40</b>	<b>1.950</b>	<b>0.003</b>
	No education	0	0	0	31				
Total		8	18	67	118				
Occupation	Employed	8	18	67	57	<b>0.720</b>	<b>0.25</b>	<b>1.85</b>	<b>0.001</b>
	Unemployed	0	0	0	61				
Total		8	18	67	118				

#### **4.4.5 Male Partner Support during Pregnancy**

Majority 147 (69.7%) of the respondents provide funds for ANC compared to helping with household chores and reminding the woman about her ANC. Table 4.10 shows majority of the respondents aged between 15 and 34 provide funds compared to those who are between 35 and 49. The results also shows that majority 142(67.3%) of the respondents in monogamous family provide funds compared to those who are in polygamous family. From the table 4.10 below indicates that those with education and are employed provide support compared to those who have no education and are unemployed.

**Table 4.10 Male partner Support during pregnancy**

		Male partner Support provided to the wife during her last pregnancy			
		Provide funds for ANC	Reminded her of her ANC	Helped with household chores	No support
		No. (%)	No. (%)	No. (%)	No. (%)
Age	15-34	141(66.8)	5	6(2.8)	50(23.7)
	35-49	6(2.8)	0	0	34(16.1)
<b>Total</b>		<b>147(69.7)</b>	<b>5(2.4)</b>	<b>6(2.8)</b>	<b>84(39.8)</b>
Type of marriage	Monogamy	142(67.3%)	5	6(2.8)	41(19.4)
	Polygamy	5	0	0	43(20.4)
<b>Total</b>		<b>147(69.7)</b>	<b>5(2.4)</b>	<b>6(2.8)</b>	<b>84(39.8)</b>
Living together with wife	Yes	131(62.1)	5(2.4)	5(2.4)	72(34.1)
	No	16(7.6)	0	1	12(5.7)
<b>Total</b>		<b>147(69.7)</b>	<b>5(2.4)</b>	<b>6(2.8)</b>	<b>84(39.8)</b>
Education	Education	119(56.4)	5	6	50(23.7)
	No education	28(13.3)	0	0	34(16.1)
<b>Total</b>		<b>147(69.7)</b>	<b>5(2.4)</b>	<b>6(2.8)</b>	<b>84(39.8)</b>
Occupation	Employed	91(42.7)	5(2.4)	6(2.8)	50(23.7)
	Unemployed	56(26.5)	0	0	34(16.1)
<b>Total</b>		<b>147(69.7)</b>	<b>5(2.4)</b>	<b>6(2.8)</b>	<b>84(39.8)</b>

**4.4.6 Male Partner Support during Labour and Delivery**

The study results revealed that majority 133 (63%) of the respondents provide funds for transport compared to helping with household chores and staying with her during labour and delivery. Majority of the respondents 127 (60.2%) aged between 15 and 34 provide funds for transport compared to those who are between 35 and 49. The study also indicated that Monogamous type of family provide funds for transport compared to those who are in polygamous family. Those with education and are employed provide support compared to those who have no education and are unemployed (Table 4.11).

**Table 4.11: Male partner Support during labour and delivery**

Variable		Male partner Support during labour and delivery			
		Provided funds for transport	Stayed with her during labour	Helped with household chores while she was away	No support
		NO. (%)	NO. (%)	NO. (%)	NO. (%)
Age	15-34	127 (60.2)	5	6	50
	35-49	6	0	0	17
Total		133(63)	5(2.4)	6(2.8)	67(31.8)
Type of marriage	Monogamy	128(60.7)	5	6	29
	Polygamy	5	0	0	38
Total		133(63)	5(2.4)	6	67(31.8)
Education	Education	119 (56.4)	5	6	17
	No education	14	0	0	50
Total		133(63)	5(2.4)	6	67(31.8)
Occupation	Employed	89	5	6	50
	Unemployed	44	0	0	17
Total		133(63)	5(2.4)	6	67(31.8)

#### **4.4.7 Male Partner Support during Postnatal Period**

This is the support that male partners offer to their wives after delivery and it revealed that majority 150 (71%) mainly provide food compared to any other kind of support as seen in table below (Table 4.12).



**Table 4.12: Male partner support during postnatal**

Variable		Male partner support provided during the postnatal period			
		Provide funds for her upkeep	Provided food	Helped with household chore	No support
		NO. (%)	NO. (%)	NO. (%)	NO. (%)
Age	15-34	7	133	12	36
	35-49	0	17	0	6
<b>Total</b>		<b>7(3.3)</b>	<b>150(71)</b>	<b>12(5.7)</b>	<b>42(19.9)</b>
Type of marriage	Monogamy	7	109	10	42
	Polygamy	0	41	2	0
<b>Total</b>		<b>7(3.3)</b>	<b>150(71)</b>	<b>12(5.7)</b>	<b>42(19.9)</b>
Education	Education	7	129	12	32
	No education	0	21	0	10
<b>Total</b>		<b>7(3.3)</b>	<b>150(71)</b>	<b>12(5.7)</b>	<b>42(19.9)</b>
Occupation	Employed	7	131	12	0
	Unemployed	0	19	0	42
<b>Total</b>		<b>7(3.3)</b>	<b>150(71)</b>	<b>12(5.7)</b>	<b>42(19.9)</b>

Table 4.12 reveals that majority 150 (71%) of the respondents provided food during the postnatal period. The results also showed that the respondents aged between 35 and 49 together with those who are unemployed with no education never helped in household chores. Minority 7 (3.3%) of the male respondents provided funds for the upkeep of the woman (Table 4.12).

To determine whether there was association between male partner support and socio demographic characteristics of male partners. Results revealed that age, type of marriage, living together, education and occupation of the respondents ( $P= 0.001$ ) influences the male partner to participate in terms of support during pregnancy, labor and delivery and

postnatal but with variations to the extent of support (Table 2.13). From the analysis of odd ratio as shown below, the study showed that living together is more likely to make the man participate in support during pregnancy, labour and delivery and during the postnatal period than age, type of marriage, education and occupation.

**Table 4.13: Male partner support provided during perinatal period**

		Support given during				Odd ratio	95% confidence Interval		p-value
		Preg-nancy	Labour	Delivery	Postnatal		Lower	Upper	
Age of respondents	15-34	116	13	65	8	<b>0.362</b>	<b>0.40</b>	<b>0.95</b>	<b>0.001</b>
	35-49	34	2	4	0				
Total		150	15	69	8				
Type of marriage of the respondents	Monogamy	137	15	36	6	<b>0.125</b>	<b>0.10</b>	<b>0.55</b>	<b>0.001</b>
	Polygamy	13	0	33	2				
Total		150	15	69	8				
Living together with wife	Yes	127	13	66	7	1.367	1.25	2.50	0.001
	No	23	2	3	1				
Total		150	15	69	8				
Education	Education	108	13	51	8	<b>0.333</b>	<b>0.15</b>	<b>0.80</b>	<b>0.001</b>
	No education	42	2	18	0				
Total		150	15	69	8				
Occupation	Employed	85	11	48	8	<b>0.200</b>	<b>0.15</b>	<b>0.75</b>	<b>0.001</b>
	Unemployed	65	4	21	0				
Total		150	15	69	8				

#### 4.4.8 Male Partner Involved in Discussing Maternal Health Issues

The study established that male partner participation is more influenced by occupation ( $p=0.001$ ) and age ( $p=0.001$ ) of the male respondents but not education (Table 4.14).

**Table 4.14:Discussing maternal health issues**

Model		Unstandardized Coefficients		Standardized Coefficients	T	Sig.
		B	Std. Error	Beta		
1	(Constant)	8.917	.234		38.032	.000
	Education	.097	.219	.028	.443	.658
	Occupation	.723	.193	.233	3.738	.000
	Age of respondents	2.254	.230	.559	9.785	.000

a. Dependent Variable: discuss maternal health issues

The participation of male is more influenced by education and age but not the occupation of the respondents. From the analysis, at 5% significance level, the null hypothesis is rejected that there is no male participation during labor, delivery and postnatal. Therefore we conclude that male participated in during labor, delivery and postnatal, though with variations in terms of physical and moral support.

#### **4.5 Factors that Influence Male Partner Involvement in Maternity Care**

This section deals with health facility factors that include staff attitude, space and privacy of clients during perinatal period. To establish whether there were factors that influenced male partner involvement in maternity care, a sample of 422 selected married males and female respondents gave their response about the attitude of the health care staff and the time they had to spend at the health facility. The summary of the findings is as shown below.

#### 4.5.1 Attitude of Health Care Staff

The health care facility staffs were friendly as indicated by male partner who at least visited the health facility (87.7%).

**Table 4.15: Attitude of health facility staff**

		Describe the attitude of the health staff			
		Friendly	Unfriendly	Indifferent	Don't know
		No. (%)	No. (%)	No. (%)	No. (%)
Age	15-34	181(85.7)	0	0	21(10)
	35-49	4(1.9)	14(6.6)	22(10.2)	0
<b>Total</b>		<b>185(87.7)</b>	<b>14(6.6)</b>	<b>22(10.2)</b>	<b>21(10)</b>
Education	Education	157(74.4)	2(0.9)	0	21(10)
	No education	28(13.3)	12(5.7)	22(10.4)	0
<b>Total</b>		<b>185(87.7)</b>	<b>14(6.6)</b>	<b>22(10.2)</b>	<b>21(10)</b>
Occupation	Employed	131(62.1)	0	0	21(10)
	Unemployed	54(25.6)	14(6.6)	22(10.2)	0
<b>Total</b>		<b>185(87.7)</b>	<b>14(6.6)</b>	<b>22(10.2)</b>	<b>21(10)</b>

The study revealed 10% who did not attend the health facility didn't have information on the attitude of staff. It was also noted that majority (81%) of the respondents said they spend reasonable time at the health facility while 23.7% reported to have taken too long time duration.

**Table 4.16: Time spent at health facility**

		Assess the time you had to spend at the health facility		
		Reasonable	Too long	Don't know
		No. (%)		
Age	15-34	131(62.1)	14 (6.6)	16 (7.5)
	35-49	40 (19)	36 (17)	7(3.3)
<b>Total</b>		<b>171(81)</b>	<b>50 (23.7)</b>	<b>21(10)</b>
Education	Education	109(51.7)	50(23.7)	1(0.5)
	No education	62 (29.4)	0	20(9.5)
<b>Total</b>		<b>171(81)</b>	<b>50(23.7)</b>	<b>21(10)</b>
Occupation	Employed	81 (38.4)	39(18.5)	14(6.6)
	Unemployed	90 (42.7)	11 (5.2)	7(3.3)
<b>Total</b>		<b>171(81)</b>	<b>50(23.7)</b>	<b>21(10)</b>

When asked to assess the time spent at the health facility, majority of the respondents found the time spent in hospital to be reasonable as shown in Table 4.16 above.

#### **4.5.2 Male Partners Allowed to be Present during Labour**

To find out whether male partners were allowed to stay with their wives during labour, twenty one respondents who escorted their wives during labour responded. Majority (80.8%) said that men were not allowed in labour while a smaller percentage (19.2%) acknowledged that men were allowed to be present during labour. Those who never took their wives to the health facility during labour didn't know whether male are allowed in during labour.

**Table 4.17: Male partners allowed to be present during labour**

		Male partners allowed to be present during labour in the facility they attended (No. attended 26 =100%) Never attended 162		
		Yes (%)	No (%)	Don't know
Age	15-34	5(19.2)	21(80.8)	162
	35-49	0	0	23
<b>Total</b>		<b>5(19.2)</b>	<b>21(80.8)</b>	<b>185</b>
Education	Education	5(19.2)	21(80.8)	154
	No education	0	0	31
<b>Total</b>		<b>5(19.2)</b>	<b>21(80.8)</b>	<b>185</b>
Occupation	Employed	5(19.2)	21(80.8)	124
	Unemployed	0	0	61
<b>Total</b>		<b>5(19.2)</b>	<b>21(80.8)</b>	<b>185</b>
Type of marriage	Monogamy	4	0	168
	Polygamy	1	21(80.8)	17
<b>Total</b>		<b>5(19.2)</b>	<b>21(80.8)</b>	<b>185</b>
Living together	Yes	3(11.5)	19(73.1)	165
	No	2(7.7)	2 (7.7)	20
<b>Total</b>		<b>5(19.2)</b>	<b>21(80.8)</b>	<b>185</b>

#### 4.5.3 Male Partners Allowed to be Present during Delivery

During delivery all male who escorted their wives during labour were not allowed to stay with their wives during delivery (Table 4.18)

**Table 4.18: Male partners allowed to be present during delivery**

		Male partners allowed to be present during delivery in the facility they attended	
		No	Don't know
Age of respondents	15-35	26(100%)	162
	35-49	0	23
<b>Total</b>		<b>26(100%)</b>	<b>185</b>
Education	Education	26	154
	No education	0	31
<b>Total</b>		<b>26(100%)</b>	<b>185</b>
Occupation	Employed	26(100%)	124
	Unemployed	0	61
<b>Total</b>		<b>26(100%)</b>	<b>185</b>
Type of marriage	Monogamy	26(100%)	168
	Polygamy	0	17
<b>Total</b>		<b>26(100%)</b>	<b>185</b>
Living together	Yes	22	165
	No	4	20
<b>Total</b>		<b>26(100%)</b>	<b>185/211(87.7%)</b>

From the results in Table 4.18, it is clear that majority (87.7%) of male respondents who did not escort their wives to the health facility during labour don't know whether to be present during delivery or not.

#### **4.5.4 Space in the Health Facility**

From the results the respondents indicated that space and privacy in the health facility was not adequate hence are factors that will influence male partners to be involved in maternity care (Table 2.18). Those male partners who escorted their wives during labour responded on the issue of space and privacy in labour room.

**Table 4.19: Space in the health facility**

		Availability of space in the health facility for male partners during labour and delivery		
		Yes	No	Don't know
Age	15-35	2(7.7)	24(92.3)	162
	35-49	0	0	23
<b>Total</b>		<b>2(7.7)</b>	<b>24(92.3)</b>	<b>185</b>
Education	Education	2(7.7)	24	154
	No education	0	0	31
<b>Total</b>		<b>2(7.7)</b>	<b>24(92.3)</b>	<b>185</b>
Occupation	Employed	2(7.7)	24(92.3)	124
	Unemployed	0	0	61
<b>Total</b>		<b>2(7.7)</b>	<b>24(92.3)</b>	<b>185</b>
Type of marriage	Yes	0	0	168
	No	2(7.7)	24(92.3)	17
<b>Total</b>		<b>2(7.7)</b>	<b>24(92.3)</b>	<b>185</b>
Living together	Yes	1(3.8)	23(88.5)	165
	No	1(3.8)	3(11.5)	20
<b>Total</b>		<b>2(7.7)</b>	<b>24(92.3)</b>	<b>185</b>

Study findings showed that majority (87.7%) who never attended the health facility of the respondents don't know whether there is space in the health facility during labor and delivery.



**Table 4.20: Space in the health facility**

		Privacy in the health facility you attended during labour and delivery	
		No	Don't know
Age	15-34	26(100%)	162
	35-49	0	23
<b>Total</b>		<b>26(100%)</b>	<b>185</b>
Education	Education	26 (100%)	154
	No education	0	31
<b>Total</b>		<b>26(100%)</b>	<b>185</b>
Occupation	Employed	26(100%)	124
	Unemployed	0	61
<b>Total</b>		<b>26(100%)</b>	<b>185</b>
Living together	Yes	22	16
	No	4	20
<b>Total</b>		<b>26(100%)</b>	<b>185</b>
Type of marriage	Monogamy	0	168
	Polygamy	26(100%)	17
<b>Total</b>		<b>26(100%)</b>	<b>185</b>

From the results it is clear that majority of the respondents 185(87.7%) don't know whether there is privacy in the health facility during labor and delivery. The researcher sought to find out whether space in the health facility influences the man to attend antenatal clinic services. The null hypothesis that space does not influence man to attend antenatal clinic was tested at 5% significance level.

**Table 4.21 Regression Analysis on Space**

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	4.361	.393		11.109	.000
	Space in the health facility	.182	.068	.182	2.676	.000

a. Dependent Variable: accompany

From the analysis, space in the health facility has influence on the male partner involvement in maternal care.

The results also showed that privacy in the health facility influences the male to attend antenatal clinic services. Regression analysis was used to determine whether privacy is a predictor in influencing male partners to escort their wives to the health facility during perinatal period. This was tested at 5% significance level.

**Table 4.22 Regression analysis on privacy**

Model		Unstandardized Coefficients		Standardized Coefficients	T	Sig.
		B	Std. Error	Beta		
1	(Constant)	4.207	.438		9.614	.000
	Privacy in the health facility	.208	.076	.187	2.750	<b>.000</b>

a. Dependent Variable: accompany

From the regression analysis in Table 4.22, study findings showed that the relationship between accompaniment versus privacy in the healthy privacy is statistically significant (0.000). Thus privacy will influence the male partner involvement in maternal care.

**Table 4.23 Regression Analysis**

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
	(Constant)	2.648	.127		20.808	.000
	Age	.116	.020	.370	5.860	.000
	Educational	.075	.021	.224	3.570	.000
	Number of children	-.056	.031	-.109	-1.800	.073
	Were you living together with your wife at the time of her last pregnancy	-.149	.069	-.130	-2.151	.033

a. Dependent Variable: Was there space in the health facility you attended during labour

From the analysis, age and educational level of the respondents are statistically significant ( $p=0.000$ ), hence will influence the male partner involvement in maternity care. Conversely, number of children and living together ( $p>0.05$ ), may not influence the man to be involved in maternal care as seen in Table 4.24 below.

**Table 4.24 Regression Analysis**

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
	(Constant)	.395	.147		2.689	.008
	Age	.288	.023	.671	12.559	.000
	Educational	.030	.024	.066	1.249	.213
	Number of children	.078	.036	.111	2.168	.031
	Were you living together with your wife at the time of her last pregnancy	.005	.080	.003	.058	.954

a. Dependent Variable: Did the male partner accompany his wife to the antenatal clinic during her last pregnancy

From the regression analysis, age (0.001) of the male respondents, is more likely to influence the male partner involvement in maternity care but education level (0.213), living together (0.954) and the number of children (0.031) will not influence the male partner involvement in the maternal care.

## **CHAPTER FIVE**

### **DISCUSSION**

#### **5.1 Introduction**

The issue of maternal health has predominantly been seen and treated as a purely feminine matter over the years. However, the exclusion of male partners from active involvement in these issues represents a lack of appreciation of the social reality of daily living in most developing societies, particularly in Africa. In this study Male partner involvement in maternity care services during perinatal period in Mumias East and West sub-counties provided an insight on male involvement in maternity care during perinatal period. Although many studies have reported positive benefits of male involvement in developed and developing countries which include: access to antenatal and postnatal services, male who were part of antenatal and postnatal clinic per take in the education given at this clinics. In this study we determine male partner influence on pregnant woman's decision to seek antenatal care, investigated the participation of male partner during perinatal period and thirdly was to determine factors that influence the male partner to be involved in maternal care.

#### **5.2 Demographic Characteristics**

The demographic pattern shows that majority of the respondents (89.1%) were found within the age groups of 15 to 34 years; this meant that most men with the youngest child equal or less than one year in Mumias community were still within their active reproductive years. The results also shows that most women get married earlier than men as seen in ages 20-24 (41.7%). The early marriage of women can be attributed to low level of their education as majority of them had primary education (58.3%) or no

education (16.1%).The low level of education among the women was also portrayed by the rate of unemployment (58.3%) compared to that of men (28.9%) unemployed. The results also showed that the respondents between ages 35- 49 were few, this is because of the inclusion criteria of the sample where the respondents were supposed to have their younger child equal to or less than one year old.

Majority of the respondents are unemployed or are employed as casual labourers making it a challenge to support maternal issues. The results shows that 82% were Christians and since the Christian values does not allow polygamy, it is assumed that the high percentage of monogamy is reflected by the Christian values. From the analysis majority of the respondents have 2-4 children while minority have more than five children. This is most likely reflected by the majority of the age group of both male and female being below 30 years.

### **5.3 Male Partner Influence on Pregnant Woman's Decision to Seek Antenatal Clinic**

From the study the husband and wife living together will influence pregnant woman's decision to seek antenatal care (ANC) this could be attributed to the fact that they are staying together hence can remind or escort the wife to the ANC clinic. Another study done in cape town in male involvement in PMTCT revealed that couples who lived together were involved and could escort their wives to the health facility for maternity care(Barron *et al.*, 2013). However, the age of the male partner respondents did not have any influence. This concurs with the study done in eastern Uganda on male partner antenatal attendance who did not find any association between the male's age and Male

involvement (Byamugisha *et al.*, 2011). It also agrees with (Wassie *et al.*,2014) and differs with the study done in Kinshasha Zaire (Ditekeman *et al.*, 2012) who revealed that men with women older than 35 years were more involved in maternity care. The husband's role during the antenatal period was explained by gender-specific reasons that household chores were women's job, men only assist when the woman is pregnant and cannot manage to perform. This was well illustrated during both male and female FGD.

*“My husband and I live together and he will make sure I have gone to antenatal clinic for checkup, he reminds me that the baby's health is important.... But he (husband) doesn't come with me to the clinic... (A mother of two – FGD)*

Educated men that escorted their wives were stereotyped and subjected to gossip by their male counterparts and interestingly by women found in the clinics while in the process of seeking pregnancy care. This resulted to prejudicial views like, husband's too much love for the wife, the clinic being a domain of women and therefore women were expected to escort their colleague women to clinics to the health facility. From the FGD participants reiterated that a large age gap within couples was another factor that restricted men from escorting women to clinics. Older men who married the young girls, felt ashamed to visit health facilities together with their partners despite the status attached to marrying a young wife.

*“The men who dared escort their wives for ANC clinic were seen as weak and that their wives must have cooked something for them in terms of witchcraft therefore this men were ridiculed and sidelined by other real men.... I would not like that to happen to me....” (A male respondent during FGD)*

Men were identified with masculine role of providing financial support as narrated during FGD. From the study it was clear that male partners supported their spouses with material support like finances and providing food. 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.

Male partners 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.

*“Where are these men, my husband leaves very early in the morning and comes back at night. He is not even there to see whether he can escort me to antenatal clinic, though he has to go out and work to enable us get what to eat and even get some money for transport to attend ANC clinic.”(A mother of two, Housewife during FGD)*

On Decision on where the woman would seek ANC the male partner with education, occupation and living together (OR: 2.030, 2.103, 2.064) were two times more likely to influence the pregnant woman decision on where to attend ANC as compared to those without education, no employment and were not living together. 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.

#### **5.4 Participation of Male Partner during Pregnancy, Labor and Delivery and Postnatal**

Male partner’s ability to be present at antenatal care is subject to numerous external constraints, such as, social cultural factors, time, work demands and other family members’ attitudes toward men’s involvement. The data revealed that male partners who discussed maternal health issues with the wife were more likely to discuss with the health care provider. This was seen with significant value on those who discussed maternal health issues which included those aged 15-34 years and were educated. Though the male

partners also acknowledged the first priority given to them when they accompany their wives for care.

*“When a woman goes to the antenatal clinic together with her husband she is allowed to go in first than the one who comes alone. Even if a woman comes at 12 noon with her husband and the other one came early in the morning but without a husband, she is told to wait and the woman who came with her husband would be served first. Just because it is the law that the government put in place to promote male involvement in this program but still being ridiculed by colleague men supersedes the first priority that will be given to me and my wife”(Male participant during FGD)*

Decision making powers of men were mostly based on religious obligations, cultural and traditional reasons and husbands being main providers and custodian of money for transport fares for women to access antenatal care. However, women’s decision to seek delivery care was largely determined by the pregnant women themselves contrary to a study done in Busia Kenya by Nanjala &Wanjala (2012) and in Gambia where mothers and mothers’ in-laws and elderly women in the communities were the key decision makers(Lotching *et al.*, 2010). The mothers in laws took care of the pregnant women. Essentially, few respondents saw decision making and care seeking as a process that requires communication between couples, but this was restricted by culture and individual disposition, which seemingly rendered men’s limited understanding of reproductive needs of women.

Some informants felt ashamed to talk to their partners about pregnancy and child birth issues and this further spurred women’s perceived difficulties in informing their husbands about their proposed visit to seek antenatal care. A few others felt they were just ashamed to talk to a man about reproductive issues. Lack of communication often resulted to male

partners being unaware of women's health care. This therefore, makes male partners keeping to themselves and only waiting for the woman to make a request. From the study spouses living together were 1.7 times more likely to discuss maternal health issues with the partner (OR 1.706). This differs from a study done in Nigeria indicating that, those educated were more likely to discuss reproductive health issues with the wife (Banalola *et al.*, 2009).

*“When my wife is pregnant....She never tells me... I only know by observing her stomach....A tree flowers before bearing fruits (literally look for signs of pregnancy)...most women do hide pregnancy issues from their husbands... and you know one can offer help on something one knows about...that's why we (men) keep to ourselves, but we see then we provide good food for her health and the baby” (A 28 years husband narrated during FGD)*

Some women expressed similar feelings suggesting some social cultural factors to some extent influenced individual dispositions regarding husband and wife reproductive health communication and care seeking attention.

*“I never discuss pregnancy and child birth issues with my husband...I do feel ashamed...In our culture it is very hard for a man and woman to discuss pregnancy and child birth which is a good morale” (A 32 year old woman during FGD).*

The study revealed that male partners participated during perinatal period but with variations. Those with education living together were 1.4 times more likely to participate by supporting the wife during perinatal period (OR 1.4). Kululanga (2011) found that male involvement during the perinatal, newborn and early childhood periods can lead to favorable outcomes for the entire family and increases the likelihood that the father will continue to provide care throughout his children's lives. Additionally, Olayemi *et al.*, (2010) argued that men can participate in helping pregnant women stay health by making sure that the women get proper antenatal care which may entail providing transportation

or funds to pay for her visits. This included accompanying the wife during antenatal visits where the man can learn about the symptoms of pregnancy complications and how to respond to an obstetric emergency.

### **5.5 Factors that Influence Male Partner Involvement in Maternity Care.**

The respondents had the belief that antenatal clinics were women's places and men should not interfere. This finding is in agreement with Byamugisha (2010), who reiterates that men frequently perceive ANC services were designed and reserved for women, thus men are embarrassed to find themselves in such "female" places. Some men believe it was 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 identification of men with masculine roles affirm the notion that men are socialized to be superior in terms of decision making and to be financial providers. As such it has proved to be a challenge for male partners to participate in activities that are feminine including health issues concerning their wives. This agrees with a study done in Kinshasha Zaire (Wassie *et al.*, 2012), one of the participants made an exclamation;

*"Heheeee!!! (Exclamation made) "Mwanaume Mwanga" (A Wanga man) cannot dare wash utensils or do household chores. He can't, he is a man and therefore household chores are meant for women. Even his own mother can't allow him do that....." (A mother of one, primary school teacher)*

Although some male partners desired to support their spouses, they have been curtailed by cultural definitions of maleness and roles of masculinity. As a result, they fear being

excluded and ridiculed by other men in the community whom they imagine will call their manhood into question. Similarly, in a study done in western Kenya, Onyango *et al.*, (2012) observed that gender norms were one of the factors that inhibit male involvement in maternal health care. For instance, men are not expected culturally to accompany their wives to the clinic. If they do, this was perceived by their peers as a demonstration of weakness.

Male partners during FGD indicated that distance and time spent attending ANC with wife would result to time wasted for work to earn since most of them were either casual labourers like “Bodaboda” riders. A previous qualitative study conducted in western Kenya by Reece *et al.*, (2010) found that, the distance male partners have to travel to the clinics to participate in the education, blood tests and counseling, the costs of the transport to the clinics and the amount of time per appointment at the clinic were identified as barriers to male involvement. Access or logistical challenges on the part of men prevented them from participating in ANC. Men talked about their perceived principal responsibilities as providers. Thus, time spent at clinics and away from work or other income generating activities was clearly perceived as a barrier to their participation in ANC program distance, the cost of transport and the clinic operation hours were also mentioned with some frequency (Reece *et al.*, 2010).

*I have not escorted my wife to any of her ANC during pregnancy because I care and I have to provide for their food and everything they need for survival..... (Male Respondent during FGD)*

Majority of the respondents appreciated the fact that the clinic was quite heavy and that the health care providers tried a great deal to remain friendly and helpful despite the burn out. The findings established that there was dominance of the female staff in the clinic

which should be improved if it is to encourage the men to go to the clinics. The main complaint was the congestion in the clinic which made male partners feel out of place and the long queues wasted so much of their time in the clinic. The above finding differs with the previous studies where Byamugisha *et al.*, (2010), reported that harsh, critical language directed at Ugandan women from skilled health professionals was a barrier to male partner participation.

Most of the suggestions made by members of both the male and female focus-groups for improving male partners' involvement had to do with the cultural norms and health facilities factors such as space and privacy. Contrary to the notion that men were just not interested in their partners' maternity care, this study revealed that men are interested but the cultural norms and health facility factors were strong barriers to their involvement.

Furthermore, in relation to support during labour and delivery, health care providers did not allow men access. Men mentioned health-care workers not allowing men to enter the delivery room with their partners". This was affirmed by one of the male respondents who mentioned that;

*"When I took my wife to hospital for delivery, I was told by sister (nurse midwife), that I have done my part therefore, I should not be seen around. I was told I could only come the next day to check if she had delivered and take her home. So whom am I to disobey the doctor's orders? (A father of one, primary school teacher)"*

*"I have had my three children and my husband has never escorted me to antenatal clinic. To me those are women's issues and we discuss it with other women but he will provide money for transport and food and that is good responsibility for a man (housewife, a mother of three children)"*

There were assumptions and beliefs that husbands' presence during labour was mostly restricted by cultural and traditional beliefs, such as the belief that men became sick and swollen when witnessing their spouse deliver. They also believed that men became

impotent when they see delivery, blood and men losing the potential spiritual powers of their amulets (jujus) if witnessed their spouse deliver. Some of these beliefs ran through different ethnicities and some were specific to certain ethnicity. Some cultures even restricted physical contact of men and the newly born baby in the first three and four days of postpartum. Religious beliefs were another factor that restricted men from being involved in the delivery process of their spouse. Finally, Male partners during FGD reiterated that there were actually no taboos or cultural beliefs that really restricted the male partners in participating in maternity care. However, majority only believed and followed what was said by their seniors without question.

A minority of the male partners who escorted their wives to the smaller health facilities were allowed and were able to stay in with their wives unless they opted out by themselves.

## **CHAPTER SIX**

### **CONCLUSION AND RECOMMENDATION**

In this chapter conclusions and recommendations based on the study findings is done. This chapter draws out the key points regarding the Male partner involvement in maternity care services during perinatal period in Mumias East and West Sub-Counties, Kakamega County, Kenya. Furthermore, recommendations are also given based on the study findings.

#### **6.1 Conclusion**

Male partner involvement on maternal care services during perinatal period in Mumias East and west Sub Counties was not very strong. Male partners' involvement was influenced by various factors that includes socio-demographic, socio-cultural factors and health facility factors. In regard to participation by discussing maternal health issues and support, Male partner's involvement in the health care of their wives was low since very low percentage escorted their wives to the health facility. However, Male partners supported their spouses in terms of finances and provision of food. This still shows that men lag behind in their responsibilities in improving maternal health especially accompanying spouse to the health facility.



## **6.2 Recommendations**

The following recommendations are made to the County government of Kakamega, based on the study findings and conclusions;

- There is need to sensitize and advocate for male partners to be involved during the antenatal care of their spouse
- Health services need to be re-orientated to see men as clients who are also undergoing practical and emotional changes during pregnancy, and that they need to be prepared for parenting in the same way as women.
- There is need to promote and advocate for increased level of education to improve the socio economic status of the men to enable them support their wives during perinatal period.
- To improve men's access to maternity services and facilitate the need for adequate space both in ante natal clinics, labour and delivery rooms.
- The County government of Kakamega to reorient maternal health services to include hospital delivery centres and sensitization of clients, perhaps through mass media efforts on the importance of male partner involvement in maternity care.

## REFERENCES

- 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.
- Allendor F. K. (2007). Couples' reports of women's autonomy and health-care use in Nepal. *Stud FamPlann*, 38:35-46.
- 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.
- Anderson N, Omer K, Caldwell D, (2011) Male responsibility and Maternal Morbidity: A cross sectional study in two Nigerian states. *BMC health service*; 11(suppl 2) 1-11
- 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.
- Backstrom C, and Wahn E., (2009). Support during labour: first time father's descriptions of requested and received support during the birth of their child. *Midwifery* 27: 67-73.
- Barron P, Pillay Y, Doherty T, (2013). Eliminating mother-to-child HIV transmission in South Africa. *Bull World Health Organ.*; 91:70–74.
- Bhatta (2013). Involvement of males in antenatal care, birth preparedness, exclusive Breastfeeding and immunizations for children in Kathmandu, Nepal. *BMC Pregnancy & Childbirth* 13:14.
- 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.
- Clark MW. (2002) 'Because he loves me': husbands' involvement in maternal health in Guatemala. *Culture, Health & Sexuality: An International Journal for Research Intervention and Care*; 4(3):259–279. doi: 10.1080/13691050110112784.
- Cohen, S.I., and M. Burger, (2000). Partnering: A New Approach to Sexual and Reproductive Health. Technical Paper No. 3. New York, NY, USA: *United Nations Population Fund. Curr Opin Obstet Gynecol*, 22(6):525-529.

- 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.*
- Dansowaa DOE R., (2013) Male partner involvement in maternity care in Ablekuma South district, Accra, Ghana.*University of Ghana*<http://ugspace.ug.edu.gh>
- David Wamalwa (2012).Determinants of male partner involvement in promoting deliveries by skilled birth attendant in Busia, Kenya. *Global journal of health science. Vol.4:2*
- D’Alieso L, Vellone E, Amato E., (2009)The Positive effects of fathers’ attendance to labour and delivery; a quasi-experimental stud. *Int. Nursperspect* 9; 5-10.
- Dolan A and Coe C., (2011). Men, masculine identities and childbirth. *Social Health Illn* 2011 33(7):1019-34
- Feldman PJ, Dunkel-Schetter C, Sandman CA, Wadhwa P.D., (2010) Maternal social support predicts birth weight and fetal growth in human pregnancy. *Health CareWomenInt, 31(7):621-635.*
- Iliyasu 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.*
- IRIN Plus News (August, 2009). KENYA, Doting dads can lower their children's HIV risk'.
- Johansson M, Rubertsson C, Radestad I, Hildingsson I., (2012). Childbirth – an emotionally demanding experience for fathers. *Sex ReprodHealthc,3(1):11-20.*
- John Ditekemena, Olivier Koole, Cyril Engmann, Richard Matendo, Antoinette Tshefu, Robert Ryder and Robert Colebunders (2012): Determinants of male involvement in maternal and child health services in sub-Saharan Africa: a review. *Reproductive Health, 9:32.*
- Judith Yargawa., (2015).Male involvement and maternal health outcomes: *systematic review and meta-analysis JECH Online /10.1136/jech-2014-204784*
- 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.*
- Kakaire,O., Kaye, D. K., &Osinde, M. O., (2011). Male involvement in Birthpreparedness 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>

- Kenya Bureau of Statistics (KNBS), (2009). *Kenya Census*.
- Kenya National Bureau of Statistics (KNBS) [Kenya], and ICF International (2010). *Kenya Demographic and Health Survey 2008 – 2009*. Calverton , MD, USA: KNBS and ICF International.
- Kenya Demographic Health Survey, (2014). Kenya National Bureau of Statistics (KNBS) and ICF Macro. *Kenya Demographic and Health Survey*.
- Kululanga LI, Sundby J, Malata A, Chirwa E., (2011). Striving to promote male involvement in maternal health care in rural and urban settings in Malawi – a qualitative study. *Reprod Heal*, 8:36.
- Kulunya L. I., J. Sundby, E. Chirwa, A. Malata, and A. Malura (2012). Barriers to Husbands’ Involvement in maternal health care in a Rural setting in Malawi: A qualitative study. *Journal of Research in Nursing and Midwifery* 1(1): 1-10
- Lochting L.I., (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*.
- Longworth H, Kingdon C., (2010). Fathers in the birth room: What are they expecting and experiencing? A phenomenological study. *Midwifery* 27: 588-594.
- Morshan-Bello I O, Adedokun B O, Ojengbede O A, Olayemi O, Oladokun A, Fabamuo O A., (2009). Assessment of the Effect of Psychosocial Support during Childbirth in Ibadan, SouthWest Nigeria: A Randomised Controlled Trial. *Australian and New Zealand Journal of Obstetrics and Gynecology*, 49: 145–150.
- Mugenda O.M and Mugenda A.G., (2003). *Research Methods: Quantitative and Quantitative Approaches, Africa Centre for Technology Studies, Nairobi*.
- 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.
- MundiI., (2013). Nigeria demographics profile. Available from:[http://www.indexmundi.com/nigeria/birth\\_rate.html](http://www.indexmundi.com/nigeria/birth_rate.html). [Last updated on 2013 Feb 21, Last cited on 2013 Mar 20].
- 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.

- Nations U., (2011). The Millennium Development Goals Report New York, USA: *United Nations*.
- Nkuoh, G. N., Meyer, D. J., Tih, P. M., & Nkfusai, 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>
- Onyango M., Owoko S., Oguttu M., (2010). Factors that influence male involvement in sexual and reproductive health in Western Kenya: A Qualitative study. *African Journal of Reproductive Health*; 14(4):33-43.
- 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
- Population Census, (2009) Kenya National Bureau of Statistics
- 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.
- Sapkota S., Kobayashi T., Takase M., (2012). Husbands experiences of supporting their wives during childbirth in Nepal. *Midwifery*, 28:45–51.
- 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 journal*, 10:8.
- Story, W. T., & Burgard, S. A., (n.d.) (2012). Couples' Reports of Household Decision-making and the Utilization of Maternal Health Services in Bangladesh. *Social Science & Medicine* doi:10.1016/j.socscimed.2012.09.017.
- Theuring S, Mbezi P, Luvanda H, Jordan-Harder B, Kunz A, Harms G., (2009). Male involvement in PMTCT services in Mbeya Region, Tanzania. *AIDS Behav*, 13(Suppl 1):92–102.
- Titus K. Kwambai., (2013). Perspectives of men on antenatal and delivery care service utilization in rural western Kenya. *BMC Pregnancy and childbirth*. 13: 134
- Tweheyo, R., Konde-Lule, J., Tumwesigye, N. M., & Sekandi, J. N., (2010). Male partner attendance of skilled antenatal care in peri-urban Gulu district, Northern Uganda. *BMC Pregnancy and Childbirth*, 10(1), 53.

- UNAIDS. (2012). 'Global Report: *UNAIDS Report on the Global AIDS Epidemic*'
- United Nations Population Fund (UNFPA), (2009). Family Planning in Kenya: Not for Women Only. New York, NY, USA: *United Nations*. Available at <http://www.unfpa.org/public/News/pid>.
- United Nations, (1996). Report of the Fourth World Conference on Women. 4-15 Sept 1995; Beijing. *New York, USA: United Nations*.
- 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).
- 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).
- Willis. Y.O, Onen, D., (2009). Writing Research Proposal and Report. A Handbook for *Beginning Researchers, Nairobi, Jomo Kenyatta Foundation*.
- World Health Organization, (2012). Trends in maternal mortality, Available from [www.who.int](http://www.who.int). Accessed on 14th January 2013.
- Wyrod R.,(2008): Between women's rights and men's authority: masculinity and shifting discourses of gender difference in urban Uganda. *GendSoc*, 22(6):199–823.

## **APPENDICES**

### **APPENDIX I: CONSENT FORM**

I am Sally Jepkosgei, a Master of Science in Nursing student and a researcher currently studying Master of Science in Nursing (Midwifery) at Masinde Muliro University of Science and Technology. I invite you to participate in the study “Male Partner Involvement on maternal care services during perinatal period.

#### **What is the purpose of the study?**

Purpose of the study is to explore barriers for male partner involvement in maternity care of their partners so as to inform policy and hence improve maternal and Neonatal outcome.

#### **How about the procedure**

The questionnaire will be used to obtain information by answering questions and for Focus Group Discussion; the proceedings will be taped and noted.

#### **What are the benefits of the study?**

The study will help in understanding the need of women adequately during pregnancy, preparation for childbirth and post-delivery. This will also assist to understand the role of male partners during this period. The results will help inform policy on the challenges partners face and strategies on how to improve maternal and neonatal outcomes.

#### **What are the risks of the Study?**

The process of the study especially during collection of data may bring about psychological stress upon recalling a sad moment especially if she was not supported by her husband.

The male partner may feel guilty for not fulfilling the expected responsibility towards his wife during the interview.

### **Confidentiality**

The information about what I observe or you provide during the study will be kept confidential. Questionnaires will be administered separately for both husband and wife. Only the Principal Investigator and the interviewers will have access to the information. The information will be kept under lock and key by the Principal Investigator during the course of the study.

### **Contact information of the Principal investigator**

Name: Sally Jepkosgei Kiptoo

Mobile no. 0722-508984

Email Address: [sallykosgei97@gmail.com](mailto:sallykosgei97@gmail.com) , [wamukoyasally@yahoo.com](mailto:wamukoyasally@yahoo.com)



**Declaration of the Participant**

I have read the above information / it has been read to me. I have been given the chance to ask questions about the study and any question that I have asked has been answered to my satisfaction. Therefore, I consent voluntarily to participate as a participant in this study and understand that I have the right to withdraw from the study at any time without in anyway affecting my duties.

Signature volunteer/ participant: .....

Date.....

Signature of observer / interviewer: .....

Date:.....

**APPENDIX II: QUESTIONNAIRES**

**QUESTIONNAIRE FOR MEN**

**MALE PARTNER INVOLVEMENT IN MATERNITY CARE SERVICES  
DURING PERINATAL PERIOD IN MUMIAS EAST AND WEST SUB  
COUNTIES KAKAMEGA COUNTY, KENYA**

STUDYNO:.....SUB-COUNTY.....

VILLAGE.....HOUSE-NUMBER: .....

INTERVIEWER:.....DATE:.....

**PARTICIPANT**

NAME/INITIALS .....

**(Instructions: The questions to be asked should all relate to the last  
pregnancy/Youngest child of one year and below)**

**SOCIODEMOGRAPHIC CHARACTERISTICS**

1. Age (As per last birthday).....
2. When did you get married (Year of marriage).....
3. Educational level completed:  No education =1  Primary =2   
Secondary =3  Tertiary and above
4. Occupation:  Unemployed =1  
 Employed:  Private sector =2  
 Government sector =3  
 Casual labourer  
 Self Employed
5. Religion:  Christianity =1  Islam =2  Other =3
6. Number of children per couple: .....

7. Age of last child (Months): .....

<3 months =1

3 - 6 months =2

6- 12 months =3

### **ANTENATAL CARE**

8. Were you living together with your wife at the time of her pregnancy? (Last pregnancy)  Yes =1  No =2

**(If no, go to question 11)**

9. Were there other family members living with you during her last pregnancy?

Yes =1  No =2

10. If yes, which family member was living with you?

Her mother =1  My mother =2  Siblings =3  Others (specify) =4

11. Was the pregnancy planned? (Last pregnancy)  Yes =1  No =2

12. Were you aware your wife attended antenatal clinic?  Yes =1  No =2

**If NO then go to Q. 15**

13. Where did she attend antenatal clinic? ..... =1  Don't know =2

If don't know: explain.....

14. Were you involved in the decision on where she had antenatal care?

Yes =1  No =2

15. Did you make any joint plans for emergency situations during the pregnancy?

Yes =1  No =2 **(if no, go to question 17)**

16. If yes, please specify the preparation made:

Put money aside for emergency = 1

Made transport arrangement=2

Decided on where to go in case of emergency =3

Others (specify) =4 .....

If No to Q 15 Explain .....

17. Did you ever accompany your wife to the antenatal clinic during her last pregnancy?

Yes =1  No =2(**if no, go to question 21**)

18. If yes, how many times did you accompany her?

Once =1

Two – three times =2

4 or more times =3

19. How would you describe the attitude of the staff?

Friendly =1  Unfriendly =2  Indifferent =3

20. How would you assess the time you had to spend at the health facility?

Reasonable =1  Too long =2

21. If no to Q. 17, why were you never present?

.....

22. What support did you provide your wife during her pregnancy? (Last pregnancy)

Provided funds for ANC visits =1

Reminded her of her ANC visits =2

Helped with household chores =3

Others (specify) =4 .....

23. Did you discuss health issues relating to the last pregnancy with your partner?

Yes =1  No =2

If Yes Explain.....

24. Did you discuss health issues relating to the last pregnancy with her health care providers?  Yes =1  No =2

If Yes Explain .....

**LABOUR AND DELIVERY**

25. Were you living together with your wife at the time of her labour and delivery?

Yes =1  No =2

If No where were you at that time .....

26 Did you accompany your wife to the health facility at the time of labour and delivery?

Yes =1  No =2  Did not deliver in a health facility =3

27. If yes, was there space for you to sit and stay with your wife during labour and delivery?

yes  No

29. Was the room enclosed for you and your wife (privacy)?

yes  No

**If she did not deliver in Health Facility then go to Q. 28**

30. If you did not accompany her, how did she get to the health facility that day?

I delegated somebody to take her =1  She went alone =2

Others (specify) = .....

Don't know =4

31. Did you make any joint prior plans for labour and delivery during the pregnancy?

Yes =1  No =2

If yes, what plans.....

If No, Explain .....

32. What support did you provide to your wife during labour?

Provided funds for transport =1

Stayed with her during labour =2

Helped with household chores while she was away =3

Others (specify) =4 .....

33. What support did you provide her during delivery?

Delegated someone to stay with her during delivery =1

Stayed with her during Delivery =2

Others =3 .....

34. Did you discuss health issues relating to the labour with your wife? (Last pregnancy)  Yes =1  No =2

If Yes what did you discuss.....

If No, Explain .....

35. Did you discuss health issues relating to the delivery with your wife? (Last pregnancy)  Yes =1  No =2

If Yes what did you discuss.....

If No, Explain .....

36. Did you discuss health issues relating to the labour with your wife's health care providers?  Yes =1  No =2

If Yes what did you discuss.....

If No, Explain .....

37. Did you discuss health issues relating to the delivery with her health care providers?

Yes =1  No =2

If Yes what did you discuss.....

If No, Explain .....

38. Are male partners allowed to be present during labour in the facility you attended? [

Yes =1  No =2  Don't know =3

39. Are male partners allowed to be present during delivery in the facility you attended?

Yes =1  No =2  Don't know =3

40. Were you present during labour?  Yes =1  No =2

If No, Explain.....

41. Were you present during delivery?  Yes =1  No =2

If No, Explain.....

42. Do you wish you were present?  Yes =1  No =2

If Yes, Explain.....

If No, Explain.....

43. In your opinion if one person should be allowed in the labour room with the labouring woman, who should it be?  Husband =1

My Mother =2  Her Mother =3

Others (specify) =4 .....

### **POSTNATAL CARE**

44. Were you living with your wife after delivery?  Yes =1  No=2

If no, whom did she live with?  My Mother =1

Her Mother =2

Others (specify) =3.....

45. Did you ever accompany your wife for postnatal visits to the health facility?

Yes =1  No =2

If no, Explain.....

46. Were you involved in making prior plans for your wife's postnatal care?

Yes =1  No =3

If Yes, Explain.....

If No, Why.....

47. What support did you provide during the postnatal period?

Provided funds for her up keep =1

Helped with household chores =2

Others (specify) =3 .....

48. Did you discuss health issues relating to the postnatal period like family planning with your wife?  Yes =1  No =2

If Yes, what did you discuss.....

If No, Explain.....

49. Did you and your wife discuss health issues relating to the postnatal period like family planning with her health care providers?

Yes =1  No =2

If Yes what did you discuss.....

If No Explain.....

**THANK YOU VERY MUCH**



**QUESTIONNAIRE FOR WOMEN**

**MALE PARTNER INVOLVEMENT IN MATERNITY CARE SERVICES  
DURING PERINATAL PERIOD IN MUMIAS EAST AND WEST SUB  
COUNTIES KAKAMEGA COUNTY, KENYA**

STUDYNO:.....SUB-COUNTY.....

VILLAGE.....HOUSE-NUMBER: .....

INTERVIEWER:.....DATE:.....

**PARTICIPANT**

NAME/INITIALS .....

**(Instructions: The questions to be asked should all relate to the last  
pregnancy/Youngest child of one year and below)**

**SOCIODEMOGRAPHIC CHARACTERISTICS**

1. Age (As per last birthday).....

2. Marital status: [ ] Married =1 [ ] Single =2 [ ] Separated/Divorced =3

[ ] Cohabiting =4 [ ] Other (Specify) =5

When did you get married (Year of marriage).....

3. Educational level completed: [ ] No education =1 [ ] Primary =2 [ ] Secondary =3

[ ] Tertiary and above

4. Occupation: [ ] Unemployed =1 [ ] Private sector =2

[ ] Government sector =3

5. Religion: [ ] Christianity =1 [ ] Islam =2 [ ] Other =3

6. Number of children: .....

7. Age of last child (Months): .....

<3 months =1

3-6 months =2

6-12 months =3

**ANTENATAL CARE**

8. Were you living together with your husband at the time of your pregnancy? (Last pregnancy)  Yes =1  No =2

**(If no, go to question 11)**

9. Were there other family members living with you during your last pregnancy?

Yes =1  No =2

10. If yes, which family member was living with you?

My mother in law =1  My mother =2  Siblings =3

Others (specify) =4 .....

11. Was the pregnancy planned? (Last pregnancy)  Yes =1  No =2

12. Did you attend antenatal clinic?  Yes =1  No =2

13. Where did you attend antenatal clinic? .....

14. Were you involved in the decision on where to attend antenatal care?

Yes =1  No =2

15. Did you make any joint plans for emergency situations during your pregnancy?

Yes =1  No =2 **(if no, go to question 17)**

16. If yes, please specify the preparation made:

Put money aside for emergency =1

Made transport arrangement =2

Decided on where to go in case of emergency =3

Others (specify) =4

.....

If No, to Q 15 Explain .....

17. Did your husband ever accompany you to the antenatal clinic during your last pregnancy?

Yes =1  No =2(**if no, go to question 21**)

18. If yes, how many times did your husband accompany you?

Once =1

Two – three times =2

4 or more times =3

How many times did you attend antenatal clinic? .....

19. How would you describe the attitude of the staff?

Friendly =1  Unfriendly =2  Indifferent =3

20. How would you assess the time you had to spend at the health facility?

Reasonable =1  Too long =2

21. If no, why was your husband never present?

.....

22. What support did your husband provide during your pregnancy? (Last pregnancy)

Provided funds for ANC visits =1

Reminded me of ANC visits =2

Helped with household chores =3

Others (specify) =4 .....

23. Did you discuss health issues relating to the last pregnancy with your partner? [ ]

Yes =1 [ ] No =2

If Yes Explain.....

24. Did you discuss health issues relating to the last pregnancy with your health care providers? [ ] Yes =1 [ ] No =2

If Yes Explain .....

**LABOUR AND DELIVERY**

25. Were you living together with your husband at the time of labour?

[ ] Yes =1 [ ] No =2

If No, Where was he at that time .....

26. Did your husband accompany you to the health facility at the time of labour?

[ ] Yes =1 [ ] No =2 [ ] Did not deliver in a health facility =3

**If you did not deliver in Health Facility then go to Q. 28**

26 b. If you delivered in a hospital, was there space for your spouse to sit and stay with you during labour and delivery?

[ ] yes [ ] No

26 c. Was the room enclosed for you and your spouse (privacy)?

27. If he did not accompany you, how did you get to the health facility that day?

[ ] He delegated somebody to take me =1 [ ] I went alone =2

[ ] Others (specify) =3.....

28. Did you make any joint prior plans for labour and delivery during the pregnancy?

[ ] Yes =1 [ ] No =2

If yes, what plans.....

If No, Explain .....

29. What support did your husband provide during labour?

Provided funds for transport =1

Stayed with me during labour =2

Helped with household chores while I was away =3

Others (specify) =4 .....

30. What support did your husband provide during delivery?

Delegated someone to stay with me during delivery =1

Stayed with me during Delivery =2

Others =3 .....

31. Did you discuss health issues relating to the labour with your husband? (Last

pregnancy)  Yes =1  No =2

If Yes, what did you discuss.....

If No, Explain .....

32. Did you discuss health issues relating to the delivery with your husband? (Last

pregnancy)  Yes =1  No =2

If Yes, what did you discuss.....

If No, Explain .....

33. Did you discuss health issues relating to the labour with your health care providers?

Yes =1  No =2

If Yes what did you discuss.....

If No, Explain .....

34. Did you discuss health issues relating to the delivery with your health care providers? [ ] Yes =1 [ ] No =2

If Yes what did you discuss.....

If No, Explain .....

35. Are male partners allowed to be present during labour in the facility you attended?

[ ] Yes =1 [ ] No =2 [ ] Don't know =3

36. Are male partners allowed to be present during delivery in the facility you attended?

[ ] Yes =1 [ ] No =2 [ ] Don't know =3

If Don't know Explain.....

37. Was your husband present during labour? [ ] Yes =1 [ ] No =2

If no, why was he not present?.....

38. Was your husband present during delivery? [ ] Yes =1 [ ] No =2

If No, Explain.....

39. Do you wish your husband was present? [ ] Yes =1 No =2

If Yes, Explain.....

If No, Explain.....

40. In your opinion if one person should be allowed in the labour room with the

labouring woman, who should it be? [ ] Husband =1 [ ] Mother =2 [ ]

Mother in law =3

[ ] Others (specify) =4 .....

### **POSTNATAL CARE**

41. Did you live with your husband after delivery? [ ] Yes =1 [ ] No =2

42. If no, whom did you live with?

My Mother in law=1

My Mother =2

Others (specify) =3.....

43. Did your husband ever accompany you for postnatal visits to the health facility?

Yes =1  No =2

44. If no, Explain.....

45. Were you involved in making prior plans for your postnatal care?

Yes =1  No =3

If Yes, Explain.....

If No, Why.....

46. What support did your husband provide during the postnatal period?

Provided funds for my up keep =1

Helped with household chores =2

Others (specify) =3 .....

47. Did you discuss health issues relating to the postnatal period like family planning with your husband?  Yes =1  No =2

If Yes, what did you discuss.....

If No, Explain.....

47. Did you and your husband discuss health issues relating to the postnatal period like family planning with your health care providers?  Yes =1  No =2

If Yes, what did you discuss.....

If No, Explain.....

**THANK YOU VERY MUCH**

## **APPENDIX III: FOCUS GROUP DISCUSSION QUESTIONNAIRE**

### **MALE PARTNER INVOLVEMENT IN MATERNITY CARE SERVICES DURING PERINATAL PERIOD IN MUMIAS EAST AND WEST SUB COUNTIES KAKAMEGA COUNTY, KENYA**

#### **FOCUS GROUP DISCUSSION GUIDE FOR MEN AND WOMEN SEPARATELY**

Welcome and thank you very much for agreeing to be part of this focus group discussion. As explained to you earlier, the information we seek from you includes your views on cultural norms, your perceptions of gender roles, perceptions of male friendliness of health facilities and attitudes of peers and the community at large to male involvement in maternity care. Feel free to share your honest and candid opinion. Once again we wish to assure you of confidentiality and anonymity.

1. What do you think is the role or responsibility of men during their partner's pregnancy?

**Probe:** for Role during pregnancy?

**Probe:** for role during labour

**Probe:** for role during delivery?

**Probe:** for role during the postpartum period?

2. What is the role of other members of the family especially females like mothers, mothers in-law and siblings?
3. What are the cultural norms or taboos in this Mumias community (Aba Wanga) that affect male involvement in maternity care?  
(Pregnancy, Labour, delivery and postnatal)



4. What would you think of a man who accompanies the pregnant wife to the hospital? (Pregnancy, Labour, delivery and postnatal)

**Probe:** What about a man who helps with the household chores?

5. What experiences at the health facilities encourage men to accompany their partners to the antenatal clinic and postnatal clinic?

**Probe:** What about being present during labour and delivery?

6. What factors at the health facilities discourage men from accompanying their partners to the antenatal clinic and postnatal clinic?

**Probe:** What about being present during labour and delivery?

7. Are there any other factors that you think affect men's involvement in maternity care?
8. What suggestions can you make as to how male involvement in maternity care could be encouraged in this community?
9. What further comments can you make on the issues we have been discussing?

**Thank you very much for your time and for sharing your opinion on the issues discussed.**

**GROUP.....DATE.....**

**TIME.....**

**SUB COUNTY.....**

**VILLAGE .....**

**DESCRIPTION.....**

<b>Moderator</b>	<b>Marital status</b>	<b>Education al level completed</b>	<b>Occupation</b>	<b>Religion</b>	<b>Number of Children</b>	<b>Age of last child</b>

Research

Assistant.....

Mobile

no.....

Study ID number.....

## APPENDIX IV: LETTER OF APPROVAL TO CONDUCT RESEARCH



MASINDE MULIRO UNIVERSITY OF SCIENCE AND TECHNOLOGY  
Tel: 056-31375 P. O. Box 190  
Fax: 056-30153 Kakamega  
E-mail: [rel@mmust.ac.ke](mailto:rel@mmust.ac.ke) 50100  
Website: [www.mmust.ac.ke](http://www.mmust.ac.ke) Kenya

### Institutional Ethics Review Committee (IERC)

MMU/COR: 403009( 21)

30<sup>th</sup> March, 2016

Sally Jepkosgei Kiptoo  
Registration No. HNR/G/05/14  
Masinde Muliro University of Science and Technology  
P. O. Box 190-50100  
KAKAMEGA

Dear Jepkosgei,

#### RE: Ethical Approval to Conduct Research

The IERC received your proposal titled "*Male Partner Involvement in Maternal Care Services During Perinatal Period in Mumias East and West Sub-Counties, Kakamega County, Kenya*" for review. Having reviewed your work, the committee has given ethical clearance for you to conduct research as proposed.

On behalf of IERC and the University Senate, my congratulations. We wish you success in your research endeavour.

Yours faithfully

**Prof. F.K. Matanga**  
Chairman, Institutional Ethics Review Committee

Copy to:

- The Secretary, National Bio-Ethics Committee
- Vice Chancellor
- DVC (PR&I)
- DVC (A & F)
- DVC (A&SA)

## APPENDIX V: RESEARCH PERMIT

**THIS IS TO CERTIFY THAT:** **Permit No. : NACOSTI/P/16/21243/10894**  
**MS. SALLY JEPKOSGEI CHARLES KIPTOO**, **Date Of Issue : 9th June, 2016**  
**of MASINDE MULIRO UNIVERSITY OF** **Fee Received :Ksh 1000**  
**SCIENCE AND TECHNOLOGY, 359-50100**  
**Kakamega, has been permitted to**  
**conduct research in Kakamega County**

**on the topic: **MALE PARTNER****  
**INVOLVEMENT IN MATERNAL CARE**  
**SERVICES DURING PERINATAL PERIOD IN**  
**MUMIAS EAST AND WEST**  
**SUB-COUNTIES, KAKAMEGA COUNTY,**  
**KENYA**

**for the period ending:**  
**9th June, 2017**

  
**Applicant's**  
**Signature**

  
**Director General**  
**National Commission for Science,**  
**Technology & Innovation**

**CONDITIONS**

- You must report to the County Commissioner and the County Education Officer of the area before embarking on your research. Failure to do that may lead to the cancellation of your permit**
- Government Officers will not be interviewed without prior appointment.**
- No questionnaire will be used unless it has been approved.**
- Excavation, filming and collection of biological specimens are subject to further permission from the relevant Government Ministries.**
- You are required to submit at least two(2) hard copies and one(1) soft copy of your final report.**
- The Government of Kenya reserves the right to modify the conditions of this permit including its cancellation without notice**

  
**REPUBLIC OF KENYA**  
**NACOSTI**  
**National Commission for Science,**  
**Technology and Innovation**

**Serial No. A 9450**  
**RESEARCH CLEARANCE**  
**PERMIT**  
**CONDITIONS: see back page**



**NATIONAL COMMISSION FOR SCIENCE,  
TECHNOLOGY AND INNOVATION**

Telephone: +254-20-2213471,  
2241349,3310571,2219420  
Fax: +254-20-318245,318249  
Email: dg@nacosti.go.ke  
Website: www.nacosti.go.ke  
when replying please quote

9<sup>th</sup> Floor, Utali House  
Uhuru Highway  
P.O. Box 30623-00100  
NAIROBI-KENYA

Ref. No: **NACOSTI/P/16/21243/10894**

Date  
**9<sup>th</sup> June, 2016**

Sally Jepkosgei Charles Kiptoo  
Masinde Muliro University of  
Science and Technology  
P.O. Box 190-50100  
**KAKAMEGA.**

**RE: RESEARCH AUTHORIZATION**

Following your application for authority to carry out research on "*Male partner involvement in maternal care services during perinatal period in Mumias East and West Sub-Counties, Kakamega County, Kenya.*" I am pleased to inform you that you have been authorized to undertake research in Kakamega County for the period ending 9<sup>th</sup> June, 2017.

You are advised to report to **the County Commissioner, the County Director of Education and County Coordinator of Health, Kakamega County** before embarking on the research project.

On completion of the research, you are expected to submit **two hard copies and one soft copy in pdf** of the research report/thesis to our office.

**DR. STEPHEN K. KIBIRU, PhD.  
FOR: DIRECTOR-GENERAL/CEO**

Copy to:

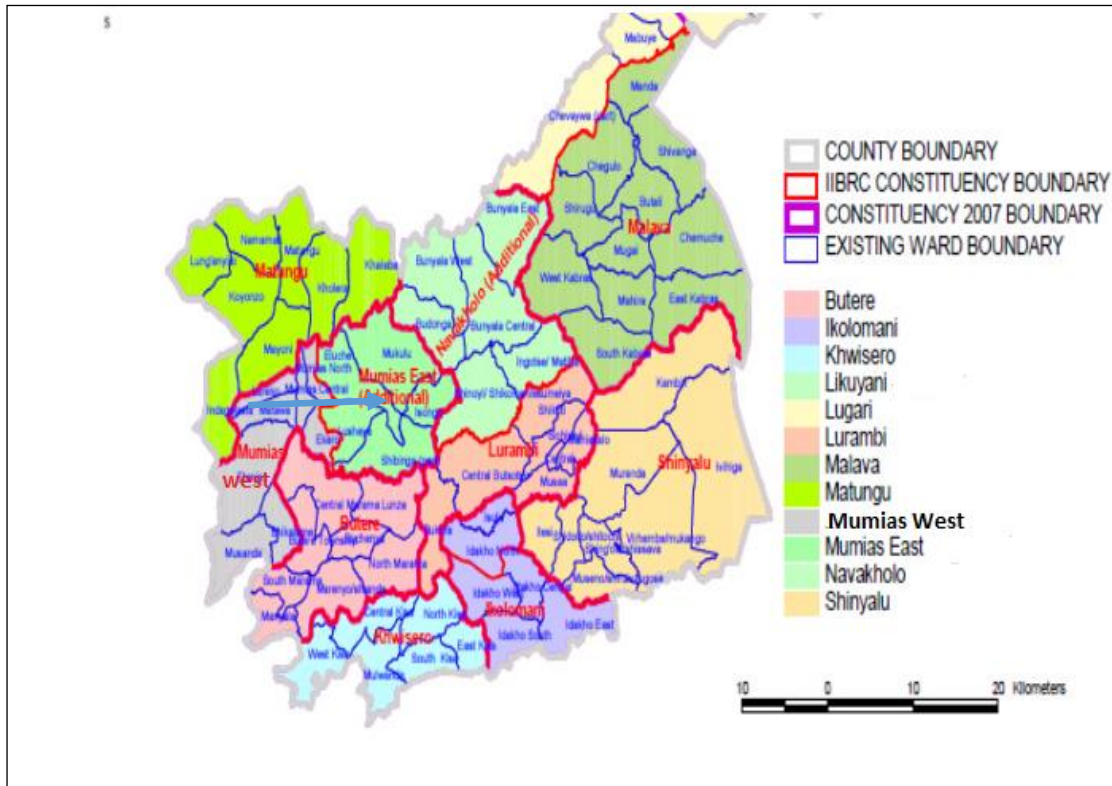
The County Commissioner  
Kakamega County.

The County Director of Education  
Kakamega County.

The County Coordinator of Health  
Kakamega County.



**APPENDIX VI: MAP OF KAKAMEGA COUNTY WITH TWELVE SUB COUNTIES**



*Adopted from the Kenya fact sheet 2014*