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**FACTORS INFLUENCING MALE INVOLVEMENT IN SAFE  
MOTHERHOOD AMONG COMMUNITIES IN KWALE AND  
KILIFI IN COASTAL KENYA**

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## **FACTORS INFLUENCING MALE INVOLVEMENT IN SAFE MOTHERHOOD AMONG COMMUNITIES IN KWALE AND KILIFI IN COASTAL KENYA**

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### **Abstract**

**Purpose:** The main purpose of the study was to determine the factors influencing male involvement in safe motherhood among communities of Kwale and Kilifi Counties of Coastal Kenya.

**Materials and methods:** The study was descriptive cross sectional design. The study focused on women of child-bearing age 15 – 49 and men aged 15 – 54 from Kilifi and Kwale counties in 14 health facilities. Qualitative and quantitative methods of data collection were used. Interviewer-administered questionnaire were administered to women who were attending ANC. Data was also collected using semi-structured interviews with health service providers, community leaders and county directors. Focus group discussions were conducted using FGD guide with four women and men groups. Analysis was done using SPSS and NVivo softwares.

**Results:** The findings of the study revealed that Men and women interviewed in the two rural counties believed safe motherhood practices especially in pregnancy and childbirth are a preserve of women. Illiteracy, sociocultural factors, weak health systems and economic factors were found to be the major barriers to male involvement. Traditional gender roles defined the involvement of men mostly perceived to be provision of funds for transport and food.

**Unique Contribution to Theory, Practice and Policy:** This study recommended a defined program that target male involvement strategy. It will involve male champions/men ambassador/agents being supported to go to the *Mnazi* dens and educate, sensitize and support dialogues with men aged 35 years and below. A targeted alcohol abuse sensitization and education will go a long way. A friendly health system be put in place to accommodate men. Friendlier timing including weekends and late hours, space at the clinics to accommodate men and responsive health workers.

**Keywords:** *Safe Motherhood Practices, Male Involvement and Social Demographic Factors.*

## 1.0 INTRODUCTION

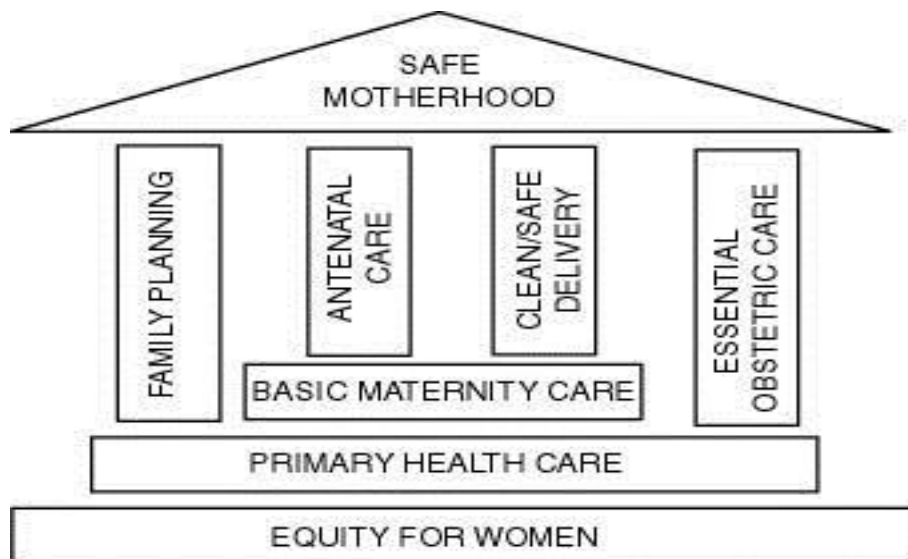
A significant decline in maternal mortality ratio (MMR) has been reported globally. Against this backdrop decline, Sub-Saharan Africa has the highest MMR in the world albeit strategies and interventions that prioritize maternal health (Hogan *et al.* 2010; WHO 2012). MMR was estimated to be 500 per 100,000 live births in 2010 in sub-Saharan Africa. The United Nation Millennium Development Goals (MDG) on maternal health aims to reduce the number of women dying during pregnancy and childbirth by three-quarters between 1990 and 2015. To achieve this goal, it is estimated that an annual decline in maternal mortality of 5.5% is needed; however, between 1990 and 2010 the annual decline was only 1.7% in the sub-Saharan region, (WHO 2012). Thus many countries in sub-Saharan Africa were not be able to achieve the goal by 2015.

Globally, awareness of the issue of maternal mortality began in 1987 at the Safe Motherhood Conference in Nairobi, which drew the attention of the world and developed countries in particular to this issue and the commitment to strive for reducing the mortality and morbidity related to pregnancy and childbirth was obtained. This commitment was reinforced in the ICPD conference held in Cairo in 1994 where in addition to the call to reduce maternal mortality and morbidity by at least 50 percent by the turn of the century, Safe Motherhood (SM) was recognized as one of the key components of reproductive health. Attention was also drawn to creating an enabling environment, enhancing gender equality equity and empowerment of women. It also gave priority in promoting reproductive health, including family planning and sexual health and reproductive rights.

Globally, low male involvement in maternal health care services remains a problem to health care providers and policy makers. Since the Cairo international conference on population and development (ICPD 1994), and the Beijing world conference for women 1995 a lot of emphasis has been to encourage male involvement in reproductive health including maternal health. The Beijing conference emphasized that man's attitudes, knowledge base and ways of reacting influences not only men's health but also women's reproductive health (WHO 2001).

Since the Nairobi Safe Motherhood Conference of 1987, the government of Kenya and non-governmental organizations (NGOs) have committed resources to promote safe motherhood. This has encompassed the male involvement intervention as a key ingredient in achieving the objective of safe motherhood. The concept of safe motherhood is multifaceted, encompassing more than simply the health of women throughout pregnancy and childbirth. However, efforts to increase safe motherhood must also acknowledge the critical role of sexual and reproductive health (SRH) services, including family planning (FP) and HIV/AIDS and STI prevention, and nutrition in ensuring the health of mothers, newborns and their families. WHO (1996) clearly provides the various elements of safe motherhood in the table below;

**Figure 1: The four pillars of safe motherhood**



*Source: WHO 1996*

In Kenya, policy developments and efforts by the government and other stakeholders have resulted in progress on several fronts. For example, the 2008/9 Demographic and Health Survey (DHS) found that at a national level, there have been considerable declines in child mortality over the last five years, decreases in the total fertility rate (TFR) and increases in contraceptive prevalence rate (CPR). On the other hand, maternal mortality rates remain unacceptably high and policies are not always translated into practice (KDHS 2010). Moreover, improvements have been uneven, with wide disparities between provinces and socio-economic groups.

In Coast Province, the situation remains troubling, especially for young women. The DHS found that fertility rates are higher than the national average and childbearing begins early, with 46% of women giving birth by the age of 20. Alarming, the proportion of underweight children in the province has increased in the last 5 years. With the exception of North Eastern Province, women and girls in Coast have the lowest levels of education in the country, and married women in the province are the least likely to make decisions about their own health care. CPR is the second lowest in the country, unmet need for FP is high and the prevalence of STIs and STI symptoms reported among women is high compared with other provinces pointing to a major challenge.

Low uptake of PMTCT and antenatal care is frequently a result of rigid gender roles, as low male involvement and lack of spousal accompaniment to health centres for these services discourages women from receiving care. The slow progress in reducing maternal mortality is as a result of a

number of factors including lack of maternal health services and in some cases where services exist husbands have been reported to refuse their wives to seek maternal health services more so in Kwale and Kilifi.

The behavior of men, their beliefs and attitudes towards safe motherhood affect the maternal health outcomes of women and their babies. The exclusion of men from safe motherhood services has resulted to few women seeking maternal health services and as a result worsening the negative maternal health outcomes for women and children. Increasingly, recognition is growing on a global scale that involvement of men in reproductive health policy and service delivery offers both men and women important benefits (Naomi 2005).

Evidently the renewed interests in involving men stem not only from women's reproductive health needs, but also to address men's own sexual health concerns, as well as efforts to achieve the Millennium Development Goals (MDGs) for reduction of maternal mortality and HIV transmission. According to Tsui and others (2010), access to safe motherhood including the use of modern contraception and family planning services is integral in the prevention of unwanted pregnancy, reduction of unsafe abortions, and promotion of childbirth spacing to lower maternal and child mortality risks in developing countries.

## **1.2 Problem Statement**

Male involvement is often and traditionally poorly understood and too narrowly defined. Minimal attention has been given to their important role in decision-making within the family and community context. Barriers such as low levels of education, the lack of available social support, the perception that pregnancy and child-bearing are "women's responsibilities", and prevailing gender norms and societal stigma persist. Moreover, the concept of male involvement cannot be viewed only through the lens of sexual and reproductive health; it must extend to the broader context – including economic empowerment, financial decision-making within the household, nutrition to education.

The role played by men and their relationship with women in reproductive health has been appreciated by many and even documented. There is absolutely little excuse for overlooking men in this regard. Ten years ago, the 1994 United Nations International Conference on Population and Development (ICPD) stressed "male responsibilities and participation" in sexual and reproductive health. In fact Dudgeon *et al.* confirms that for several decades, medical anthropologists have conducted reproductive health research that explores male partners' effects on women's health and the health of children.

Although there are more considerations for male involvement strategies in the current programming in sub Saharan Africa, the lack of data on successes has limited the replication and further investment in this intervention. In a documentary by FAO, the technical *occasional Paper Series No. 1* June 1998, sites the lack of data to understand male perspectives and the extent of their involvement in reproductive health issues as a major setback. It presupposes that the surveys most relied upon for reproductive health (RH) programmes usually ask questions only of women, assuming that they are the ones who make the decisions regarding reproduction and that the men are either not involved or marginally involved. This is why this study will

deliberately target men in male unions and groups to try and provide opportunity of fair participation.

Men are traditionally the decision-makers within Kenyan households, and women's access to and use of sexual and reproductive health services often depends upon their partner's knowledge and decisions. Commonly referred to as "*mwenye syndrome*" in the coastal region meaning men own women and hence all the decisions depend on them including accessing safe motherhood services. Men play crucial role in contraceptive decision-making, particularly in highly gender-stratified populations like in the coastal region.

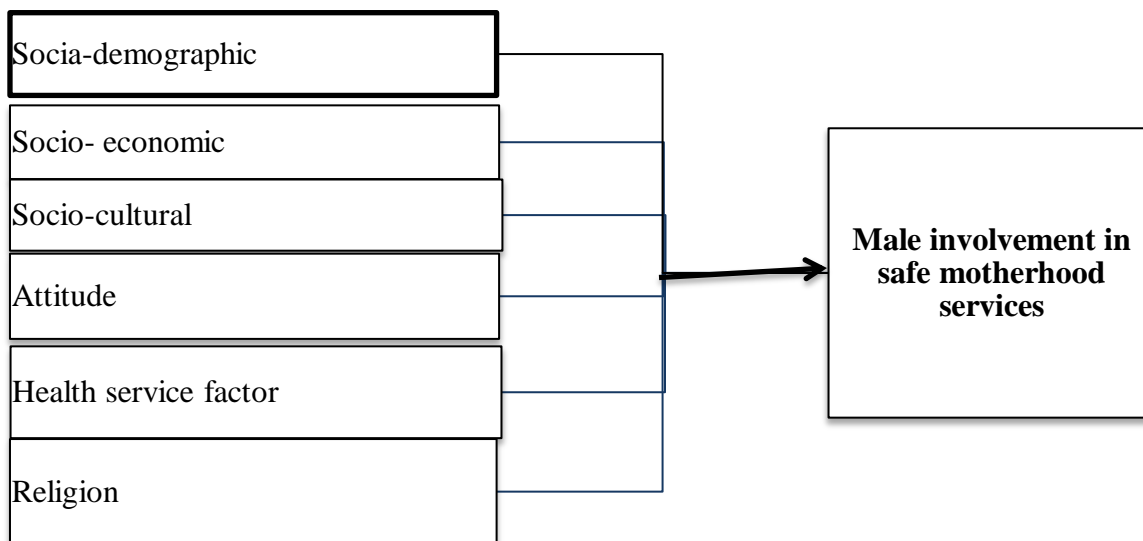
Research suggests that male involvement can increase uptake and continuation of family planning methods and by extension safe motherhood services by improving spousal communication (Awah 2002) through pathways of increased knowledge or decreased male opposition. The need to understand barriers to male involvement and participation and whether there are any association with access to services and health seeking behaviors towards safe motherhood is crucial. This study will therefore determine the factors that influence male involvement in safe motherhood among communities in Kwale and Kilifi counties of coastal Kenya.

### **1.3 Theoretical review/conceptual framework**

#### **1.3.1 Socio-ecological model**

This study is focusing on perception based on different aspects of motivators and barriers in health seeking behaviors among women. The ultimate source of support in respect to the variables at individual, community and the environment is men. This study will therefore be based on the social ecological model adapted from the Centers for Disease Control and Prevention (CDC, 2014). The Social Ecological Model (SEM) is a theory-based framework for understanding the multifaceted and interactive effects of personal and environmental factors that determine behaviors, and for identifying behavioral and organizational leverage points and intermediaries for health promotion within different setups.

**Figure 2: Factors that Determine Male Involvement in Safe Motherhood**



## 2.0 LITERATURE REVIEW

The role of gender equality, when women and men have equal participation in decision- making and control of resources, and equal value and treatment, has been shown to influence a number of maternal and child health (Bloom *et al.* 2001) outcomes positively (Acharya 2010). Most of the research that has focused on decision making around contraception has focused on how women's lower autonomy in these decisions, and men's attitudes on family planning have a strong influence on contraceptive use. Particularly, studies from South Asia have shown that women's self- reported decision-making (autonomy) has a significant effect on women's uptake of antenatal care and tetanus toxoid immunization, and other childhood immunizations (Allendorf *et al.* 2007) as well as contraceptive use (Retherford *et al.* 1996). Research from Sub-Saharan Africa also shows a relationship such that women's fertility preferences and contraceptive adoption are influenced by husband's influence on women's decision-making as well as their own attitudes (Ezeh 1993).

Traditionally, health providers and researchers in the field of reproductive health have focused almost exclusively on women when planning programmes and services, especially with regard to FP, prevention of unwanted pregnancies and of unsafe abortions, and promotion of safe motherhood (WHO 2001). However for purposes of this discussion, barriers to male involvement in safe motherhood services will be considered under the following categories.

### 2.1 Socio- demographic

Educated people are more likely to listen to radio than the non-educated persons hence getting more information about family planning. With the new government policy of universal primary education and the universal secondary education in the pipeline will go a long way to eradicating this barrier. It's a known fact that illiteracy or low education is associated with many risks (KAIS

2007). This study also found that people with low education are unlikely to embrace the modern ways of safe motherhood. For example many women prefer TBAs that skilled facility delivery (KDHS, 2008/9). The ICPD 1994, recommended a focus to education for women to ensure they meet the basic human needs and ensure they exercise their rights. This underpins the necessity of education when it comes to access safe motherhood services, which is considered a right.

## **2.2 Socio-Cultural factors**

Men do not seek health information and services due to traditional notions of masculinity, where asking for help from a nurse or doctor is viewed as a sign of weakness. Many men feel it is their right to refuse contraception, to allow their partners or even discuss FP (Engender Health, 2008). These refusals can lead to unwanted pregnancies, unsafe abortion and maternal death or disability. Reporting their findings from the study on women's autonomy and male involvement in Nepal, Britta et al, concluded that higher women autonomy was associated with lower male involvement in pregnancy health. Barriers to male participation include the perception of family planning and reproductive health as concerns of women maternal-child health services that do not target men, the limited availability of male contraceptive methods, and societal attitudes unfavorable to explicit support for equality of men and women (Ormel 1997).

Communication problems between men and women are certainly a significant social barrier as well. A theme that emerged repeatedly is that use or even discussion of FP may be interpreted as a sign of unfaithfulness or lack of commitment to the marriage. There was clear evidence among the focus groups that there was distrust of women's fidelity. Some men think that if they use FP their women will become promiscuous. This partly stems from failure to involve both partners as a couple right from the beginning of using family planning. The program should aim at counseling both parties together if possible. The degree and quality of spousal communication must be improved for the good of the family planning program.

## **2.3 Socio-Economic factors**

Some men feel it is a duty to facilitate their wives in terms of transport and if they do not have means of transport they see no point in escorting them while both are walking. Yet in many situations in Africa where the man is economically in position to provide the basic necessities of life he tends to have more than one wife, which also negatively affects his willingness and ability to escort the wife to seek care. Multiple partner relationships promotes different interests for the man and his partners and this will hamper possibilities for transparent decision making on maternal health service issues in addition to involvement in maternal health services of all his wives when needed.

Reporting his findings (Ratcliffe 2001) noted that men are often involved in multiple sexual relationships that present a considerable challenge to fertility awareness and reproductive health programmes. Alcohol consumption by the men has also been noted to plays an important role in keeping men away from involvement in safe motherhood services as most of the time they may be drunk, leaving them with no money or time to facilitate the needed care.



## **2.4 Health service factors**

Generally research shows that service related factors are more important than user related factors in affecting male involvement in maternal health care services. The most important ones pointed out include, long physical distance from the health unit, lack of transportation, inconvenient clinic hours, long waiting time at the clinic, poor technical and interpersonal skills. The situation is worsened by the fact that information received from health workers on maternal health care is primarily aimed at women as was reported by (UNFPA 1999) in several developing countries that women not men were the targets of reproductive health programmes yet most of them are not financially or culturally positioned to make decisions about these issues without consulting their husbands. This may actively discourage men from participating in maternal health care services by the structure of services or by attitudes of health care workers.

## **2.5 Attitude**

Majority of health care workers are women in the Kenyan healthcare service delivery with the two rural study counties having a high number. Men are therefore not inclined to visit the facilities as they deem to have very little to help the women. This is complicated by the perception that safe motherhood is a women domain hence more women service providers. In the Muslim community of Kwale most men do not allow their wives to be examined by men which underpin the misconception associated by men in the delivery of safe motherhood services. Family planning for example has suffered a significance blow due to men attitude. Most men believe its against the religion and therefore deter their wives from utilization. This has been supported by studies in India by (Shattuck *et al.* 2011) which found that spousal disagreement can be a deterrent to use of FP, as women may fear initiating a difficult conversation about FP. Additionally, male attitudes towards FP was found to affect contraceptive use indirectly. Specifically the absence of explicit communication was attributed to women incorrectly perceiving that their partners being opposed to FP and therefore use contraception without telling their partners or don't use contraception at all. In the coastal region of Kenya most men report no intention to use FP in the future citing major reasons as wanting to have a child and feeling that FP was against their religion.

## **3.0 METHODOLOGY**

The study was carried out in two counties; Kilifi and Kwale counties of coastal Kenya. The populations in these counties are primarily with low levels of education and poor, hence compromising their health service utilization. The study was descriptive cross sectional. The study focused on women of child-bearing age 15 – 49 and men aged 15 – 54 from Kilifi and Kwale counties in 14 health facilities. Specifically the study conveniently recruited 22 male of 18 years of age and above, and 66 pregnant women and mothers 18 years or older attending ANC and were either accompanied by their partners, had delivered at the hospital or attending postnatal care services, and had consented to participate. Qualitative and quantitative methods of data collection were used. Interviewer-administered questionnaire were administered to women who were attending ANC. Data was also collected using semi-structured interviews with health service providers, community leaders and county directors. Focus group discussions were

conducted using FGD guide with four women and men groups. Analysis was done using SPSS and NVivo softwares.

#### 4.0 RESEARCH FINDINGS AND DISCUSSIONS

##### 4.1 Socio-economic and socio-demographic characteristics of women attending ante natal care services

Socio-demographic characteristics of the study participants drawn from the mothers attending ANC. Majority of the mothers (33.8 %) were aged between 21 and 25 years, 28.8% aged between 26 and 30 years with average age of 30 years. 17.2% were aged between 15 and 20 years. A bigger proportion (40.8 %) of the respondents belonged to the Digo ethnic group while 60.8 % were Muslims compared to 37.5% from the Christian affiliated religious denominations. 184(54.9 %) of the respondents had attained senior primary level of education with only 78(23.3%) attaining secondary primary level of education. A big percentage of the mothers (93.5%) were married with only 3.8% being single and 2% separated from their spouses (Table 1 below shows the characteristics of women attending ANC)

**Table 1: Characteristics of women attending ANC study participants**

Characteristics	Women attending ANC
	<b>N=400</b>
	<b>N (%)</b>
<b>Age (Years)</b>	
15-20	70(17.5)
21-25	135(33.8)
26-30	115(28.8)
31-35	57(14.4)
36+	23(5.8)
<b>Marital Status</b>	
Married	372(93.5)
Single	15(3.8)
Separated	9(2.3)
Widowed	2(0.5)
<b>Education</b>	
Junior primary	46(13.7)
Senior primary	184(54.9)
Secondary	78(23.3)
Tertiary	27(8.1)
<b>Means of Livelihood</b>	
Business	103(25.8)
Piece work	118(29.5)
Office work	26(6.5)
Farming	42(10.5)
Others	111(27.8)
<b>Religion</b>	
Christians	147(37.6)
Muslims	237(60.6)
No Religion	7(1.8)

For the male partners accompanying their partners to health facilities for Safe Motherhood services most of them were reported to have low education levels. 93.4% were married considering that the same percentage of women interviewed was married. 49.1% of male partners (husbands) were doing piecework while 23% engaged in businesses. Majority (53%) of male partners who did piecework had at least one child. They also scored the highest (5%) for category of having more than 4 children. Figure 4.2.2 below summarizes male study participants' characteristics.

**Table 2: Husband's Livelihood \* No. of deliveries Cross tabulation deliveries**

		No. of deliveries						Total
		None	One	Two	Three	Four	More than four	
Husband's Livelihood	Business	13	30	16	15	4	9	87
	Piece work	24	49	45	28	19	21	186
	Office work	8	25	13	12	3	5	66
	Farming	0	2	5	4	8	9	28
	Other (specify)	2	5	1	1	1	2	12
Total		47	111	80	60	35	46	379

**4.2 Proportion of women accompanied by their partners to the health facility for ANC, reasons for not attending and spouse discussion.**

20.6 percent of the mothers who are married said YES they were accompanied to the clinic as compared to 79.4 percent who said NO they were not accompanied. The table 4.3.1 below illustrates.

**Table 3: Spouse accompaniment - Antenatal clinic attendance**

Description	Response	Frequency	Percent
<b>Women Accompanied</b>	YES	80	20.6
<b>Women NOT Accompanied</b>	NO	309	79.4

The absence of men accompanying their spouses to the facility has been misconstrued to indicate lack of involvement yet 84.2% granted permission for the spouse to attend antenatal care (ANC) compare to 3.9% by mothers, 1.2% by mother in law and 4.8% by others.

**4.3 Socio-cultural characteristics of male partners influencing male involvement to health facilities for Safe Motherhood.**

The role of men however was not limited to giving permission to attend ANC but also provided the resources to attend ANC. 172 (46.2%) of women who attended ANC were spouses of

husbands who engaged in piecework as livelihood activity. Generally 93.5% of women who attended ANC had their husbands engage in either business, piecework, farming, office work and any other form of livelihood activities.

**Table 4: Husband's Livelihood \* Attendance to Antenatal care-previous pregnancy**

		Attendance to Antenatal care-previous pregnancy		Total
		Yes	No	
Husband's Livelihood	Business	78	6	84
	Piece work	172	12	184
	Office work	59	5	64
	Farming	28	0	28
	5	11	1	12
Total		348	24	372

#### **4.4 Levels of knowledge, attitude and practice of ante natal care attending mothers on safe motherhood**

Generally knowledge on safe motherhood was wide with 91% seeking permission for antenatal clinic attendance and 90% having attended antenatal care during the previous pregnancy and after discussion with spouse. Out of 366 women interviewed, 39.6% (145) discussed preparation for the baby while 28.4% (104) discussed where to attend ANC and deliver and why. This is confirmed by the respondent in FGDs and KII who emphasized that SM is: services to mothers for safety and wellness; better life for children; mothers being safe and happy; care of the baby and ANC; period between ANC, delivery, PNC; It's also the journey of a woman and a man during pregnancy. They argued it starts from adolescent- pregnancy -ANC - delivery and post-natal care up to 28 weeks. These definitions are reflected in the spousal discussion during pregnancy. It's clear that most women were knowledgeable about their roles during pregnancy and engaged men in discussion and decision making in various components of safe motherhood.

During the FGDs, community health volunteers and male union members reported a basic knowledge of safe motherhood as encompassing women preparing to give birth for nine months. Health during pregnancy was regarded as a key element of safe motherhood. Interestingly though pregnancy and its outcome are keenly the interest of the entire household with husbands, mothers and mother in law being very involved in the process. A pregnant woman delivering in the facility was seen as the safest means available and well appreciated by the various families and interest parties. However, most women preferred to deliver at home with the help of traditional birth attendants. This is confirmed by the low number of women (28.4%) who discussed where to deliver. The spouses, husbands and mother in laws all agree on the importance of self-care before pregnancy; traditionally it was translated to mean a woman is legally married.

There was evidence of women knowledge in the benefits of being accompanied to the ANC. Most believed that those accompanied tend to benefit from knowing HIV status, knowledge of ANC and health. Most men were busy looking for food and money to support their families so had no choice but to prioritize confirming the finding that 94.8% were engaged in livelihood activities. . Traditionally the communities did not object to cross generational marriages and in this particular study old men married young girls and unable to be seen with them publicly. This similar to the finding from interview with women whom 93.5% were married and this included age groups of between 15-20 and 21-25 years. Although there are benefits of being accompanied to the facility, the idea had not been embraced and only 20.6% were accompanied to the health facility.

#### **4.5 Factors influencing male involvement in safe motherhood among communities of Kwale and Kilifi Counties**

There are various reasons participants gave for women not able to attend ANC including the fear by women of the frequency of attending ANC once one starts and also the time taken to get to the facility. Other reasons given include health service providers not being available at the dispensary, women wait until they feel the fetus is playing in the tummy, women fear that they will be examined in the uterus, and the thinking that placenta disposal must be at home thus a tradition for women to deliver at home.

#### **Practices**

97.8% of women who had previous pregnancy attended ANC. The strong feeling of women to seek permission from their husbands to attend antenatal clinic was a clear evidence of male dominance in decision making compared to 91% who sort permission to attend ANC. According to most respondents men/ husbands were traditionally the decision makers and their decisions were not subject to any discussions. In the study this is described as “Mwenye Syndrome” which basically means that the man is the owner of all the property including their women and children and that they are the ultimate decision makers. This finding is confirmed by respondents who confirmed that 75.9% husbands were to be told first about the pregnancy.

*“The Mwenye syndrome, so men just give instruction, ignorance, they are not involved by women. Women are more knowledgeable so they feel inferior”* (Chief, female, Kilifi)

Early marriages also came out as an issue affecting safe motherhood. Some women are married very young (approx. 14%) and have no idea about safe motherhood or because of shame they are hiding from everybody. Stigma and discrimination especially for under age marriages is associated with high disability are high because women do not to come out of their hiding leading to birth complications and largely home deliveries. Early marriages in both counties was the norm and it was due to the high teenage pregnancy hence being perceived as a solution.

Sometimes men thought their women were unfaithful when they have to go the hospital frequently hence most women wait until later in the pregnancy. Geographical access to facilities was also reported as a challenge in some areas and this deters women attending the regular ANC appointments but rather value mainly the first visit which was attached to an opportunity to get ANC profile done and baby-mother booklet issued. Moreover women reported that they fear the

frequency they have to attend ANC as a result therefore they wait until they feel the fetus is playing in the tummy. They argued that if they went early the doctor won't feel anything. Women would like to lessen the frequency to the facility, but also some are not sure on action to take as they are too young or on FP and therefore delay going to the facility and does not discuss the same with men. Amenorrhea for those on long acting FP make women ignorant of their pregnancy status.

Ignorance was reported for both for men and women particularly not being sure of being pregnant because of not having periods and lack information on FP which led to many women getting pregnant without knowing. For instance, a woman reported to have gotten pregnant of the second one when the first child was only four months but fears of being examined in the uterus deterred her from going for ANC.

Our findings also show that Health service providers often are not available at the dispensary. Staff shortage therefore was a deterrent factor for men's involvement in safe motherhood practices. Most men however were reported to be cowards as they feared they might be tested for HIV hence did not accompany their spouses to ANC.

*TBAs are the main health service providers. Facilities are run by women and men don't bow to women.* (Village elder, male Kilifi)

Beliefs and taboos surrounding placenta disposal that it must be at home and it's a tradition for women to deliver at home contributed to ANC apathy. Most women preferred to wait until they have a complication to visit health facilities.

### **Religion**

For Muslim women, there were perceptions that going for ANC would facilitate women being introduced to family planning use yet it was against their religion. Interestingly however, FP and other services use such as HIV were particularly low in Kilifi County. There were more Muslim women (56%) attending ANC than Christians (35%) and more so in Kwale than in Kilifi and as seen in figure 4.6.1 below, Muslim household appear to more resources to spend in health compared to the Christians. Moreover, religion also impacted greatly on men accompanying their spouses to the ANC and as one FGD participant observed:

*For Muslims pregnancy is a woman's responsibility, men are not supposed to interact with other women, men are not supposed to see half naked women that's why they don't go to the maternity. For Christians men are supportive, considerate and some go to the clinic with their wives.* (Male religious leader, Kwale)

**Table 5: Religion or denomination \* Attendance to Antenatal care-previous pregnancy**

		Attendance to Antenatal care-previous pregnancy		Total	
		Yes	No		
Religion or denomination	Christian	Count	137	10	147
		% within Religion or denomination	93.2%	6.8%	100.0%
		% of Total	35.0%	2.6%	37.6%
Muslim		Count	220	17	237
		% within Religion or denomination	92.8%	7.2%	100.0%
		% of Total	56.3%	4.3%	60.6%
No religion		Count	6	1	7
		% within Religion or denomination	85.7%	14.3%	100.0%
		% of Total	1.5%	.3%	1.8%
Total		Count	363	28	391
		% within Religion or denomination	92.8%	7.2%	100.0%
		% of Total	92.8%	7.2%	100.0%

### Attitude

Men perceive pregnancy is women thing and have their mothers supporting. The role of men was perceived to facilitating their women with transport as part of their involvement in safe motherhood as confirmed by their engagement in looking for money. Pregnancy was considered the responsibility of women and men perceived themselves as mere providers as one community health extension worker noted:

*“Mostly pregnancy is a woman thing and the mothers both in law and mother have the responsibility to support as men look for the finances”* (CHEW, female, Kwale)

The feeling is that men should not walk with their wives as it's a sign that they are under their wives and this contributed to men's 'absence' during the pregnancy processes that were required of them. Generally, pregnancy, delivery and newborn care was seen as merely for the mother. Men queuing with women was reported as unacceptable thus in hospitals its women who are the majority. Men were said to be more involved when the baby start going to the clinic.

### Education

Many men in the village were reported to be illiterate and less informed. They could not read even information from the materials that women took home. Inadequate or lack of education therefore came out as a major hindrance although some community members on the contrary reported education did not have any bearing in male involvement.

*“Low education levels mean men do not understand many things are less exposed to current medical interventions” (Village Elder, Male Kwale)*

### Sociocultural

There was a clear indication that most women had to obtain authority to access health care. This is evident by over 90% of women seeking permission. Experienced mothers in the village were trusted to give advice to the new ones especially when it came to attending ANC. This is confirmed by a higher proportion (14.9%) of women seeking advice to attend ANC from other people compared to mother (6.4%), mother in law (1.8%) and boyfriend (1.0%). Interestingly 79.7% of women interviewed were pregnant because they wanted to have a child and were in recognized marriage relationships indicating men involvement begins with the discussion to have a baby. This is compared to 18.4% of women who accidentally got pregnant and 1.5% who were forced by their husbands to get pregnant. Majority 317 (81%) of the married women who sort permission from their husbands, 79.5% attended antenatal care in previous pregnancy.

**Table 6: Permission for Antenatal clinic attendance verses attendance to Antenatal care in previous pregnancy**

			Attendance to Antenatal care-previous pregnancy		Total
			Yes	No	
Permission for Yes Antenatal clinic attendance	Count	311	6	317	
	% of Total	79.5%	1.5%	81.1%	
No	Count	52	22	74	
	% of Total	13.3%	5.6%	18.9%	
Total	Count	363	28	391	
	% of Total	92.8%	7.2%	100.0%	

Most men 293 (73.8%) were the bread winners of their families and the permission to go to attend antenatal clinic was sort from them. Majority of Husbands 295 (75.9) were the first to be



told about pregnancy especially among the Digo (32.6%) community. The Durumas' had a high interest in where the children were to be delivered while other tribes discussed a lot on the preparation for the baby. The traditions surrounding pregnancy did not feature explicitly in spousal discussion even though it was expected to form a major part. Maternal nutrition however was the least discussed despite its correlation with pregnancy outcome.

There was a great deal of what spouse discussed according to age. For instance those between ages of 15-20 were majorly concerned with preparation for the baby, ages 21-25 were majorly discussing where to attend ANC and preparation for the baby. It was clear from the data that ages 36 – 45 years did not discuss maternal nutrition at all. These discussions were based on what roles to play during the pregnancy until delivery.

*“Men and women play different roles in the family and pregnancy is for women. Alcoholism (Mnazi) takes men's free time. A lot of decisions are based on culture including how many babies. Men wait for babies”* (Respondent in male union in Kilifi)

### **Economic**

Most women considered themselves lower middle income level in Kilifi while their counter parts in Kwale consider themselves middle income level. Generally 39% (156) women perceived themselves as middle income level. There was a clear investment in health as indicated in the amount spent on health during the month. Most families (55%) spent at least Ksh 500 on a monthly basis on health while those on the low middle level income spent at least Ksh. 200 per month. Most husbands were the bread winners of their families and majorly generated their income from farming, wages/salaries and other forms of sources. Its men's responsibility to finance all the Expenditures. Most of the time they are away from home and delegate women to take care of the children. Poverty is a major issue that only allow families to plan resources for food and education and only some resource is left for health.

*“Men are always in the Mnazi dens and also looking for money. Work related responsibilities makes men unavailable to offer support. Men are always out to get money and wait for the child to be born. Men are busy looking for work. Transport only available for women”.* (Women group leader, Kilifi)

**Table 7: Monthly cost of health expenditures**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	0-500	190	47.5	55.2	55.2
	501-1000	58	14.5	16.9	72.1
	1001-3000	66	16.5	19.2	91.3
	3001-6000	21	5.3	6.1	97.4
	6001-9000	5	1.3	1.5	98.8
	9001-12000	3	.8	.9	99.7
	12001-15000	1	.3	.3	100.0
	Total	344	86.0	100.0	
Missing	System	56	14.0		
Total		400	100.0		

**Table 8: Average monthly income of the household**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	0-1000	74	18.5	21.4	21.4
	1001-5000	119	29.8	34.4	55.8
	5001-10000	104	26.0	30.1	85.8
	10001-15000	27	6.8	7.8	93.6
	15001-20000	16	4.0	4.6	98.3
	above 20000	6	1.5	1.7	100.0
	Total	346	86.5	100.0	
Missing	System	54	13.5		
Total		400	100.0		

### Health Services and health seeking behaviors

Health Service Providers educate mothers for clinic revisits, create awareness and need to seek health services. In other instances, Community Health Volunteers' advice on health seeking behaviors through sensitization, education and counseling during home visits. This study found out that infrastructure, attitude of human resource and distance to facility was an issue for men. The timing and a high number of women service providers was a barrier for men to be involved in safe motherhood practices. As one man noted:

*“Most service providers are women and look at men differently. Most facilities have so many women and no space for men. The booklet for baby mother excludes men even in the parenting process. The ANC clinic for example is full of women. Working hours for facilities close do not allow men to be involved”.* (Male participant from men unions, Kwale)

### **Role of Men in safe motherhood**

The respondents had varied opinion as what men’s roles should be in safe motherhood and had the following recommendations: Accompany their spouse, provide finance, provide food, protect their women, and direct their women.

Provide for their family in finance, food and education.

To take care of family - children and health of family and especially post-natal support for the mother and provide care, love and company

Educate and understand the FP and Make faster decisions especially regarding family planning

Supporting prenatal health and make their women feel safe and advice the teenage daughters

Following up on the immunization of the child

Men are the family support system to be with their women and treat children equally.

## **5.0 SUMMARY, CONCLUSIONS AND RECOMMENDATIONS**

### **5.1 Summary of Findings**

Men and women interviewed in the two rural counties believed safe motherhood practices especially in pregnancy and childbirth are a preserve of women. Illiteracy, sociocultural factors, weak health systems and economic factors were found to be the major barriers to male involvement. Traditional gender roles defined the involvement of men mostly perceived to be provision of funds for transport and food. Women believed in seeking permission and discussing components of safe motherhood more so birth preparedness, ANC attendance and delivery. Maternal nutrition though key was not prioritized. This study also reveals that cultural practices have to a large extent presented insurmountable bottlenecks for change yet in reality culture is fluid and allows for gradual change.

### **5.2 Conclusion**

The study shows that there numerous roles of men in safe motherhood and that it was also important to involve men. Negative attitudes, low level of education, economic factors- poverty, negative cultural practices, and unfriendly health systems (unavailable health workers, women only health workers, and lack of space) have affected the involvement of male partners in promoting safe motherhood. There are strong male cultural perception related to safe motherhood especially that pregnancy is a “woman’s affair” and a naturally prescribed stage that

a woman has to go through and does not warrant them being involved. Income was perhaps the most challenging for men as poverty levels were high and the cost of transport was only enough for the pregnant mother. Men were generally illiterate and poor as their households were rated as low income level. Farming and peace work were the major livelihood activities and generated less enough for health investment.

Women were more knowledgeable of safe motherhood matters and initiated discussions with their husbands. Maternal nutrition was however passively discussed yet a very important issue and warrants further investigation. Additionally the study reveals which women do not attend ANC. Men had more roles to play in safe motherhood than understood by many. Overall taking care of family needs was crucial in addition to being the head of household. There are numerous benefits to accompanying spouses to the health facilities if the gender norms were to be demystified. This study confirms the need for education, economic empowerment and male targeted interventions supported by policies in counties and Kenya at large.

### **5.3 Recommendations**

This study recommended a defined program that target male involvement strategy. It will involve male champions/men ambassador/agents being supported to go to the *Mnazi* dens and educate, sensitize and support dialogues with men aged 35 years and below. A targeted alcohol abuse sensitization and education will go a long way. A friendly health system be put in place to accommodate men. Friendlier timing including weekends and late hours, space at the clinics to accommodate men and responsive health workers. Use CHVs to educate men on complications related to pregnancy and child birth could be crucial in promoting male involvement. To influence cultural facades, Use Kaya elders to mobilize and provide leadership in health will free men of negative attitudes. Recognize men and prioritize services and youth friendly services to support men. Support Men to understand the importance of their role and protecting girl child and teenage pregnancy. Review of baby mother booklet to reflect both parents and entrench responsibility. As poverty is an issue initiate Income generating activities both for men and women. Develop a work place program to net as many men as possible. Advocacy for policies to prioritize male involvement as a key component of safe motherhood is crucial. A future study on maternal nutrition and birth complications is worth exploring and why women do not attend ANC should be explored in future research.

### **Declarations**

#### **Ethics approval and consent to participate**

Ethical approval was sort by the researcher and provided by Pwani University Ethics Review Committee (REFERENCE NO: ERC/MSc/040/2014) (Annex 5) and additional formal permissions obtained from the office of the Chief Officer of health Kwale county Ref no: CG/KWL/6/5/1//COH/44/12 (Annex 3) and Director of Health Kilifi County. Further, the researcher obtained authorization and ethical approval from the study supervisor and the local

Research Ethics Coordinator of the academic unit at the university. To gain access to the participants and study approval, both local and national permission were sought formally and received from the County and Sub County Health Management Team. Further, the Community Strategy technical support staff from DSW project working in the county were contacted to link the researcher with the target participants as they closely work with them.

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